WASHINGTON STATE PLANNING GRANT
ON
ACCESS TO HEALTH INSURANCE

REPORT to the SECRETARY

Submitted to:

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Health Resources and Services Administration

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Making Health Care Work for Everyone

Washington State Planning Grant on Access to Health Insurance

2005 Report to the Secretary

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EXECUTIVE SUMMARY

Background

This Report to the Secretary focuses on activities during Washington's fourth year as a State Planning Grant (SPG) program participant (September 2004 – August 2005).[1] Consistent with federal guidelines, Washington focused its '04-'05 work on planning activities (data and policy) relevant to the federal SPG goals of covering the uninsured and to the coverage goals of Healthy People and Rural Healthy People 2010 (see Box ES-1).

In this Executive Summary, we briefly review last year's political and economic context relevant to our grant work, comment on the status of coverage in Washington, summarize the alignment between our '04-'05 goals and activities, and reflect on lessons/recommendations to other states and the federal government.[2]

Box ES-1 Federal Program Coverage Goals

Federal SPG Program Expectations:
- Initiate research on the uninsured (e.g., profiles, consequences, disparities, gaps).
- Engage in planning activities to identify strategies (realistic to state) for providing access to insurance for the state's uninsured.

Healthy People and Rural Healthy People 2010:
- Increase the proportion of persons with health insurance (objective 1-1).
- Increase the proportion of insured persons with coverage for clinical preventive services (objective 1-2).

Washington Context

The **political environment** shifted in 2004-2005 with the election of Governor Christine Gregoire who made improving health, health care, and health coverage priority items. Her focus, from day one, on these issues has inspired renewed energy. There was significant collaboration between the Governor and legislative leadership on a variety of health care issues during the 2005 legislative session. Some *examples directly related to sustaining or expanding access to coverage* include (1) reinstating state-funded coverage for undocumented immigrant children and funding children's Medicaid at a level that reinstated 12-month continuous eligibility (from 6-month, non-continuous) and precluded implementation of children's premiums[3], (2) allocating additional funding to the Kids Get Care program which provides integrated preventive medical, oral, and developmental health services to young children and serves as a gateway to get eligible children enrolled in coverage, and (3) ensuring that the Basic Health program[4] would be funded to keep pace with medical inflation so that enrollment could be maintained at 100,000 without

[1] The U.S. Department of Health & Human Services, Health Resources and Services Administration (HRSA), funds the State Planning Grant program. Grants are awarded on an annual basis through a competitive solicitation process. Washington received its first grant in March 2001 (through August 2002) and subsequently received three continuation awards for planning activities (September 02-August 03; September 03-August 04; September 04-August 05). As a result of the work from these previous planning grants, Washington has been awarded a demonstration (pilot) grant from the SPG program for 2005-2006. The primary focus of the demonstration grant is the development of a small business assistance program.

[2] Throughout the 2005 Report we try to focus on things that may be most helpful to other states.

[3] These actions alone mean that some 36,000-37,000 children are receiving coverage that otherwise would not.

[4] Basic Health is a state-only funded coverage program for low-income (at and below 200% federal poverty) individuals, many of whom are members of working families. Premiums are subsidized based on income.

increasing cost-sharing or reducing benefits.[5] [6] Although a bill did not pass, the Governor pushed the need to provide assistance to small businesses and their employees/families vis-à-vis affordable coverage. There was significant agreement among legislative leadership on the need; the "how" and the role of government were constructively debated. As a result, the Governor spearheaded a proactive, and successful search for grant money to help develop a small business assist program with a targeted implementation date of January 2007.[7]

The **financial / economic context** continues to be a challenge, especially as it impacts the state budget. While state revenue growth is predicted to stay around 5%, state health care costs are rising at about 10% annually and thus consuming an ever-larger part of the state budget (at a time when other infrastructure needs such as education, transportation, and public safety are equally high). In the midst of its economic recovery (which has lagged somewhat behind the nation as a whole), a minor setback is the recent strike by Boeing machinists (representing one of the strongest unions in the country)[8]. A gas tax increase was passed by the 2005 legislature to help address some of the state's transportation problems; an initiative on the fall ballot seeks to overturn the increase.[9] The relevance for health coverage is clear – if additional money for transportation must be found in the existing state budget there will be less left in the pie to address health, health care, and health coverage.

Status of Coverage in Washington

We have found that it's easy for people to lose the story of the uninsured within the plethora of numbers (arising from different questions, data sources, analysis approaches, and presentation styles). So, sans the numbers, the story for Washington is:

- *Compared to other states, we're pretty average.*
  Washington is generally in the middle of the pack (maybe a bit better) – we are neither as good as the best nor as bad as the worst. We cannot stand up and cheer, neither should we hang our heads.
- *Compared to ourselves, things are getting worse.*
  Numbers and rates of uninsured are increasing.[10] The uptick in rates tells us that the issue is systemic and goes beyond population growth, i.e., something is terribly wrong with our approach to coverage. Returning to "our better selves" (the time of our lowest rates of uninsurance) is a good place to start.
- *We know all we need to know about the uninsured.*[11]

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[5] Without this action, approximately 17,000 adults would have lost coverage.

[6] Other actions taken that are less directly related to coverage but nonetheless serve the uninsured include: (1) continued funding for community clinics, (2) initiating the state-sponsored prescription drug consortium in order to reduce drug costs for anyone who chooses to participate, and (3) creating a non-profit foundation to provide more effective and efficient access to prescription drug programs for uninsured and underinsured individuals.

[7] In addition to the HRSA demonstration grant mentioned in note (1), Washington also received a complementary grant from the Robert Wood Johnson Foundation, State Coverage Initiatives Program, to develop the small business assist program.

[8] Thankfully this began and ended in September, the shortest strike in Boeing's history. Pension benefits and wages increased while employee health insurance contributions held steady. Puget Sound Business Journal / NPR September 30, 2005.

[9] As a side note, also on the November ballot in Washington are two measures related to medical malpractice, one of which caps non-economic damages at $350,000.

[10] Uninsured rates for the total population based on point estimates for 2000, 2002, and 2004 are 7.7%, 8.4%, and 9.8%, respectively. The trend is clear - the difference between 2000 and 2004 is significant at the 5% level.

[11] This is a picture for the pool of uninsured as a whole. Clearly it changes somewhat depending on different slices, for example children compared to adults.

The overall picture is relatively consistent over time -- the uninsured population is fairly fluid with a core of long-term members but also with substantial numbers of people who move in and out of coverage. These people are generally lower income, part of working families, and often employed in service, agricultural, retail and construction fields. They are the people who build our homes; harvest our food; wait on us at the local store, hotel or restaurant; clean our workplaces; and take care of our aging parents and youngest children.

- *Affordability IS the issue – we have infrastructure in place that could help.* Almost two-thirds of uninsured adults and 70% of uninsured children have incomes low enough that they likely would be eligible for Washington public programs, if funding were available to match the need. Purchasing on the private market for many of these people is a false option given their incomes compared to what it takes to be self-sufficient (i.e., having the financial ability to purchase the basics of living including private insurance coverage).

2004-05 Goals and Activities

With fewer resources than in previous grant cycles[12] and faced with an uncertain political future (e.g., a yet-to-be-elected Governor taking office in January 2005[13]), the primary goal of the SPG team for 2004-2005 was both simple and complex – ensure that issues around lack of insurance coverage for some 600,000 Washington residents remained visible. We chose research and policy work consistent with that goal and consistent with our on-going guiding principles (see Appendix 1 of the full Report). Although it is difficult to directly tie SPG efforts to coverage maintenance and expansion outcomes, we believe SPG-supported activities have had a strong and positive influence. In Box ES-2 we summarize our '04-'05 funding proposal goals and our '04-'05 activities – we leave it to the reader to judge the tightness of their alignment (which we believe is clearly evident).

"Cover all children by 2010 " and "Small business assist program" are the primary coverage expansion options moving forward with executive and legislative branch leadership. These and other initiatives shown in Box ES-2 are discussed in more detail in the body of the Report. In addition, Appendices 2 and 3 (of the full Report) round out the picture of legislative and statewide activities concerning coverage and access.

[12] In the 2004-05 funding cycle, SPG funding supported slightly over 1.5 full-time equivalents; compared to more than twice that in the first funding cycle.

[13] The Republican and Democratic candidates for Governor had very different ideas regarding coverage issues, particularly with respect to the role of government.

Box ES-2: Goals and Activities for 2004-05, Access to Health Insurance Project, Washington State Planning Grant Program

'04-'05 SPG Proposal Goals	'04-'05 SPG Activities
Primary Goal: Maintain supportive and active work environment in Governor's Office for addressing the wide range of data and policy issues related to understanding Washington's uninsured and providing affordable coverage with adequate benefits **Objectives**: ▪ *Ensure the visibility* of coverage issues statewide ▪ *Maintain expertise in executive branch for discussions on who the uninsured are, strategies for addressing coverage, lessons from others' efforts* ▪ *Provide neutral, 3rd party input into state & community coverage efforts* ▪ *Influence thinking & decision making vis-à-vis coverage for all Washington residents*	**Coverage Maintenance** ▪ Evaluation of Basic Health benefit design changes ▪ Evaluation of Children's Medical caseload decline **Coverage Expansion – Governor/Legislature** ▪ Cover all children by 2010 ▪ Small business assist program **Coverage Expansion - Other** ▪ Coverage for artists (& those with similar work patterns) (Washington Artists Health Insurance Project) ▪ Community-based, universal coverage for low-income (Community Health Works) ▪ Coverage for employees of large businesses (Health Care Responsibility Act) ▪ Small group market improvements – moving beyond reinsurance (Insurance Commissioner) ▪ Medical homes as entrée to coverage (Kids Get Care Model) **General Data & Policy Analysis Support** ▪ Resolution of data issues important to understanding the scope of Washington's coverage challenges ▪ Turning data into information – evolution of helpful data sources ▪ Technical assistance & clearinghouse for coverage related issues (a growing & unexpectedly demanding part of our time)

Lessons/Recommendations for Other States and Federal Government

We have woven comments we believe will be helpful to other states throughout this Report, in the relevant discussion areas. For example, the evolutionary nature of policy and research discussions is noted in Section 4, and many sample products we have found helpful translating data for policy discussions are included as attachments.

Recommendations included in our past reports remain largely relevant today. Those of particular interest included in this Report are:

- Federal encouragement and support for States already "doing the right thing". For example, maintain the use of SCHIP dollars to support children that were served via Medicaid expansions prior to SCHIP (e.g., children below 150 percent of federal poverty.

- Federal support for development of data resources including standardized small area estimates and refined periodic and longitudinal state-specific data collection (both population-based and employer-based) – that allow analyses at relevant sub-state levels.

- Federal support for policy and planning efforts – during the continued fiscal challenges facing states there is precious little money to meet priority needs for services, with little (if any) left over for future planning efforts.

Report Preview

The remainder of this Report to the Secretary is organized as requested by HRSA. In Sections 1-3 we discuss baseline information relevant to individuals and families in Washington, our employer-based coverage, and Washington's health care market, respectively. Discussions regarding our approach to studying the uninsured, how those findings informed coverage option discussions, and consensus-building activities are included in Section 4.[14] Finally, in Sections 6 and 7, respectively, we present lessons learned that may have relevance to other states and recommendations to the federal government.

[14] We did not include a separate Section 5 (Consensus Building Strategies) in the 2005 Report. Appendix 4 of the full Report (included in previous Reports to the Secretary) describes the general consensus-building approach we have taken throughout the project (since March 2001). 2004-05 consensus activities related to specific coverage options are addressed in Section 4 of this Report as those options are discussed.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

In Section 1 we update our baseline information on the insurance status of individuals and families. To avoid duplication in other sections of the report our approach to studying the uninsured, providing information, and resolving data issues, is described later in Section 4 where it links directly to options and progress in expanding coverage.

Status of Coverage in Washington

It's become clear to us that all too often the story of who's uninsured gets lost in the plethora of numbers. Therefore, although we do include the data requested by HRSA (in Attachment 1-1) we've chosen to focus our description of Washington's uninsured on the story behind the numbers. From whatever perspective we look, nationally, statewide, or locally, coverage in Washington follows several persistent themes.

A. Compared to other states we're pretty average.
B. Compared to ourselves, things are getting worse.
C. We know what we need to know about the uninsured.
D. Affordability IS the issue – we have infrastructure in place that could help.

A. Compared to other states we're pretty average.

Compared with the rest of the nation Washington is about average with respect to rates of coverage. Based on the 2004 Current Population Survey[1] there are 29 states now doing better than Washington, although we're doing better than the United States as a whole[2]. The story for children is a little more promising, only 18 states are doing better than Washington[3]. However, for uninsured children we rank in the bottom third states with respect to their likelihood of receiving any medical care, slightly better than average on their likelihood of receiving all needed medical care and slightly worse than average on their likelihood of having a medical home. The link between coverage and care has become of increasing interest, particularly with respect to children.

Although we should not view Washington's coverage status as terrible, the implications are troubling. The latest edition of *America's Health: State Health Rankings* indicates that the health of Washington residents is declining relative to other states. In 1998 Washington was ranked the 7th healthiest state in the nation (i.e., 6 other states were considered healthier than Washington). Between 2003 and 2004, Washington's rank slipped from 11th to 15th, the 2nd greatest health decline in health status of all states. While access to health insurance does not ensure access to health care it does pave the way (as a financing vehicle) for the chain of access, appropriate use, and improved outcomes, to more readily occur.

In the end we find that comparisons to other states can obfuscate the story. Among the G7 countries (Canada, the United States, Germany, Japan, France, Italy, and the United Kingdom), 2004 rankings of health status place the United States dead last[4]. To say that Washington is pretty average in that context is not the standard we should want to be held to; we know we can and need to do better.

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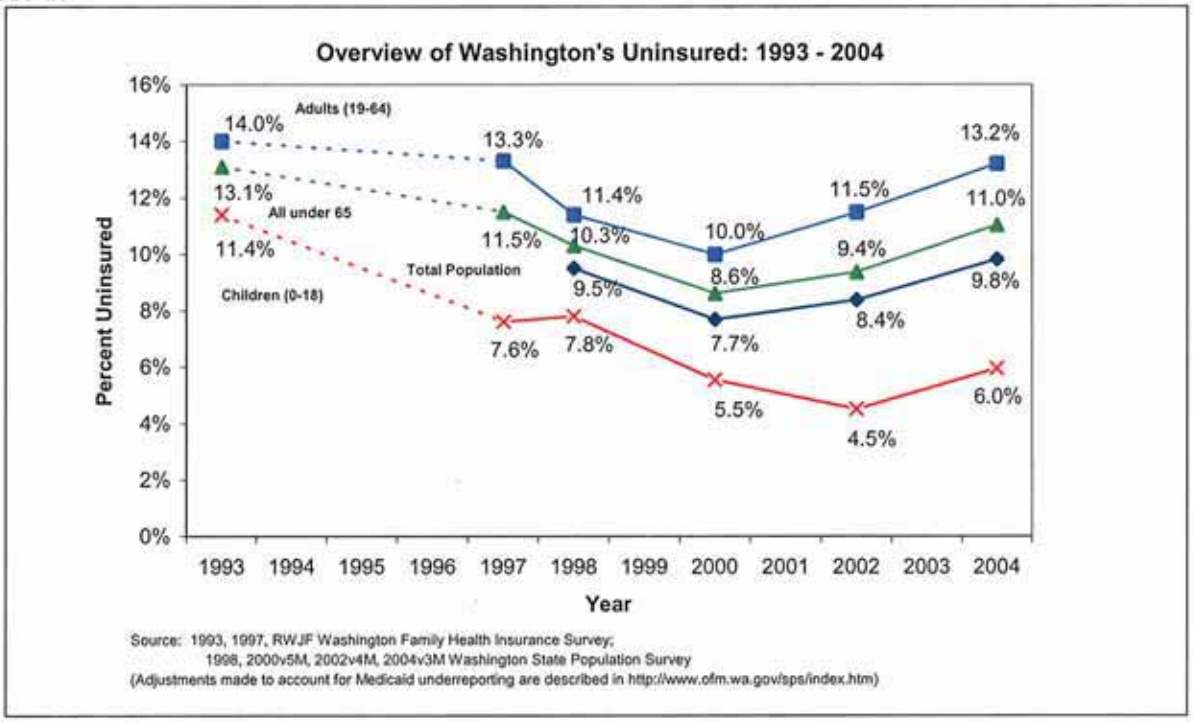
[1] DeNavas et al. 2005. Income, Poverty, and Health Insurance Coverage in the United States: 2004. US Census Bureau. Figure D-3 - three-year-averages for 2002-2004 based on the 2003 –2005 Annual Social and Economic Supplements.
[2] Rates for the nation are driven by a few very large states, Texas, California and New York, all of which have higher uninsurance rates than Washington.
[3] SHADAC August 2005. Going Without: America's Uninsured Children.
[4] World factbook - http://www.odci.gov/cia/publications/factbook/

B. Compared to ourselves, things are getting worse

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working families (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.

Figure 1.



As shown in Figure 1, more recently Washington has been losing ground. The uninsured rate for the total population increased from 8.4% in 2002 to 9.8% in 2004[5] (i.e., from about 506,000 to almost 606,000 individuals). The vast majority of the population age 65 and older (over 99%) has coverage through Medicare, albeit inadequate for those who need multiple prescription drugs. However, the under-age-65 population is not so fortunate in having access to such a (nearly) universal coverage program.

The number of uninsured under-age-65 continued to rise in 2004 – Washington now has nearly 603,000 uninsured under-age-65, about 16% of whom are children, compared to nearly 503,000 in 2002. This isn't just a function of population growth. We know it's a systemic issue as well because the rate of uninsurance also continued to rise, from 9.4% in 2002 to 11.0% in 2004. Neither adults nor children escaped – the uninsured rate for adults ages 19-64 rose from 11.5% in 2002 to 13.2% in 2004 while the uninsured rate for children ages 0-18 rose from 4.5% in 2002 to 6.0% in 2004. Effectively this change returns Washington to coverage levels of the mid 1990's. The trend is clear – the decline in coverage between 2000 and 2004 is significant at the 5% level.

[5] Uninsurance rates are based on information collected by Washington State's biennial household survey. They include adjustments that account for Medicaid underreporting common in population surveys and therefore differ from rates derived from national surveys that do not include the adjustment.

On the surface this might not seem so bad when we consider that if 1993 rates of coverage had continued into 2004 we'd have 113,000 *more* uninsured individuals in the state today. However, our lowest rates of uninsurance in 2000 show that we could be doing much better than we are. If 2000 rates of coverage had continued into 2004, we would have at least 132,000 *fewer* individuals uninsured than today.

C. We know what we need to know about the uninsured.

Although numbers and rates of uninsurance have varied over time, and vary across data sources and analysis approaches, the profile of Washington's uninsured remains quite consistent and mirrors the story conveyed by national surveys for most states and the nation. This group is fairly fluid with a core of long-term members but also with substantial numbers of people who move in and out of coverage. These people are generally lower income, part of working families, and often employed in service, agricultural, retail and construction fields. They are the people who build our homes; harvest our food; wait on us at the local store, hotel or restaurant; clean our workplaces; and take care of our aging parents and youngest children.

The characteristics of Washington's insured and uninsured residents requested by HRSA are detailed in Attachment 1-1, a spreadsheet of numbers and rates for 2000-2004 based on Washington's State Population Surveys (WSPS). The uninsured are found in all income groups, among all racial/ethnic groups, among the young and old, and in all areas of the state. Yet several characteristics are important for designing policy solutions.

- Over 70% are **members of working families**, however, within this group there is substantial diversity in the workplace connection. Many are members of self-employed families whose options for coverage are limited and often expensive, and many don't have access to employer-based coverage (described in Section 2).
- Almost 62% are **members of low-income families** who earn less than 200% of federal poverty, $37,700 for a family of four in 2004[6].
- Close to 40% are both **low-income and members of working families**.
- While very poor families (up to 100% of federal poverty) and near-poor families (100-200% of federal poverty) continue to be most likely to be uninsured, **lower-middle class families** (200-300% of federal poverty) **face a growing problem**. The rate of uninsurance for this latter group increased about 50% between 2000 and 2004 (from 9.5% in 2000 to 14.3% in 2004). This is not surprising given the weakened economy of recent years during which the ranks of the poor and near poor grew much faster than any other group – nearly 1/3 of Washington's population under age 65 lives in poor or near poor families.
- Close to 44% are **young adults ages 19-34**, who are more likely to be uninsured than other age groups (almost 20% are uninsured), however, when young adults are offered and eligible for their employer's health insurance program they typically do sign up. Although this group has grown most in sheer numbers, **middle-age adults** (ages 35-64) **confront the fastest growing problem**; their rate of uninsurance increased about 44% between 2000 and 2004 (from almost 6.8% in 2000 to just over 9.7% in 2004). **Children ages 0-18** make up about 16% of the uninsured.

[6] Washington's minimum wage in 2004 was $7.16, which means a family of 4 with two wage earners, each earning minimum wage, would have earned almost $30,000 in 2004, a little over 160% of federal poverty. The state's estimated median household income for 2004 was $51,762. Although Washington's minimum wage level is relatively high compared with other states, families whose total income is based on minimum wages are virtually guaranteed to need public assistance to obtain coverage when employer-based coverage is not an option for them.

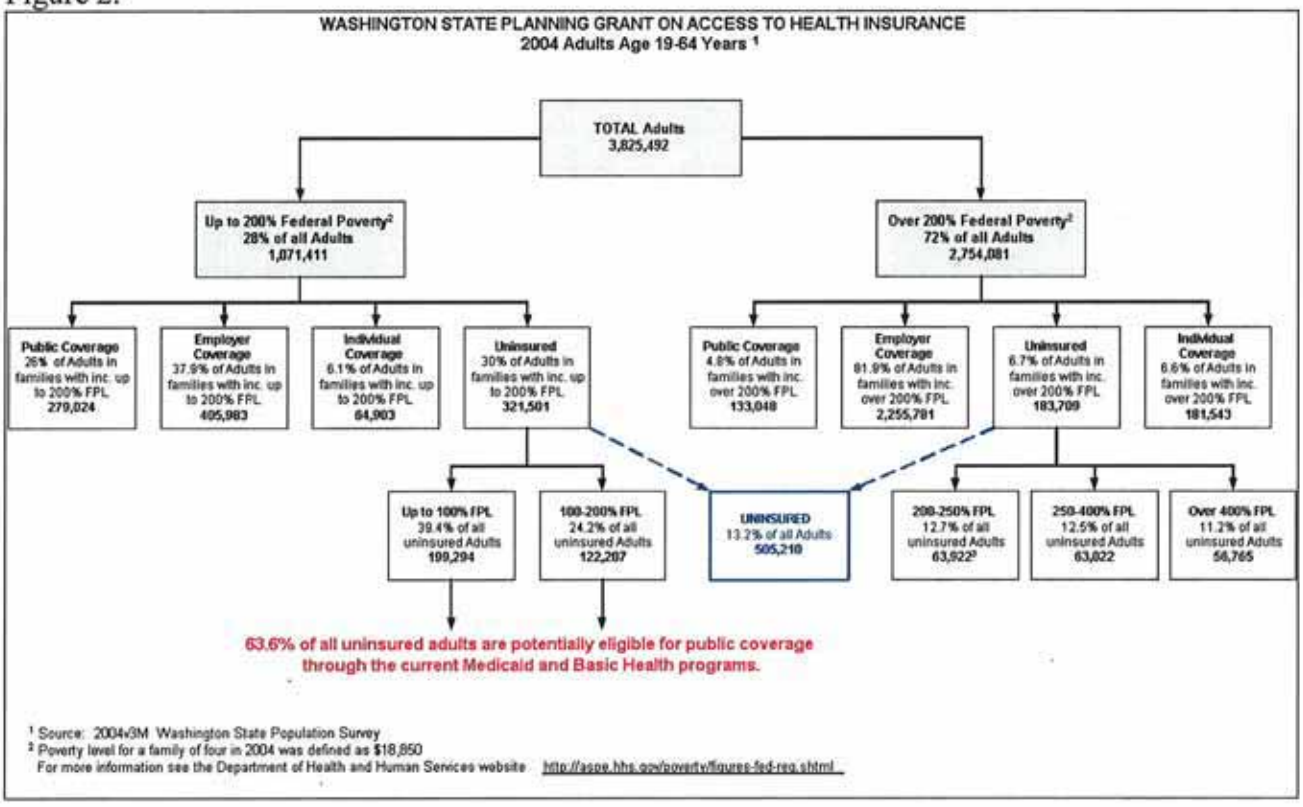
- Although most of the uninsured are white, **minority or ethnic groups remain more likely to be uninsured** (e.g., about 18% of Hispanics and 17% of American Indian/Alaskan Natives are uninsured whereas only about 10% of whites are uninsured).

D. Affordability IS the issue – we have infrastructure in place that could help

WSPS captures a variety of reasons for families not having coverage; chief among them is that many families simply can't afford what's available. While some don't know they have options and a few choose to go uncovered, overwhelmingly surveys from all sources report affordability as the reason given for not having coverage. Research conducted during the initial phase of our grant shows that in Washington, many families can't afford to buy private coverage unless their incomes are above 250% of federal poverty (see http://www.ofm.wa.gov/accesshealth/research/33affordability.pdf.) For these families, purchasing coverage on the private market is clearly a false option given their incomes compared to what it takes to be self-sufficient. Regardless, many policy-makers continue to ask, "How much are people willing to pay for coverage?" For most of the uninsured this really boils down to a question of what basic living expense - food, housing, transportation, clothing, child care – they're willing to "trade-off" to purchase or contribute towards coverage. In these circumstances going bare looks like the only practical choice.

Affordability is clearly an issue for the state as well as families. For most of the uninsured we have infrastructure already in place that could provide coverage. Yet, as Figure 2 shows, almost two-thirds of uninsured adults have family incomes low enough that they likely would be eligible for Washington public programs[7] if funding were available to meet the need.

Figure 2.



[7] Basic Health is a state-only funded program for low-income individuals (up to 200% of federal poverty). Funding limitations have kept its enrolment around 100,000 for the past few years.

The story for children is even more pronounced. As shown in Attachment 4-4 (in Section 4) almost 70% of all uninsured children have family incomes low enough that they likely would be eligible for Washington public programs[8] if funding were available to meet the need. This belies the clear priority Washington has historically placed on ensuring that children have access to health insurance. Attachments 1-2 and 4-5 make it clear that public programs have done a good job of meeting coverage needs for our most vulnerable children. (As might be expected, the pattern of public coverage is greatest in the most rural areas of the state, as shown in attachment 1-3). Over 60% of all children under 250% of poverty have public coverage; including more than 80% of children in poverty. However, we appear to be falling short for children between 200 and 250% of federal poverty. These children are technically likely eligible for coverage through the SCHIP program, so it's somewhat surprising to see that they are considerably *more* likely to be uninsured than all children.

To close the gap in coverage for children, ensuring that public programs cover all potentially eligible children would leave less than 2% of all children uninsured. This information has been most useful in getting to the "short list" of coverage strategies for children described in Section 4 of this report.

Attachment 1-4 makes it clear that adults face a different situation; about 30% of adults in families whose incomes make them likely eligible for public programs (i.e., Basic Health) are uninsured. But, as shown in attachment 1-5, the situation is worst for the most vulnerable - well over 1/3 of adults *in poverty* are uninsured. Setting aside the financial implications for the state in funding public programs to close this gap, ensuring that public programs cover all potentially eligible adults would leave less than 5% of all adults uninsured.

You might ask why many uninsured families appear to be eligible for public coverage and yet choose not to receive benefits that seem in their financial best interests. Research by the Washington State Office of Financial Management[9] shows that many of these families in fact believe they "make too much money to be eligible". Other studies have shown that administrative barriers, misconceptions over eligibility requirements, and language barriers play a role in keeping otherwise eligible families from public coverage. These are also factors that inform discussions on outreach strategies for covering Washington's uninsured.

The bottom line of all this is that we have the infrastructure in place to make a big dent in the uninsured – if all under age 65 likely eligible for public coverage were enrolled, the uninsured rate for this population would drop from 11% to just under 4%. The issue boils down to money, as it does in all states.

[8] For children, public options include a variety of Medicaid programs, SCHIP and Basic Health, i.e., children with family incomes up to 250% of federal poverty.

[9] Zeidenberg, D. 2005. *Going it Alone. Why Eligible Families Choose Not to Receive Public Benefits.* WorkFirst Performance Team, Washington State Office of Financial Management, January 2,2005.

Attachment 1-1

Washingtonians With or Without Health Insurance Coverage by Selected Characteristics: 2000 - 2004

CHARACTERISTIC	2004 Distribution of Uninsured	2004 Percent Uninsured	2004 Uninsured	2004 Insured	2004 TOTAL	2002 Distribution of Uninsured	2002 Percent Uninsured	2002 Uninsured	2002 Insured	2002 TOTAL	2000 Distribution of Uninsured	2000 Percent Uninsured	2000 Uninsured	2000 Insured	2000 TOTAL
Total Population		9.8%	605,790	5,563,056	6,168,846		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%	11.0%	602,729	4,861,260	5,463,989	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	43.8%	19.6%	263,776	1,079,010	1,342,786	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	31.9%	10.4%	192,150	1,656,451	1,848,601	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	8.2%	7.8%	49,284	584,821	634,105	6.3%	5.8%	31,546	513,743	545,289	5.5%	5.2%	24,682	446,435	471,117
19 to 64 years	83.8%	13.2%	505,210	3,320,282	3,825,492	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	16.2%	6.0%	97,519	1,540,978	1,638,497	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	100.0%	6.0%	97,519	1,540,978	1,638,497	100.0%	4.5%	73,325	1,556,056	1,629,381	100.0%	5.5%	89,480	1,525,652	1,615,132
Under 6 years	26.2%	5.3%	25,522	452,378	477,900	21.9%	3.3%	16,060	465,614	481,674	25.2%	4.5%	22,530	479,263	501,793
6 to 12 years	36.7%	5.8%	35,777	582,284	618,061	44.0%	5.1%	32,230	596,479	628,709	37.6%	5.8%	33,668	550,686	584,354
13 to 18 years	37.1%	6.7%	36,220	506,316	542,536	34.1%	4.8%	25,035	493,963	518,998	37.2%	6.3%	33,282	495,703	528,985
6 to 18 years	73.8%	6.2%	71,997	1,088,600	1,160,597	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	62.9%	5.6%	61,299	1,034,662	1,095,961	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% of FPL	36.3%	24.2%	218,806	685,422	904,228	29.3%	19.6%	147,164	603,220	750,384	32.0%	19.2%	144,052	607,589	751,641
100-200% of FPL	25.6%	18.8%	154,087	666,285	820,372	28.8%	18.0%	144,540	659,466	804,006	29.2%	17.1%	131,732	637,838	769,570
200-300% of FPL	19.5%	14.3%	117,590	703,018	820,608	18.6%	12.8%	93,654	639,240	732,894	15.9%	9.5%	71,852	680,800	752,652
300-400% of FPL	7.2%	6.1%	43,500	667,109	710,609	8.6%	5.9%	43,009	691,052	734,061	10.6%	6.5%	47,994	689,859	737,853
400-500% of FPL	5.3%	5.7%	32,202	534,661	566,863	5.9%	5.0%	29,447	553,809	583,256	3.8%	2.6%	17,057	646,014	663,071
Over 400% FPL	11.4%	3.1%	68,746	2,139,756	2,208,502	14.8%	3.2%	74,323	2,274,500	2,348,823	12.2%	2.5%	55,064	2,167,032	2,222,096
Over 500% FPL	6.1%	2.2%	36,544	1,605,095	1,641,639	8.9%	2.5%	44,876	1,720,691	1,765,567	8.4%	2.4%	38,007	1,521,018	1,559,025
Up to 200% of FPL	61.9%	21.6%	372,893	1,351,707	1,724,600	58.0%	18.8%	291,704	1,262,686	1,554,390	61.2%	18.1%	275,784	1,245,427	1,521,211
Over 200% of FPL	38.1%	6.1%	229,836	3,509,883	3,739,719	42.0%	5.5%	210,986	3,604,792	3,815,778	38.8%	4.7%	174,910	3,537,691	3,712,601
FAMILY INCOME (Children under 19 years)															
Up to 200% of FPL	52.7%	7.9%	51,392	601,797	653,189	54.8%	6.2%	40,187	607,232	647,419	59.3%	9.1%	53,087	531,347	584,434

CHARACTERISTIC	2004 Distribution of Uninsured	2004 Percent Uninsured	2004 Uninsured	2004 Insured	2004 TOTAL	2002 Distribution of Uninsured	2002 Percent Uninsured	2002 Uninsured	2002 Insured	2002 TOTAL	2000 Distribution of Uninsured	2000 Percent Uninsured	2000 Uninsured	2000 Insured	2000 TOTAL
Over 200% of FPL	47.3%	4.7%	46,127	939,181	985,308	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	17.2%	11.5%	16,736	128,408	145,144	13.0%	7.8%	9,501	113,069	122,570	10.4%	6.9%	9,343	127,028	136,371
Up to 250% of FPL	69.9%	8.5%	68,128	730,205	798,333	67.8%	6.5%	49,688	720,301	769,989	69.8%	8.7%	62,430	658,375	720,805
Over 250% of FPL	30.1%	3.5%	29,391	810,773	840,164	32.2%	2.8%	23,637	835,755	859,392	30.2%	3.0%	27,050	867,277	894,327
FAMILY INCOME (Adults 19 to 64 years)															
Up to 250% of FPL	76.3%	28.1%	385,423	984,827	1,370,250	68.2%	25.5%	292,938	855,686	1,148,624	70.4%	21.8%	254,133	912,757	1,166,890
Over 250% of FPL	23.7%	4.9%	119,787	2,335,455	2,455,242	31.8%	5.3%	136,427	2,455,736	2,592,163	29.6%	4.4%	107,081	2,344,709	2,451,790
FAMILY COMPOSITION															
Children	16.2%	6.0%	97,519	1,540,978	1,638,497	14.6%	4.5%	73,325	1,556,056	1,629,381	19.9%	5.5%	89,480	1,525,652	1,615,132
Adults with Children	39.0%	12.8%	235,156	1,599,402	1,834,558	35.6%	10.2%	178,959	1,567,356	1,746,315	38.0%	9.8%	171,394	1,578,018	1,749,412
Childless Adults	44.8%	13.6%	270,054	1,720,880	1,990,934	49.8%	12.6%	250,406	1,744,066	1,994,472	42.1%	10.2%	189,820	1,679,448	1,869,268
EMPLOYMENT STATUS															
No Workers in Family	28.6%	19.9%	172,679	693,042	865,721	30.7%	16.3%	154,341	794,390	948,731	24.3%	16.5%	109,505	555,677	665,182
1 Worker in Family	52.2%	13.0%	314,372	2,101,897	2,416,269	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	19.2%	5.3%	115,678	2,066,321	2,181,999	18.8%	5.0%	94,448	1,784,473	1,878,921	16.4%	3.4%	73,943	2,093,322	2,167,265
RACE/ETHNICITY [1]															
White, Non-Hispanic	71.3%	10.0%	429,763	3,853,294	4,283,057										
Black, Non-Hispanic	3.5%	9.9%	20,814	189,006	209,820										
Hispanic	15.0%	17.8%	90,577	418,725	509,302										
Am. Indian/ Al. Native	2.7%	16.5%	16,028	81,345	97,374										
Native Hawaiian	2.4%	16.8%	14,714	72,772	87,486										
Asian	5.1%	11.1%	30,833	246,118	276,950										
CITIZENSHIP (Up to 64 years)															
Citizen	93.2%	10.7%	561,855	4,712,482	5,274,337	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	6.4%	21.7%	38,738	139,681	178,419	5.6%	15.4%	27,927	153,864	181,791	12.4%	26.2%	55,742	157,017	212,759
Unknown	0.4%	19.0%	2,136	9,097	11,233	0.5%	17.7%	2,362	11,020	13,382	0.1%	3.6%	452	12,239	12,691
CITIZENSHIP (Children under 19 years)															
Up to 250% FPL	69.9%	8.5%	68,128	730,205	798,333										
Citizen	67.2%	8.4%	65,513	711,881	777,394										
Non-Citizen + Unknown[2]	2.7%	12.5%	2,615	18,324	20,939										
Over 250% FPL	30.1%	3.5%	29,391	810,773	840,164										
Citizen	30.0%	3.5%	29,207	802,529	831,736										

CHARACTERISTIC	2004 Distribution of Uninsured	2004 Percent Uninsured	2004 Uninsured	2004 Insured	2004 TOTAL	2002 Distribution of Uninsured	2002 Percent Uninsured	2002 Uninsured	2002 Insured	2002 TOTAL	2000 Distribution of Uninsured	2000 Percent Uninsured	2000 Uninsured	2000 Insured	2000 TOTAL
Non-Citizen + Unknown	0.2%	2.2%	184	8,244	8,428										
GENDER															
Male	58.4%	12.7%	352,032	2,419,891	2,771,923	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%	9.3%	250,697	2,441,369	2,692,066	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	58.1%	6.7%	56,649	787,074	843,723	56.5%	4.9%	41,396	797,029	838,425	52.1%	5.6%	46,642	785,732	832,374
Female	41.9%	5.1%	40,870	753,904	794,774	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	49.6%	8.3%	298,695	3,296,076	3,594,771	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	35.7%	15.7%	215,328	1,160,297	1,375,625	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	14.7%	18.0%	88,706	404,887	493,593	13.2%	15.7%	66,486	357,037	423,523	12.7%	15.1%	57,201	321,119	378,320
EDUCATION (Age 19-64 Years)															
Less than High School	16.5%	30.5%	83,311	189,550	272,861	17.8%	27.3%	76,397	203,706	280,103	22.2%	27.8%	80,202	208,813	289,015
High School	40.6%	18.2%	204,980	918,355	1,123,335	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	28.3%	12.8%	143,212	973,933	1,117,145	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	14.6%	5.6%	73,707	1,238,444	1,312,151	16.1%	6.0%	69,335	1,085,773	1,155,108	13.5%	4.1%	48,603	1,123,241	1,171,844
REGION [3] (Up to 64 years)															
North Puget	7.1%	13.1%	42,675	282,644	325,319	7.6%	12.2%	38,323	276,736	315,059	7.9%	11.5%	35,620	273,866	309,486
West Balance	7.6%	12.7%	45,522	313,034	358,556	10.2%	14.3%	51,165	305,649	356,814	7.5%	9.7%	33,751	315,946	349,697
King	24.7%	9.3%	148,947	1,450,571	1,599,518	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	29.6%	10.7%	178,564	1,482,667	1,661,231	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	6.5%	11.4%	39,044	304,824	343,868	4.6%	7.1%	23,348	305,681	329,029	4.2%	6.1%	19,110	294,034	313,144
East Balance	10.8%	16.1%	65,261	339,682	404,943	11.0%	13.8%	55,101	343,598	398,699	12.2%	13.9%	55,144	340,216	395,360
Spokane	7.5%	12.0%	45,447	333,594	379,041	6.7%	9.0%	33,517	337,845	371,362	6.7%	8.3%	30,249	335,060	365,309
Yakima-Tri-Cities	6.2%	9.5%	37,269	354,244	391,513	8.2%	10.8%	41,241	339,328	380,569	9.4%	11.3%	42,291	330,329	372,620
REGION (Children under 19 years)															
North Puget	8.4%	8.3%	8,159	90,481	98,640	9.3%	7.1%	6,788	88,867	95,655	6.2%	5.9%	5,580	89,164	94,744
West Balance	5.8%	5.2%	5,691	103,049	108,740	14.9%	10.0%	10,958	98,345	109,303	6.6%	5.3%	5,888	106,046	111,934
King	16.2%	3.8%	15,774	399,263	415,037	16.0%	2.8%	11,752	405,863	417,615	30.8%	6.7%	27,604	387,274	414,878
Other Puget Metro	38.7%	7.4%	37,761	475,679	513,440	27.9%	4.0%	20,467	486,441	506,908	17.8%	3.2%	15,890	484,166	500,056
Clark	8.0%	7.0%	7,778	103,187	110,965	6.0%	4.1%	4,398	103,594	107,992	4.6%	3.9%	4,080	100,940	105,020
East Balance	8.7%	6.4%	8,489	124,261	132,750	9.9%	5.4%	7,284	128,843	136,127	16.2%	10.8%	14,487	119,641	134,128
Spokane	7.3%	6.1%	7,077	109,123	116,200	4.8%	3.0%	3,509	113,628	117,137	6.1%	4.7%	5,462	110,221	115,683

			2004					2002					2000		
CHARACTERISTIC	Distribution of Uninsured	Percent Uninsured	Uninsured	Insured	TOTAL	Distribution of Uninsured	Percent Uninsured	Uninsured	Insured	TOTAL	Distribution of Uninsured	Percent Uninsured	Uninsured	Insured	TOTAL
Yakima-Tri-Cities	7.0%	4.8%	6,790	135,935	142,725	11.1%	5.9%	8,169	130,475	138,644	11.7%	7.6%	10,489	128,200	138,689

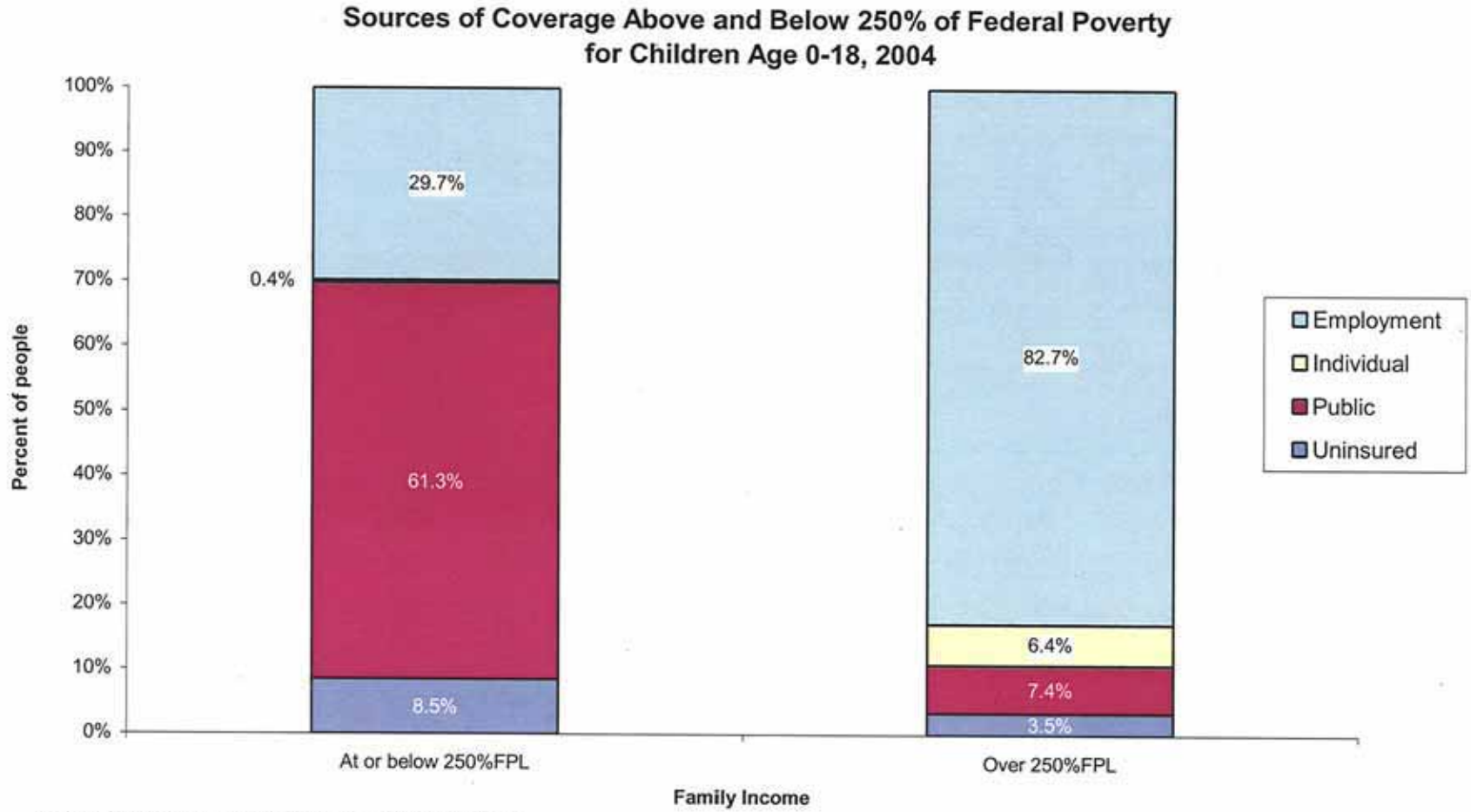
Source: Washington State Population Survey 2000v5M, 2002v4M, 2004v3M.

[1] Adjustments made to account for Medicaid underreporting (described in http://www.ofm.wa.gov/sps/index.htm) do not accurately capture race/ethicity distribution in Washington. Race/ethnicity estimates are based on the distribution of the uninsured using unadjusted weights (described in http://www.ofm.wa.gov/researchbriefs/brief037.pdf).

[2] Non-citizen estimates include a handful of children whose citizenship status was unable to be collected in the survey (i.e., it was unknown or refused to be provided).

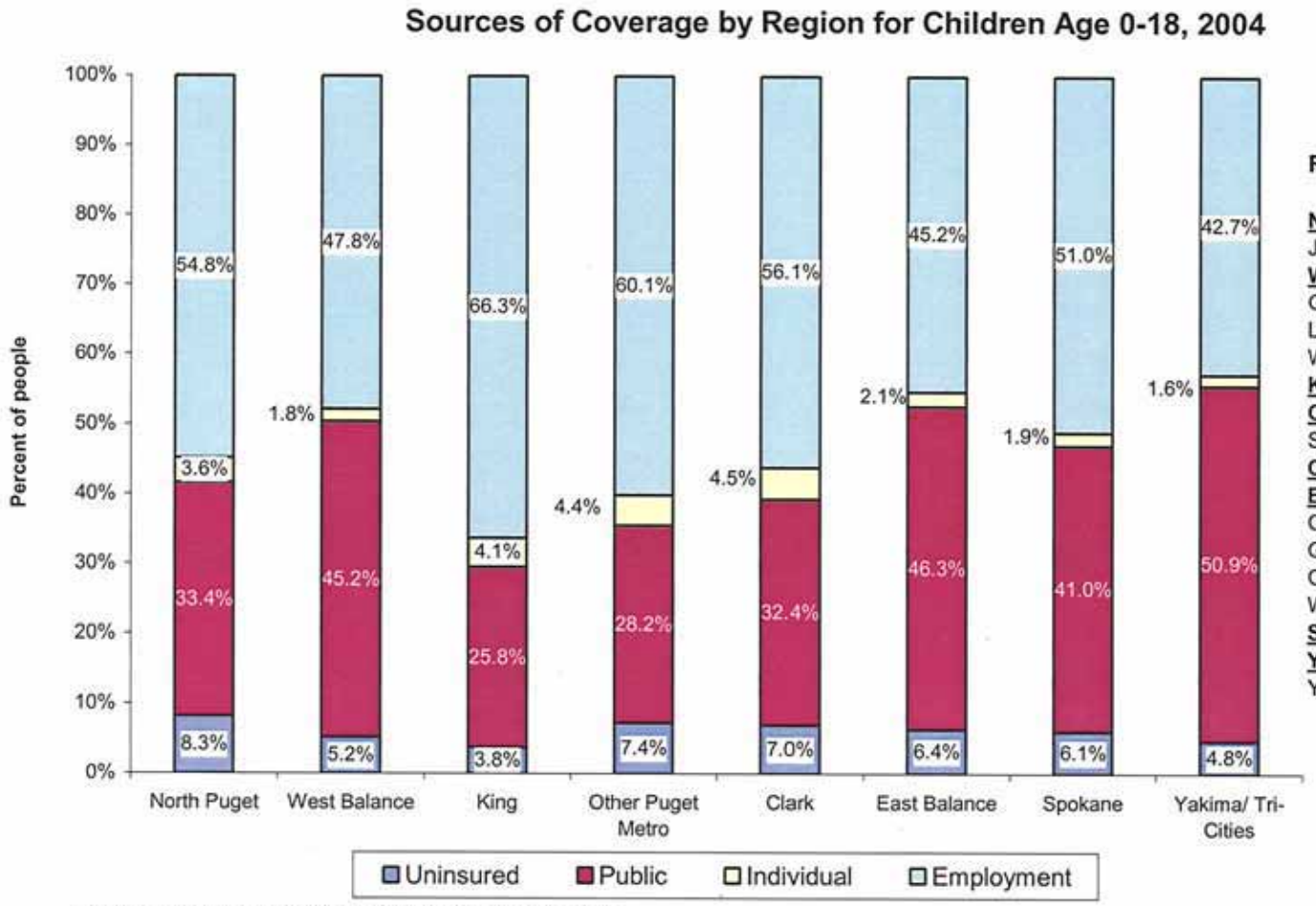
[3] **Regions** and Counties: **North Puget Sound:** Island, San Juan, Skagit, Whatcom; **West Balance:** Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum; **King**: King; **Other Puget Metro**: Kitsap, Pierce, Snohomish, Thurston; **Clark:** Clark; **East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

Attachment 1-2



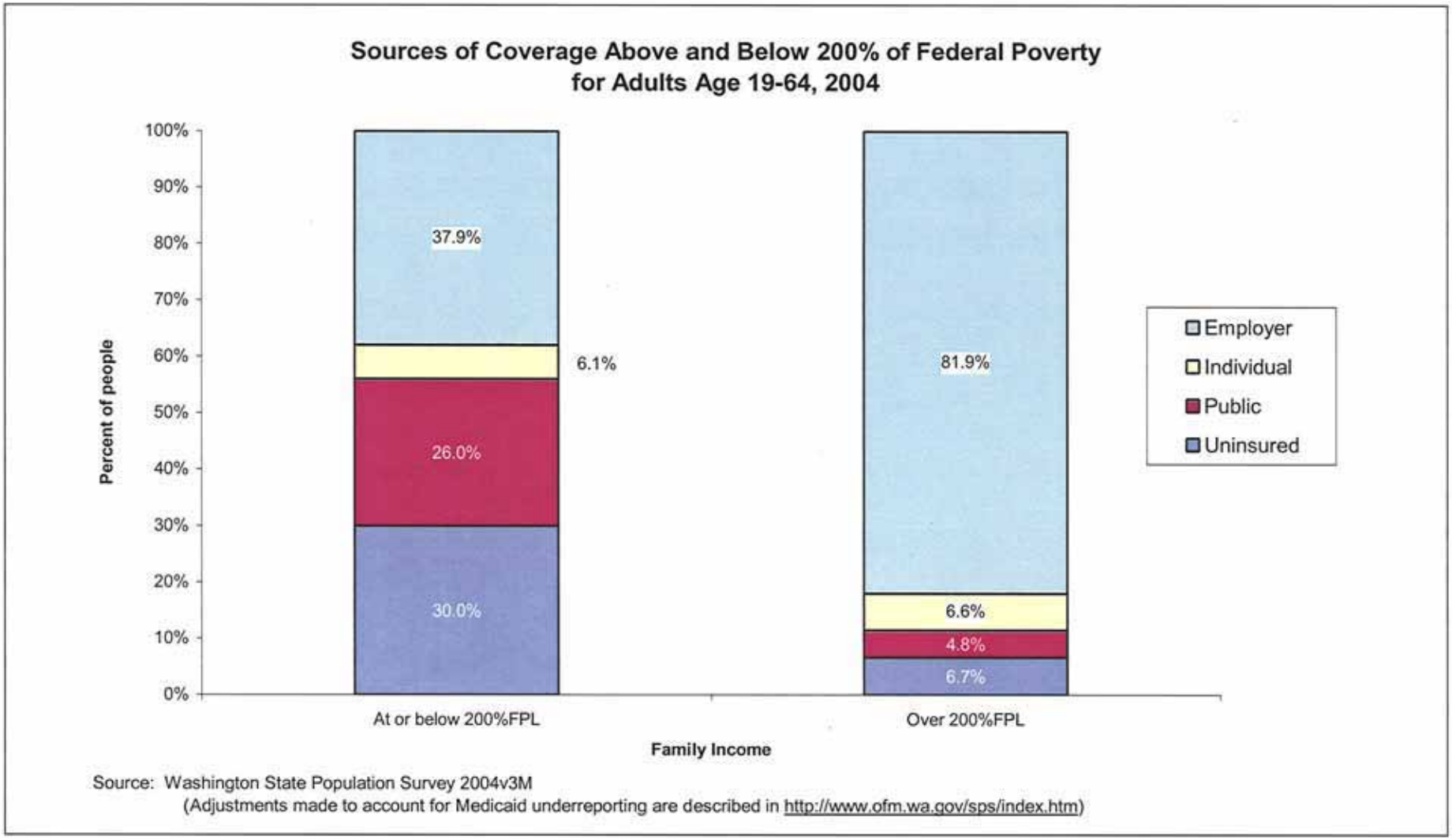
Source: Washington State Population Survey 2004v3M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Attachment 1-3



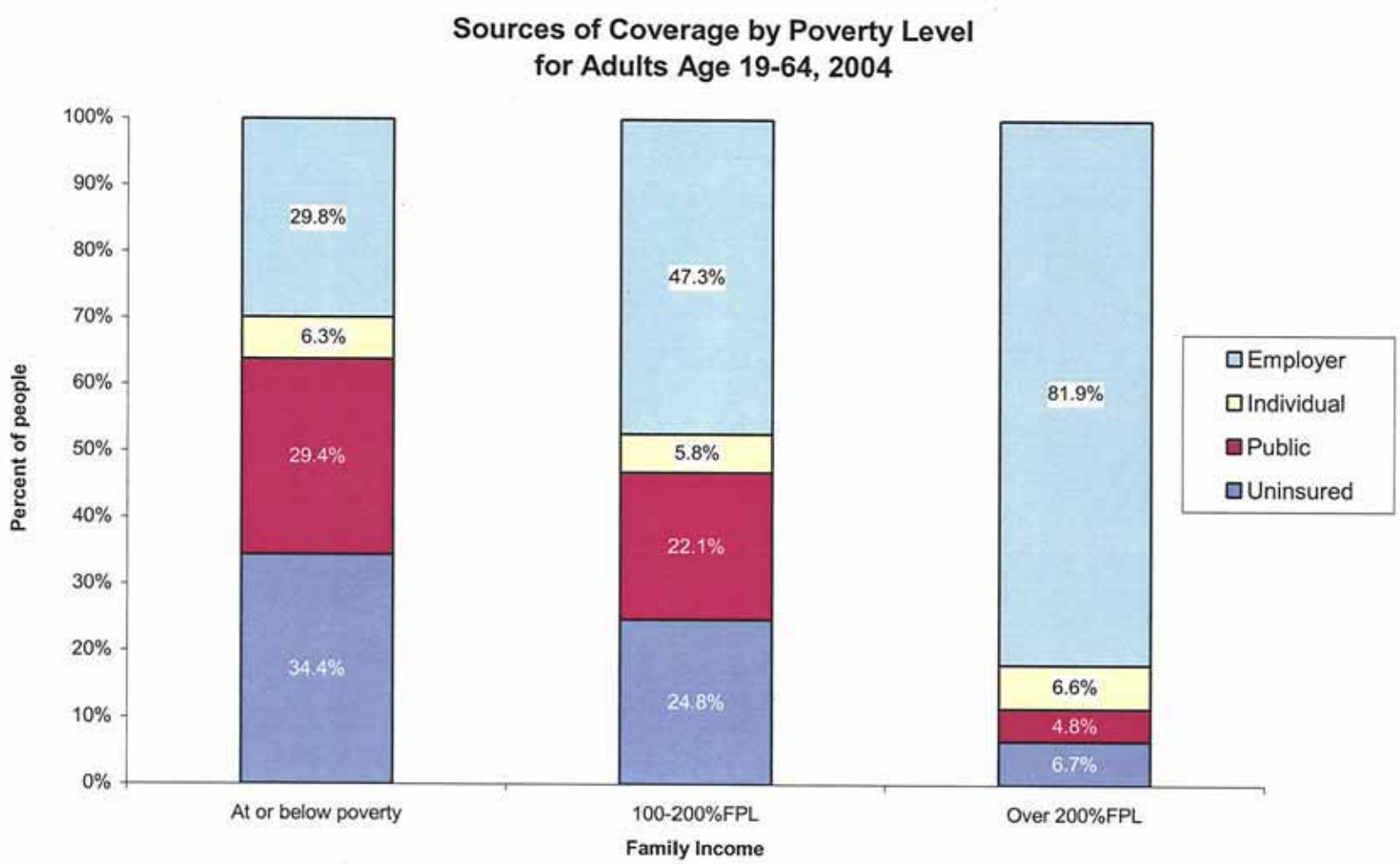
Source: Washington State Population Survey 2004v3M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Attachment 1-4



Source: Washington State Population Survey 2004v3M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Attachment 1-5



Source: Washington State Population Survey 2004v3M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

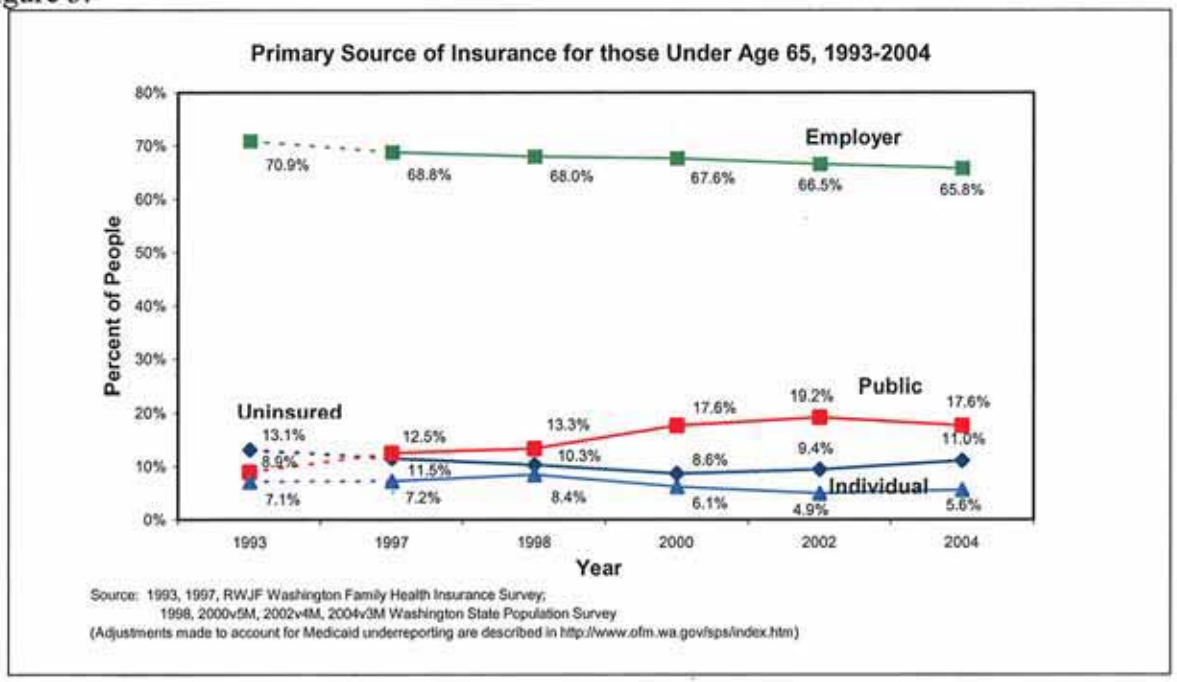
SECTION 2. EMPLOYER-BASED COVERAGE

In this section we update our baseline information on employer-based coverage from the perspectives of employers and their workers. Since our most recent work has focused on information about small employers we've included a description of the related small group market place here rather than in Section 3. We defer discussion of our approach to studying employer-based coverage to Section 4 where it fits better with description of our technical assistance and clearinghouse role in informing coverage options.

Employer-Based Coverage is Declining

Employer-based coverage remains the primary source of health insurance coverage in Washington for workers and their dependents, as is clearly visible in Figure 3.

Figure 3.



However, for those who do have coverage, the trend based on the most recent State Population Survey seems to be a continuation of the decade-long decline in access via employers, coupled with a rise in access through public programs. For the under-age-65 population, coverage via an employer has slowly but steadily dropped from 70.9% in 1993 to 65.8% in 2004. Over the same period, coverage via public programs (Medicaid and Basic Health) has almost doubled, increasing from 8.9% in 1993 to 17.6% in 2004. But, public program expansions haven't been able to keep pace with declines in the employer-based (and individual) markets. The devil is in the details – although access via employers *appears* to have changed rather modestly over time, at least until 2002 it has been the *primary* driver of Washington's increasing uninsurance rate simply because so many of Washington's residents usually gain access to health insurance via an employer. If employer coverage had continued in 2004 at the same levels as in 1993, an additional 280,000 individuals would have been covered via an employer. Even more striking is that if public coverage had continued at 1993 levels, close to 480,000 more individuals would *not* have coverage today.

Washington's decline in employer-based coverage is consistent with the national picture. September's 2005 Kaiser Family Foundation and Health Research and Educational Trust Employer Health Benefits Summary of Findings (HRET) pins the decline on small firms[1] for which there has been a significant decrease in *offer*s of coverage between 2000 and 2005. This has been accompanied by a shift in work from large to small employers where the likelihood of employer-based coverage is lower to begin with.

On the "seemingly" bright side, the HRET survey also shows that the "rate of growth of health insurance premiums declined for the second straight year, slowing to 9.2% in 2005". While this sounds like good news, they note "premiums continued to increase much faster than overall inflation (3.5%) and wage gains (2.7%)". Using Halvorson's rule of thumb[2], "in which a 12% increase in health care premium makes a 4% salary raise completely disappear for the average worker", it comes as no surprise to discover that *take-up* rates in large Washington firms are declining in response to years of rapidly rising premiums (see Appendix 7).

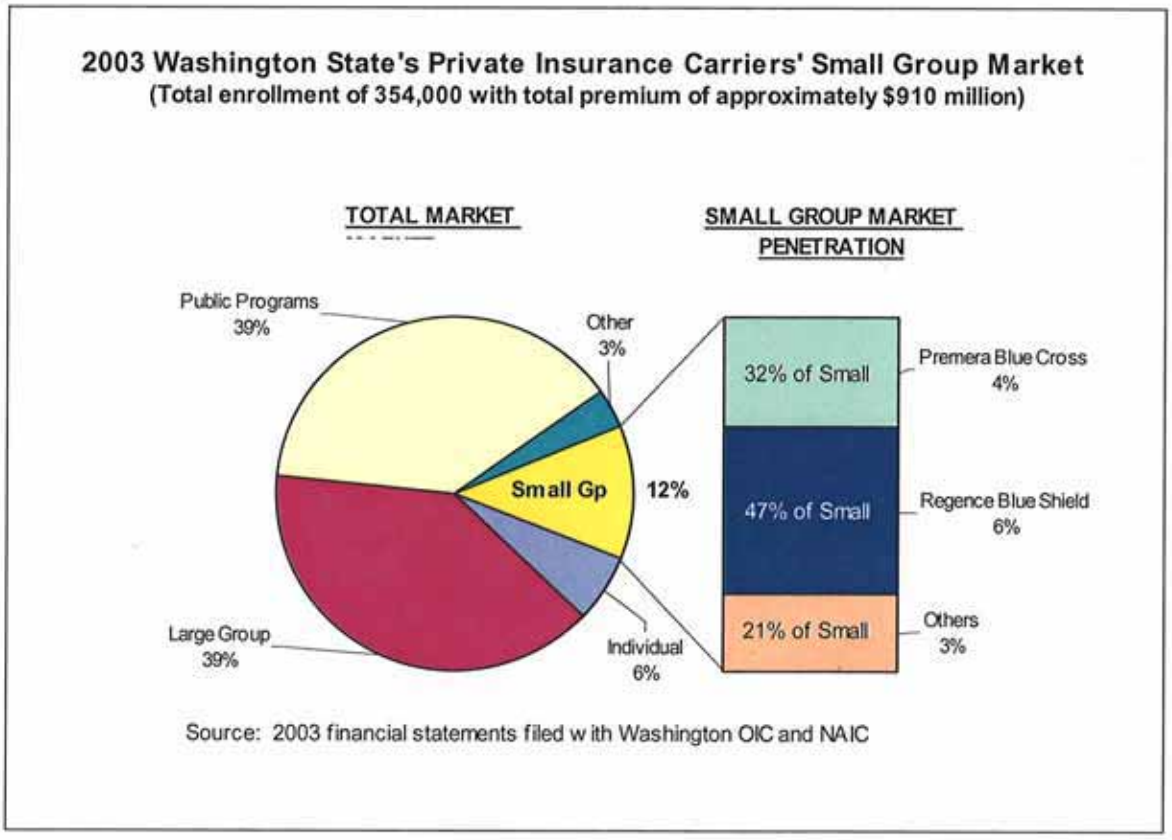
Washington's Group Market

Within the employer-based coverage 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, Premera Blue Cross, Regence Blue Shield, and Group Health, provide coverage for over 80% of the total employer market[3].

As Figure 4 shows, this is strikingly true for the small group market, which represents just over 12% of the regulated market (enrollment and premium). In 2003, close to 80% was split between two carriers, Regence Blue Shield (47%) and Premera Blue Cross (32%). Preliminary estimates from 2004 carrier filings to the Office of the Insurance Commissioner (OIC) suggest that this stronghold has increased to over 87%. Several carriers share the remaining portion (e.g., Asuris Northwest, Kaiser Foundation, Group Health Cooperative, Aetna, PacifiCare, KPS). To be successful, *any* options that propose to increase coverage of Washington's uninsured through the private market, and particularly for small employers, require the support of the few major carriers.

[1] Small firms are defined as 3-199 employees –definitions differ among surveys and state regulations.
[2] Halvorson, G., et al. 2003. Epidemic of Care. Jossey-Bass, San Francisco.
[3] Managed care penetration (i.e., HMO penetration) in the state, taken from the current 2004 Kaiser Family Foundation state health facts is 13.6%, ranking the state at 27 in the nation, up from 31 in 2003. HMO enrollment (approximately 842,052 enrollees) includes enrollees in both traditional HMOs and HMO point-of-service plans through: group/commercial carriers, Medicare, Medicaid, FEHBP, direct pay plans and unidentified HMO products.

Figure 4.



Coverage and Employer Characteristics

While the majority of firms in Washington are small (70% have 2-9 employees, about 14% of the work force), employment is concentrated in larger firms where 54% of the work force is employed in the 3% of firms with 100 or more employees. Appendix 7 captures preliminary estimates of employer-sponsored coverage by several characteristics. Distinct variations in the offer and cost of coverage occur based on firm size, industry, and wage composition of workers.

Although Washington's health insurance market works well for many employers (and individuals), the high level and volatility of premiums create barriers for small groups seeking private insurance coverage[4]. While virtually all large employers have offered health insurance since 1993 (see Attachment 2-1), less than half of all small employers have been able to do so. In 2002 and 2003, about 8 out of every 9 jobs in firms not offering health coverage were in small firms[5]. But, among small employers, averages don't tell the full story - firms with between 10 and 49 employees have consistently been much more likely than the "micro" firms with less than 10 employees to offer coverage (see Attachment 2-2) – more than half the jobs without coverage in 2002 and 2003 were in these "micro" firms. But, regardless of firm size, eligibility, take-up, and coverage rates are quite similar among workers in firms that do offer coverage (Attachments 2-3 to 2-6.).

[4] Watts, C., et al. Pooling and Reinsurance in Washington state Health Insurance Markets: Review of the OIC Proposal. February 25, 2005.

[5] Medical Expenditure Panel Survey 2003 and 2004 (data for 2002 and 2003).

Close to half the small group market serves workers in the construction, retail-trade, health care / social assistance, and accommodation and food service industries[6]. These are also the industries in which we find low-wage workers and the lowest offer of coverage rates in Washington. Among small low-wage firms in construction, only 18% offer coverage to workers; among large high-wage firms in construction almost all (99%) offer coverage. To make inroads in improving coverage rates for small, low wage firms, substantial subsidies for employers and/or their workers will be likely.

Our research shows that private sector firms in Washington spend nearly $5 billion annually on health insurance premiums, averaging about 7% of total wages paid. Average spending per *enrollee* doesn't vary dramatically across firm sizes or industries, but due to differences in offer rates, average spending per *worker* does vary considerably. For only those firms that offer coverage, expenditures average 11% of total wages paid, about $2,779 per worker, or $4,014 per enrollee. Small firms' spending on premiums averages about 12% of total wages paid; large firms spend considerably less, about 9%. The range is even wider based on workers' wages; firms with the lowest paid workers spend the equivalent of 26% of total wages paid in premiums, while firms with the highest paid workers spend only 6%.

In comparison with large firms, small firms have consistently experienced greater increases in insurance premiums since 1989, and greater variability in increases each year[7]. Their premiums buy fewer benefits with higher cost-sharing that varies more from firm to firm. Their administrative costs are higher and their risk pools more unstable as a result of greater cycling in and out of the market, employee turnover, and firm failure[8]. These factors drive carriers' concerns about unpredictable risk and consequently impact premiums and benefit designs.

Insurance products in the small group market are therefore becoming increasingly costly, prompting small employers to shift costs to their employees or drop coverage altogether. For small firms that don't currently offer coverage, especially those small firms with low-wage workers, employer-sponsored coverage is either unaffordable or doesn't pass the "bang for the buck" value test. Small firms with high-wage workers, on the other hand, have relatively high offer rates, regardless of industry. The disparity in offer rates between high and low wage workers is much greater in small firms than in large firms.

For firms that do offer coverage there is a big difference between "single" coverage purchase rates by employees of small vs. large firms - for firms that do offer we know that 67% of insured workers in the smallest firms (with less than 10 employees) purchase "single" coverage while only 41% of insured workers in the largest firms (with 1000 or more employees) purchase "single" coverage. Small firms are more likely to offer coverage to employees only. Does that leave family members of small firms' employees uninsured, or are they covered through other means? We expect to answer these questions through enhancements in our data sources described in Section 4.

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[6] Office of the Insurance Commissioner, Washington State Small Group Insurance Statistics, 2003.

[7] Gabel, J., et al. 2004. Risky Business: When Mom and Pop Buy Health Insurance for their Employees. *The Commonwealth Fund.*

[8] Lee, J. 2002. Are Health Insurance Premiums Higher for Small Firms? *The Synthesis Project. Robert Wood Johnson Foundation.*

What about Washington's Workers?

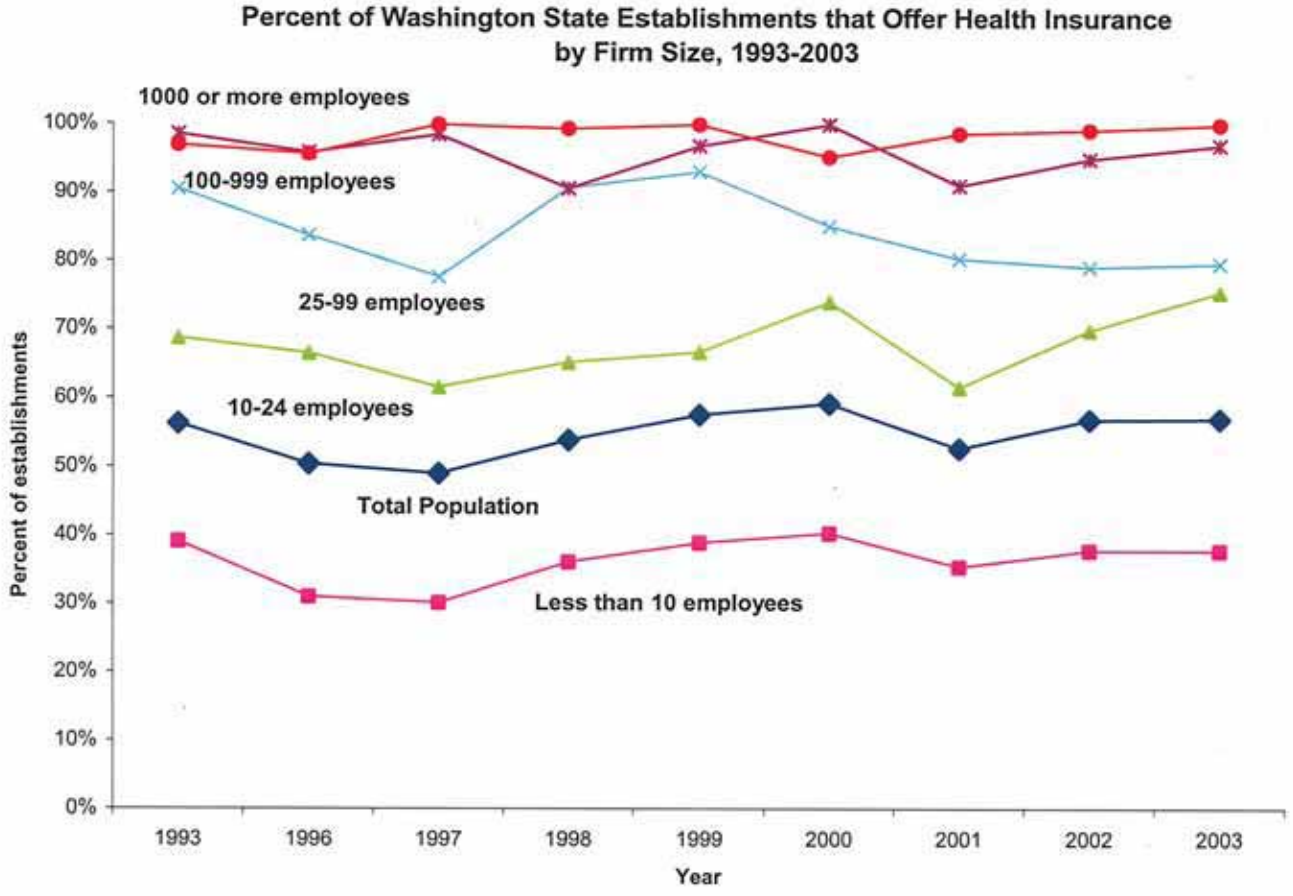
Parallel with research on employers, there is a solid body of literature on the patterns of health insurance coverage among workers. Again Washington's story repeats the national picture (see Appendix 8). As noted, large firms and firms that employ higher-wage workers offer insurance more often than 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 more than the public sector. And they are more likely to work part-time or in seasonal activities, be low-wage workers; be unmarried, and live in low-income households.

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[9]. Although down from an average of 7.5% in 2003 (6.0% nationally) to 5.8% in August 2005[10] (4.9% nationally) the recovery trend has not been as fast as anticipated. Manufacturing, construction, leisure and hospitality sectors were slow to recover, although they picked up well this past summer encouraging many more Washington residents to look for work. As a result the unemployment rate was actually pushed up in August 2005, by the biggest monthly increase in the labor force in the last five years.

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

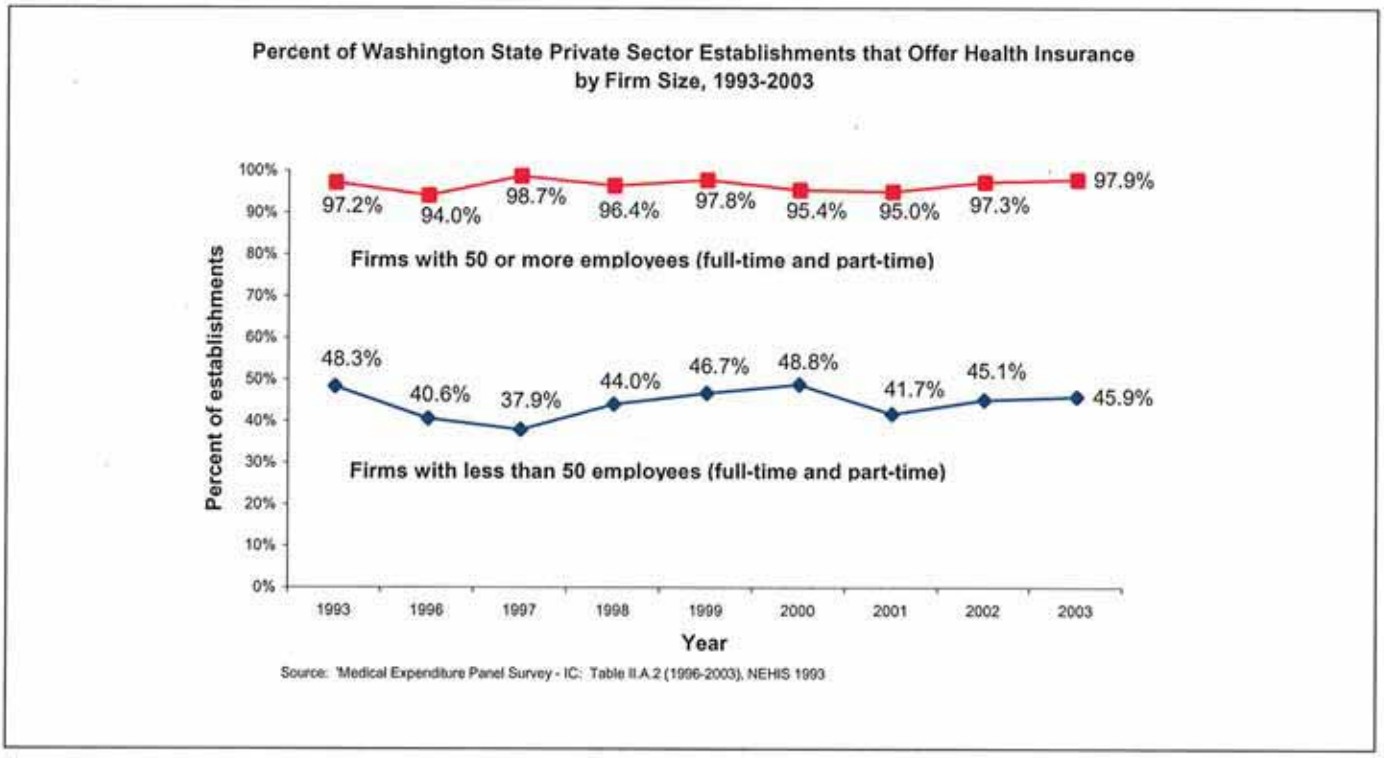
[10] See September 13, 2005 news release available at: http://fortress.wa.gov/esd/portal/info/newsroom/releases/nr091305.htm

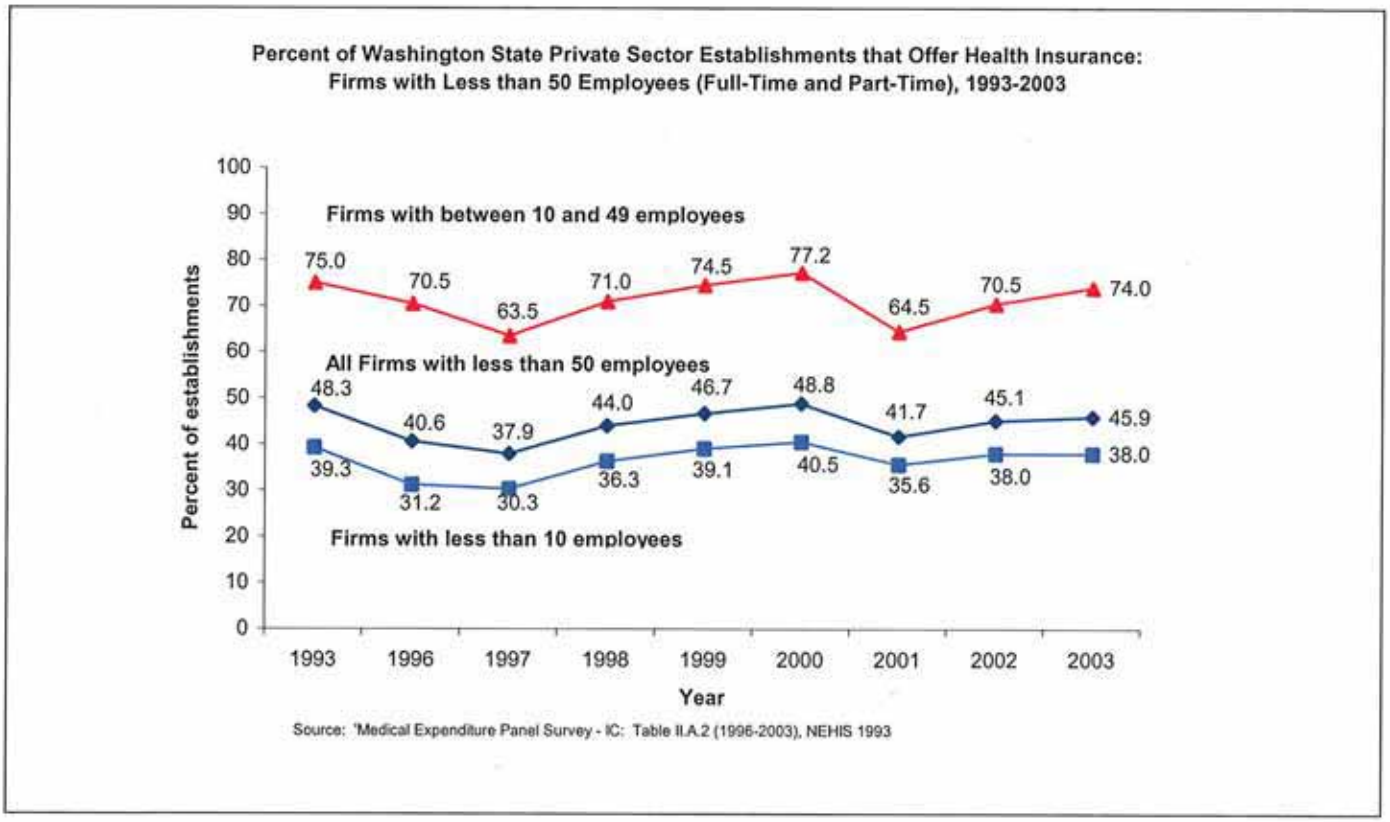
Attachment 2-1



Source: Medical Expenditure Panel Survey - IC: Table II.A.2 (1996-2003), 1993 National Employer Health Insurance Survey

Attachment 2-2





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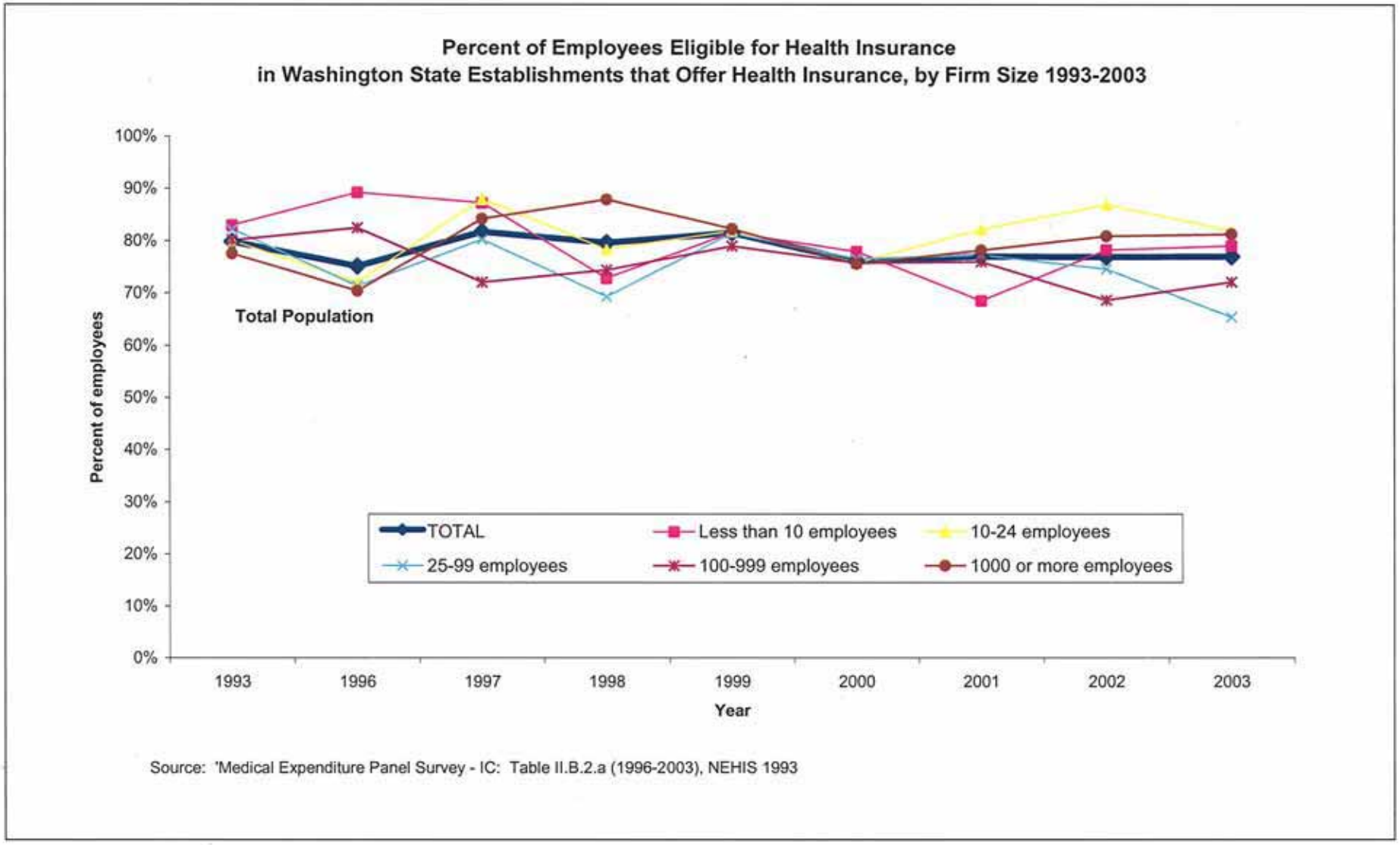
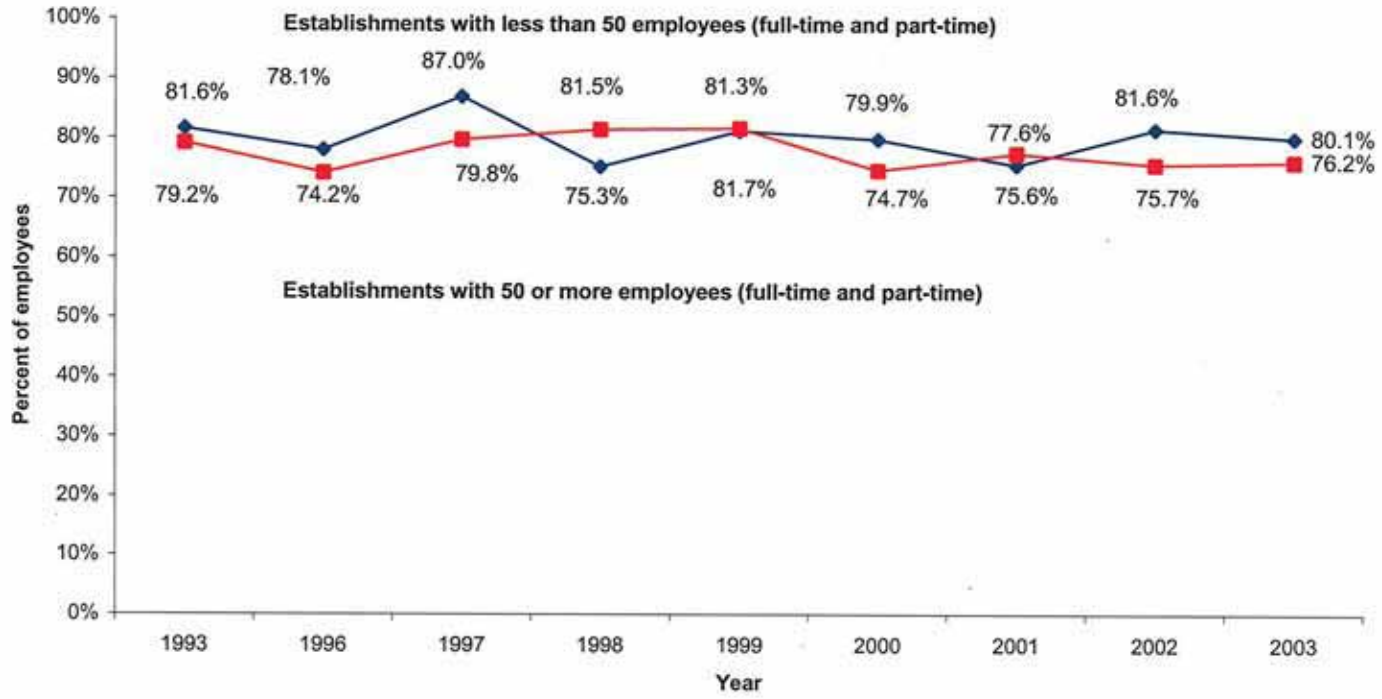


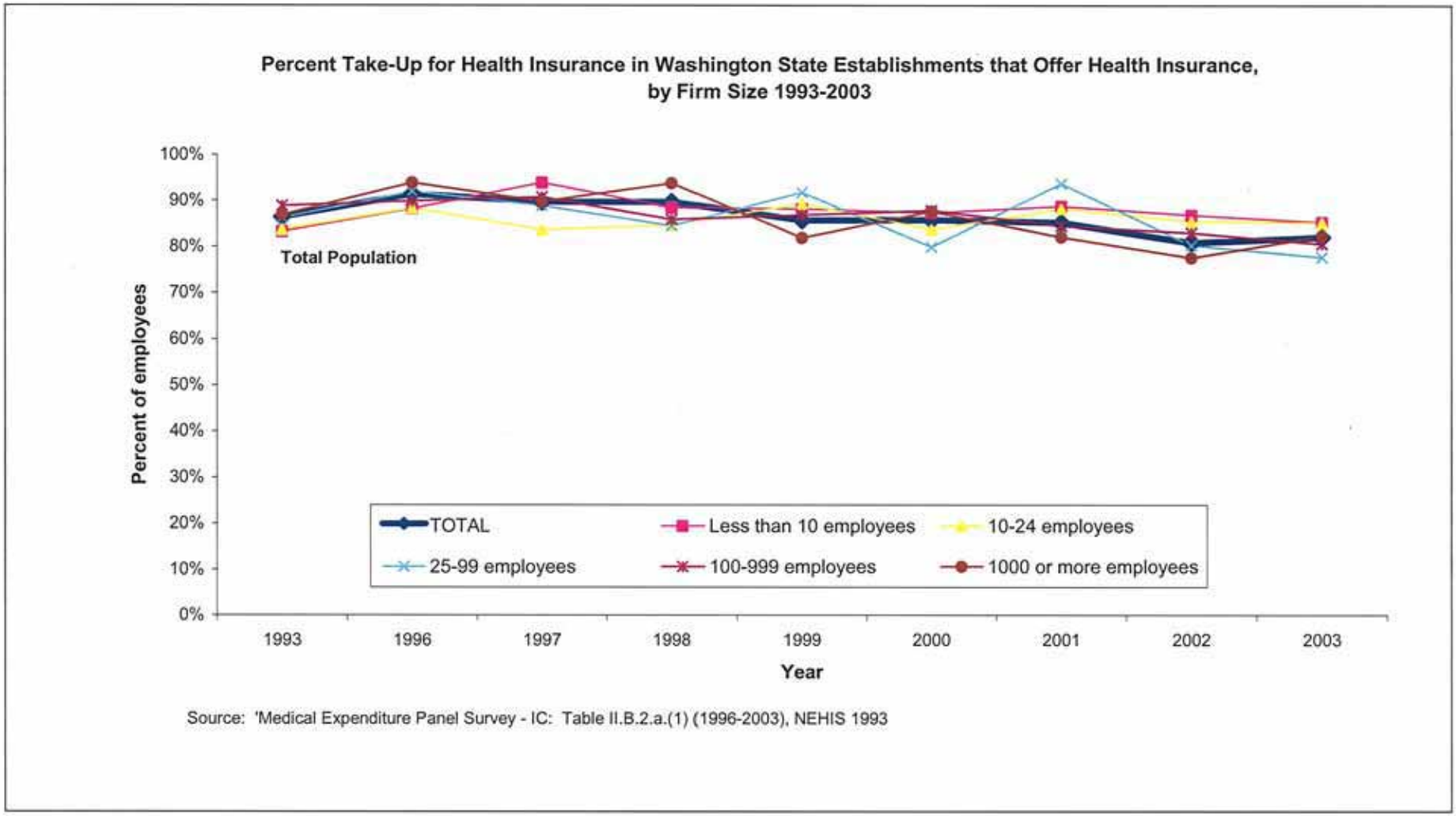
Source: 'Medical Expenditure Panel Survey - IC: Table II.B.2.a (1996-2003), NEHIS 1993

Attachment 2-4

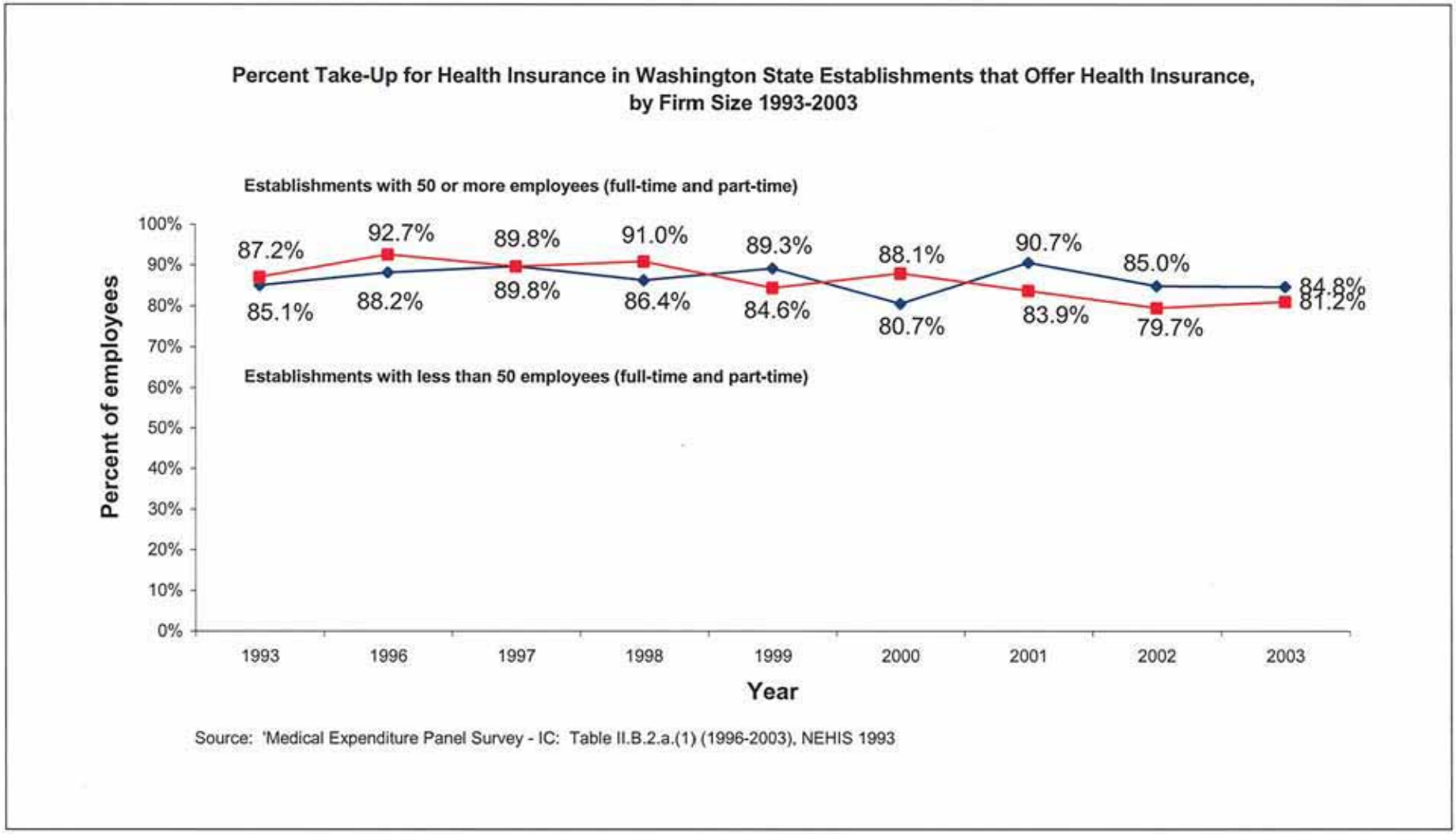


Source: 'Medical Expenditure Panel Survey - IC: Table II.B.2.a (1996-2003), NEHIS 1993

Attachment 2-5



Attachment 2-6



Source: 'Medical Expenditure Panel Survey - IC: Table II.B.2.a.(1) (1996-2003), NEHIS 1993

SECTION 3. HEALTH CARE MARKETPLACE

In previous Reports to the Secretary we described findings of our research on Washington's health care marketplace structure, history, and premium affordability. SPG work in this area over the past year has been limited to technical assistance to clarify opportunities for action in two areas, (1) improving the private market for small groups (in particular) and (2) sustaining public coverage. This work is described in Section 4 of this Report.

To provide some context for Washington's current coverage direction, Section 3 summarizes and updates descriptions of Washington's marketplace included in previous Reports.

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 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 Basic Health 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.

Between Medicaid and Basic Health, 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[2] – at least up until 2002.

Washington's public program history, beginning with the 2001-03 biennium, 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 fairly fragile. People have lost coverage and rates of uninsurance have increased – immigrant children that were moved from Medicaid to Basic Health didn't 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, and radical changes to the cost-sharing design of Basic Health (including deductibles, out-of-pocket maximums, and co-insurance) were implemented. SPG collaborations with Medicaid and Basic Health to evaluate the impacts of the latter two changes are described in Section 4 of this report.

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[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.

[2] 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 Medicaid programs target only the lowest income adults with a disability or children. Basic Health is the only "real" option for most low-income adults, although it isn't currently funded to meet the potential need.

During this time there were a few "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage[3], and the delay of premiums intended for some Medicaid children (below 200% of federal poverty), although children in SCHIP (201% - 250% of federal poverty) saw an increase in premium sharing starting July 2004.

In addition to its struggles with sustaining public program coverage, Washington also has a fairly recent history with problem-ridden individual and small group insurance markets. In an effort to keep individual insurance profitable insurers adopted eligibility standards that denied coverage to those most likely to incur medical expenses. Countering legislation attempted to increase access but resulted in the withdrawal of insurance carriers from the individual market in 1998-1999. You could not buy individual coverage in Washington until 2000-01 following Legislative action that in part allowed health underwriting to return. The "8% most costly" applicants, responsible for an estimated 60 percent of total claims dollars, are screened into a high-risk pool, Washington State Health Insurance Pool (WSHIP). While WSHIP subsidizes insurance for individuals denied private insurance,[4] less than 9% percent of those eligible purchase coverage.

Since 2003, the small group market has been the focus of attention. Although it didn't collapse in the same way as the individual market, the warning signals were clear. Lively debates continued into 2004 and resulted in Legislative action that was the final bill to pass before the session ended. Key steps taken to support the small group market redefined small employers as 2-50[5] employees; authorized carriers to offer limited health plans with a limited schedule of benefits; and further modified community rating laws to allow premiums to vary more widely than previously allowed based on risk. 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 small group market continues to struggle while the business community and carriers remain relatively united in expressing ongoing concerns that:

- Washington's modified community rating limits carriers' ability to offer affordable products in the small group market.
- Benefit mandates are driving premiums and restricting carrier flexibility in benefit design – in particular, the requirement to reimburse any licensed provider whose scope of practice allows treatment covered under the Basic Health program, is believed to be the "single most expensive mandate in Washington". From a business perspective benefit mandates eliminate the likelihood that new carriers will be attracted to Washington with affordable products that have been successful in other states. ("Value" plans, set in statute in 1988 to encourage creativity, have not been attractive. Small employers want "low cost" coverage options but they also want "value" – these two concepts appear to be in collision).
- The state act as a safety-net rather than a "competitor", helping with premium assistance for low income employees so they can join their small business employer's health care plan.

[3] Enrollment in this program in August 2005 was dismal to say the least, i.e., 37 enrollees, but up from 6 in March 2005.
[4] WSHIP subsidies are funded by an assessment on all carriers in the private market.
[5] Previously groups of 1 were included – those who had coverage were grandfathered under the new definition. Now "groups" of 1 are left to find coverage in the expensive individual market.

Washington's Delivery System Challenges:
While policy makers interest has typically focused on the coverage marketplace, there is increasing recognition that coverage is not equivalent to access; coverage is simply the financial vehicle that paves the way for the chain of access, use, and health outcomes to more readily occur. Studies of Washington's safety net before the full impact of the recession and subsequent rising unemployment levels (ranking Washington 2nd in the nation) indicated that the capacity to serve the uninsured in Washington was strong.[6] But increases in the number of uninsured alongside cuts in provider reimbursement rates and outreach (nationwide) have put pressure on this system; access to care pathways are increasingly fragile. For example:

- Reports from hospitals and community health centers indicate that levels of uncompensated care provided are increasing. Preliminary estimates of uncompensated care provided by hospitals in 2003 indicate that charity care may have increased an additional 75% and bad debt 48%.[7] (Washington State statute requires hospitals to provide care for emergency conditions, provide "charity care" for those persons with family incomes below federal poverty, and use sliding scales discounts from charges for those persons with income between 100-200% of federal poverty.)
- From a survey of their clients, community health centers reported a 50% increase in the number who were UNinsured between January 2002 and December 2003[8] while the number who were INsured rose by only 10%. 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 as indicated in the following table.

INSURANCE STATUS OF COMMUNITY HEALTH CENTER PATIENTS

BPHC Community Health Centers	Washington State[9]	Nationwide[10]
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%

Over half of their clients are working (57%); over half of these employed full-time, nearly 1/3 employed part-time and the remainder employed in seasonal or temporary jobs.

- Hospital emergency room (ER) doctors are also reporting growing numbers of uninsured individuals seeking non-emergent care through the ER. Fiscal year end reports to the Department of Health indicate that ER volume has increased 30% since 1999, primarily in urban hospitals.
- Providers have been affected by the managed care reforms of the 1990's, by controls in Medicaid reimbursement rates and by continuing escalation of malpractice insurance rates. The

[6] Long, S.H. & Marquis, M.S. (1999). Geographic Variation in Physician Visits for Uninsured Children: The Role of the Safety Net. *Journal of American Medical Association,* 281 (21), 2035-2040.
Holahan, J. & Spillman, B. (January 2002). Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance. *New Federalism, Series B, No B-42.* The Urban Institute.
[7] Washington State Department of Health, *hospTrends,* July 2004.
[8] Kavoussi, K. & Burchfield, E. *Stretching the SafetyNet: The Rising Uninsured at Washington's Community Health Centers.* May 2004.
[9] Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics.
[10] 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.

Washington State Hospital Association reports that hospitals are charging "other payers" over 120% of costs to makeup for public program shortfalls. In 2000, Washington ranked 31st in the nation in its Medicaid reimbursement of fee-for-service providers and that position is not improving.[11] Washington's malpractice problems have created access issues for both insured and uninsured, with access to specialty care of greatest concern. On the November ballot there will be two competing measures related to medical malpractice, one caps non-economic damages at $350,000.

A New Governor and a New Outlook:

The **political environment** shifted in 2004-2005 with the election of Governor Christine Gregoire who made improving health, health care, and health coverage priority items. Her focus, from day one, on these issues has inspired renewed energy. There was significant collaboration between the Governor and legislative leadership on a variety of health care issues during the 2005 legislative session. Some *examples directly related to sustaining or expanding access to coverage and care* include:

- reinstating state-funded coverage for undocumented immigrant children and funding children's Medicaid at a level that reinstated 12-month continuous eligibility (from 6-month, non-continuous) and precluded implementation of children's premiums[12,]
- providing additional funding to the Kids Get Care program which provides integrated preventive medical, oral, and developmental health services to young children and serves as a gateway to get eligible children enrolled in coverage, and
- ensuring that the Basic Health program would be funded to keep pace with medical inflation so that enrollment could be maintained at 100,000 without increasing cost-sharing or reducing benefits[13 14]

Although a bill did not pass, the Governor also pushed the need to provide assistance to small businesses and their employees/families vis-à-vis affordable coverage. There was significant agreement among legislative leadership on the need; the "how" and the role of government were constructively debated. As a result, the Governor spearheaded a proactive, and successful search for grant money to help develop a small business assistance program with a targeted implementation date of January 2007.[15]

The **financial / economic** context continues to be a challenge, especially as it impacts the state budget. While state revenue growth is predicted to stay around 5%, state health care costs are rising at about 10% annually and thus consuming an ever-larger part of the state budget (at a time when other infrastructure needs such as education, transportation, and public safety are equally high)[16]. In the midst of its economic recovery (which has lagged somewhat behind the nation as a whole), a minor setback is the recent strike by Boeing machinists (representing one of the strongest unions in

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[11] Testimony by Medical Assistance staff, Senate Ways and Means Committee hearing, February 9, 2005.

[12] These actions alone mean that some 36,000-37,000 children are receiving coverage that otherwise would not.

[13] Without this action, approximately 17,000 adults would have lost coverage.

[14] Other actions taken that are less directly related to coverage and more related to care, but nonetheless serve the uninsured include: (1) continued funding for community clinics, (2) initiating the state-sponsored prescription drug consortium in order to reduce drug costs for anyone who chooses to participate, and (3) creating a non-profit foundation to provide more effective and efficient access to prescription drug programs for uninsured and underinsured.

[15] In addition to its 2005 HRSA SPG pilot grant, Washington also received a complementary grant from the Robert Wood Johnson Foundation, State Coverage Initiatives Program, to develop the small business assist program.

[16] Washington's Six Year Outlook available at www.ofm.wa.gov projects an increasing budget deficit in the Health Services Account (the source of funding for many of Washington's public programs) beginning in 2008, and the return of a growing budget shortfall in 2009 that will be back near $1 billion by 2010.

the country)[17]. A gas tax increase was passed by the 2005 legislature to help address some of the state's transportation problems; an initiative on the fall ballot seeks to overturn the increase. The relevance for health coverage is clear – if additional money for transportation must be found in the existing state budget there will be less left in the pie to address health, health care, and health coverage. Our financial struggles in health care are not over yet.

[17] Thankfully this began and ended in September, the shortest strike in Boeing's history. Pension benefits and wages increased while employee health insurance contributions held steady. Puget Sound Business Journal / NPR September 30, 2005.

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

In Section 4 we describe 2004-05 State Planning Grant (SPG) work directly tied to coverage maintenance and expansion in Washington State. The ways in which our data analyses facilitated coverage discussions and consensus-building are included where applicable.[1] The structure of this section follows that given in Box 4-1.

In addition to the specific activities described in this section, Appendix 2 is a summary of 2002-2005 Washington legislation (proposed and/or passed) most directly aligned with the SPG goals of sustaining and expanding coverage. Appendix 3 rounds out the picture of coverage and access activities in Washington State (and links them to our initial research on potential coverage options). Appendix 5 provides a history of Washington's SPG activities and Appendix 6 shows the evolution of activities in supporting HRSA's coverage goals. Finally, project principles in place since we began (March 2001) continue to guide our choice of research and policy work – these Guiding Principles are included as Appendix 1.[2]

Box 4-1: Access to Health Insurance Project, 2004-05 Grant Activities

Coverage Maintenance
- Evaluation of Basic Health benefit design changes
- Evaluation of Children's Medical caseload decline

Coverage Expansion – Governor/Legislature
- Cover all children by 2010
- Small business assist program

Coverage Expansion - Other
- Coverage for artists (& those with similar work patterns) (Washington Artists Health Insurance Project)
- Community-based, universal coverage for low-income (Community Health Works)
- Coverage for employees of large businesses (Health Care Responsibility Act)
- Small group market improvements – moving beyond reinsurance (Insurance Commissioner)
- Medical homes as entrée to coverage (Kids Get Care Model)

General Data & Policy Analysis Support
- Resolution of data issues important to understanding the scope of Washington's coverage challenges
- Turning data into information – evolution of helpful data sources
- Technical assistance & clearinghouse for coverage related issues (a growing & unexpectedly demanding part of our time)

A. COVERAGE MAINTENANCE

Sometimes it's as important to ensure that you don't go backwards as it is to ensure that you move forwards. In light of Washington's increasing rates of uninsurance[3], we collaborated on

[1] We did not include a separate Section 5 (Consensus Building Strategies) in this Report. Appendix 4 (included in previous Reports to the Secretary) describes the general consensus-building approach we have taken throughout the project (since March 2001).

[2] Throughout the 2005 Report we try to highlight things that may be most helpful to other states.

[3] According to analysis of Washington's biennial State Population Survey, the rate of uninsurance in Washington increased for the second time in a row to 9.8% in 2004 (from 7.7% in 2000 and 8.4% in 2002) – a significant increase from 2000 to 2004. Rates for adults ages 19-64 followed roughly the same pattern, increasing to 13.2% in 2004, from 10.0% in 2000 and 11.5% in 2002. For children 0-18, there was an increase in 2004 to 6.0% from a low in 2002 of 4.5%.

two evaluation projects designed to inform policy makers about the impacts of cost-sharing or administrative changes on the ability of public programs to serve their target populations. Would these changes drive enrollees from the programs and add them to the growing population of uninsured?

A.1. Evaluation of Basic Health Benefit Design Changes.

This collaboration, with researchers from Washington State University and with the State Health Care Authority as the administrator of Basic Health[4], began during the 2003-04 funding cycle and was completed in the current cycle. In the 2004 Report to the Secretary we discuss the background, process, survey methodology, and some of the early findings.[5] The completed evaluation has been submitted to *Health Affairs* and is attached as Appendix 9. In Box 4-2 we summarize the final results by quoting from the Abstract.

Box 4-2 Final Results of Basic Health Benefit Design Changes

"We tested the hypothesis that the introduction of cost-sharing increases would be the major reason for disenrollment from Washington's Basic Health program. Results from a randomized telephone survey indicated three main reasons for disenrollment, which varied by enrollee income: finding other coverage, becoming financially ineligible, or dropping coverage as too expensive. Seventeen percent of disenrollees cited the cost-sharing increases as a reason for drop-out, less than figures reported in previous research for Medicaid enrollees. Both enrollees and disenrollees often experienced negative consequences in their ability to obtain health care."

From: Abstract of "The Impact of Increased Cost Sharing on Enrollees in a Subsidized State Health Insurance Program." Hendryx, M., Onizuka, R., Wilson, V., and Ahern, Melissa. Submitted September 2005 and under review by *Health Affairs*. Not for citation without primary author's permission.

By way of background, the Basic Health program was directed by the Legislature to reduce the actuarial value of the Basic Health benefit package by 18% effective January 2004. The result was increased premium- and other cost-sharing for enrollees, including the introduction of deductibles, co-insurance, and out-of-pocket maximums. The concern was that this new financial load would increase disenrollment for otherwise eligible individuals. A telephone survey was used to explore the role of the changes on enrollees' decisions to stay in or leave the program; and for those who left, to understand their current coverage, financial, and access to care situations. A stratified random sample was selected based on 2 status groups (Stayer, Leaver) and 3 income groups (< 65% federal poverty; 65-124% federal poverty; 125-200% federal poverty).

There are three points we want to emphasize. First, the impact of the cost-sharing changes on enrollees' decisions to disenroll may be understated in the findings presented in Box 4-2. Specifically, over one-third (34%) of the people who *voluntarily* left Basic Health (i.e., they were still income eligible) cited the cost-sharing changes as a reason for disenrollment – substantially higher than the 17% of *all leavers* (i.e., those who continued to be eligible as well as those who were not). Thus, for those who were actually in the position of making a decision to stay or

[4] Basic Health is a state-only funded coverage program for low-income (at and below 200% federal poverty) individuals, many of whom are part of working families. Premiums are subsidized based on income.

[5] The 2004 Report also includes as an Appendix a summary of the survey contents.

leave (i.e., they continued to be eligible) a much higher percent cited the cost-sharing changes as a factor in their decision to leave.

Second, the single most important reason cited by people who stayed in the program was that no other insurance choices were affordable. Thus, when options for coverage are limited, the "choice" of staying becomes somewhat of a false option (assuming one wants to maintain coverage).[6]

Last, the results begin to raise the issue of whether the program changes are leading to a situation of underinsurance for those who stay. Unhealthy percentages of Stayers indicated that over the last 5-6 months they had not gotten needed care and/or had spent $500 or more out of pocket for health care.[7] Furthermore, one-third of the Stayers (27% of Leavers) reported skipping or cutting back on other bills in order to pay for health insurance, prescriptions, or medical care.

While the study has several limitations, all in all it provides policy makers with a sense that further increases in premiums and other cost-sharing may stretch the ability of Basic Health to serve its target population (especially as prices for essential needs such as fuel, food, and housing increase relative to income).[8]

A.2. Evaluation of Children's Medical Caseload Decline

In this project we collaborated with researchers from the Department of Social and Health services, i.e., Washington's state Medicaid agency, on a client survey of parents whose children left the Medicaid program following implementation of several eligibility policy changes. Subsequent to these changes there was a substantial decline in the Children's Medical caseload; the purpose of this evaluation was to explore the degree to which the eligibility changes contributed to the decline. The client survey was the second of a two-part effort – the first part involved analysis of administrative data. Presented in Box 4-3 is the Executive Summary for the entire evaluation; SPG staff collaborated solely on Part II (the client survey). The entire two-part report is attached as Appendix 10.

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[6] Previous State Planning Grant research indicates that it takes an income of approximately 250% of federal poverty to be self-sufficient in Washington, i.e., cover one's basic living expenses including the purchase of coverage on the private market. So clearly for Basic Health enrollees (whose incomes are at or below 200% of federal poverty) the "choice" to find coverage elsewhere is a bit of a challenge. See http://www.ofm.wa.gov/accesshealth/research/33affordability.pdf

[7] Percents for Leavers on these two measures were significantly higher than for Stayers.

[8] Decisions on program design changes are generally made the year before they are implemented, e.g., Jan-Apr 2004 for calendar 2005. No change in Basic Health's design was made for 2005; to do so would require making changes before seeing the impacts of the 2004 changes. Early results of this evaluation were available in time for 2005 decision making for 2006. The Governor's and legislative leadership's decision was to fund Basic Health for 2006 at a level to keep pace with medical inflation so that enrollment would be maintained at 100,000 without increasing cost-sharing or reducing benefits. Without this action, approximately 17,000 adults would have lost coverage.

Box 4-3: Evaluation of Children's Medical Caseload Decline

Why an interest in Washington State's Children's Medical Caseload decline?
Beginning in April 2003, a series of eligibility changes led to a decline in Washington State's Children's Medical caseload. The policy changes included new signature and income verification requirements, a shorter (6-month) eligibility review cycle, and termination of continuous eligibility.[1] Among the issues that drive interest in more restrictive eligibility rules for public programs are the potential for cost savings and the appeal of ensuring program integrity. Underlying both issues is the desire to direct limited dollars to people most in need (as defined by eligibility criteria), believing that money spent on the ineligible means coverage denied to the eligible. At the same time there is concern whether the benefits (cost-savings from lower enrollment, increased program integrity) are worth the costs (loss of coverage for eligible children, costs to implement more restrictive eligibility rules). A key objective of this study is to help assess the benefit-cost tradeoff for the eligibility policy changes affecting the Children's Medical caseload.

What this report tells us . . .
Part I of this study examined administrative data and found a net decline of 39,085 children on the Children's Medical caseload in the 18 months following the eligibility policy changes. Most of the loss of coverage was attributable to increased exits, as opposed to few newer entries or increased cycling off and on the caseload.

Part II of this study used client survey data to better understand why children left the Children's Medical program after the policy changes. Key findings include:

- ***Do children leaving the Children's Medical caseload have non-DSHS medical coverage? If not, are they still eligible for DSHS coverage?***
  Most "leavers" (60 percent) had non-DSHS coverage at the time of the interview, but almost all uninsured "leavers" were still eligible for DSHS coverage.
- ***Why did the DSHS eligible but uninsured children leave? And do they plan to return?***
  Most parents say DSHS made the decision, and about half cite administrative-related reasons. Almost all parents say they plan to reapply for Medicaid.
- ***Do the DSHS eligible but uninsured differ from the kids who exited to other medical coverage?***
  They are poorer, more likely to use the emergency room, less likely to have physician or clinic visits, and more likely to be Hispanic.
- ***What might have been the consequences of maintaining 12-month continuous eligibility?*** The 36 percent of "leavers" who were DSHS eligible but lost coverage and were uninsured would likely have remained on Medicaid for another 6 months. The 32 percent of leavers who were "ineligible" would likely have continued on Medicaid for another 6 months.
- ***Are there opportunities to identify more children on Medicaid with private coverage?***
  Many "leavers" who remained DSHS eligible had other coverage when interviewed. Enhanced efforts to coordinate benefits or buy into employer-provided coverage may be warranted.

[1] The Governor has since issued an administrative order restoring the 12-month continuous eligibility policy. The return to a 12-month review cycle was effective in May 2005 and restoration of continuous eligibility occurred in July 2005.

From: Executive Summary, Children's Medical Caseload, Why the Decline? Parts I and II, August 2005, Washington State Department of Social & Health Services, Report 9.74.

The implications of these findings are clear for public policy makers and, in fact, were recognized early by Governor Gregoire who, even prior to completion of the study, reinstated 12-month continuous eligibility for Medicaid children. That one action alone increased the number of children on Medicaid by 26,000.

While these two evaluation efforts focused on different populations (adults in Basic Health and children in Medicaid) and different policy changes (cost-sharing in Basic Health and eligibility in Medicaid), their stories nonetheless complement each other. That is: While it is important to have shared responsibility with enrollees in order to maintain program existence and integrity, the challenge is to share that responsibility in a way that ensures the programs' ability to adequately serve their target populations.

B. COVERAGE EXPANSION – GOVERNOR/LEGISLATURE

State initiated expansion efforts continue to be a challenge in an environment of tax-aversion and growing infrastructure needs (education, transportation, criminal justice, and emergency preparedness). Nonetheless, two expansion ideas have considerable support by both executive and legislative leadership – cover all children by 2010 and assist small businesses and their employees/families in accessing affordable, adequate insurance coverage. Attachment 4-1, included at the end of Section 4, is a diagram that links these initiatives (and some others discussed later in Section 4) with broad groupings of Washington's uninsured.

With respect to coverage options that have been "taken off the table" in Washington, it's probably fair to say that nothing is ever completely off the table. Included at the end of Section 4, as Attachment 4-2, is a one-page "cheat sheet" of common coverage categories we have used through our SPG work. A scan of 2002-2005 legislation (Appendix 2) clearly shows that many of these common coverage ideas continue to be brought forward.

B.1. Cover All Children by 2010

Governor Gregoire has turned the spotlight on health, health care, and health coverage in Washington State. She has three health care priorities for which she is holding her administration accountable; cover all children by 2010 is one of them.[9] Parallel with the Governor's interest in children, the 2005 Legislature passed E2SHB 1441 which stated a similar intent, building on both private and public options and linking children with medical homes.

As with any big-picture policy goal, consensus on covering all children has been a maturing process that reached its tipping point with single-party leadership (Democrat) in the executive and legislative branches. However, even with consensus on the "what", work remains on the

[9] The Governor's other two health priorities are Quality Improvement & Cost Containment (bringing down the cost of care for everyone via the state buying smarter for greater value and increased return on investment) and Healthier Washington (improving residents' health and raising awareness about the need to care as much about being healthy as about not being sick). The Governor has implemented Government Management Accountability & Performance (GMAP) as the formal process through which she and her senior staff will help executive branch agencies achieve her priorities

"who and how" (e.g., priority groups of children, specific programs and their operational development).[10]

The Governor tasked an inter-agency work group with developing strategies from which specific operational programs can be developed. The workgroup has been meeting since spring 2005. Presented in Box 4-4 is the current "short list" of ideas. These strategies are in addition to the immediate steps taken by the Governor in the 2005 legislative session to expand coverage to nearly 37,000 low-income children, i.e.,

- Delayed for at least two years premiums for Medicaid children, ensuring an additional 4,000 would get coverage;
- Removed administrative barriers by reinstating 12-month continuous eligibility for Medicaid children, increasing by 26,000 the number of children with coverage.
- Restarted the state-only program for low-income (below 100% federal poverty) undocumented immigrant children, providing coverage to approximately 6,700 additional children.

Box 4-4: Tentative "Short-List", Governor's Work Group on Cover All Children by 2010*

- Maintain current public programs (e.g., continue to pursue SCHIP dollars for use below the current allowed poverty level)
- Conduct outreach to increase enrollment for children currently eligible for but not enrolled in state programs[11]
- Expand existing pilot to encourage Medicaid clients to use employer-sponsored coverage by providing premium assistance[12]
- Conduct a phased expansion of the state-only Children Health Program for non-citizen children below 100% federal poverty
- Develop a program to help small employers offer affordable coverage to families (not just employees)
- Support programs and evaluate models that provide a medical home for children as a gateway to getting them enrolled in coverage

* The short-list is a work-in-progress and undergoes revision as the Governor and her senior staff provide input and as the Governor's work group and a separate Legislative work group come into alignment.

Work group discussions with the Governor and her senior staff regarding the strategies presented in Box 4-4 will continue over the next few months. Also occurring are parallel discussions among the Governor, Governor's staff, Legislators, legislative staff, community and advocacy groups, labor and business regarding these and other strategies. There is no specific "due date" for a final plan although the specter of the 2006 legislative session (begins January 2006) is giving the discussions a sense of urgency and vitality.

It's nearly impossible to capture the breadth and depth of the work group discussions. However, we thought it might be helpful to other States to see examples of some of the SPG-generated

[10] Attachment 4-3 may be of use to other states to demonstrate the importance of agreeing on operational definitions of "political" language. Different definitions can lead to different strategies and different measures of success.

[11] A few years ago Washington conducted a highly successful outreach program to enroll eligible Medicaid children. Much of that infrastructure still exists and could be quickly mobilized if a decision is made regarding adequate, sustainable funding to cover the costs of an increased caseload.

[12] The pilot makes a payment to the family if their employer-sponsored coverage for dependents is cost-effective for the state. The Medicaid family member also receives wrap around services not covered by the employer plan. The pilot has enrolled 640 clients (488 currently enrolled) from October 2004 through August 2005. 80% of enrollees are children. The pilot has employed 3.5 FTEs over an 11-month start-up and operations period.

products used to facilitate discussion. Sample issues are listed below and attached at the end of Section 4 are work products related to each.[13]

- Where do uninsured children fit in the picture of all children; how many have coverage and from where? See Attachments 4-4 and 4-5.
- Are there large segments of uninsured children that can be addressed by a single strategy? Does it make sense to expand efforts to engage employers in covering children? See Attachment 4-6.
- Is insurance coverage (compared to something else) really that important for children? See Attachment 4-7.
- How can the work group decide which strategies to move to the short-list? See Attachment 4-8.

B.2. Small Business Assist Program

Development of a small business assist (SBA) program is the focus of Washington's successful pilot proposal to the State Planning Grant program for the 2005-06 funding cycle.[14] It is the second area (along with cover all children) around which there is considerable consensus as well as on-going discussion.[15]

As with all major policy issues in Washington State, consensus building around the SBA initiative occurred through the Legislative process – with SPG work supporting the process but certainly not driving it. Helping small employers offer, and their employees/families afford, coverage is an issue that has "legs" of its own – the impact of increasing costs of coverage are no secret to any elected official![16]

While SPG work did not drive the discussion it certainly helped to clarify the degree to which this is an area where action can be taken to address Washington's increasing uninsured rate. For example, our data clearly show that the characteristics of Washington's uninsured population tend to be quite consistent over time (even as individuals themselves move in and out of coverage). These people are *overwhelmingly part of working families*, are frequently low-income, and are often employed in the service, agricultural, retail, and construction industries. Furthermore, our analyses show a *decade long decline in employer-based coverage in Washington*. (This decline has been accompanied by increases in public program coverage;

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[13] Most of the discussion facilitation products are 1-2 pages – we quickly learned that anything longer is not likely to get used.

[14] Development of the small business assist program is one of the strategies under the Governors' Quality Improvement & Cost-Containment priority, which makes sense given that her vision for this initiative is to make things better in the market and delivery system for everyone, not just those for whom the state directly purchases.

[15] Cover All Children and Small Business Assist are not mutually exclusive; many uninsured children are in low-income families where parents work for small employers – see attachment 4-6.

[16] For example, initial steps towards helping small employers and their employees/families who are being priced out of the market were taken in the 2004 session when Washington enacted legislation to help shore-up the small group market. As a follow-up, the 2005 session saw a slew of bills introduced by a variety of legislators of both parties to assist small employers with health coverage. The SBA pilot being developed under our 05-06 funding is modeled on legislation introduced by the Governor in 2005; although the bill did not pass it provided the occasion for discussions that led to substantial agreement on important elements of a future program (which as noted earlier, the Governor has made part of her top three health care initiatives).

however, not to the extent of filling the gap.) Our earlier work pinpoints that it is getting *more and more difficult for Washington's small employers to offer and their employees/families to purchase* health insurance coverage. The issue is one of both affordability and quality, i.e., the ability to offer *coverage that is of value* to the parties involved in the purchase (employer and employee). In addition, our work makes it clear that the issue is most acute for small employers whose work force is dominated by *low-income workers* and for *"micro" employers* with fewer than ten employees. (See Sections 1-3 of this Report for supporting documentation.)

The target population for the SBA program is the approximately 150,000 uninsured employees (and their dependents) of small business – a substantial portion (around 40%) are low-income and/or work in micro firms of fewer than 10 employees where affordability issues are most acute. This 150,000 represents about one-quarter of Washington's uninsured. The other three-quarters are members of families that are unemployed or not in the labor force (~ 29%), identify themselves as self-employed (~ 33%), or are employed by large business (~ 13%). More specifically, we are aiming at the roughly 112,000 that are *full-time*. We are focusing on small businesses whose workers are predominantly full-time because these employers are the most likely ones to offer coverage if provided affordable, predictable, administratively simple options, and full-time employees are the most likely to take-up that coverage if available.

Managing expectations of what can realistically be accomplished "number-wise" is important for any state considering a similar initiative. For example, one of (if not *the*) most successful purchasing pools for small business is California's PacAdvantage (sponsored by the Pacific Business Group on Health). The enrollment is roughly 150,000 in a state of 36 million people. Applying that proportion to Washington, the maximum enrollment we could ever hope for (in the long-run) is ~25,200 covered lives – highly optimistic! Thus, in the best of all worlds, this program would ultimately impact about 4.2% of our uninsured; reducing the rate of uninsurance by just under one-half of one percent.[17]

We have a "working" go-live date of early 2007. Current status of the project is that (1) the Governor has designated a lead agency (the State Health Care Authority), (2) a project manager has been appointed, (3) internal work groups are meeting, and (4) the work plan is being updated to ensure that any necessary enabling legislation can be ready for the January 2006 session.

Attachment 4-9 is the Statement of Project Goals included in our '05-'06 HRSA proposal, including a list of design questions to be tackled. The design questions fall into the eight categories shown in Box 4.5.

Box 4-5: Design Question Categories, Small Business Assist Program

- Benefit designs and pricing
- Risk management / premium volatility management
- Shared funding / financing
- Public / private linkages
- Targeting
- Governance
- Implementation
- Monitoring / evaluation

[17] However, one of the goals of the SBA program is to test ideas that could be exported to the private sector or incorporated into public programs and, as a result, have an impact on covering the uninsured that is larger than reflected by this one initiative. Admittedly, we have no way of quantifying this potential impact.

C. COVERAGE EXPANSION – OTHER

There is a lot of activity around coverage occurring in Washington that could impact state policy. Described below are several efforts that (1) we felt would be of interest to other states and (2) to which the SPG team provided technical assistance in either direct (e.g., active involvement on advisory groups) or indirect (e.g., use of data and policy work products) ways. Included with each description is a source to contact for additional information. Appendices 2 and 3 fill-in the picture of what is happening in Washington.

Since most of these activities are on-going and we previously reported on them (primarily in our 2004 Report to the Secretary), our focus in the following brief descriptions is on current status and progress during the 04-05 funding cycle.

C.1. Coverage for artists (Washington Artists Health Insurance Project[18] *)*

In the 2004 Report we noted that the Washington Artists Health Insurance Project (WAHIP) had just begun its work towards developing new strategies to improve access to health insurance for artists. We chose to support this effort because of its natural connection to our small business assist thinking and the potential to apply our learning about artists to other occupations and work groups with similar work patterns (e.g., self-employed, contract, temporary, contingent, multiple-employers). These are the groups whose likelihood of being uninsured is high. In addition, a key WAHIP goal was to "provide leadership in developing models relevant to artists in other regions and for other populations with similar characteristics."[19]

Major steps during the past year include:

- Formation of an Advisory Group of experts from health policy, workers' benefits, insurance and the arts that guided WAHIP as a cross sector effort. An unexpected bonus of our participation has been the witnessing of a re-energizing of Washington experts who had drifted from the health policy forefront in recent years.
- Analysis and synthesis of existing local and national data on artists, with information gaps identified to be filled through a follow-up survey. Attachment 4-10 is a limited profile of artists we developed based on recent Washington State Population Surveys.
- An interactive survey of Washington State artists focused on health care and insurance access and needs.
- A provocative summer WAHIP Forum that brought together Washington State and national experts and innovators in health policy, health insurance and services for artists. Information gathered through WAHIP research, local experts, and the experience of successful groups in other states was shared as the basis for working sessions that creatively explored ideas on potential models for insuring artists.
- Preliminary plans to move WAHIP forward based on recommendations from the Forum.
- This month, the current Advisory Group met for the last time to confirm development of task forces in four focus areas (education and information; a health coverage model; coalition

[18] *WAHIP* is part of Leveraging Investments in Creativity (LINC) (www.lincnet.net) a ten-year national campaign to improve conditions for artists in all disciplines through collaboration in and outside the arts. Leadership funding for LINC has been provided by the Ford Foundation, Allen Foundation for the Arts, Nathan Cummings Foundation, John S. and James L. Knight Foundation, and the Rockefeller Foundation.

[19] WAHIP hopes to design a coverage model(s) in Washington state that will readily transfer around the nation. LINC and its funding partners are highly supportive because of this leveraging opportunity.

building and advocacy; and new subsidy and funding streams). These will become the advisory leadership for the project during its second year.

Research products and a summary of the Forum proceedings are available at the WAHIP web site: http://www.artisttrust.org/news/wahip.html.

For more information about WAHIP: Claudia Bach, 7702 14th Avenue NW, Seattle, WA 98117, 206-789-2418, Claudia@advisarts.com.

C.2. Community-based, universal coverage for low-income (Community Health Works)

To repeat what we said in the 2004 Report, we chose to become involved in this project because of its "transforming health coverage and access" orientation. The project goal is to pilot a community-based (5-county region) coverage, delivery, and administrative model in 2008 that will achieve 100% access for all residents below 250% federal poverty. Some of the major "forward steps" of the last year include:

- Closure on a basic benefit package that everyone should have access to.
- Development of a financing model that identifies the "gap" between potential sources of revenue (to be blended into a centralized source) and the cost of the basic package; including buy-off by the advisory council that the gap is sufficiently within the "tolerance zone" to not derail the project.
- Conceptualization of a care model for community health that is based on the chronic care model developed by Dr. Ed Wagner and colleagues, MacColl Institute for Health Care Innovation, Group Health Cooperative of Puget Sound.
- Initial recommendations by the Service Delivery work group on ways to improve the regional delivery of services that will achieve savings and improve care (built on the work of earlier teams on care coordination, services & benefits, and administrative simplification).
- Active interest by several Washington communities in testing whether a current statute that authorizes the formation of "county public health care service districts" can be used to pilot the Community Health Management District concept. This concept (described in the 2004 Report) was developed as part of the Community Health Works vision; very broadly, it is a community run model with taxing authority that would contract and pay for the primary care tier of services for everyone in the community in a way that is administratively simple and predictable for consumers and providers.

For more information on the Community Health Works project: Kristen West or Dan Rubin at CHOICE Regional Health Network, 2409 Pacific Avenue SE, Olympia, WA 98501, 360-493-4550. westk@crhn.org and rubind@crhn.org

C.3. Coverage for employees of large businesses (The Health Care Responsibility Act)

In essence this is Washington's version of "pay or play". Although we haven't had direct involvement in the "fair share" coalition that developed legislation on this issue, we have provided data (to gauge potential impact) and feedback on bill drafts (potential public policy and operational stumbling blocks) to legislative staff. We give it special mention because so many states continue to be interested in "pay or play" types of legislation.

The bill has been introduced in the last two legislative sessions (2004 and 2005) but has yet to make it to a floor vote. Among the reasons are:

- Leadership concerns re the lack of business support.
- Need to focus on other health care issues such as covering all children.
- A fiscal analysis showing the bill would cost the state money rather than adding revenue.
- Inability to develop an approach that would "hold harmless" companies already providing coverage to their employees/families (i.e., in some instances companies "playing" -- and playing well by covering most of their employees/families -- would still end up "paying").

The 2005 bill (SSB 5637) can be found at www.leg.wa.com, click on Bill Information. The coalition continues work on a revised version of the bill that likely will be introduced in the January 2006 legislative session.

For more information on the Health Care Responsibility Act: Robby Stern, Washington State Labor Council, Rstern@wslc.org.

C.4. Small group market improvements (Insurance Commissioner)

The State's Insurance Commissioner (independently elected official) has taken a special interest in how to reduce the number of uninsured and moderate uncompensated care costs by bringing stability and predictability to premiums in the private market (most notably the individual and small group). Because of SPG involvement in the small business assist program, there was a natural link to the interests of the Office of the Insurance Commissioner (OIC) as it developed its pooling and reinsurance proposal.[20] The question for us was: What lessons can be learned from the OIC reinsurance proposal, and reactions to it, to inform design of the small business assist program? To that end, SPG staff provided technical assistance to the OIC effort (e.g., feedback on the financial/economic model underlying the design and on the final reinsurance proposal).

An independent evaluation of the OIC's 2005 proposal[21] provides some key lessons for the small business assist development team:

- There is substantial potential in pursuing a pooling and reinsurance approach to moderate the level and volatility of private market premiums; however, forms of reinsurance other than the one proposed by OIC should be considered;
- Because the real driver of premiums is the increasing cost of care for high-risk people, effective pooling and reinsurance strategies should simultaneously redistribute the costs of

[20] By way of background, the OIC's initial work (resulting in proposed legislation in 2004 and 2005) focused on developing a pooling and reinsurance program with these basic features: (1) high risk enrollees would be pooled across the individual, small, and large group markets, (2) reinsurance would kick in when a patient reached $25,000 in medical expenditures, (3) above $25,000, the pool would pay 75% of the cost of care and the carrier would pay 25%, (4) part of the resulting savings (from reduced carrier risk) would be recaptured by the state and used to help low-income individuals purchase coverage in the Basic Health program. (This reinsurance program would be separate from the Washington State Health Insurance Pool, i.e., the state's high-risk pool. Carrier's in the individual market can reject up to 8% of applicants based on health status and refer them to the high-risk pool where costs are shared across carriers.)

[21] The Commonwealth Fund and OIC co-funded an independent evaluation by Carolyn Watts (University of Washington), Deborah Chollet (Mathematica), Karen Swartz (Harvard University), and James Matthisen (Mercer Consulting Group). SPG staff participated in the evaluation meetings with these experts.

care for high-risk individuals and reduce cost through care management approaches that improve quality and reduce expenditures.
- If pooling and reinsurance is to be a key component of the small business assist program it will be important to determine how other segments of the market will be impacted (or included).

The OIC interest in moderating costs in the private market, expanding coverage for the uninsured, and lowering the costs of uncompensated care continue. Currently, they are looking at a broader array of approaches (beyond but including reinsurance) for improving Washington's insurance market.

The OIC proposal as submitted in the 2005 legislative session (HB 1910 / SB 5861 companion bills) can be found at www.leg.wa.gov, click on Bill Information.

For more information contact: Michael Arnis, Office of the Insurance Commissioner, 360-725-7043, MichaelA@oic.wa.gov.

C.5. Medical homes as entrée to coverage (Kids Get Care Model)

The Kids Get Care (KGC) model is another of the on-going efforts discussed in our 2004 Report. We mention it again this year because it's a model that other states may find useful as an outreach strategy for hard-to-reach children who are not enrolled in public programs (Medicaid) but are eligible. In addition, it is on the tentative "short-list" of ideas for the "covering all children" initiative (discussed earlier in this report).

In brief, KGC is a program designed to "ensure that low-income 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." Key aspects of the program include:
- Community-agency staff are trained on the importance of prevention, including health and developmental red flags (the program "goes" to where children are normally found, e.g., local day care center);
- The prevention message emphasizes the importance of a regular source of care and children are linked to a regular medical and dental home;
- Visits to the provider are "holistic" rather than issue-specific, e.g., oral health and developmental screening occur during a regular medical preventive visit;
- Once the children are getting services, the KCG case manager works with the medical home staff (often a community clinic) to help the family enroll in existing public coverage.

This last step provides the direct link to expanding coverage.

For more information: Lisa Podell, KGC Program Manager, 206-296-2780, lisa.podell@metrokc.gov. www.metrokc.gov/health/kgc/

D. GENERAL DATA & POLICY ANALYSIS SUPPORT

Since our first 2001 SPG award our data and policy analysis work has become increasingly focused on improving access to information to better understand the coverage challenges and options in Washington. We continue to participate in (and often instigate) efforts to improve the collection and use of data (local in particular), and build on our baseline information in answer to whatever questions come up. The trick has been to balance the thirst for more and better data with the need to maintain focus on the key messages; it's been easy to lose sight of the story within the plethora of numbers (based on different questions, different data sources, different analysis approaches and different presentation styles). This is an ongoing challenge.

D.1. Resolution of Data Issues

Our primary data source for information about Washington's population is the Washington State Population Survey (WSPS) [22]. We've been fortunate to be co-located with WSPS researchers from the Office of Financial Management who are ready allies in resolving questions that arise in the use of WSPS and other data. Box 4-6 shows examples of issues that motivated a need for data improvements –as WSPS has earned its reputation as the most comprehensive source of data on Washington's population expectations have increased. We suspect that most of our issues exist for other states whatever their prime data source. Our credibility as a data resource has improved as we have been seen tackling these issues.

Box 4-6 Data Issues Summary

Medicaid undercount – Are individuals with Medicaid coverage accurately represented?
Race – Should adjusted or unadjusted weights be used for insurance estimates by race?
County-level estimates – How do we get estimates of the uninsured at the local level?
Different numbers - Which uninsurance number is right?
Immigrants – Can we estimate documented and undocumented immigrants?

Medicaid Undercount - In the 2004 Report to the Secretary we discussed the background, methodology and effect of our efforts to make adjustments to WSPS data to account for Medicaid underreporting[23]. The adjustment process continues, alongside efforts to improve Medicaid administrative data that are the basis for the undercount correction. Without the adjustment the undercount was estimated to be 27% in 2002, declining to 2% in 2004[24]. In addition to the Medicaid undercounting we recognize that the sampling methodology results in some undercounting of other much smaller groups; the homeless population, individuals living in group quarters, individuals without telephones and undocumented immigrants[25].

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[22] The Washington State Population Survey is a biennial survey conducted since 1998. Detailed information and data on all surveys are available at: http://www.ofm.wa.gov/sps/index.htm

[23] A full description of the Medicaid undercount correction methodology is available at http://www.ofm.wa.gov/sps/2002/Reports/briefing01.pdf.

[24] Some factors that contributed to this abrupt change include: revisions to survey questions to clarify the distinction between Medicaid and Medicare coverage, improved response edits at the time of interview, simplifications in administrative procedures, and sampling variation.

[25] "Undocumented" immigrants are often referred to as unauthorized migrants, illegal immigrants, illegal aliens, and undocumented aliens. They mostly include individuals who a) entered the country without legal documents or b) entered the country legally but overstayed their visa. A few may be here legally, as asylum applicants or with temporary protected status.

Race - Although the adjusted weights generally allow for more accurate estimates, they introduce inaccuracies in race and ethnicity estimates because these variables are not available to use in the post-stratification weighting step. As a result we withdrew our previous estimates by race. But, when others released their own estimates of insurance by race/ethnicity regardless of the data issues (then called us with questions) it quickly became obvious that we needed a solution. We now minimize the data noise for race/ethnicity analyses by using the UNadjusted weights to distribute the total population determined by the adjusted weights, as described in Attachment 4-11.

County-level estimates – WSPS divides Washington state's 39 counties into eight geographic regions which enable fairly detailed sub-state analysis of the uninsured that includes the 3 largest counties as separate entities. Nevertheless, the need for more localized (i.e., county-level) data has been a recurring theme since the SPG inception as local communities look to federal and other sources to fund community-based health care solutions. We've toyed with a variety of approaches for developing credible local-level estimates – application of regional uninsurance estimates to county-level populations; an econometric model based on county differences in Medicaid enrollment, income, and employment; recent US Census Bureau Small Area Health Insurance Estimates (SAHIE) facilitated by SHADAC; administratively based "cell" estimates. – like others we continue to pursue alternatives in search of "the best" local estimates.

Different numbers – Perhaps the most niggling data issue to date has been the question of *which uninsurance number is right?* Having an abundance of data sources capturing the uninsured in different ways has brought about competition among the estimates and confusion among policy makers who want to know *THE* number of uninsured in Washington State. Our "data resolution" has been to consistently use WSPS data as the baseline for comparing Washington with itself, and national surveys, CPS in particular, for comparing Washington with the rest of the nation. For the most part this has been acceptable, although rankings against other states are frequently debated. We've attempted to capture reasons for data differences (listed in Box 4-7) and educate at every opportunity, but are still working on the "right succinct overview" that satisfies all questioners. Because numbers of uninsured at a specific point-in-time are about half those at some-point-during-the-year, these differences can matter in discussions about cost and impacts of coverage options.

Box 4-7 Some Reasons Why Estimates of the Uninsured Differ Across Surveys

Survey definitions: • Units of measure differ e.g., WSPS captures uninsurance at a point-in-time, CPS captures uninsurance for the entire year. • Coverage responses not consistent - do respondents consider "vision-only" plans coverage?
Data collection methods: • Sample design, size, organization of survey questions, mode of data collection differs – e.g., WSPS samples about 5 times as many households as CPS.
• Survey refinements occur over time – e.g., CPS didn't ask about Basic Health in 2000; verification questions were added to CPS and WSPS, CPS samples expanded.
Time-period specifications: • Response accuracy dependent on recall – e.g., WSPS asks about coverage at the time of interview, CPS asks about coverage at any time in the past year and infers lack of insurance.
Data treatment: • Adjustments for survey bias (Medicaid undercount) not standardized – WSPS weights include adjustment for Medicaid undercount; CPS weight adjustments depend on the researcher.

Immigrants – With the resurrection of the Children's Medicaid Program for some immigrant children an interest in distinguishing "documented" from "undocumented" immigrants has resurfaced, primarily to estimate how many of which group might potentially be "eligible" for public programs and what that would cost[26]. Researchers have used different data sources (e.g., PUMS, INS, CPS, WSPS, NSAF) none of which captures Washington State's picture accurately. However, triangulating from the variety of research findings gets us a ballpark estimate for immigrant children of 2-4% of all children. While this passes the straight face test for now, we will need to continue refining our estimates to answer policy makers' queries.

D.2. Turning Data Into Information

Although there is more to be done, we've made considerable progress on several fronts in the past year, collaborating in the evolution of helpful data sources that allow us to turn data into information to facilitate coverage discussions and consensus building. We suspect that our experience is not uncommon in other states.

A picture's worth a thousand words. We've already mentioned our long-standing issue with the assortment of numbers that obfuscate the story and our need to find clearer ways to convey key messages along with the numbers. We've learned that charts seem to be more readily digestible than spreadsheets or lists of bullets. For example, Attachments 4-4 to 4-6 referenced in our description of expansion projects were developed to show children's insurance status at a glance. They've struck a chord – the message that funding public programs to meet the need would cover almost all uninsured children is being widely repeated, and local stakeholders have requested similar "pictures" of their community to carry the message at that level. "Pictures" have brought clarity to the potential roles of coverage sources (i.e., government, employer-based, private individual) at different income levels so that difficult conversations about realistic options proceed more easily when grounded in information.

Interactive data access. In the context of a changing (and currently declining) health system, telling the nuances of yesterday's news can mislead today's discussions or even be irrelevant. Even though the data tend to tell a fairly consistent story, their timeliness and accessibility are constantly in question. We've tried various approaches to making them more readily accessible, without leaving them ripe for torture. In the 2004 Report to the Secretary we described progress towards participation in the Multi-State Integrated Database (MSID) championed by Arkansas[27]. Our goal was to make WSPS widely available through the MSID, but we weren't able to resolve technical issues around our need to store both adjusted and unadjusted weights, and discovered that we realistically couldn't sustain the ongoing resource load to maintain the system outside the SPG. Regardless, the experience was extremely valuable – it spawned collaboration on a simple web-based system for accessing WSPS which will be available at **http://wa-state-ofm.us/SPSOnline/** shortly and is resourced to live on after the grant. Attachment 4-12 is a snap shot of the initial

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[26] Recently published research by Mohanty, S., et al. [Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis. *Am. Journal of Public Health* 95 (8):1431:1438] found that total health care expenditures for uninsured and publicly insured immigrants were 55% lower than for their US-born counterparts, although emergency department expenditures were 3 times higher for immigrant children.

[27] Appendix 11 is a Washington data briefing book developed by the Arkansas SPG project from the MSID's national data sets.

query options and results for a regional coverage breakdown of Washington's under-age-65 population. Additional phases of data access are being planned.

Enhanced data sources. In our 2004 Report to the Secretary we described the background, approaches, and problems in our efforts to build a credible body of local data that would allow in-depth analysis of employers and employees. When interest peaked in understanding the cost of health care borne by Washington employers, we collaborated with OFM researchers to link existing data sources, listed in Box 4-8, to fill gaps in our information.[28]

Box 4-8 Employer Health Insurance Database Sources

2004 Employee Benefits Survey – Annual survey by the Washington Employment Security Department (ESD) - http://www.workforceexplorer.com/article.asp?ARTICLEID=4618&PAGEID=24&SUBID=8

Business Tax & Premium Database – Select business data collected by ESD, OFM, Department of Revenue, and Department of Labor and Industries and merged under inter-agency data sharing agreements.

2004 Medical Expenditure Panel Survey (MEPS-IC) – Public data made available by the US Department of Health and Human Services, Agency for Healthcare Research and Quality - http://www.meps.ahrq.gov/Data_Public.htm

Data from three databases, originating from five agencies, have now been linked to build a single database covering 94,000 Washington employers. Attachment 4-13 provides an overview of this Washington Employer Health Insurance Database. Although we've barely begun to mine this resource, its value is already clear; requests for further analyses have sprung from a very limited distribution of preliminary information included in Section 2 as Attachment 2-1. For example; What percent of employees' incomes/ employers' payroll is going to health coverage and how is this changing in comparison to other financial burdens? What impact on insured rates would we likely make if "pay-or-play" targeted employers with 1,000 or more employees, 5,000 or more etc? How do health benefits for Government employees compare with comparable private sector firms? Which firms would benefit from tax breaks, but are they already offering health insurance benefits? How long and to what degree must firms be profitable before offering coverage is affordable?

With the renewed commitment to specific options for coverage and the expansion of our technical assistance role we've also found it important to explore opportunities for improvements in our State Population Survey. Since the survey covers more than just health-related information, balancing the need to fill coverage information gaps against adding complexity and length to the survey that may compromise response is a challenge. In the end we added only one question to the 2006 survey to help us understand which family members were covered by whose insurance (i.e., we sought to answer the question *are family members covered by their own or another family member's insurance*?) Other questions and probes we considered for inclusion relate to better understanding of:

- *Chronic vs. sporadic uninsurance spells*: In earlier surveys a question asked respondents about the duration of their time without insurance but data collected were unusable so the question was dropped. Our hope was to use this information to shed light on recurring suspicion over differences between CPS and WSPS-based coverage rates in Washington.
- *Working families*: Which working member's employer "covers" or "could potentially cover" the family; were adults/children/spouses eligible for employer coverage but waived it

[28] The 2005 Employer benefits Survey was also revised to include a question on employers' total expenditure for health care.

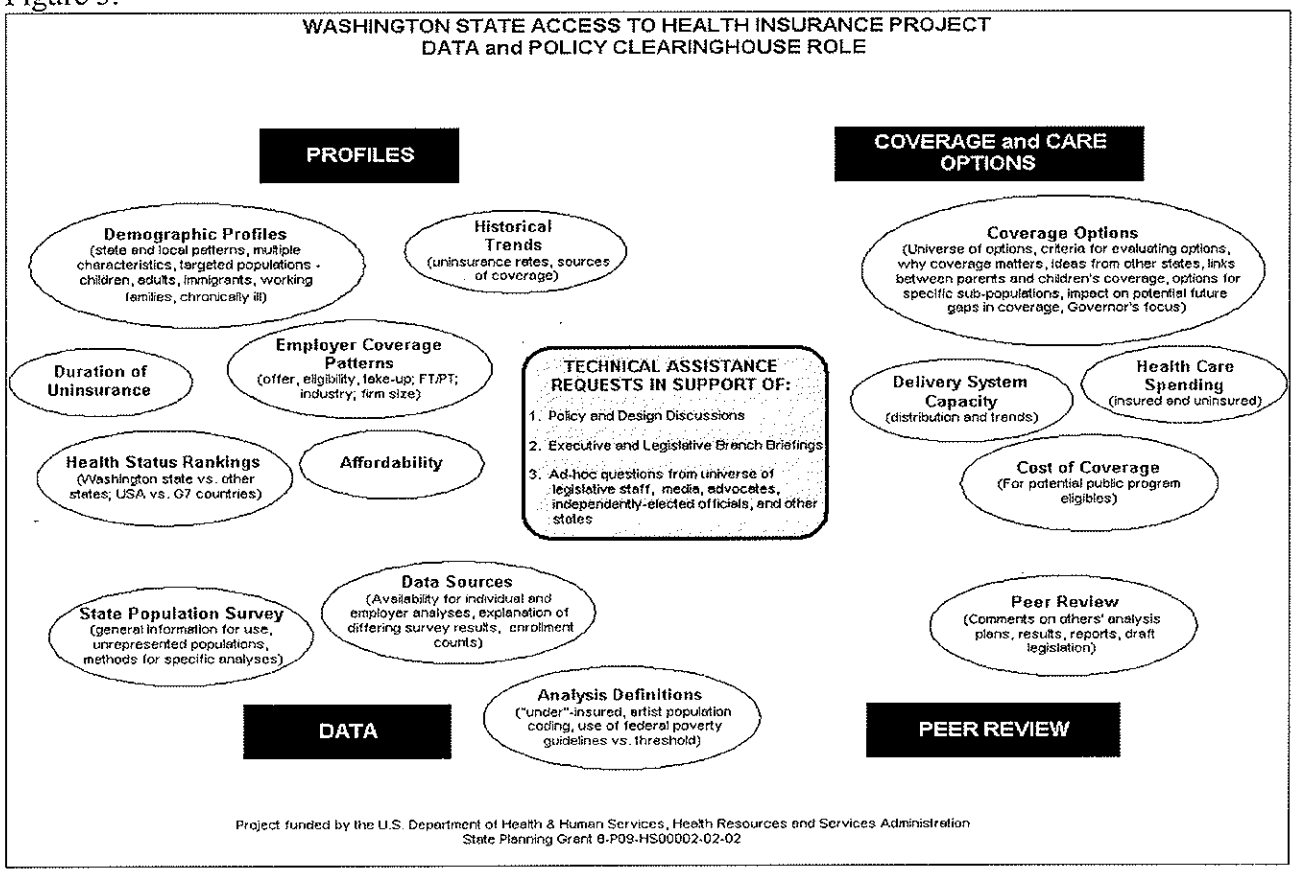
because they're covered through another family member; impact of rising costs on employees' coverage decisions for themselves and their families (do they retain employer-based coverage, switch to public coverage or go bare); how much are families in different industries/incomes/regions etc contributing to coverage?

- *Employer details*: Although respondents are currently asked to estimate the number of employees working for their employer it's an ongoing frustration that this information is missing for over 50% of working families. Furthermore, we're missing the employer sector for about 10% of uninsured workers. Producing information on working families attached to large or small businesses (including businesses of one - the self-employed) gets tricky. We're hoping that additional probes will help improve these data.
- *Children's coverage options*: Who's responsible for a child's coverage when the "legal guardian" is not in the surveyed household?

D.3. Technical Assistance and Clearinghouse

Over the life of our grant our technical assistance and information clearinghouse role has gradually matured. People have come to rely on us for expert assistance on issues and questions related to Washington's uninsured population as well as anything to do with health care and health policy. If we don't have an answer, the expectation is that we'll find one or at least provide a referral to someone else who might. Attachment 4-14 lists many data and policy-related questions we've dealt with in the past year. These are also summarized in Figure 5, which gives more perspective on the breadth of questions and requests thrown our way.

Figure 5.



From a data perspective we provide technical assistance on when, where, and how to use certain data sources; conduct ad-hoc analyses in response to questions from various private, public, non-profit, and community groups; and do self-initiated analyses to prod discussion of issues and encourage consensus-building. For the policy analogue of this we operate as an expert resource vis-à-vis questions and issues on coverage strategies, e.g., providing input on effective coverage strategies to consider, doing policy analyses on of-the-moment ideas such as pay-or-play for large employers, and providing input on specific legislation intended to eliminate barriers to coverage or affecting public program coverage. We've conducted individual and group briefings for members of the executive and legislative branches, media, and advocates, and collaborated with local municipalities and community organizations to translate data into information about the uninsured.

Attachment 4-1:

Link Between Coverage Initiatives and Groups of Washington's Uninsured

General Concept: Example of Broad Groupings of Washington's Uninsured Population

		Child		Adult	
	Uninsured Status	Chronic	Periodic	Chronic	Periodic
Family Connection to Labor Force	Unemployed / not in labor force				
	Self-employed				
	Employed				

People are grouped broadly by

- age (child or adult),
- whether they experience spells of uninsurance that are of long duration (chronic) or are transitional in nature (periodic), and
- by the family's connection to the labor force.

Coverage expansions can be targeted to a given cell, row or column of this table, e.g., children who are chronically (long-term) uninsured and are part of families with no connection to the labor force (shaded box). Furthermore, each cell, row, or column of this table can be dissected further to better hone in on a group of interest.

Specific Targeting: Examples of Broad Strategies Targeted to Specific Uninsured Groups

		Child		Adult	
	Uninsured Status	Chronic	Periodic	Chronic	Periodic
Family Connection to Labor Force	Unemployed / not in labor force	**(1)**		**(4)**	
	Self-employed			**(3)**	
	Employed			**(2)**	

Area (1) is addressed by the Governor's/Legislature's interest in developing strategies to cover all children by 2010.

Area (2) targets the adult-employed population; examples of two ideas currently in play are development of a small business assist program and work on a "pay or play" incentive program to encourage all large employers to offer coverage.

Areas (3) and (4) are a bit more difficult – the need is recognized but ideas for specific coverage approaches are few. Strategies for group **(3)** (i.e., self-employed adults) focus on restructuring the private market (e.g., reinsurance across individual, small, & large group sectors), shoring-up the state's high-risk pool, and sustaining the Basic Health program. The strategy for area **(4)** (i.e., unemployed / not in the labor force adults) is less about coverage per se than about sustaining the community clinic / hospital safety net.

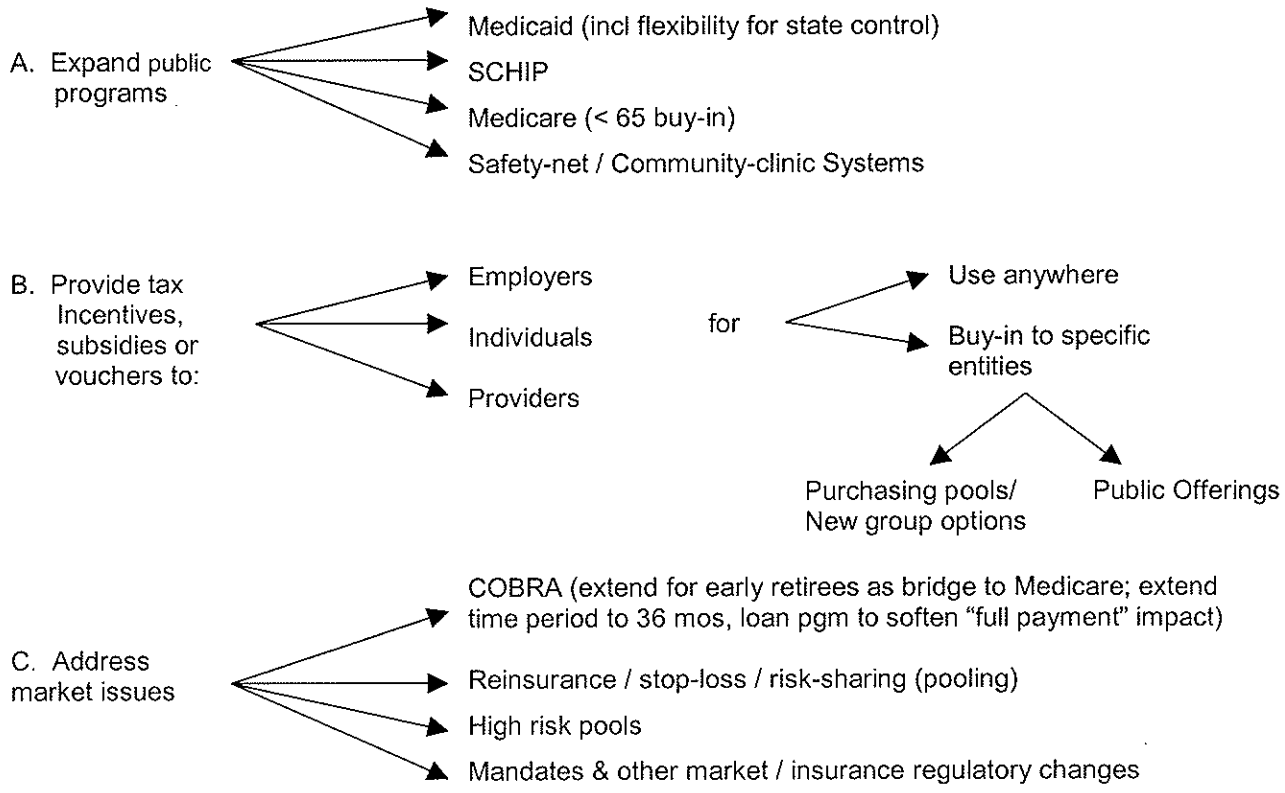
Clearly this schematic is a very simplistic view of who the uninsured are and strategies for coverage given that all uninsured have multiple characteristics and most coverage strategies cut across these characteristics.

State Planning Grant on Access to Health Insurance

COMMON CATEGORIES IN DISCUSSION (for expanding insurance coverage)[1]

1. Maximize / expand / streamline enrollment in public programs (e.g., Medicaid/HIFA waiver for flexibility; maximize SCHIP dollars -- especially use to cover parents)
2. Create buy-in opportunities for individuals and employers to existing options (e.g., state or federal employee programs; existing small employer purchasing pools – must include premium assistance)
3. Create buy-in opportunities through creation of new purchasing pool arrangements / insurance exchanges (i.e., new large group options)
4. Provide direct subsidies to employers and individuals (premium assistance programs; one-third share arrangements – employer, employee, gov't)
5. Create lower cost (limited) benefit options (preventive only; catastrophic only; all basics except inpatient hospital; "proven" evidence-based coverage only)
6. Provide tax incentives for employers to provide and individuals to purchase coverage (e.g., refundable tax credits; credits against state B&O tax)
7. Reduce carriers' financial risk / administrative burden (e.g., conventional reinsurance – as market stabilization approach; corridor stop-loss – a type of subsidy system; risk-sharing – redistribution approach)
8. Implement individual and small group market reforms (e.g., combine the two)
9. Provide direct service support (e.g., community clinic expansions; safety net provider financial support)
10. Mandates: Individual and/or employer mandates for coverage (e.g., pay or play) or business-partner mandates (e.g., mandate coverage by those who do business with the state).
11. single-payer (e.g., with single financing source – gov't; with multiple financing sources – employers, individuals, gov't) (with public or private or public/private delivery system)
12. Consumer-directed options involving MSAs, HRAs, etc. (usually coupled with catastrophic coverage)

COMMON REFORM IDEAS (sans mandates & single-payer)



[1] High level, for illustration (many variations on these themes)

Attachment 4-3

Working Paper for Discussion
Cover All Children by 2010 Work Group

Why Words Matter (clarifying the definition and appropriate measures of success)

The Important Concepts

Cover *all* children vs. Cover *all uninsured* children
Incremental vs. Piecemeal[1]
Measure what you want to see change

The Difference

Cover *all* children: At its most fundamental level this means that no child will experience a spell of uninsurance from birth to 18 (or age ?).

> *Incremental* implementation (e.g., by age groups) is possible and implies a final outcome of no gaps in coverage for any child, at any time.

Cover *all uninsured* children: A different concept that implies targeting a subset of children, i.e., those who are uninsured or low-income & uninsured, and will inevitably result in an outcome of *some* children experiencing *some* spells of uninsurance, *sometimes*.

> Piecemeal implementation is the more likely approach under this goal, as we "attack" one identified gap after the other and children move in and out coverage.

The Analogy

Although not perfect, an analogy is the jigsaw puzzle.

> Cover *all* children: Pieces come together in a logical way, one building on the next, to create a coherent, complete, recognizable picture with no holes. (Whole with no holes.)
>
> Cover *all uninsured* children: Pieces come together, sometimes logically and sometimes opportunistically, to create a recognizable picture but one where there will always be holes (i.e., gaps in coverage for some children at some points in time). (Whole with holes.)

Measure What You Want to See Change

The measures of progress likely differ between these two goals.

If the goal is Cover *All Uninsured* Children: A single measure based on a single definition of uninsurance may suffice. The most straightforward measure (readily available) is rate of uninsurance from the biennial Washington State Population Survey.

If the goal is Cover *All* Children: If we want to ensure that we are building a system that results in this outcome, then at least four measures of uninsurance should be considered for tracking:

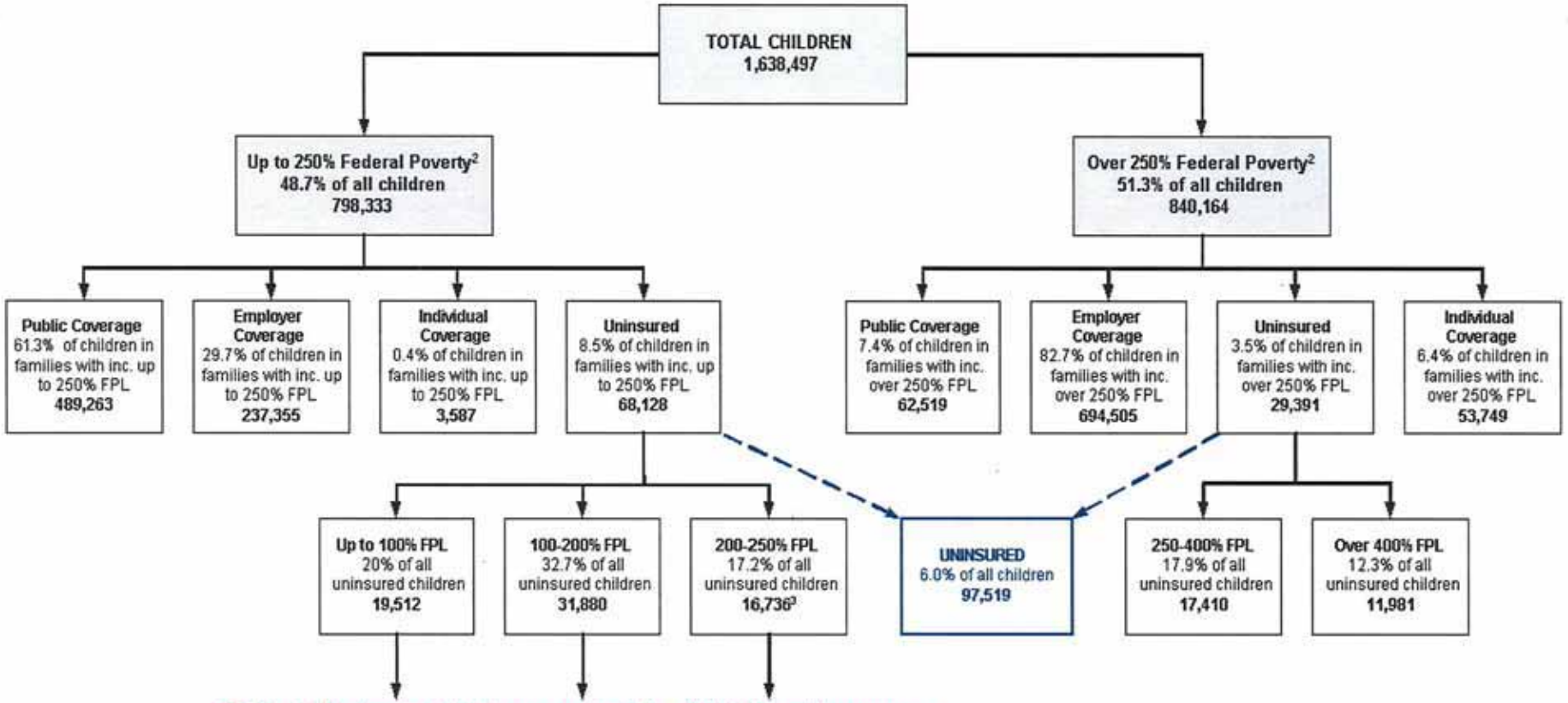
a. Point-in-time ("uninsured right now) estimate
b. "uninsured all year" estimate
c. "ever a spell of uninsurance during a year" estimate
d. duration of spells of uninsurance

---

[1] Incremental = series of regular additions or contributions
Piecemeal = in pieces, apart

Attachment 4-4

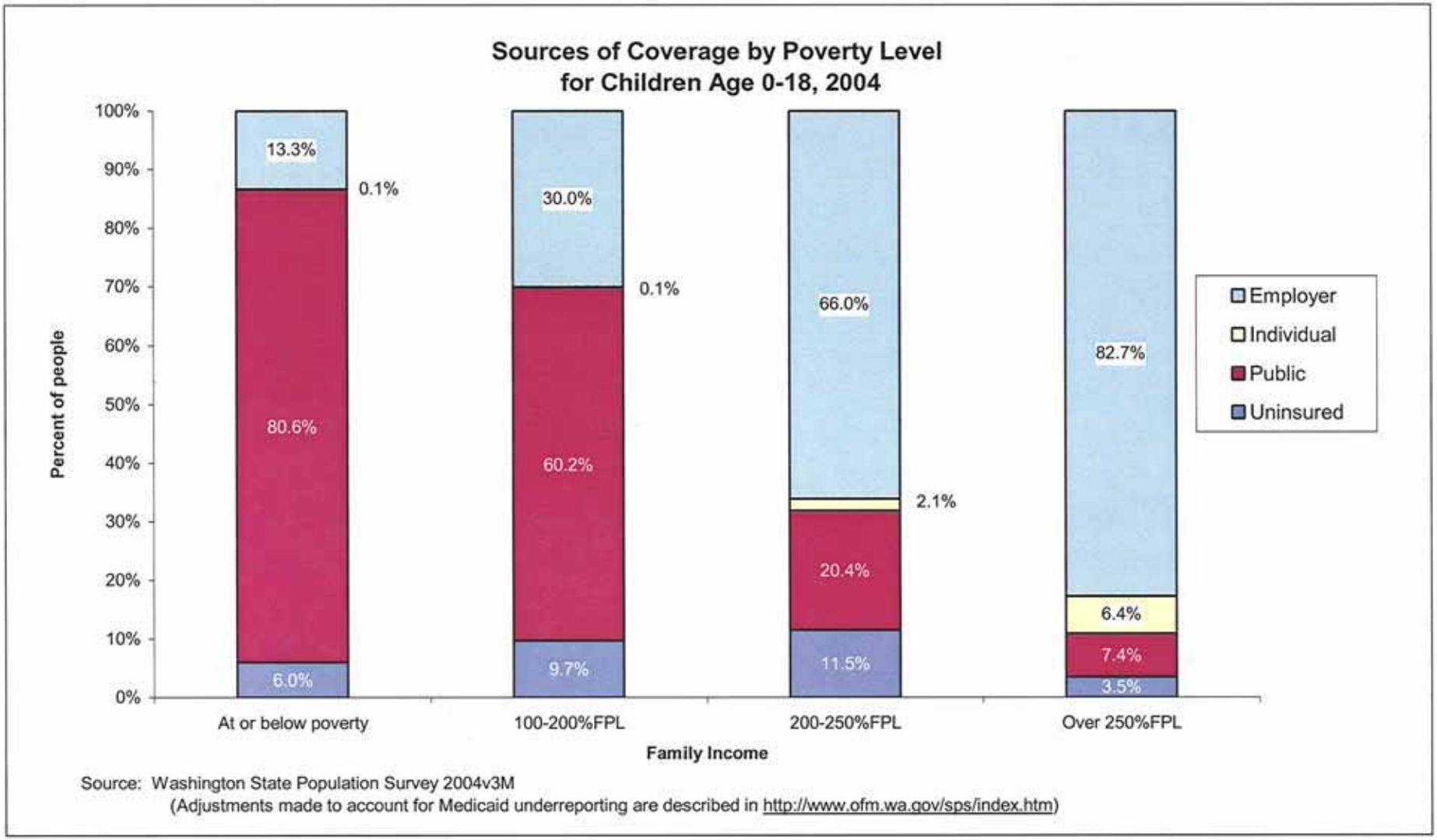
WASHINGTON STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE
2004 Children Age 0-18 Years [1]



[1] Source: 2004v3M Washington State Population Survey
[2] Poverty level for a family of four in 2004 was defined as $18,850
For more information see the Department of Health and Human Services website http://aspe.hhs.gov/poverty/figures-fed-reg.shtml
[3] Close to 400 children whose citizenship status is "unknown" may not be eligible for public coverage

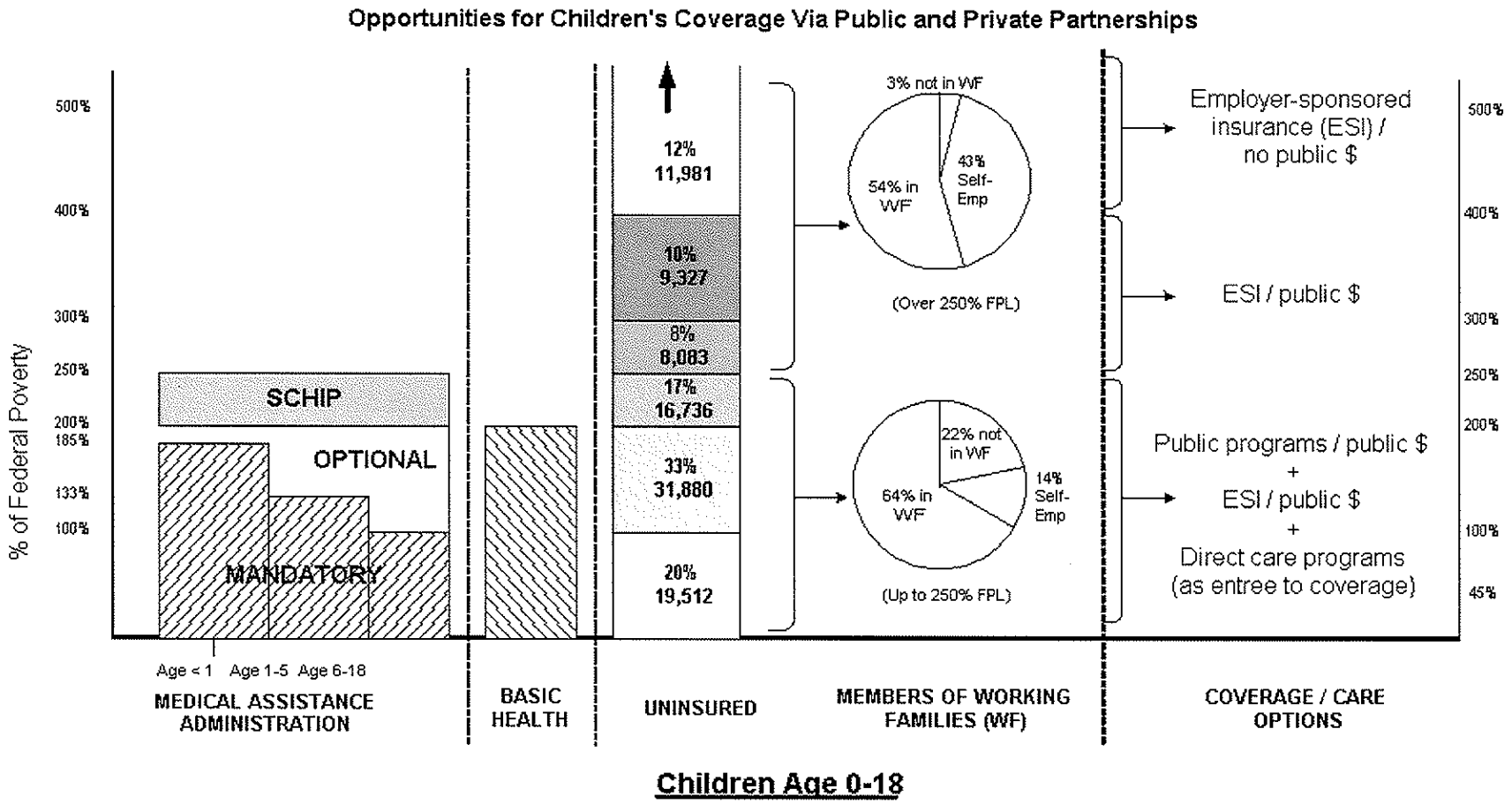
Project funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration' State Planning Grant #1 P09 HS 00002-02

Attachment 4-5



Source: Washington State Population Survey 2004v3M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Attachment 4-6:



1. 70% of uninsured children are potentially eligible for public programs, if funding were available.
2. 78% of low-income uninsured children, 0-250% FPL, are in families with at least one working member (either employer-based or self-employed).

Therefore:

1. There are many low-income uninsured children who are members of working families that potentially could benefit from a blend of public financing/programs and private coverage.
2. For higher income uninsured children there is further opportunity to encourage employer-based coverage.

Source: 2004v3M Washington State Population Survey

Attachment 4-7:

Working Paper for Discussion
Cover All Children by 2010 Work Group

Cover All Children – Why?

The imperative to "provide health insurance coverage to all children" rolls off the tongue so easily as to seem a no-brainer. But is it? Aren't most kids healthy -- implying that insurance coverage is, at best, unnecessary for the majority and, at worst, an avoidable expense? And when they get sick, need basic immunizations, or suffer traumatic incidents, don't uninsured children get needed care through resources such as emergency departments and community clinics?

The Bias:

Many things we need can wait. The child cannot. Now is the time his bones are being formed, his blood is being made, his mind is being developed. To him we cannot say tomorrow, his name is today. (*Children's Health, The Nation's Wealth: Assessing and Improving Child Health*, Institute of Medicine, 2004)

Gabriela Mistral
Chilean Poet
1889 -1957

So why the push to expand children's coverage (especially for lower income children)? Can we say beyond reasonable doubt that coverage leads to better outcomes and healthier kids? To be honest, the pathway is a bit indirect and heavily based on a chain of logic: **Coverage leading to better access, access leading to increased and more appropriate use of services, more appropriate use leading to better outcomes, and finally, better outcomes leading to healthier kids growing into healthier, more productive adults**. The following quotes from *Health Insurance is a Family Matter* serve to illustrate this chain.

- "Uninsured children have less access to health care, are less likely to have a regular source of primary care, and use medical and dental care less often compared to children who have insurance. Children with gaps in health insurance coverage have worse access than do those with continuous coverage." (page 111)

- "Previously uninsured children experience significant increases in both access to and more appropriate use of health care services following their enrollment in public health insurance programs." (page 113)

- "Uninsured children often receive care late in the development of a health problem or do not receive any care. As a result, they are at higher risk for hospitalization for conditions amenable to timely outpatient care and for missed diagnoses of serious and even life-threatening conditions." (page 122)

- "Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect children's functioning and opportunities over the course of their lives. Such conditions include iron deficiency anemia, otitis media, asthma, and attention deficit-hyperactivity disorder." (page 124)

The Limitations of Coverage: Notwithstanding the above, it would be a disservice not to acknowledge the other side of the coin, that is, the limitations of insurance coverage for children. It would be silly to argue that coverage is equivalent to access; coverage is simply the financial vehicle that paves the way for the chain of access, use, and outcomes to more readily occur. Further, it goes without saying that children's health is impacted by many factors not directly influenced by health care. And finally, we are still learning how to make the business case for improving the quality of children's care (as we are for adults as well).

For those who want to do their own reading and draw their own conclusions, below is a **select list of resources** regarding the links between coverage, access, use, and outcomes. The sources were selected because they provide overviews or syntheses of the relevant literature.

Case, Anne, A. Fertig, and C. Paxson. April 2004. *The Lasting Impact of Childhood Health and Circumstance*. Princeton, NJ: Princeton University, Center for Health and Wellbeing.

Child Health Business Case Working Group. 2004. "Exploring the Business Case for Improving the Quality of Health Care for Children." *Health Affairs* 23 (4): 159-166.

Institute of Medicine (IOM). 2002. *Health Insurance is a Family Matter*. Washington, DC: National Academy Press.

Institute of Medicine (IOM). 2004. *Children's Health, The Nations Wealth: Assessing and Improving Child Health.* Washington, DC: National Academy Press.

The Future of Children. 2003, Volume 13 (1). *Health Insurance for Children*. Los Altos, CA: The David and Lucile Packard Foundation.

Submitted by: Governor Gregoire's Cover All Children by 2010 Work Group, August 2005

Note: This is a work-in-progress and currently is undergoing revision, including the addition of a short section on "quantifying" the return on investment for insuring children.

Attachment 4-8:

Working Paper for Discussion
Cover All Children by 2010 Work Group

Key Points and Criteria for Strategies Short-List

Background: Although "Cover *All* Children" is the phrasing used, the work group redefined the assignment to be "Cover *All Uninsured* Children". The two are not the same and potentially lead to different coverage approaches, e.g., incremental gap filling rather than transformational change.

A. Key Points

1. There are about 98,000 uninsured children 0-18, a ***6% uninsured rate***.
   This is a point-in-time estimate as of March/April 2004 (Washington State Population Survey). Other estimates go lower or higher depending on the question asked ("uninsured the full year" produces a lower estimate; "uninsured at any time during a year" produces a higher estimate).

2. The children's uninsured ***rate would drop to less than 2%*** if public programs were fully funded to cover all eligible children.
   Nearly 70% of Washington's uninsured children are eligible for public programs (Medicaid, SCHIP, Basic Health).

3. A **majority** of uninsured children are ***part of employer-based working families***.
   54% of uninsured children above 250% federal poverty and 64% below federal poverty fit this profile, thus supporting opportunities for public / private partnerships even for some of the state's poorest children.

4. ***One challenging gap*** is uninsured children who are part of **self-employed families**.
   Strategies other than making private market coverage (individual, association plan, etc.) more affordable or supplying substantial purchasing subsidies are elusive.

5. ***Another challenging gap*** not well addressed in the options is ***transitional loss*** of coverage.
   Many children are not chronically uninsured, but rather face intermittent spells of uninsurance as their parents' economic and work circumstances change.

B. Criteria for the Short-List

These criteria are for use as general yardsticks, not as hard and fast rules, for deciding if a strategy makes it to the short-list. The strategy ...

1. Targets a relatively large group of uninsured children.
2. Contributes to reducing coverage disparities.
3. Has reasonable political viability.
4. Builds on current infrastructures rather than creating new ones.
5. Capitalizes on public / private partnerships where they make sense.
6. Has potential for financial sustainability.
7. Has a proven track record.

In addition to these specific criteria, the work group is mindful of two other issues:

1. Affordability ***is*** the issue for most uninsured.
2. Coverage and access must go hand-in-hand.

Attachment 4-9:

SMALL BUSINESS ASSIST PROGRAM, STATEMENT OF PROJECT GOALS
(excerpt from March 2005 Funding Proposal to State Planning Grant Program)

This Pilot grant will provide the expert resources and technical assistance needed by Washington State to design a program to help small employers offer and their employees/families purchase affordable, predictable health coverage. The focus of the program is a small employer purchasing pool; a component of the program is premium assistance to help low-income families buy-into employer-based coverage. We will draw on lessons from (1) Washington's experience with Basic Health as one of the nation's original 3-share programs (employer/sponsor, employee/enrollee, state), (2) experience of other states that have implemented small employer pools and assistance programs, and (3) expert researchers who have evaluated the characteristics of successful versus less successful implementations.

The broad goals of the Pilot are to:

- Develop a viable underwriting pool of 6,000-10,000 employees and family members of small business (growing over time) (see Project Description for a discussion of magnitude of impact),
- Design premium assistance strategies including use of individual-based subsidies paid in a group coverage environment,
- Test ideas around development of benefit packages based on best evidence (whether traditional in nature or part of the newer consumer-directed movement), risk management mechanisms such as health-based risk adjustment and reinsurance as a potential for "buying down" the price of insurance (a type of implicit subsidy), and use of community organizations to put a local face on the program (community surveys of small employers show that they want to "buy locally"),
- Develop the specifics of a plan to seek federal matching funds on a non-Medicaid program (via a HIFA waiver), and
- Attempt a pool governance structure that is joint public / private with an option for transition of workable ideas to the private market.

There are three issues that need simultaneous attention if we are to make any inroads for small employers and their employees: (1) affordability of base level premiums, (2) yearly growth and volatility of premiums, and (3) range of options that respond to employer/employee needs. Thus, this pilot is about more than creating 1-2-3 new benefit designs; it's about creating an environment (e.g., shared-risk and funding, evidence-based delivery, community platform) for sustainable, affordable coverage.

At the end of this grant we will have addressed the following questions, resulting in the design of a viable small employer purchasing pool, a component of which is premium assistance for low-income employees and their families. An initial task of the project team is review and refinement of this list.

Area	Questions
Benefit designs and pricing	• Will product design be coordinated with Basic Health? How? • How will people be able to transition among these products? • How many designs will there be? Of what type (e.g., preventive/primary care only; catastrophic only; all basics except inpatient hospital; high deductible health savings accounts) • How can evidence-based medicine be operationalized within these designs – will that reduce costs? Improve health? • Will exemption from state mandates and current modified community rating rules improve affordability? • What kind of quid-pro-quos can be made with providers in exchange for preferred rates to lower prices?
Risk Management / Premium Volatility Management	• Will attention to health-based risk adjustment help persuade carriers to participate? Or the opposite? Will it improve affordability? Reduce volatility? • Will attention to reinsurance for high-cost or high-risk enrollees persuade carriers to participate? Or the opposite? Will it improve affordability? Reduce volatility? • How would implementation of these mechanisms in this limited environment co-exist with markets that don't use them? If used throughout all markets, would they improve affordability statewide?
Shared Funding / Financing	• How would current public expenditures be restructured to cover more people? • How would shares for each contributing partner (employer, employee, public) be determined to maximally encourage coverage? • What design characteristics would maximize the opportunity for federal match through a HIFA waiver for a non-Medicaid program? • What funding approaches would most encourage family coverage? • How can an employer group program be meshed with an individual-based subsidy program? In the context of employer coverage, what are the advantages and disadvantages for both employer and employee of basing the subsidy on family income versus employee wage? • Should the premium assistance component be limited to purchasing within *this* pool alone or be available outside the pool as well?
Public / Private Linkages	• Will this program be affiliated with Basic Health? How? • How would it work with Medicaid and SCHIP? • How will the program as a whole relate to the private market (e.g., publicly financed but privately offered)? • How will product design be coordinated with private market products – existing and evolving (e.g., high deductible plans; Association Health Plans; Health Savings Accounts)? • In what ways can this program take advantage of existing public infrastructure? Existing private infrastructure? • What are the expectations about moving between this program and other markets? • If exempt from state mandates and rating requirements, what are the consequences for carriers and other organizations not relieved of these requirements? • What opportunities / program characteristics will provide incentives for carriers to participate? • How will the program coordinate with local community and business organizations so that employers can "buy locally", as is their preference?

Area	Questions
Targeting	• How will the program meet the needs of small employers in different areas of the state? • How will the program meet the needs of small employers with different work force characteristics (e.g., employees are predominantly full-time versus part-time, predominantly low-wage or not, predominantly female or not, predominantly younger or not, predominantly one versus multiple-employer)? • What would be the pros and cons of targeting specifically to micro firms (less than 10 employees) where offer and take-up rates are lowest? • Should we consider the age of a firm as we refine our targeting? Are older, established firms more likely to be in a position to consider coverage? • How will the program handle the issue of crowd-out (e.g., is "employer hasn't offered coverage for at least six months" sufficient? Too much?)
Governance	• Would the governance structure be public, quasi-public, or private? • Would it be statewide or local? • How would it be operationalized and financed? • Should sponsorship by a large purchasing coalition (e.g., Puget Sound Health Alliance) be considered (similar to PacAdvantage and PBGH)?
Implementation	• What lessons are there from Basic Health's earlier attempt at employer coverage, Basic Health's current Sponsor program, and other states' experiences that need to be incorporated into the design? • In the end, what design elements need to be tweaked to make the program easy to access and use for employers and their employees? • Should the program be implemented statewide or phased-in? If phased-in, how (e.g., piloted in various communities)? • Are there specifics of language that need to be attended to in the context of an employer coverage program, e.g., replace subsidy with "earned health credit"? • How should the procurement process work (e.g., piggy-back on existing state agency process)? • What tools/processes are needed to ensure that program administration is efficient and effective for all parties involved? • What legal issues (state and federal) need to be addressed?
Monitoring / Evaluation	• What specific policy & program management questions do we want to answer via monitoring? Via evaluation? • What data need to be collected to monitor real-time impacts (e.g., to judge if the plug needs to be pulled because consumers are being hurt)? • What data need to be collected to evaluate the longer-term impacts such as impacts on small employer offer rates, employee/family take-up rates, premium levels and premium volatility, carrier participation and satisfaction, impacts on markets outside the purchasing pool? What else needs to be on this list? • What process, and how much would it cost, to collect this data? Who would do it? • How long would the program have to run to have the ability to conduct a viable evaluation?

We have been asked why the public sector is taking on this issue – couldn't the private sector handle it equally well?[1] We offer the following in response:

1. Consumer protection: We need to be able to try innovative ideas in a controlled environment where if the ideas are not working and consumers are getting hurt (beyond some marginal threshold) the plug can be pulled quickly.
2. The stakes: The higher the societal stakes, the less that private markets should be entrusted to take the driver's seat. Where there is a compelling public interest, as there exists regarding the public's health, markets are best used as tools but not left to their own self-interests. Simply because markets work outstandingly in some arenas doesn't mean they do so in all arenas.
3. Areas of expertise / opportunity: Washington's public sector has resources and experience that are not readily available in the private sector, e.g., providing subsidies for low-income, health-based risk adjustment to encourage coverage of anyone regardless of health status. There are also opportunities available to the public sector not available to the private, e.g., the potential for receiving federal matching dollars without any additional state investment.

[1] It has been suggested that the private market could address the growing number of uninsured workers and families associated with Washington's small businesses if current restrictions (such as mandates and modified community rating rules) were lightened. Washington markets have had the opportunity to develop and offer "limited benefit plans" for many years to employers with less than 26 employees and more recently to employers with fewer than 50 employees. To-date there hasn't been much response to this opportunity, either in terms of carriers offering or employers purchasing. In fairness, the "limited benefit plans" are not totally mandate-free, some restrictions remain (such as covering every category of provider, rating bands) and it is argued that these are the big culprits in making coverage unaffordable to small employers. We agree that it is perhaps time to see what can be done in a less restrictive environment; we simply feel the testing should occur in a controlled arena where if consumers are being hurt the "experimental trial" can be ended quickly. That would not be the case if left to the market.

Appendix 4-10:

Talking Points About Selected Washington Artists and their Family Members

The following points provide a limited profile of the sub-groups of individuals (and their family members) who identified their primary occupation as being an artist in the 2002 and 2004 Washington State Population Surveys (WSPS). Because the numbers of artist respondents were not large enough samples to be statistically representative of all artists in Washington, profiles cannot be generalized to the total population of artists. However characteristics may complement information from other sources to collectively provide a useful picture of Washington's artist community.

As table 1 shows, the 2002 and 2004 Washington State Population Surveys included artists in mostly the same set of occupations; over half were from occupations in the visual arts and less than 10% were musicians and composers. 84 artists and 96 family members (180 individuals) were included in the 2002 WSPS; 12 of these were uninsured. 105 artists and 119 family members (224 individuals) were included in the 2004 WSPS; 19 of these were uninsured.

What can be said about these people is:

Demographics

- Although scattered around the state, these 2002 and 2004 artists and their family members were concentrated in King County where approximately one-third lived. About 75% lived in counties on the western side of the state.

- These artists primarily described themselves as working for private for-profit organizations or self-employed. Among the 2002 artists 36% were self-employed; in 2004 39% were self-employed.

- The 2002 artists were primarily male (55%); the 2004 artists were primarily female (60%).

- These artists and their family members are highly educated. In 2002 and 2004, about 60% of the artists had a college degree, almost twice that of the general Washington state population.

- Adults without dependent children made up a little over 42% of these artists and their family members in 2002 and 2004. They also made up a comparable portion of the uninsured, although in the 2004 group slightly more were uninsured than in 2002.

Insurance Status

- In 2002 and 2004, patterns of insurance coverage were very similar for these artists and their family members. In 2004, about 72% were insured through an employer, about 8% were insured primarily by purchasing individual insurance; about 12% were insured through public programs such as Medicaid, Basic Health and Medicare; and just under 9% were uninsured (slightly less than the Washington state population as a whole in which 9.5% were uninsured).

- In 2002 and 2004, artists and their family members who had no health insurance were members of working families, they were poor and they were young - consistent with patterns for Washington State and the nation.

  - All these artists and their family members were members of families in which there was at least 1 worker, although those who were uninsured were more concentrated in families with only 1 worker.

- While over half these artists and their family members were age 35-64, those ages 19-34 were more than twice as likely to be uninsured.
- Although over 80% of these artists and their family members had family incomes greater than 200% of federal poverty ($37,700 for a family of four in 2004) those whose family income was less than 200% FPL were more than 4 times as likely to be uninsured.

- In 2002, reasons artists gave for being uninsured were that they cannot afford it, don't need it, are self-employed, or work part-time and are not offered coverage. In 2004, the only reason given was that they cannot afford it.

- In 2002 and 2004, most artists and their family members were white, although minority or ethnic groups were more likely to be uninsured.

Health Status

- In 2002 and 2004, these artists and their family members described themselves as generally being healthy, in excellent or very good health, whether they were uninsured or not. However, those who described themselves as having fair/poor health were more likely to be uninsured than those who described themselves as being healthy.

Table 1. Occupations Included in WAHIP Definition of Artists

Occupation	Description	Included in 2004 WSPS	Included in 2002 WSPS
25-1121	Art, Drama, and Music Teachers, Postsecondary	X	X
25-4012	Curators	X	X
25-4013	Museum Technicians and Conservators		
27-1011	Art Directors	X	X
27-1012	Craft Artists	X	X
27-1013	Fine Artists, Including Painters, Sculptors, and Illustrators	X	X
27-1014	Multi-Media Artists and Animators	X	X
27-1019	Artists and Related Workers, All Other		
27-1021	Commercial and Industrial Designers	X	
27-1024	Graphic Designers	X	X
27-1027	Set and Exhibit Designers	X	
27-1029	Designers, All Other	X	X
27-2011	Actors	X	X
27-2012	Producers and Directors	X	X
27-2031	Dancers	X	X
27-2032	Choreographers		
27-2041	Music Directors and Composers	X	X
27-2042	Musicians and Singers	X	X
27-2099	Entertainers and Performers, Sports and Related Workers, All Other		
27-3041	Editors	X	X
27-3043	Writers and Authors	X	X
27-4021	Photographers	X	X
27-4031	Camera Operators, Television, Video, and Motion Picture		
27-4032	Film and Video Editors	X	X
39-3092	Costume Attendants		X
39-5091	Makeup Artists, Theatrical and Performance		
49-9063	Musical Instrument Repairers and Tuners		
51-5012	Bookbinders (hand)		X
51-7099	Woodworkers, All others (incl. wood carver)	X	X

Attachment 4-11:

WASHINGTON STATE POPULATION SURVEY

Research Brief No. 37
September 2005

Health Insurance by Race/Ethnicity: 2004

By Erica Gardner

Using data from the 2004 Washington State Population Survey (WSPS), health insurance status is examined for Washington State's non-elderly population (ages 0-64) by race and ethnicity.

Ordinarily, when using WSPS data to produce health insurance estimates it is recommended that one use Medical Assistance Administration weights (MAA weights). The MAA weights adjust health insurance estimates for an undercount of individuals insured by Medicaid or other Medical Assistance programs. However, the MAA weights do not produce accurate health insurance estimates by race and ethnicity because race and ethnicity were not available to use in the construction of the weights (for more details see Research Brief 20: http://www.ofm.wa.gov/researchbriefs/brief020.pdf). Given substantial interest in health insurance data by race and ethnicity, we are releasing these estimates using the population weights. It should be noted that estimates produced using the population weights do not fully agree with other published data by the Office of Financial Management (OFM) on health insurance or the uninsured.

In this brief health insurance status is separated into four categories: public, employer based, private other, and uninsured. Individuals may have more than one type of health insurance plan, but if they receive Medicare, Medicaid, Basic Health Plan, or some other type of Medical Assistance, they are defined as receiving public health insurance. If a person does not receive public health insurance and receives military, employer, or union based health insurance, he/she is defined as receiving employer based health insurance (Note: Government employees are reported as receiving employer based health insurance coverage). Individuals who have health insurance, but it is not public or employer based are defined as receiving other private health insurance.[1] Finally, individuals who do not receive any type of health insurance are defined as uninsured. Unless otherwise indicated, differences mentioned are statistically significant at least at the five percent level.

Health Insurance Status by Race

Uninsured by Race

The health insurance status of non-elderly Washington State residents by race is shown in Figure 1. The rate of uninsurance for Whites is 11 percent. While the sample sizes for non-White racial groups within the WSPS are small, the following results represent our best estimates for the uninsured by race: 10 percent for Blacks, 11 percent for Asians, 17 percent for American Indians/Alaska Natives, and 17 percent for Native Hawaiian/Other Asian Pacific Islanders. However, due to the small number of minority survey respondents, none of the uninsured estimates are statistically significant by race at the 5 percent level.[2]

Many national survey results have shown that Blacks (or non-Hispanic Blacks) are significantly more likely to be uninsured compared to Whites,[3,4,5] so in that context the WSPS results are surprising. However, there is evidence to suggest that Blacks living in the West are different from Blacks in the rest of the country. Blacks in Washington and other Western States are less likely to

The **Washington State Population Survey** was conducted in the spring of 2004 to provide social, demographic, and economic information about Washington. Responses were obtained from telephone interviews of **7,097 households** that represented the state as a whole. The survey was designed by the Office of Financial Management (OFM) and conducted by the Gilmore Research Institute. More information about the state survey is available at: http://www.ofm.wa.gov/sps/index.htm. Data version 2004v3 is used in this analysis.

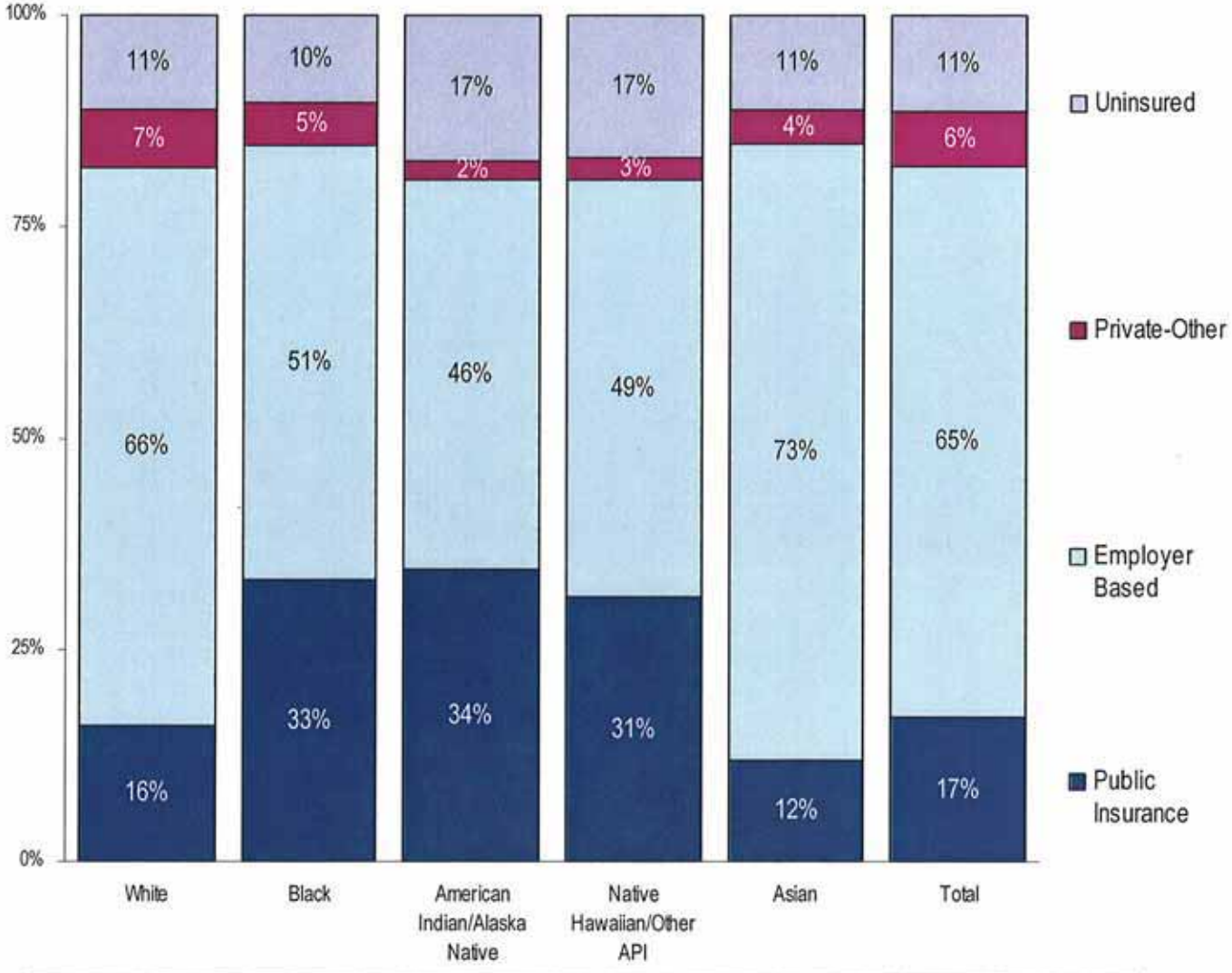
have family incomes under 200 percent of the federal poverty level, and more likely to have some college or more compared to Blacks in the rest of the country.[6] Blacks residing in Washington, in particular, are more likely to be in the military or working compared to Blacks in the rest of the country.[6] In addition, results from the 2001 California Health Interview Survey also found that non-elderly adult Blacks were not statistically more likely to be uninsured than Whites.[7]

While the WSPS's uninsurance estimates for American Indians/Alaska Natives and Native Hawaiian/Other Asian Pacific Islanders are not significantly different from the uninsurance estimate for Whites, the results are consistent with results from other surveys.[3]

The WSPS results show that Asians in Washington have rates of uninsurance similar to Whites. National surveys and the 2001 California Health Interview Survey show Asians having higher rates of uninsurance.[3,7] Explanations for the different findings might include differences between Washington's Asian population and California's or the U.S.'s Asian population, sample variations, and the different definitions of the Asian population used in the surveys.[8]

Figure 1: Health Insurance Status of the Non-Elderly Population by Race: 2004

Universe: Washington Residents Aged 0-64



Source of Health Insurance by Race

While Whites, Blacks, and Asians have similar rates of uninsurance, the source of their health insurance coverage is different. Sixteen percent of Whites and 12 percent of Asians are publicly insured compared to 33 percent of Blacks. Two-thirds of Whites and 73 percent of Asians receive their health insurance through the military, employer, or union compared to 51 percent of Blacks.

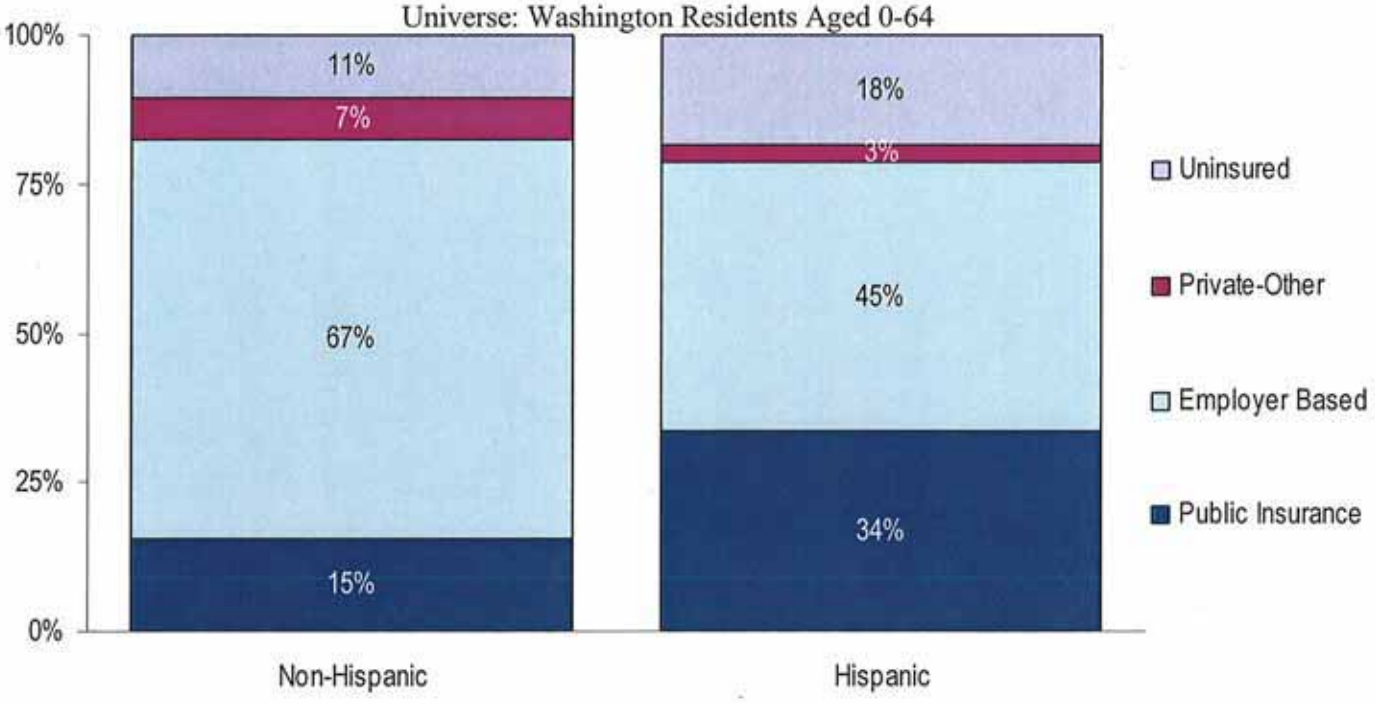
Similar to Blacks, American Indians/Alaska Natives and Native Hawaiians/Other Asian Pacific Islanders also have relatively high rates of public health insurance and relatively low rates of employer based health insurance compared to Whites and Asians.[9] American Indian/Alaska Native and Native Hawaiian/Other Asian Pacific Islanders are also less likely to have other types of private health insurance compared to Whites.

Health Insurance Status by Ethnicity

Figure 2 shows the health insurance status of Washington State's non-elderly population by Hispanic ethnicity. Hispanic residents are more likely to be uninsured, more likely to be publicly insured, less likely to be insured through the military, an employer, or union, and less likely to have other private insurance compared to non-Hispanic residents.

Figure 2: Health Insurance Status of the Non-Elderly Population by Ethnicity: 2004

Universe: Washington Residents Aged 0-64



Racial and Ethnic Composition of the Uninsured

Table 1 shows both the number of uninsured and the composition of the uninsured by race and ethnicity. The distribution of Washington's uninsured by race roughly mirrors the distribution of the population by race (i.e. they are not significantly different). Eighty-six percent or roughly 517,000 of the uninsured are White. At five percent of the uninsured, Asians make up the second largest racial group in the uninsured. Four percent of the uninsured are Black, three percent are

American Indian/Alaska Native, and two percent are Native Hawaiian /Other Asian Pacific Islander.

Hispanics are disproportionately represented among the uninsured compared to non-Hispanics. Roughly 9 percent of Washington's non-elderly population is Hispanic, but 15 percent or approximately 91,000 of the uninsured are Hispanic.

Table 1: Non-Elderly Uninsured Washington Residents by Race/Ethnicity: 2004

		% of Uninsured (a)	Number Uninsured (in 000s) (b)	% of Total Population (c)
Race				
	White	85.7%	517	87.2%
	Black	3.6%	22	3.9%
	American Indian/Alaska Native	3.1%	19	2.0%
	Native Hawaiian/Other API	2.4%	15	1.6%
	Asian	5.1%	31	5.2%
Total		100%	603	100%
Ethnicity				
	Non-Hispanic	85.0%	512	90.7%
	Hispanic	15.0%	91	9.3%
Total		100%	603	100%

(a) The percentages here are based on the distribution of uninsured by race/ethnicity using the population weight (fnlwgt)
(b) The number of uninsured by race/ethnicity was obtained by using the total number uninsured using the Medical Assistance Administration weight (maawgt) and the distribution of the uninsured using the population weight (fnlwgt)
(c) The percentages here show the distribution of total population by race/ethnicity using the population weight (fnlwgt)

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1. Other private health insurance includes those who purchase their own health insurance, receive health insurance from outside the family, and receive health insurance from "other" source.
2. Researchers typically report differences in rates if they are significantly different at the 1 or 5 percent level.
3. U.S. Census Bureau. (2005). "Table 8: Health Insurance Coverage of People by Race and Hispanic Origin Using 2-and 3-Year Averages: 2002 to 2004." (http://www.census.gov/hhes/www/hlthins/hlthin04/hi04t8.pdf)
4. Finegold, Kenneth, and Wherry, Laura (2004). "Race, Ethnicity, and Health" Snapshots III No. 20 (http://www.urban.org/UploadedPDF/310969_snapshots3_no20.pdf)
5. Rhoades, Jeffrey A. (2005) "The Uninsured in America, 2004: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 65." Medical Expenditure Panel Survey Statistical Brief No. 83. (http://www.meps.ahrq.gov/papers/st83/stat83.pdf)

6. Using data from the: 2000 Five Percent Public Use Microdata Sample (PUMS) Files (http://www.census.gov/main/www/cen2000.html)
7. California Health Interview Survey. "Current Health Insurance Coverage: Adults 18 to 64" (http://www.chis.ucla.edu/ber/stateTable31.asp)
8. Many surveys combine the racial category Native Hawaiian/Other Asian Pacific Islander into the larger category of Asian.
9. The employer based health insurance rate for Native Hawaiians/Other Asian Pacific Islanders is not significantly different from Whites at the 5 percent level.

To obtain this publication in an alternative format, contact the Washington State Office of Financial Management at (360) 902-0599.

Attachment 4-12

State of Washington Office of Financial Management

Washington State Population Survey

SPS On-line - Access to the State Population Survey

1. Select your data. Indicate which data you would like in your table by selecting Insurance Variable, Detail Level, By Category, Subset, and Display Type from the corresponding drop-down box or radio button. For additional help, click on the ?.

2. View your data. Click the Get Table button to view your selection results. For detail on how to read results click here.

1. Insurance Variable: ?

All types

2. Detail Level: ?

○ Statewide ○ Regional

3. By Category: ?

○ Age Category ○ Labor Force Status ○ US Citizenship ○ Household Type
○ Gender ○ Disability ○ Health Status ○ No Choice
○ Marital Status ○ Education Level

4. Subset Ages:

○ All Ages
○ Select Ages ==> From 0 to 0

5. Subset Income as FPL%:?

○ All Income Levels
○ Select FPL ==> From 0 to 0

6. Data Display Type:

○ HTML Table
○ Excel Spreadsheet

7. Submit Request:

Get Table

Source: 2004 Washington State Population Survey, Version 3

Attachment 4-12 continued: Results of SPS On-line Query

Percent of Persons with Health Insurance from Any Source By Region

AGE >= 0 AND AGE <= 64

Source: 2004 Washington State Population Survey On-line Results, Version 3, MAAWGT
Created: Oct 03, 2005 14:36:14

Category	Coverage	Persons	Percent
1.NORTH PUGET			
	0.NOT INSURED	42,675	13.1
	1.INSURED	282,644	86.9
2.WEST BALANCE			
	0.NOT INSURED	45,522	12.7
	1.INSURED	313,034	87.3
3.KING COUNTY			
	0.NOT INSURED	148,947	9.3
	1.INSURED	1,450,571	90.7
4.PUGET METRO			
	0.NOT INSURED	178,564	10.7
	1.INSURED	1,482,667	89.3
5.CLARK COUNTY			
	0.NOT INSURED	39,044	11.4
	1.INSURED	304,824	88.6
6.EAST BALANCE			
	0.NOT INSURED	65,261	16.1
	1.INSURED	339,682	83.9
7.SPOKANE CNTY			
	0.NOT INSURED	45,447	12
	1.INSURED	333,594	88
8.TRI-CITIES			
	0.NOT INSURED	37,269	9.5
	1.INSURED	354,244	90.5

State of Washington Office of Financial Managem

Washington State Population Survey

SPS Online Glossary

Insurance	Select the insurance variable to analyze. "No Variable" provides population characteristics.	
	All Types	Individual is currently covered by a health insurance plan including employer sponsored, Medicaid, Medicare, military, and individually purchased plans. 0 = No 1 = Yes
	Primary Source	Type of health insurance plan individual has. If individual has more than one type of coverage, the main plan is selected. 1 = Public (Medicaid, Medicare, BHP) 2 = Employer sponsored (includes military) 3 = Other private (Purchased on own) 4 = Uninsured
	Employer	Individual is currently covered by a health insurance plan through their own employer or union or through that of another family member such as a spouse or parent. 0 = No 1 = Yes
	Medicaid	Individual is currently covered by Medicaid or other DSHS Medical Assistance Administration program. 0 = No 1 = Yes
	Medicare	Individual is currently covered by Medicare. 0 = No 1 = Yes
	Military	Individual is currently covered by a military health plan such as CHAMPUS, CHAMP-VA, TRICARE or VA. 0 = No 1 = Yes
	No Variable	This selection provices basic demographic data on the state population.
Detail Level	Select level of geography at which to display data.	
	Statewide	All records are included.
		Records are grouped by region. 1 = North Sound (Island, San Juan, Skagit, Whatcom) 2 = West Balance (Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum) 3 = King County

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	Regional	4 = Other Puget Metro (Kitsap, Pierce, Snohomish, Thurston) 5 = Clark County 6 = East Balance (Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Walla Walla, Whitman) 7 = Spokane County 8 = Yakima Tri-Cities (Benton, Franklin, Yakima)
By Category	Select one variable for by-group processing.	
	Age Category	Ten-year age categories 1 = 0-9 2 = 10-19 3 = 20-29 4 = 30-39 5 = 40-49 6 = 50-59 7 = 60-69 8 = 70-79 9 = 80+
	Gender	1 = Male 2 = Female
	Marital Status	1 = Married 2 = Divorced 3 = Separated 4 = Widowed 5 = Never Married .A = Age Skip (Individual is under age 15) .D = Don't Know
	Civilian Labor Force Status	1 = Employed 2 = Unemployed 3 = Not in Labor Force .A = Age Skip (Individual is under age 16) .S = Skipped (Includes active military)
	Disability	Individual's disability prevents him or her from working for pay. 0 = No 1 = Yes .A = Age Skip (Individual is under age 16) .S = Skipped (Individual does not have a disability) .D = Don't Know
	Education Level	Highest level of school completed. 1 = Less than HS 2 = HS diploma or GED 3 = Some college or AA 4 = BA or BS 5 = Graduate or professional .A = Age Skip (Individual is under age 16) .D = Don't Know
	U.S. Citizenship	Individual is currently a U.S. citizen 0 = No 1 = Yes .D = Don't Know
		Individual's health as described by respondent.

	Health Status	1 = Excellent 2 = Very Good 3 = Good 4 = Fair 5 = Poor
	Household Type	1 = Husband-wife family household 2 = Other family household 3 = Non-family household 4 = Single-person household
Subset Variables		
	Age	Select a subset of records based on Age. Interval must be at least five years.
		Select a subset of records based on Income as Percent of the Federal Poverty Level.
	Federal Poverty Level	Threshold calculated by family size and composition below which a family is considered living in poverty. For a family of three with two children, the 2003 FPL was $14,824. The FPL is calculated by the Census Bureau.

Attachment 4-13

Washington State Employer Health Insurance Database Overview

Office of Financial Management, Forecasting Division - September 2005

The *Washington State Employer Health Insurance Database* contains estimates of health care coverage and expenditures for over 94,000 employers in Washington State. These employers include most *private sector* firms that have *two or more employees.*

Health insurance information imputed for each firm includes:

- Health insurance offers to full-time employees, part-time employees, and dependents
- Health insurance enrollment, eligibility, and take-up rates for firms that offer coverage (rates for all workers, full-time workers, and part-time workers)
- Total numbers enrolled in own employer-provided coverage (for all, full-time, and part-time workers)
- Total numbers of employees not enrolled (for all, full-time, and part-time workers)
- Health insurance premiums per enrollee for single, family and employee-plus-one coverage
- Total health insurance expenditures
- Average health insurance expenditures per worker and per enrollee
- Employer health care expenditures relative to total wages

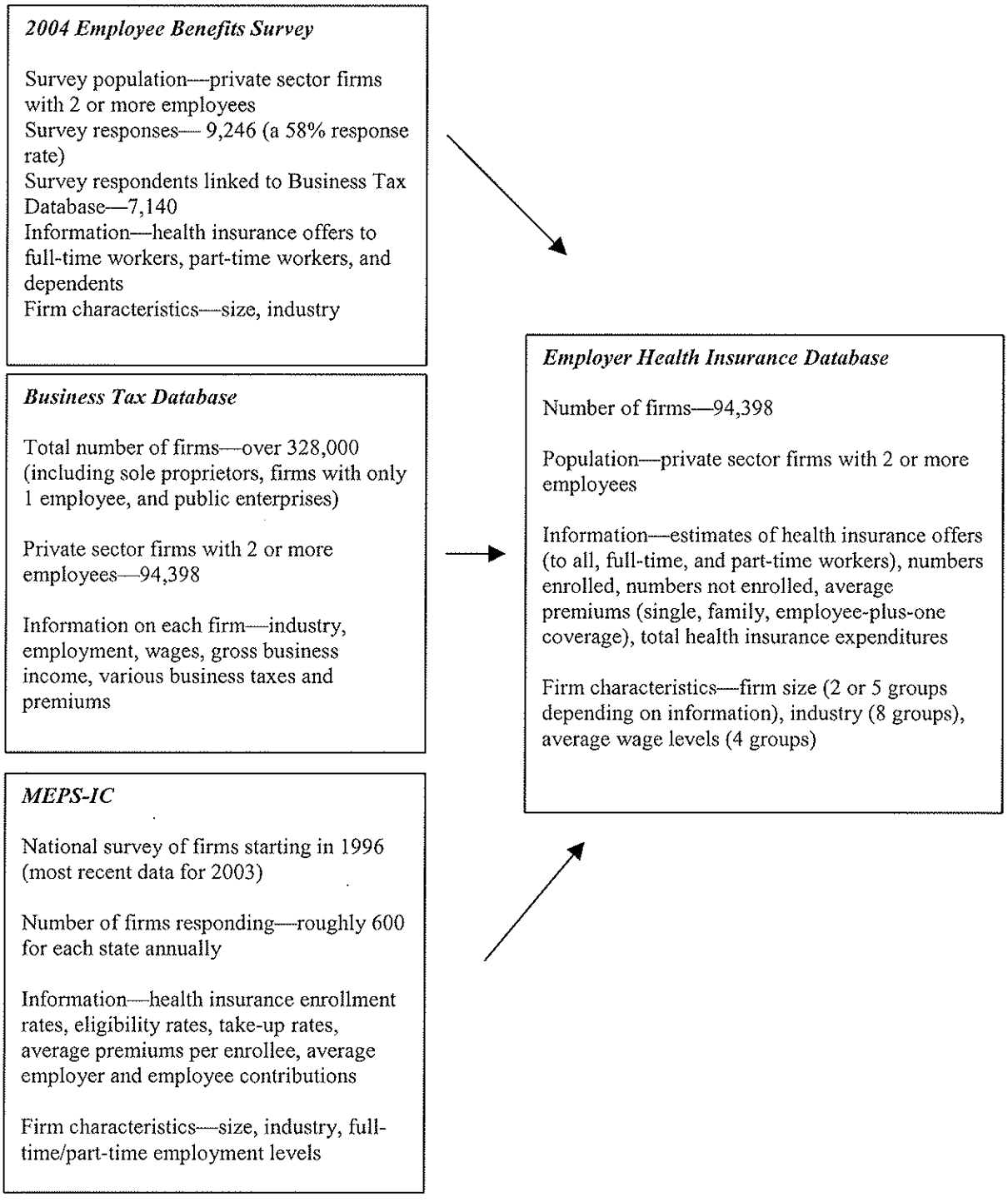
The database also includes information on firm characteristics—firm size, industry, average wage levels, business income.

Three main data sources were used to construct the database[1]:

- Washington State Employment Security Department, *2004 Employee Benefits Survey.*
- Washington State Office of Financial Management, Employment Security Department, Department of Revenue, Department of Labor and Industries; *Business Tax & Premium Database.*
- US Department of Health and Human Services, Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey—Insurance Component* (MEPS-IC).

[1] Data limitations and potential sources of error from all data resources include (1) Potential survey response bias, (2) Restricted survey populations—private sector firms with 2 or more employees, (3) Small sample sizes and large standard errors for estimates (4) Firm-based versus worker-based data. While we continue to determine the impact of these the estimates are considered preliminary. Like all estimates, they become less precise as you drill down to detail levels - industry and firm size.

Construction of Employer Health Insurance Database



Attachment 4-14:

Summary of Technical Assistance Requests

Request	Specific Interest Supported (where known)
Historical comparisons and trends in profiles of Washington's uninsured and insured • Data sources and caveats • Estimates of adults and children by age, income and source of coverage / uninsurance	Community and local researchers' interest in longitudinal links between uninsurance rates and public programs. Testimony to legislative committees contemplating health care agenda Executive speeches and media reporting during Cover the Uninsured Week and associated campaign visits from John Kerry. Constituent presentations by legislative staff Fiscal committee staff, media, academic, policy makers, advocates, independently elected officials general interest Governor's workgroups focused on options for covering all kids by 2010.
Demographics of uninsured children at varying family income levels (e.g., below poverty, aligned with public program eligibility, middle income, higher income etc) • Counts and rates without coverage • Graphical representations	Crafting of legislation to support children's coverage through understanding how far children have lost ground Analysis by local community organizations in search of grant funding Legislative staff analysis of potential linkages between public programs and employer-sponsored coverage Advocates review of children's changing circumstances
Overview of current state of coverage in Washington – demographics of uninsured and underinsured, sources of coverage, public program eligibility criteria, mental health coverage	Presentation by out-of-state experts during WAHIP Forum discussions on options for covering Washington artists Briefing of Executive branch for conference and other meeting speeches, messages
Demographics of Washington adults who are uninsured members of the working poor (defined as members of families with incomes below 200% FPL in which at least 1 member is working)	Media stories about health insurance and the working poor

Request	Specific Interest Supported (where known)
Numbers of unemployed adults (who lost their job) who lost health insurance as a result and duration of their uninsurance	Legislative interest in cost of maintaining coverage continuity for typically working adults (during economic crisis)
Patterns of uninsurance among: • children only • adults with children (single or dual parent) • adults with no children • families with children • families with no children	Understanding populations for which existing public programs may be viable alternatives, and whether the story is more easily told in terms of individuals or families
Local-level (county, city, congressional /legislative district) estimates of the uninsured; individuals in poverty • identification of useful sources of data • explanation of differences in published local level estimates • methods of estimating local level numbers	Input to community organizations and managed care plan deliberations on options for serving the uninsured including the Project Access model physician networks and Volunteers in Medicine model clinics. Advocacy group discussions with legislative representatives Basis for Legislators (and staff) understanding of constituents and for their "home" presentations
Local-level (King County) story of who's uninsured, why, why it matters, and what the Governor is planning to do about the issues.	Panel presentation to King County Board of Health
Health status of Washington's insured and uninsured targeting impact of chronic illnesses • uninsured with chronic illnesses • applicants who qualified for but didn't purchase coverage in the high risk pool	Public health graduate research by UW physician
Sources of data for estimating numbers of uninsured immigrant children (documented and undocumented)	Advocates interested in full revival of Children's Health Program (for uninsured non-citizen children)
Non-US citizens who are documented (resident aliens) and who are undocumented (illegal aliens) • Estimates by age, geographic location, documentation status	Legislative, advocate and constituent interested in understanding stories about non-citizens receiving benefits through public programs and where "savings" could be considered

Request	Specific Interest Supported (where known)
Sub-groups not fully represented in the Washington State Population Survey (or other surveys). • Individuals for whom specific programs might be real options (e.g., Children's Health Program for non-immigrant children) • Individuals for whom coverage might not be on the radar (e.g., homeless individuals)	Implications for understanding future gaps in coverage if options under discussion were implemented.
Review analyses completed by public and private "researchers" from technical perspective: • Are results consistent with WSPS and public programs? • Are WSPS data being interpreted correctly? • Which variables are most reliable? • Which variables should be used with caution?	Various individuals (researchers, advocates, legislative staff etc) interested in replicating /doing their own research with OFM data and ensuring that numbers are consistent (especially true for preliminary estimates using first release of survey data) Preparation for community advocates press conference on the uninsured
Recommendations of demographic characteristics useful in understanding uninsured sub-groups	Community organizations' analysis of their survey findings
Poverty thresholds vs. poverty guidelines • what's the difference? • which should be used when in calculating federal poverty levels (FPL)? • what FPL cut-offs make sense for analysis of the uninsured?	Input to analysis by Washington community organizations
How should we define "underinsured" and how many Washingtonians are underinsured?	Community group interest in coverage options that consider all those for whom coverage is an issue, not just the uninsured.
Approach to identifying artists in national and local surveys	WAHIP consultant's analysis of Washington artists in comparison with national artists based on multiple incomplete data sources.
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). • Definitions of insured vs. uninsured • Time period specifications • Data collection methodology • Medicaid undercount adjustment	Fiscal committee staff, widespread media, academic, policy makers, advocates, independently elected officials interested in understanding which numbers tell "truth"

Request	Specific Interest Supported (where known)
Explanation for differences in estimates of employers based coverage (i.e., do data include employees only, employees and their dependents, self-employed workers)	Understanding of differences in varying employer-based coverage profiles
Explanation for results that don't resemble HRSA and OFM results but use the same data	Various individuals interested in replicating /doing their own research with OFM data Common explanations for differences: • Different versions of WSPS used • Population definitions differ (e.g., adults 19-64; total compared with working) • Incorrect coverage attribution where 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? • Mix-up between poverty thresholds and guidelines • Variations in software rounding
Sources of data for understanding employer coverage patterns • impact of standard errors on MEPS data? • update RAND consultant's analysis of WA employer-based coverage?	Public agencies interested in comparing employer coverage trends in Washington and the rest of the nation Ongoing and increasing interest from Legislative staff, policy makers, public programs, advocates, in options for making employer coverage "more affordable"
Profile Washington employers and their offering of coverage and eligibility criteria for FT and PT employees	Ongoing and increasing interest from Legislative staff, policy makers, public programs, advocates, in options for making employer coverage "more affordable" Fiscal notes on 2005 Health Care Responsibility Act (Washington's version of Pay-or-Play / Fair Share)
Information on employers with employees enrolled in public programs (specifically Basic Health)	Advocates conversations with legislators about declining employer-based coverage.

Request	Specific Interest Supported (where known)
Information on linkage between uninsured rates, decline in employer-based coverage and benefit mandates.	Legislative conversations
Links between coverage for parents and children	Child advocates concerns that access to health insurance for children does not neglect access for their parents.
Criteria for evaluating potential options for covering the uninsured	Other states' efforts to evaluate options for coverage
Succinct overview of options for coverage	Ohio community interest in simple ways to understand and display the variety of coverage options currently being considered
Options for covering specific populations for whom uninsurance is a "recognized issue" • Universe of options commonly discussed • Creative alternatives for low-income children • Small employers / self-employed	Community group, legislative, and other policy-makers discussions on covering the uninsured
Recommended small-employer coverage options for employees and their dependents • Options available and how to find them.	Businessman wanting to provide coverage for his employees and their dependents but not knowing where to go to get started.
Health care spending for: • Washington's total population • Washington's uninsured population	General interest in present and potential costs
Who has access to affordable coverage? Who does not? Who would if enrollment limits on public programs were lifted?	Fiscal note preparations for budget discussions
Cost to state if potentially eligible uninsured adults were enrolled in the Basic Health	Local county-level "consideration" of opportunity to sponsor uninsured in BH
Numbers and cost of enrolling potentially eligible children in public programs	Legislative staff response to constituent requests during 2005 session. Governors workgroup on covering All Children by 2010
Funding sources and financing mechanisms that contribute to supporting the cost of care for the uninsured	Input to research by local advocacy group

Request	Specific Interest Supported (where known)
Washington's rank in comparison with other states for selected health measures • children and adults	Measure of state's progress in covering uninsured and sustaining the health of Washington's population
Approach to comparing health of United States residents with other countries (e.g., G7 countries)	Insurance Commissioner's speeches referencing health outcomes /life expectancy / infant mortality achieved under different care systems.
Overview of medical practitioners in Washington • Changes in #s over time • Distribution of physician practices in Seattle	Executive briefings Puget Sound Health Alliance environmental scan.

SECTION 6: LESSONS LEARNED AND RECOMMENDATIONS TO THE STATES

We have woven comments we believe will be helpful to other states throughout our report, in the relevant discussion areas. For example, the evolutionary nature of policy and research discussions is noted in Section 4, and many sample products we have found helpful translating data for policy discussions are included in the attachments. In this section we include a few additional thoughts.

Regarding the policy planning process:

a. **It just takes time** to grow the resources necessary to inform discussions and build consensus. The rigorous analysis and ongoing refinement of state-specific information takes time that must be invested to ensure conversations can begin with a firm foundation. It also takes time for resources to mature and become recognized by the wide variety of policy makers who seek information on the uninsured and options for coverage.

b. **Be disciplined and flexible**. Be disciplined and focused in conducting the substance of the work (e.g., data collection and analysis) but let the process of engaging others be flexible and evolve as information and the policy-making environment change. Be nimble with the delivery approach so it can respond to the mind-set of the moment.

c. **Be prepared when others are finally ready to hear the messages.** It can take a long time for people to "hear" the messages. For example, we first prepared materials in 2002 demonstrating that approximately 70% of our uninsured children could be served by our existing public program infrastructure. "Suddenly" these materials have caught on this year and formed the basis for critical policy discussions on covering all children. As Uwe E. Rinehart said,

> "...the champions of universal health insurance are well advised to have at their fingertips, at all times, the requisite, up-to-date analyses that policymakers might want to see...and up-to-date policy proposals that could be quickly enacted and implemented. It is the health policy analogue of permanent military preparedness."

d. **Be creative about developing useful information sources** from existing surveys and data that might not otherwise seem useful/relevant to health policy. We were able to expand our health insurance information base by linking health insurance data from state and national surveys with non-health care-related information on employers. The combined data source sheds light on the business implications of health insurance costs and realistic opportunities for coverage options.

Regarding State Level Data:

State level data have been essential for our policy discussions – they tell a story that interests and is familiar to policy-makers. But it has also been important to continue to refine them to improve local use and comfort with the numbers. For example, we have 'resolved' a Medicaid undercount issue in our household survey (described in Section 4) that has allowed us to develop more credible estimates of the uninsured. Our solution may not be "perfect", but until the estimates passed the 'straight-face' test for policy-makers they were easily discounted.

SECTION 7: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Recommendations included in our past reports remain largely relevant today. At the heart of these, we continue to recommend federal support for state specific data and policy and planning efforts, and expanded federal support with, and access to, employer data. More broadly, we continue to recommend full funding of federal health programs like Medicaid, Medicare, Indian Health Services, and Veterans.

Regarding Medicaid and SCHIP:

a. **Maintain permanent funding flexibility with SCHIP.** Maintain the use of SCHIP dollars to support children that were served via Medicaid expansions prior to SCHIP (e.g., children below 150 percent of federal poverty. States that have been doing the right thing should not be penalized.

b. **Consider expanding Medicaid.** In the wake of the recent natural disasters caused by Katrina and Rita, it has become clear that the categorical patchwork and inequity of Medicaid access across state borders does not systematically serve our nation's poor, or the health providers that care for them. It is time to modify our system and care for all our poorest residents irrespective of state borders and categorical eligibility.

Regarding support for expanding local infrastructure:

c. **Continue funding for planning, policy development, and pilot testing.** Given the ongoing challenge of state budget deficits, states may need to look more than ever to the federal government and/or foundations to support certain planning and development activities. The SPG federal funding has allowed us to provide more thoughtful research and policy support at a time when state resources for policy and planning have been severely restricted.

d. **Support and standardize "local" data collection.** Support effective monitoring of the uninsured at the state and sub-state level by (1) subsidizing and facilitating standardization and enhancement of state data collection efforts and (2) continuing to develop sub-state (county) estimates such as the Census Bureau's Small Area Health Insurance Estimates (SAHIE) model. Continue to support SHADAC's efforts to distribute information on these products and to provide technical assistance in their development. Local data are essential for Legislators and other policy makers to see their own 'neighbors' and develop or refine policy that is applicable 'on the street'. Standardizing state-level data collection techniques would allow more precise national comparisons along more detailed dimensions.

e. **Increase access to federal data resources.** Allow health care researchers to access Medical Expenditure Panel Survey (MEPS) data at the individual observation level so that exploration of interactions between employers and individuals is possible. Sophisticated statistical techniques that allow researchers to uncover the underlying causes of uninsurance for example require synthetic matching of employer and employee data sources. Currently MEPS data offer the best future potential for these analyses. As an alternative, provision of matching funds for states to conduct routine employer surveys would allow linkage with existing state population surveys.

f. **Explore opportunities to improve data collection for longitudinal and transitional analyses.** Support opportunities to build state-level sources of longitudinal and transitional data to allow exploration of the implications of changing life circumstances on coverage and access options and status.