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Targeting the Uninsured in Washington State

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Targeting the Uninsured in Washington State

Introduction and Key Findings

In this report we examine patterns of insurance coverage and characteristics of the uninsured population in Washington in order to identify groups for targeted interventions to reduce the uninsured rate. We also examine the potential effect of public program expansions in improving access for the uninsured and identify populations that might benefit from measures to strengthen private insurance markets. Finally, we measure the affordability of current public and private insurance products.

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team. The research was funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, as part of the Washington State Planning Grant on Access to Health Insurance. The project was managed by the Washington State Planning Grant staff, who collaborated with a consultant team consisting of the University of Washington Health Policy Analysis Program, Rutgers University Center for State Health Policy, RAND, William M. Mercer, Incorporated, and the Foundation for Health Care Quality to produce this report.

This report describes the insured and the uninsured and identifies possible groups for policy or community interventions. Companion reports in the Washington State Planning Grant project include policy papers that examine in some detail possible targeted interventions.

Chapter 1 of this report, "Insurance Coverage in Washington," examines current patterns of coverage and notes recent trends in levels and sources of insurance coverage.

Chapter 2, "A Profile of Washington State's Uninsured," examines the characteristics of the uninsured to identify major gaps in coverage and possible targeted interventions.

Chapter 3, "The Role of the Family in the Insurance Status of Children," investigates the relationship between family characteristics and children's insurance coverage.

Chapter 4, "Availability of Public and Private Insurance Coverage," provides a description of public program eligibility and documents the availability of private coverage in the employer-based market. It identifies characteristics of employers and their workers that are related to the likelihood that a worker is employed in a business offering health insurance coverage.

Chapter 5, "Eligibility for Public and Private Insurance Coverage," examines the specific public and private insurance sources that the uninsured can access and barriers to that access. This chapter also examines the effects of changes in public program funding, particularly the Basic Health program, on potential coverage.

Chapter 6, "Affordability of Public and Private Coverage," looks at living expenses commonly faced by families and estimates what proportion of uninsured individuals with various characteristics have access to affordable public or private coverage.

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Chapter 7, "The Role of the Safety Net," describes health care delivery systems that provide care to people who are *without* health insurance. We include a brief assessment of strengths and weaknesses of that system.

Chapter 8, "Conclusion: Gaps and Barriers in Coverage, and Implications for Policy," recaps the key findings and the policy implications of the results.

The analyses in Chapters 2 through 6 are based primarily on data collected in the 2000 Washington State Population Survey (2000 WSPS). However, the consultant team's researchers used three other surveys to impute important characteristics for our analysis that were not measured in the 2000 WSPS. These include the 1998 Washington State Population Survey (for a measure of any period of uninsurance during the year); the 1997 RWJF Washington Family Health Insurance Survey (for a measure of the length of the uninsurance spell in progress); and the 1997 RWJF Employer Health Insurance (for detailed information about the offer of employer health insurance). The imputation involves matching observations in the 2000 WSPS to the other surveys based on characteristics common to each. The imputation can be thought of as reweighting the data in the other surveys to match the distribution of characteristics of the population in the 2000 WSPS. The matches are based on characteristics that are common to the different surveys.

Some charts in this report include a statistical adjustment to examine the effect of certain characteristics after controlling for their correlation with other factors that are related to uninsured rates. Many of the characteristics that we examine are related; for example, noncitizens have lower incomes than citizens; different racial/ethnic groups have different average incomes. Looking at each characteristic in isolation, therefore, may not give a good indication of the primary factors related to being uninsured. For example, if we adjust for the income differences between citizens and noncitizens, differences in the uninsured rate between citizens and noncitizens diminishes.

The unadjusted numbers give the actual proportion of a subgroup with a particular characteristic that is uninsured and so highlight groups with important gaps in coverage. However, the adjusted numbers give a better measurement of the importance of the characteristic in explaining the lack of insurance because they remove differences in uninsured rates associated with other factors. Thus, the adjusted numbers help in formulating policy because they highlight the underlying causes of uninsurance. We have included footnotes listing the factors used in the adjustments where appropriate. Differences between subgroups, adjusted or unadjusted, that we report in the text of the discussion all meet conventional statistical significance standards unless otherwise noted.

Details about the imputation and the statistical adjustments are discussed in a **Methodology Appendix,** which also describes procedures used in the public program eligibility analysis, measurement of access to affordable coverage analysis, and estimation of the price of premiums faced by employers who do not offer insurance. A **Data Appendix** contains estimates of the population size for a number of the key groups studied in our analysis.

A companion report, Research Deliverable 3.3: *Income Adequacy and the Affordability of Health Insurance in Washington State,* examines geographical patterns of affordability for various public and private insurance products.

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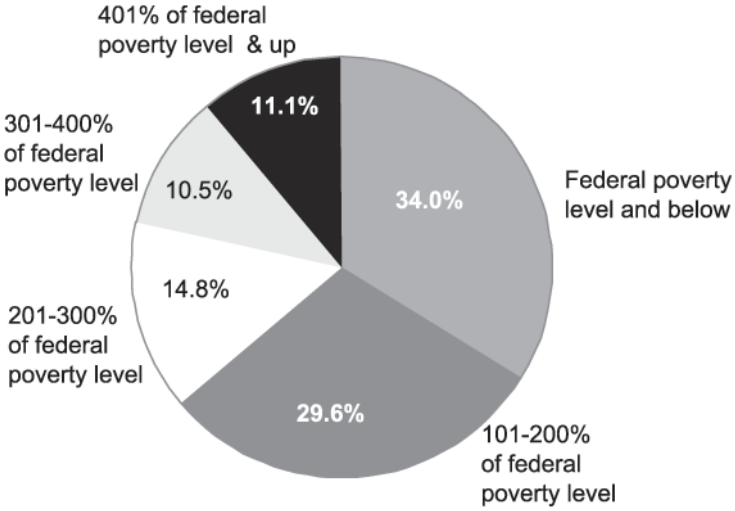
Key Findings

The Typical Uninsured Person Under Age 65 in Washington:

- Is low-income—at or below 200 percent of the federal poverty level (64 percent of the uninsured, or 308,000*)
- Is an adult without children (53 percent of the uninsured, or 256,000)
- Is between the ages of 19 and 34 (43 percent of the uninsured, or 210,000)
- Is in a family or household with at least one employed person (75 percent of the uninsured, or 365,000)
- Is uninsured for at least a year (75 percent of the uninsured, or 363,000)
- Is white (67 percent of the uninsured, or 324,000)

Out of 5,241,000 people under the age of 65 in Washington in the year 2000, 484,000, or 9.2 percent, were uninsured. The uninsured are primarily low-income, and low-income families are much more likely to be uninsured than higher-income families. This suggests that not having enough money to afford health insurance may be the key barrier to insurance. Most uninsured are also young, childless adults, who are often ineligible for public insurance programs. The vast majority of the uninsured are workers or their dependents; this indicates that policies to expand the private employer-based system may deserve consideration.

Distribution of the Uninsured Population Under Age 65 by Income, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Although certain individual characteristics—such as being an ethnic minority or living in the eastern rural side of the state—are associated with a higher likelihood of being uninsured, the majority of the uninsured in Washington do not share these characteristics. Therefore, if policies or partnerships are to assist the majority of the uninsured, general characteristics, such as low-income individual, single adult, and in a family where workers do not have access to health insurance, are important criteria for targeting. Conversely, knowledge of populations with particularly high rates of uninsurance—such as Hispanics—may be important for outreach efforts directed at underserved populations.

*Note: In this publication, population numbers are rounded to the nearest 1,000.

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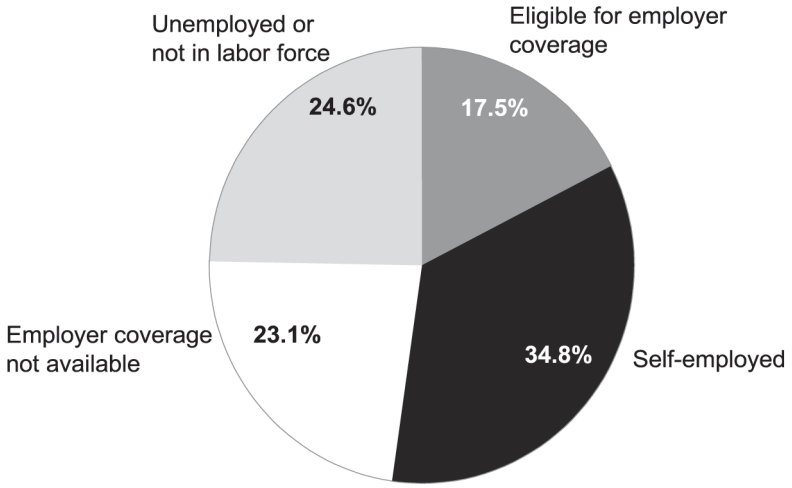
Employment-Based Insurance in Washington:

- Is the most prevalent form of insurance (covering 71 percent of the population under 65)
- Is widely available to Washington workers (80 percent work in a firm that offers insurance to at least some of its employees)
- When available, almost always offers family coverage (99 percent)
- Is offered to fewer than one in five of the uninsured (17.5 percent, or 85,000 uninsured)
- Is least available in small firms (fewer than 10 workers) and those with a high percentage of low-wage workers, part-timers, women workers, and young workers (under age 30)

Distribution of the Uninsured by Employment Status and Eligibility of Employer Coverage, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Expanding employment-based insurance for workers or their dependents who are currently uninsured would potentially reach a large number of uninsured, but reaching these individuals is not simple. Although almost one in five uninsured are eligible for employer coverage, most workers and dependents eligible for coverage are already insured, even if they are low income. Expanding access for low-income, uninsured workers through employers also poses challenges in targeting. Although many low-wage workers work for small, low-wage businesses that do not offer coverage, not all do. Moreover, although small, low-wage businesses are less likely to offer coverage, still many do so. Finally, some workers (e.g., younger and low-wage workers) may be less likely to accept coverage even if offered, meaning that subsidies to employers may not have the desired effect of increasing coverage.

About one-quarter of the uninsured do not have a current job, but almost half of this group recently lost a job or are looking for work. Policies to reduce the cost of transitional coverage might benefit this population.

Many of the uninsured are self-employed people or their dependents. These individuals already receive a federal tax subsidy for the purchase of insurance that increases with income, and the rate of this subsidy is scheduled to increase. However, uninsured rates in this group are not strongly related to income, indicating that financial subsidies may not close the insurance gap.

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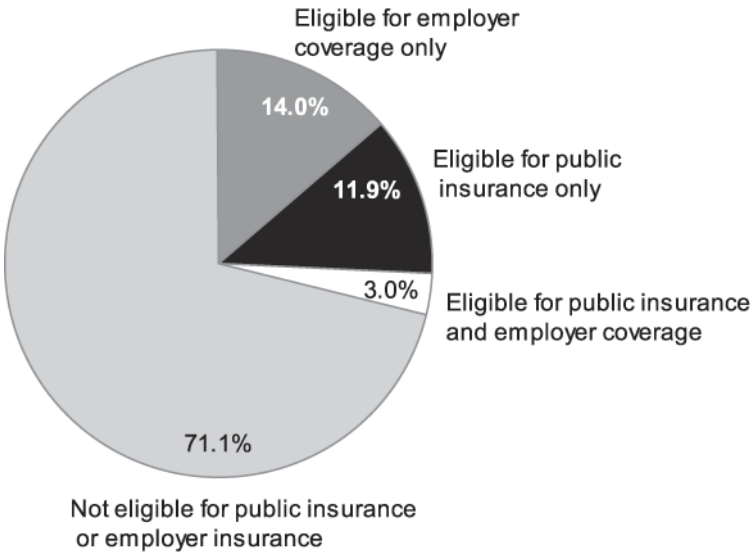
Public Insurance in Washington:

- Provides primary coverage for 20 percent of children and 12 percent of adults. This proportion has been increasing over time, primarily due to expanding eligibility standards.
- Insures more than a third (34.6 percent) of the population under 65 with incomes less than 200 percent of the federal poverty level (FPL).
- Provides potential access to about 76 percent of uninsured children under current eligibility and funding, but to only 30 percent of uninsured parents. Access for uninsured, childless adults is even lower, at less than 10 percent.
- If expanded by 50,000 enrollees, would decrease the percent of adults without access to public or employer insurance to 59 percent. If Basic Health had no enrollment limits, allowing all adults at 200 percent of the federal poverty level or below to enroll, only one in four currently uninsured adults would lack access to public or employer coverage.

Public insurance has proven highly effective in closing the insurance gap for children in Washington. Conversely, adults without children are the group most likely to be uninsured and have the worst access to public or private insurance. Reduced access for adults is related most directly to the enrollment limitations of the subsidized Basic Health program, which would otherwise cover all adults up to 200 percent FPL. New funding for Basic Health, authorized by a recent voter initiative, will allow for enrollment expansions over the next several years.

Access to Insurance Among Uninsured Adults Under Current Funding, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

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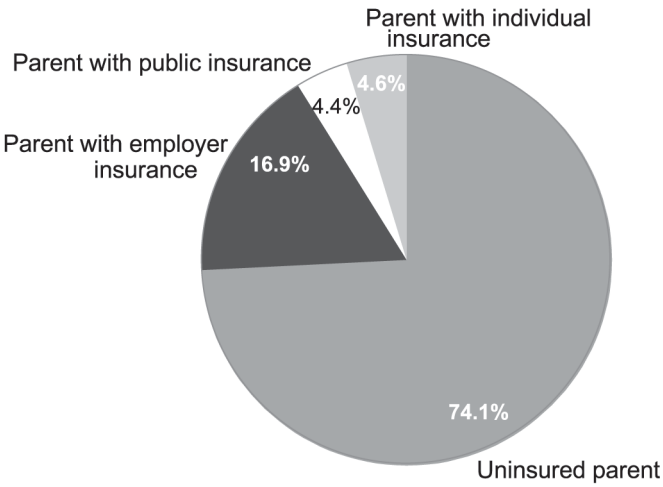
Expanding Coverage for Children:

- Children are less likely than adults to be uninsured (7.1 percent of all children, or 116,000, remain uninsured).
- Nonetheless, one in four of the uninsured are children.
- Although 68 percent of children with uninsured parents are uninsured, only 2 percent of children with insured parents are uninsured.
- Three out of four (74 percent, 86,000) uninsured children have uninsured parents.
- About 60 percent of uninsured children are school-aged (about 73,000 uninsured children in 2000).
- Most uninsured children are in families where all children are uninsured. However, families that do insure some but not all of their children tend to cover the youngest and less healthy children.

Efforts to insure children have paid off, and as a result children are the group least likely to be uninsured (with the exception of senior citizens). However, 116,000 children are still uninsured in Washington. Given that most uninsured children are already eligible for public programs, strategies to insure them would entail outreach rather than eligibility changes. Schools might be a focus for outreach efforts given that 60 percent of uninsured children are of school age. Also, since the insurance status of the parent is a key predictor of the insurance status of children, efforts to expand coverage for families may be effective in reducing the number of uninsured children.

Distribution of Uninsured Children by Parent's Insurance Status, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

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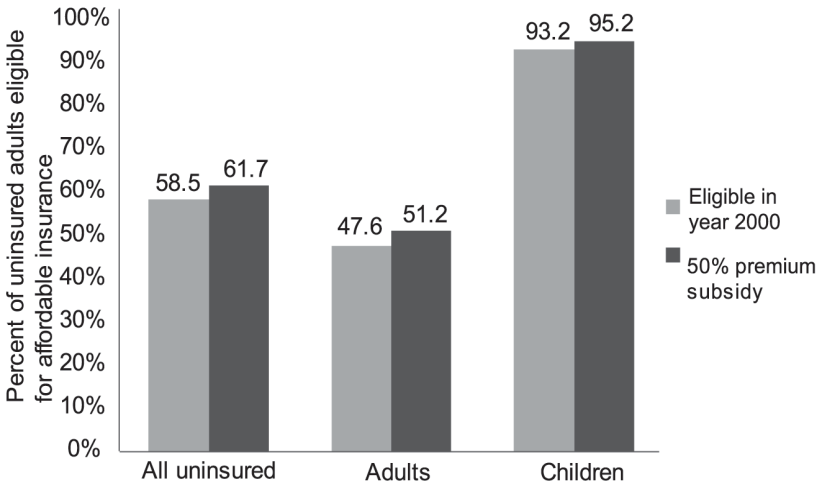
Affordable Public or Private Insurance Coverage in Washington:

- Is not accessible to half of uninsured adults, but only one in ten children lack affordable access.
- Is available to most (80 percent) of the uninsured with access to employer coverage.
- Would be only slightly more accessible even with a 50 percent premium subsidy to the price of public or private insurance.
- Is available to most uninsured adults and children above 200 percent FPL.
- Is available to only four in ten uninsured childless adults, but two of three parents have access to affordable coverage.
- Is available to only one in four adults at 200 percent FPL or below. With full funding of Basic Health, three out of four low-income adults would have access to affordable coverage.

Is the insurance available to uninsured persons affordable? We examine what proportion of different segments of the uninsured population have access to insurance within the constraints of estimated family budgets. Our analysis shows that getting affordable coverage is mainly a problem for uninsured adults, with half of the uninsured adults in the state not having access to affordable coverage. Most uninsured children have access to affordable coverage, because they are often able to participate in public programs with no premiums or cost-sharing. Three-quarters of uninsured, low-income adults and 60 percent of uninsured, childless adults do not have access to affordable coverage in either private or public markets. A 50 percent premium subsidy would have only modest effects, suggesting that very large subsidies are likely to be needed to expand coverage via the private insurance market. If there were no enrollment limitations on Basic Health, affordable coverage would be available to three-quarters of the uninsured, low-income population.

Access to Affordable Insurance, All Uninsured, Adults, and Children, Current and With 50 Percent Premium Subsidy, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

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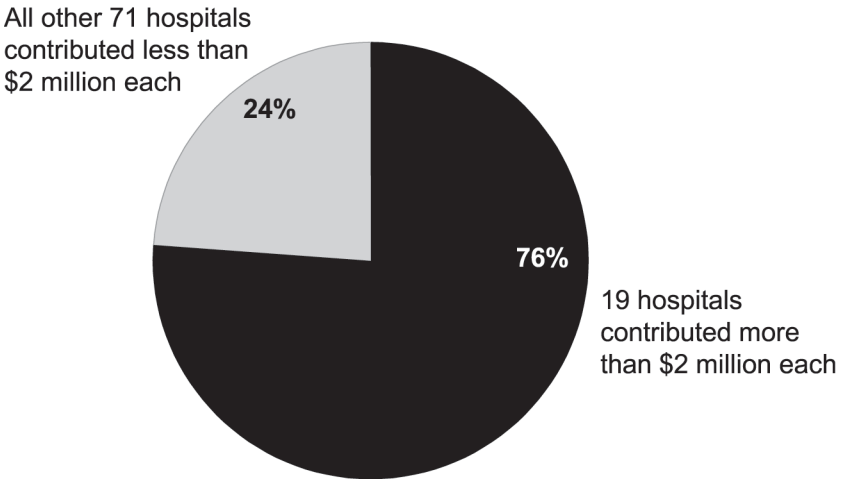
Washington's Safety Net:

- Relatively few hospitals provide most of the hospital charity care that is delivered in Washington. Nineteen of the 90 hospitals in the state provided 76 percent of all hospital charity care in 1999.
- Harborview Medical Center alone provides more than 23 percent of the statewide total contributed to charity care.
- The number of uninsured patients served by community and migrant health centers increased by more than 34 percent from 1992 to 2000. The uninsured dropped as a percentage of all patients seen by these community health centers from 39 percent to 29 percent during the same period.

Approximately 484,000 Washington residents under age 65 were uninsured in 2000. Many uninsured people rely on the health care safety net when they need health care services. Although most doctors and hospitals serve this population, safety net providers care for a disproportionate share of the uninsured. Safety net providers include many hospitals, community and migrant health centers, and rural health centers.

Figure 7-2. Total Hospital Charity Care Spending by Whether Hospital Contributes More or Less than $2 Million in Charity Care, 1999



Source: Washington State Department of Health, Center for Health Statistics, 1999.

Research has shown that the safety net in Washington is strong. In several studies, Washington ranked high among states in the resources devoted to the safety net. Whether this capacity translates into greater access to services is not as clear. Some research suggests that expanding the safety net may be a way to increase access, but other research suggests that expanding insurance may be a better strategy.

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Policy Implications and Challenges

- **A combination of policies is likely to be necessary to solve the problems of the uninsured.** Policies to make existing employer-based coverage more affordable would target about 20 percent of the uninsured. Policies to encourage more employers to offer coverage would potentially benefit about 25 percent of the uninsured. Policies to help the temporarily unemployed could assist about one-quarter of the uninsured population. Expanded public program eligibility or more effective outreach are likely to be necessary to reach the one-third of the uninsured who have incomes below the federal poverty level.
- **Effective targeting is a challenge in designing policies to expand the employment-based system.** One-fifth of the uninsured do not participate in offered employer-sponsored insurance programs, but most employees who are offered coverage do participate. Similarly, businesses with primarily low-wage workers are much less likely to offer coverage than are other businesses, but more than half do offer coverage. As such, policies to increase employee take-up of insurance wouldbenefit many who are already insured, and efforts to encourage employers of low-wage workers to offer coverage may benefit many employers who already offer insurance.
- **Substantial premium subsidies are likely to be necessary for the success of incentives designed to expand coverage.** Quite substantial differences in price have only modest effects on the likelihood of an employer offering and of an employee accepting offered coverage. Similarly, generous tax subsidies for the self-employed that increase with income would have only modest effects on insurance rates for the self-employed.
- **Expanded public program eligibility is likely to be necessary to close the gaps in coverage—especially expansions in family coverage and for childless adults.** Most uninsured children have uninsured parents, and policies to extend eligibility for public programs to parents may also reduce the number of uninsured children. Similarly, childless adults make up the largest proportion of uninsured and could benefit from expanded access to existing programs.
- **Administrative simplification, outreach, marketing, and other policy changes may be necessary to reach the uninsured through public programs.** Not all eligible individuals participate in public programs, either because they are not aware of them or because the programs are difficult to access. Further research is needed to better understand and reduce these barriers.
- **The changing nature of the uninsured population poses a number of challenges for effective policy design.** About 70 percent more people are uninsured at some time during the course of a year than are uninsured at a point in time. However, about 75 percent of the uninsured population at a point in time have been uninsured for one year or more. Policy design for the long-term uninsured differs from the transitional coverage options necessary for those experiencing short-term, uninsured episodes.

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Chapter 1. Insurance Coverage in Washington

Sources, Patterns, and Trends

Introduction

This chapter examines major sources of insurance coverage held by people in Washington and how they have changed over the previous decade. The chapter also looks at how types of insurance coverage vary according to factors such as income, geographic region, and ethnicity or race. It briefly discusses various pathways that lead to coverage by particular types of insurance. The chapter also reviews major trends in public insurance enrollment and factors affecting enrollment levels, such as eligibility expansions and welfare reform. We also briefly review trends in the availability of employment-based insurance among employed persons and discuss how observed changes in insurance were affected (or not) by changes in regulation of the insurance industry.

The rate of uninsured declined in Washington in the 1990s as a result of increased access to public insurance along with stability in the employment-based market. The major increase in public insurance enrollment has been among children. Employment-based insurance remains the largest single source, covering 71 percent of the population under age 65. The individual insurance market provides coverage for about 6 percent of Washington's population.

Almost all people over age 65 are covered by Medicare, and some of these individuals receive additional coverage through employer or public plans. Given almost universal coverage for those over age 65, the major issues for that group revolve around scope of benefits (and more recently access to providers) rather than the presence or absence of health insurance. Consequently, this chapter (and this report) focuses on the population under 65, where vulnerability for being uninsured is the greatest.

When assigning people to forms of coverage, we have used a hierarchy to sort those with more than one form of coverage. This hierarchy gives first priority to Medicare, then employment-based insurance, then other public coverage, then individual insurance. This hierarchy reflects the usual "dominant payer" when dual coverage exists. For example, when a person is covered by both Medicaid and employment-based insurance, Medicaid rules require that it be the payer of last resort. Because of this hierarchy and the fact that survey results rarely match enrollment data precisely, the proportions in public programs shown here may vary from those obtained using public program enrollment data.

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Major Findings

Major Sources of Insurance

- In 2000, 91.7 percent of Washington's total population was insured; 90.8 percent of the population under age 65 was insured.
- In 2000, about 64 percent of the total population had employer-based coverage. For the population under age 65 this proportion was about 71 percent.
- In 2000, about 20 percent of children (aged 0-18) were covered by public insurance, and about 12 percent of adults aged 19 through 64 were covered by public plans.
- In the employment-based sector, 84 percent of workers and dependents under age 65 had insurance provided by a private employer, 12 percent by federal, state, and local governments, and 4 percent by the military.
- A third category, individual insurance, covers about 6 percent of the population under age 65.

Subgroup Differences in Coverage Among Persons Under Age 65

- Those above 200 percent of the federal poverty level (FPL) are twice as likely to have employment-based insurance as lower-income individuals (82.8 percent compared to 40 percent).
- Public insurance fills the gaps for many lower-income individuals, with more than one-third (34.6%) of those under 200 percent FPL insured through public programs.
- Employment-based insurance is more prevalent in urban than rural areas of the state.
- Among racial/ethnic groups, Hispanics and Native Americans/Alaska Natives are least likely to have employment-based insurance; non-Hispanic Whites are most likely.

Trends in Insurance Coverage and Patterns of Coverage

- Washington saw a generally declining rate of the uninsured from 1993 through 2000. An increase in the proportion enrolled in public programs accounted for most of this decrease. The proportion enrolled in employment-based insurance remained stable.
- From 1993 to 1997, there was little change in the share of employees eligible for coverage, offered coverage, and actually enrolled at their workplace. Most employees who are eligible do enroll.
- Individual insurance remained a small portion of the market. Enrollment in the high-risk pool, a government-regulated "safety net" for high-cost enrollees, expanded or contracted according to the availability of individual commercial coverage in different parts of the state.

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Major Sources of Insurance in Washington

The chart below summarizes major pathways of receiving insurance in Washington state by age group. For the rest of the report we will be focusing on the population under age 65 since the uninsured rate for the 65 and older population is minimal due to Medicare, and the purpose of this report is to identify uninsured populations that might benefit from state-level policy changes designed to improve coverage.

Figure 1-1. Major Insurance Coverage Pathways, Washington State

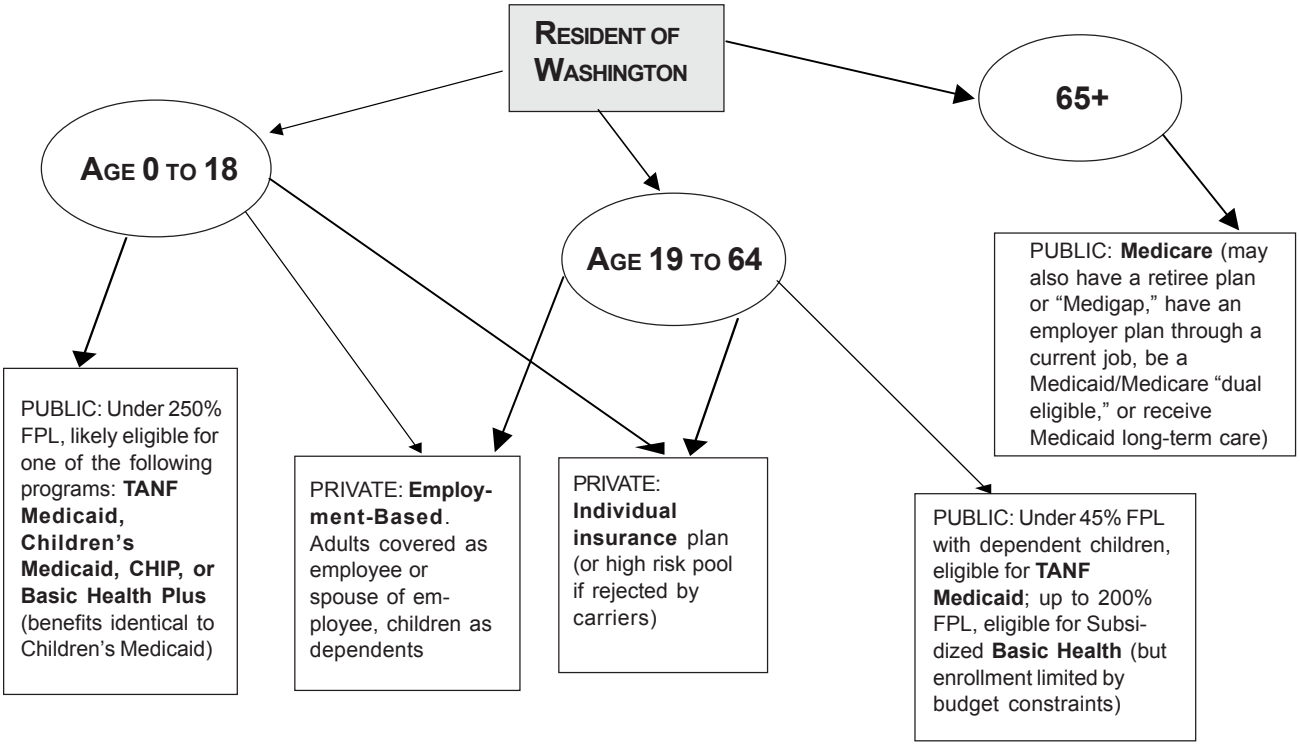
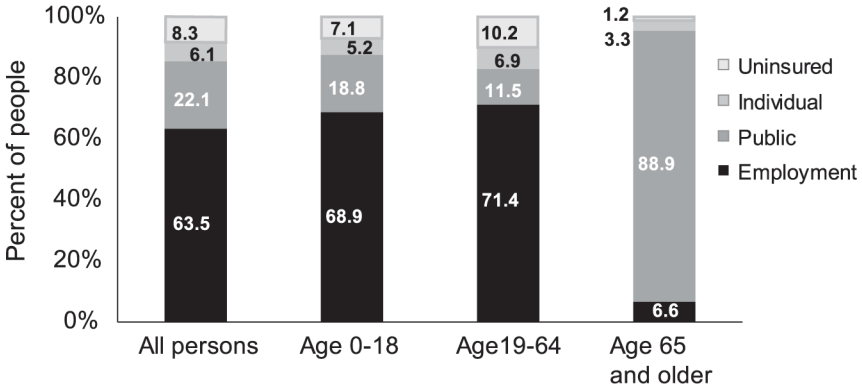


Figure 1-2. Primary Source of Insurance Coverage by Age Group, 2000



Sources of insurance vary with age. Public insurance is dominant for those over age 65, with 88.9 percent primarily covered by Medicare and only 6.6 percent receiving primary coverage through an employer. Employment-based insurance is predominant for other age groups, although almost one in five children is primarily covered by public plans.

Source: 2000 Washington State Population Survey.

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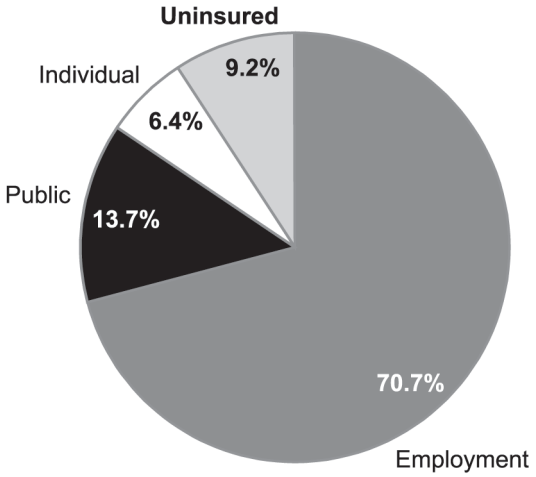
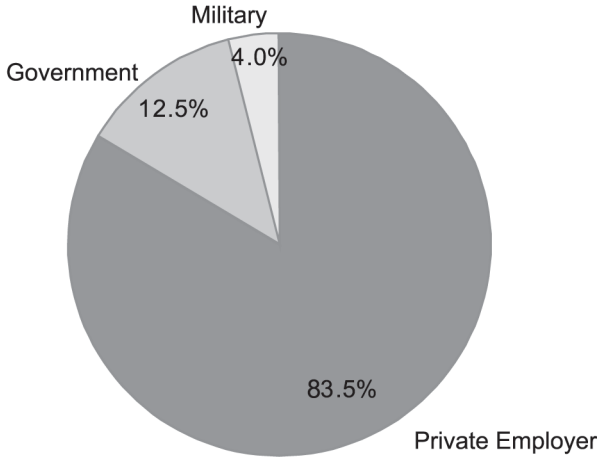
Figure 1-3. Primary Source of Insurance Coverage for those Under Age 65, 2000



Source: 2000 Washington State Population Survey.

For the population under 65, about 71 percent have employer-sponsored coverage, 14 percent are primarily covered by public plans, and 6 percent are in individual insurance. Despite a relatively small enrollment, individual insurance provides coverage for those who become unemployed, retirees not yet eligible for Medicare, and employees (and their dependents) who work in firms that do not offer insurance or are self-employed.

Figure 1-4. Major Sources of Employer Coverage for Workers Under Age 65 (and Their Dependents) with Employer Coverage, 2000



Source: 2000 Washington State Population Survey.

Among workers under age 65 and their dependents with employer coverage, about 84 percent have insurance provided by a private employer, about 13 percent have insurance provided by federal, state, and local governments, and 4 percent have coverage provided by the military.

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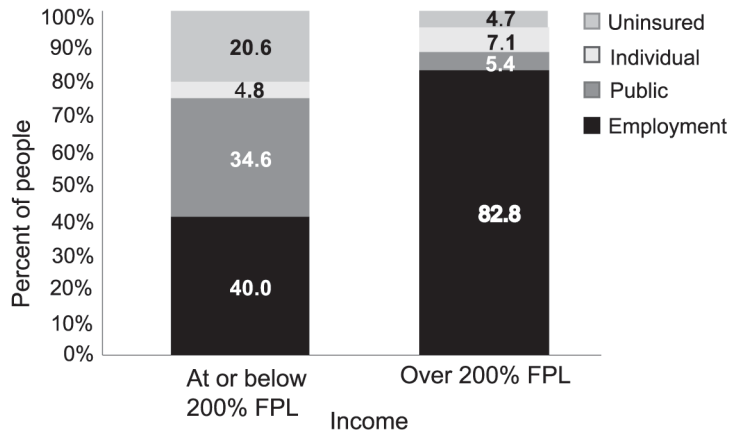
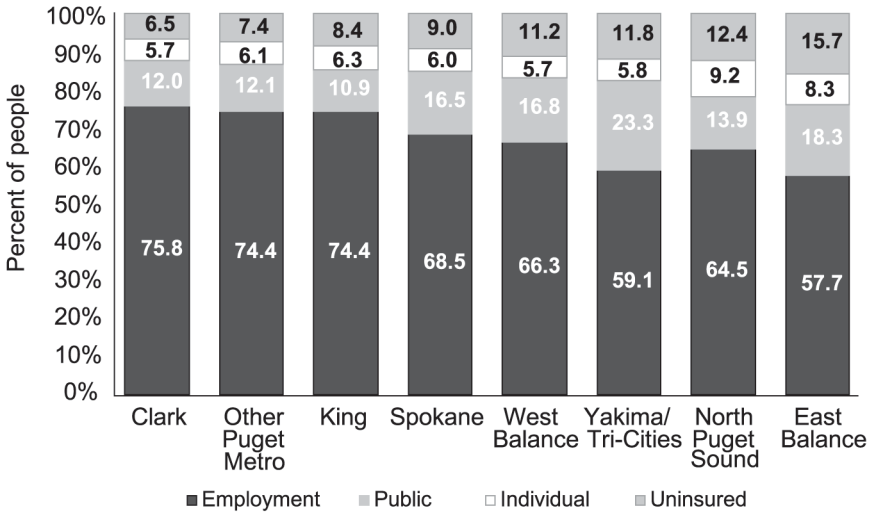
Figure 1-5. Sources of Insurance (and Uninsured) Above and Below 200 Percent of the Federal Poverty Level, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Figure 1-6. Sources of Insurance (and Uninsured) by Region, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

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

Factors Affecting Sources of Coverage for Those Under Age 65

The type of insurance coverage varies substantially by income. The likelihood of having employer coverage is twice as high among those with family incomes above 200 percent FPL compared to those with lower incomes. Among those with a family income at or below 200 percent FPL, 40 percent are in an employment-based plan, compared to 82.8 percent for those above 200 percent FPL.

Public insurance fills in the gap for many low-income individuals, more than one-third of whom are insured through public programs. Still, one in five (20.6 percent) low-income individuals under age 65 is uninsured.

Coverage also varies by region. Three out of four of the population under 65 has an employment-based plan in highly urbanized Clark and King counties, and in the other parts of the Puget Sound metro area. In the more rural counties, employment-based plans cover about two-thirds of the population or less. For public coverage, a reverse pattern exists, with one in ten King County residents covered by a public plan, in contrast to almost one in four with public coverage in the Yakima/Tri-Cities area.

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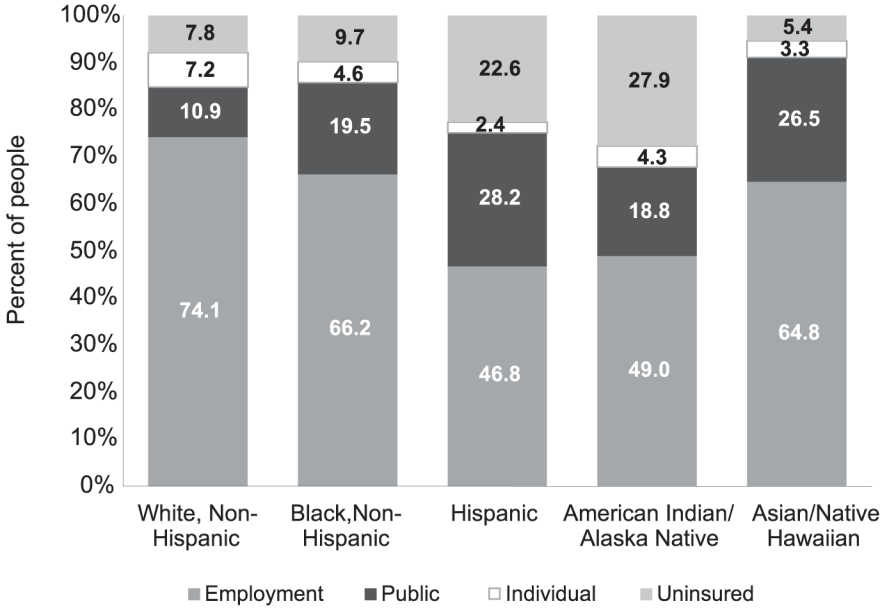
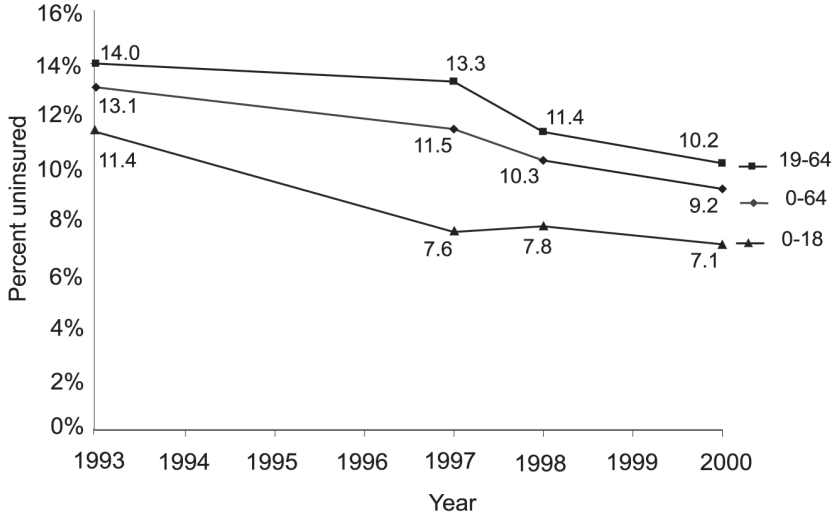
Figure 1-7. Insurance Coverage by Race or Ethnicity, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Figure 1-8. Uninsured Rates by Age, 1993-2000



Source: 1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000, Washington State Population Survey. Data refer to the population under 65.

Insurance coverage also varies by race and ethnicity. Three out of four non-Hispanic Whites have an employer plan, but only about half of Hispanic and American Indians have employment-based insurance. More than a quarter of Hispanics and Asians/Native Hawaiians have public insurance. American Indians/Alaska Natives have the highest uninsured rate, at 27.9 percent, and over one in five Hispanics is uninsured.

How Have Insurance Sources Changed Over Time?

During the 1990s, the uninsured rate in Washington declined steadily, according to surveys commissioned by The Robert Wood Johnson Foundation and the Washington State Office of Financial Management. These four surveys indicate that the uninsured rate for adults aged 19 to 64 dropped from 14.0 percent in 1993 to 10.2 percent in 2000. For children, the uninsured rate dropped from 11.4 percent to 7.1 percent over this period.*

*For a comparison of surveys with Washington State data, see Rutgers University Center for State Health Policy, Research Deliverable 1.0. *Data for Assessing Access to Health Insurance Coverage in Washington State*, April 2002.

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Figure 1-9. Sources of Insurance Coverage, 1993 to 2000

	1993	1997	1998	2000
Employment-based	70.9	68.8	68.0	70.7
Public	8.9	12.5	13.3	13.7
Individual	7.1	7.2	8.4	6.4
Uninsured	13.1	11.5	10.3	9.2

Source: 1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000, Washington State Population Surveys. Data refer to the population under 65.

A major factor in the declining rate of uninsurance is the expanding role of public insurance. During the 1993-2000 period, public insurance increased its role, while employment-based insurance remained stable, resulting in an overall decline in the proportion of uninsured.

The timeline below identifies major enrollment milestones and expansions in public programs during this period.

Figure 1-10. Major Public Program Changes in Washington, 1989-2000

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Basic Health*	Basic Health (BH) enrollment begins		First BH "wait list" imposed		BH goes state-wide; Non-subsidized program begins	BH Plus (children) begins enrollment to 200% FPL	BH homeworker and employer groups created					
Medicaid	First Steps program (infants and pregnant women) created	Children's Medicaid expands to 133% FPL (aged 1-5)	Children up to Aged 18 covered to 100% FPL	Children Aged 19 covered to 100% FPL	"Healthy Options" Medicaid managed care begins	Children's Medicaid Eligibility Expansion to 200% FPL to age 19	Healthy Options (Medicaid managed care) now statewide		Work-First TANF program implemented	Medicaid outreach begins in numerous counties		Medicaid outreach operating in 36 counties; CHIP enrollment begins

*A complete history of Basic Health is available at www.wa.gov/hca/basichealth/bhhistory.htm.

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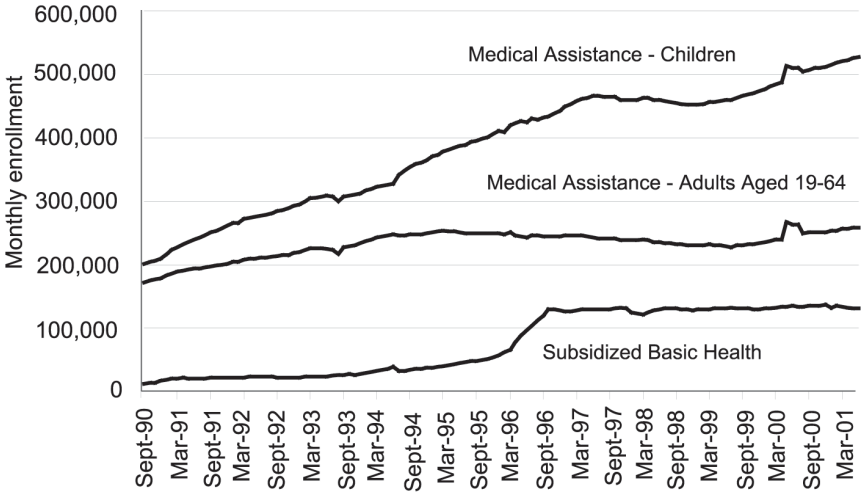
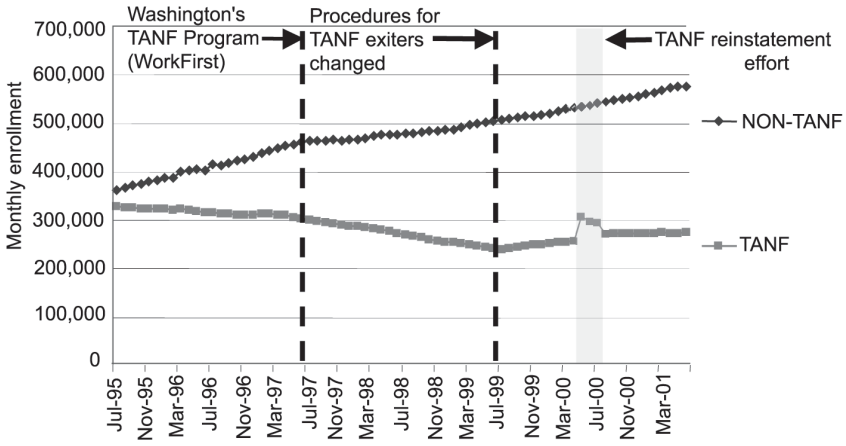
Figure 1-11. Medical Assistance and Basic Health Enrollment, September 1990 Through June 2001



Source: Medical Assistance Administration Database, Health Care Authority enrollment history file.

The chart at left documents the steady expansion of public health insurance. The subsidized Basic Health program expanded from less than 25,000 in 1993 (as a pilot program) to 130,000 in 1997, remaining at approximately that level through mid-2001. In 1994, eligibility for the Children's Medicaid program expanded to 200 percent FPL, and enrollment of children increased from 317,000 in January 1993 to over 500,000 by May 2000. The number of adults on Medical Assistance grew through 1995, dropped slightly from then to 1999, and began to rise again after that.

Figure 1-12. Effect of Washington's WorkFirst Program on Medicaid Enrollment



Source: HPAP analysis of Medical Assistance Administration database.

Welfare reforms contributed to a reduction in total Medicaid enrollment between 1997 and 2000, although these changes were counteracted to some extent by increasing enrollment in other areas, especially the Children's Medicaid program. The implementation of Washington's TANF program, WorkFirst, in mid-1997 caused the TANF-related Medicaid enrollment to decline. TANF Medicaid enrollment began to increase again in mid-1999 after the state began to implement new Medicaid procedures for families leaving welfare. A TANF reinstatement effort in mid-2000 for those erroneously removed from Medicaid had little long-term enrollment effect.

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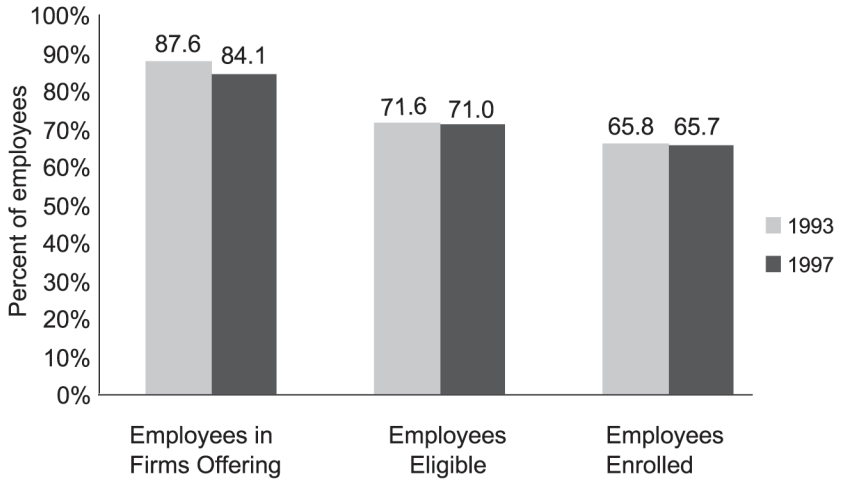
Figure 1-13. Employment-Based Insurance: Offer, Eligibility, and Enrollment Rates, 1993 and 1997



Source: 1993 National Employer Health Insurance Survey (NEHIS); 1997 RWJF Employer Health Insurance Survey. Data refer to Washington employees only.

The role of employment-based coverage and individual coverage did not change significantly over the 1993-1997 period. This stability is illustrated by data from two employer surveys that indicate little change in the percent of employees in companies offering coverage, the percent of employees eligible for coverage, and the percent of employees enrolled. Regulatory efforts to increase access to and affordability of coverage for small employers in Washington were tried in the 1990s, but available evidence indicates that these reforms had little effect on the employment-based system.*

* M. Susan Marquis and Stephen H. Long, "Effects of 'Second Generation' Small Group Health Insurance Market Reforms, 1993 to 1997," *Inquiry*, Vol. 38 No. 4, Winter 2001/2002, pp. 365-380.

The timeline below illustrates some major changes in regulation of private markets designed to increase access generally or in the employer or individual market.

Figure 1-14. Major Changes in Market Regulation in Washington, 1988-2000

1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
High risk pool created (up to 150% of small group rates)		Legislature authorizes small group plans without mandated benefits			Health Services Act: Uniform Benefit and coverage mandates, guaranteed issue, etc.	Guaranteed issue, 90 days pre-existing, portability implemented	Uniform benefit and coverage mandates repealed	High risk pool closed exc. for Medicare			Commercial insurers close enrollment in individual plans	Individual market reopened; pre-existing condition exclusion expanded to 9 months
						Insurance open enrollment with no waiting period declared	Commercial "BH look alike" model plans created				High risk pool opened to those unable to get individual plans	Insurers allowed to exclude 8% of riskiest applicants

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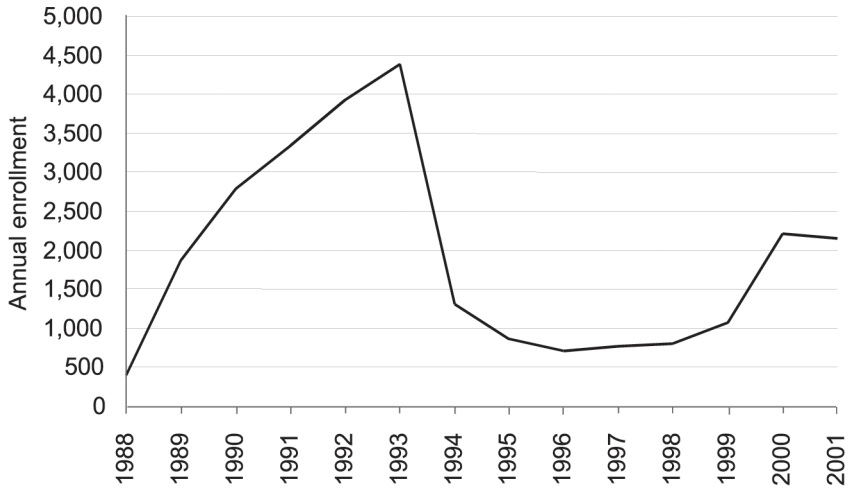
Figure 1-15. Enrollment in the High-Risk Pool, 1988 to 2001



Source: Data from Washington State Health Insurance Pool.

The individual insurance market fluctuated between 6 and 8 percent of the population between 1993 and 2000. A high-risk pool, created in 1988, was designed to provide insurance to the sickest individuals who would otherwise be priced out of the individual market. Regulations in the 1993 Health Services Act requiring guaranteed issue and shortening the preexisting condition exclusion period for insurers opened the commercial market to higher-risk individuals. This led to declining enrollment in the pool, which went from 4,400 in 1993 to 700 in 1996. Soon, however, growing losses among carriers, most of which they attributed to the individual market, led to a series of market withdrawals by the larger insurers. By 2000, the private individual market was closed to new enrollees. Correspondingly, enrollment in the high-risk pool began to increase again.

The passage in 2000 of the Health Insurance Reform Act led to the reentry of insurers into the individual market in 2001, with the high-risk pool taking on a new role. The law allows companies to screen out up to 8 percent of the least healthy applicants, who are then eligible to apply for coverage in the high-risk pool.

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Chapter 2. A Profile of Washington's Uninsured

Introduction

This chapter presents a profile of Washington's uninsured. We focus on the uninsured population under age 65, since these individuals account for most of the uninsured and are most likely to be affected by state policies to expand insurance. This chapter examines factors that are related to the uninsured rate such as age, income, presence or absence of children, numbers of workers in a family, race and ethnicity, citizenship status, geographic region, education levels, gender, and health status. We also look briefly at the length of time without insurance among the uninsured.

We highlight major uninsured populations who are potential targets for policies or partnerships designed to expand coverage. Potential target groups include low-income individuals and childless, young adults. The majority of the uninsured are in families with at least one employed person. Although other characteristics, such as rural location or being a racial or ethnic minority, help predict being uninsured, the majority of the uninsured are whites in the Puget Sound region. Hispanics make up the next largest ethnic group of uninsured and may benefit from enrollment efforts.

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Major Findings

Major Gaps in Insurance Coverage for the Population Under 65

- Most of the uninsured are low income. Those with incomes at or below 200 percent of the federal poverty level (FPL) account for almost two-thirds of the uninsured, or about 308,000 people in 2000. This suggests that lack of affordable insurance for low-income people is a major barrier to coverage. Among the low-income population, 20 percent are uninsured. The rate is 14 percent even when controlling for other characteristics that tend to affect the likelihood of being uninsured.
- Young adults between the ages of 19 and 34 are the largest uninsured group among all age groups.
- Over half (53 percent) of the uninsured are adults without any children, comprising about 256,000 people. As Chapter 5 shows, many of these people are not eligible for any public program.
- More than three-quarters (75.4 percent) of the uninsured are in families with at least one worker. This suggests that policies to expand the employer-based system may be a way to bring these people into the private insurance system.
- The likelihood that an individual will be uninsured is highest for American Indians/ Native Alaskans (27.9 percent) and Hispanics (22.6 percent). However, although the *rate* of uninsured is lower for non-Hispanic Whites (7.8 percent), this group accounts for two-thirds (67 percent) of the uninsured, given its majority status in the population.
- The highest rate of uninsured (15.7 percent) in the state can be found in the eastern rural region. However, in terms of absolute numbers, most of the uninsured reside in the more populated western half of the state.
- Although 9.2 percent of the population under 65 were uninsured in early 2000, the percent of uninsured almost doubles when measured over the course of a year (15.5 percent) since many periods without coverage are short-term or transitional. This suggests that transitional policies to help those who have recently lost insurance could help a substantial number of people.
- Three-quarters of those who were uninsured at a point in time in 2000 had been uninsured for at least a year. Therefore, although policies designed to help the short-term uninsured may be beneficial, these policies may not substantially reduce the

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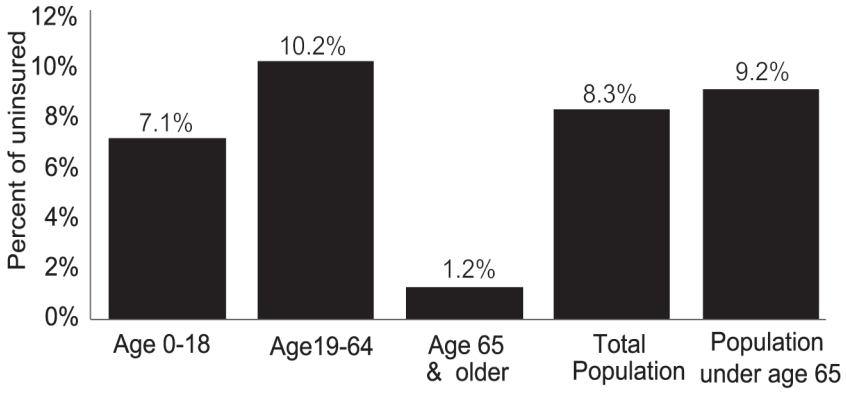
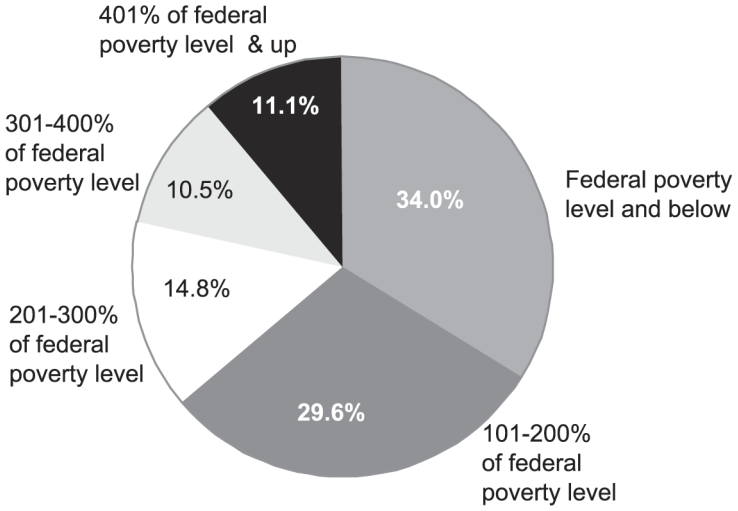
Figure 2-1. Percent Uninsured by Age, 2000



Source: 2000 Washington State Population Survey.

In 2000, 8.3 percent of all Washingtonians were uninsured. However, rates of uninsurance vary with age. Those over 65 have the lowest uninsured rate, primarily because of Medicare. The rate of uninsured children is also relatively low, at 7.1 percent. Those of prime working age—19 to 64—are the most likely to be uninsured, despite relatively wide access to employment-based insurance. The analysis in this chapter focuses on the population under 65, given their greater likelihood of being uninsured.

Figure 2-2. Distribution of the Uninsured by Income, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

In Washington, almost two-thirds of the uninsured under the age of 65 are in families with income levels below 200 percent FPL. More than three-quarters of the uninsured are in families earning less than 300 percent FPL.

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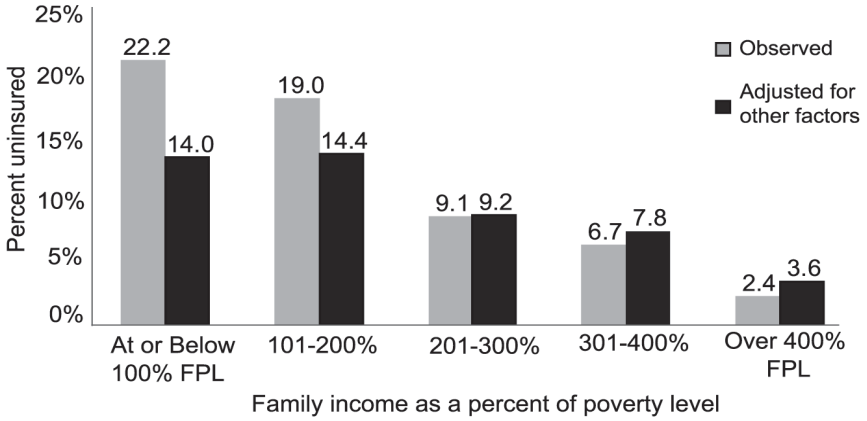
Figure 2-3. Percent Uninsured by Family Income, Observed and Adjusted, 2000

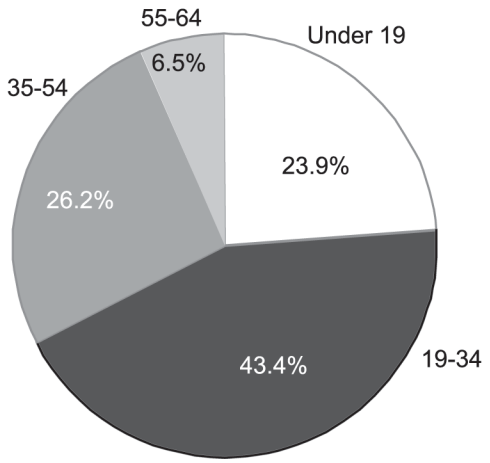


Source: 2000 Washington State Population Survey. Data refer to the population under 65. Statistical adjustments are for health status, region, race/ethnicity, age, education, citizenship, and number of workers in a family.

Family income is one of the key factors in the uninsured rate; it persists even when controlling for other characteristics that affect the likelihood of being uninsured. The uninsured rate among those in poverty is 22.2 percent and 19.0 percent among those with income between poverty and 200 percent FPL.

By contrast, the uninsured rate is only 6.7 percent among those with income between 301 and 400 percent FPL and is even lower among those with income above 400 percent FPL. The difference in uninsured rates between the low-income and high-income groups is smaller when we adjust for other factors, but the difference remains substantial.

Figure 2-4. Distribution of the Uninsured by Age, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Young adults aged 19 to 34 make up the largest proportion of the uninsured at 43.4 percent. This group is also largely without children (60 percent). Adults aged 35 to 54 make up the next largest segment. Children under age 19 make up about one in four of the uninsured (23.9 percent).

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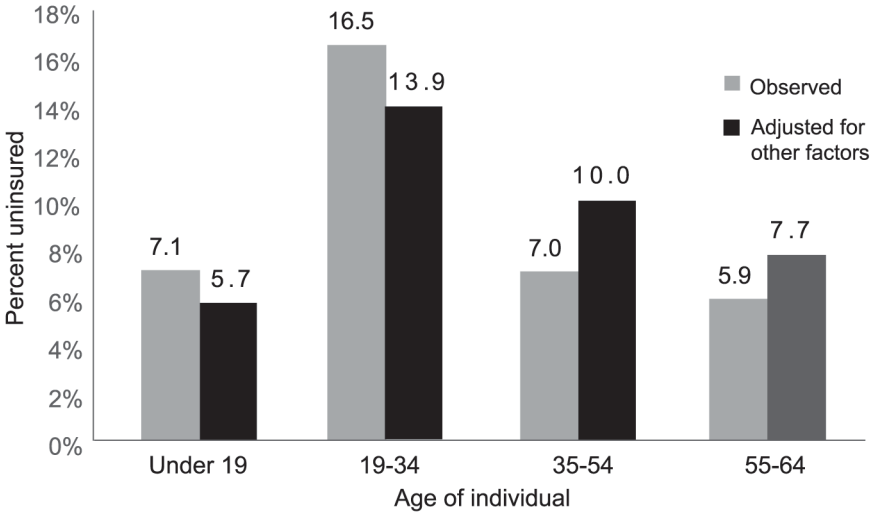
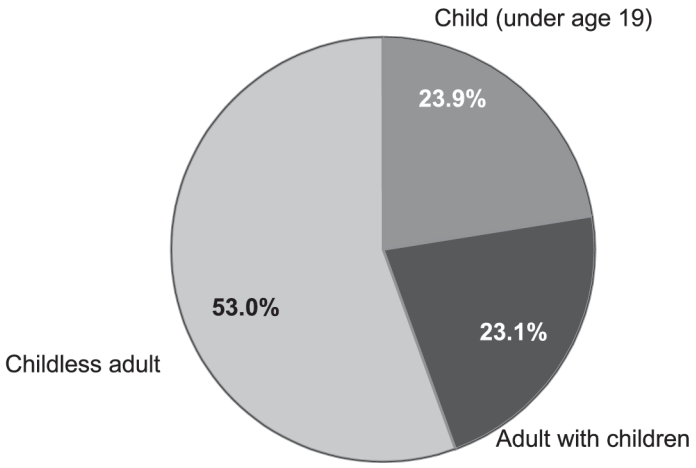
Figure 2-5. Percent Uninsured by Age, 2000



Source: 2000 Washington State Population Survey. Statistical adjustments are for health status, region, income, race/ethnicity, education, citizenship, and number of workers in a family.

When we look at the uninsured rates according to age, a similar pattern appears. The rate of uninsurance is highest for those aged 19 to 34, even when adjusted statistically for other factors that may affect the likelihood of being uninsured. The second highest uninsured rate (after adjustment) is among adults aged 35 to 54.

Figure 2-6. The Uninsured by Age or Parental Status, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

More than half of the uninsured (53 percent) are adults without children. This is not surprising, as public programs have mostly been targeted toward children and their parents.*

*Note: Our analyses in this paper categorize legal guardians of children (such as a grandparent) as parents.

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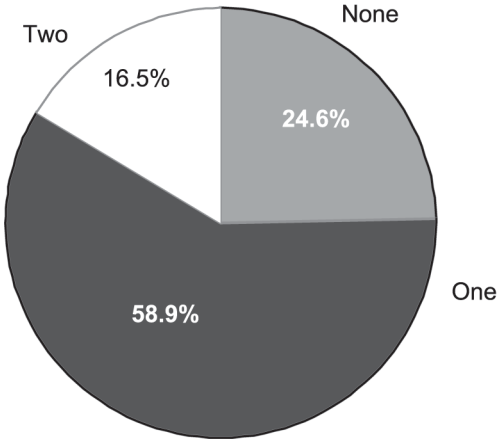
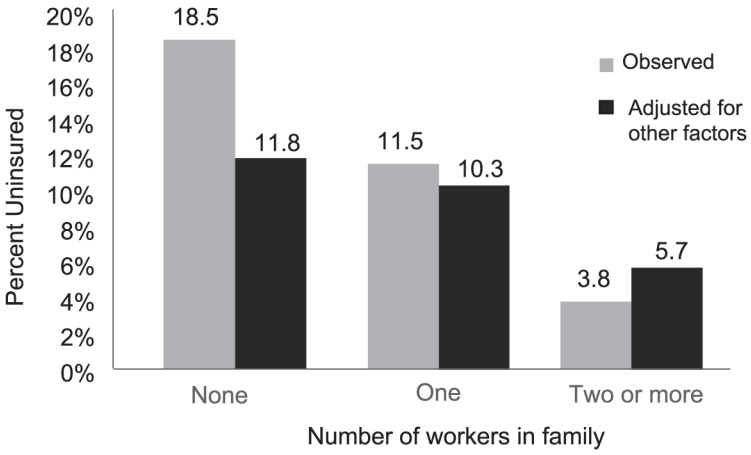
Figure 2-7. Distribution of the Uninsured by Number of Workers in the Family, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

More than three-quarters (75.4 percent) of the uninsured in Washington are found in families with at least one worker.

Figure 2-8. Percent Uninsured by Number of Workers in Family, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65. Statistical adjustments are for health status, region, income, race/ethnicity, age, education, and citizenship.

The uninsured rate is highest among people with no employed family member and lowest among those with two earners in the family. When adjusted for other factors, the differences diminish, but the pattern remains.

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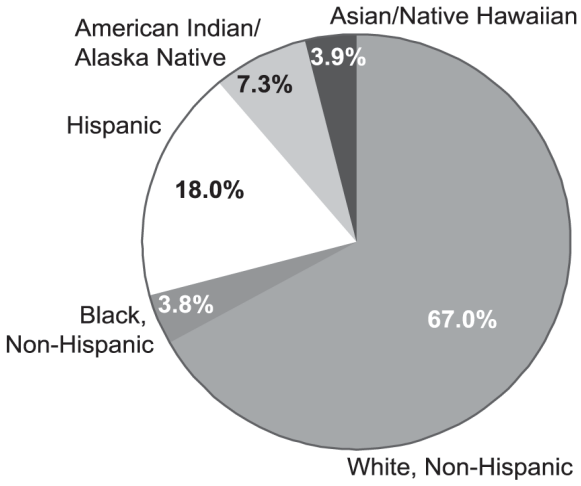
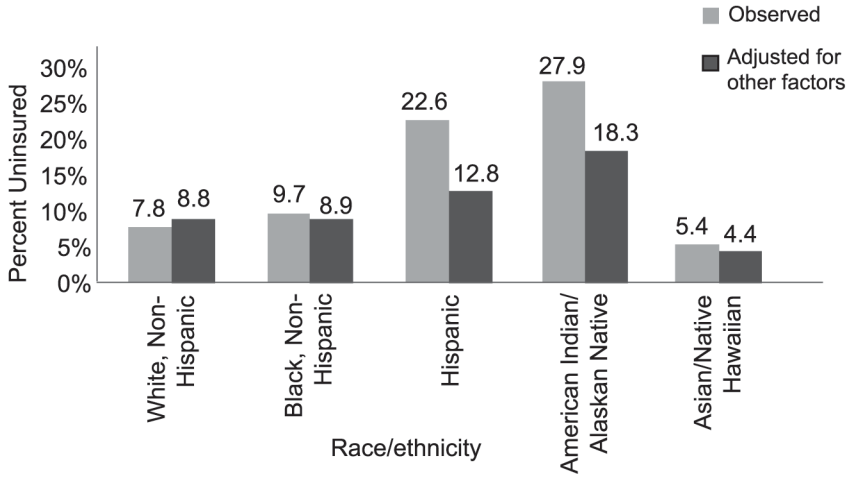
Figure 2-9. Distribution of the Uninsured by Race/Ethnicity, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

The uninsured population is primarily White non-Hispanic (67.0 percent). The second largest group is Hispanics, which accounts for 18.0 percent of the uninsured, followed by the American Indian/Alaska Native group, which makes up 7.3 percent.

Figure 2-10. Percent Uninsured by Race/Ethnicity, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65. Statistical adjustments are for health status, region, income, race/ethnicity, age, education, citizenship, and number of workers in a family.

However, the likelihood that an individual will be uninsured is highest for American Indians/ Alaska Natives, at 27.9 percent, and for Hispanics, at 22.6 percent. The disparity declines somewhat when adjusted for other factors, but these racial/ ethnic groups remain more likely to be uninsured.

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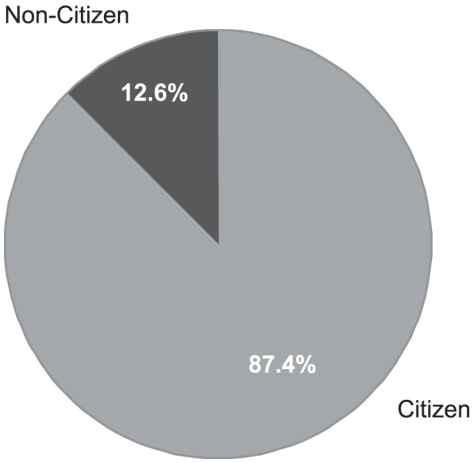
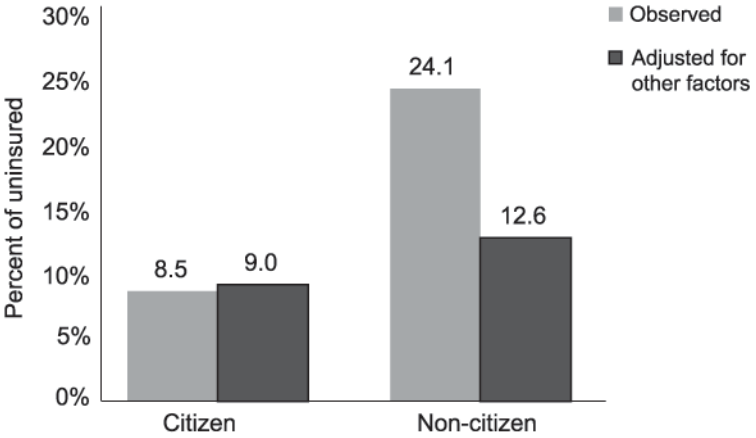
Figure 2-11. Distribution of the Uninsured by Citizenship Status, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

The uninsured are overwhelmingly United States citizens (87.4%).

Figure 2-12. Percent Uninsured by Citizenship Status, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65. Statistical adjustments are for health status, region, income, race/ethnicity, age, education, and number of workers in a family.

However, non-citizens are three times as likely to be uninsured as U.S. citizens. The difference in the uninsured rate between citizens and non-citizens drops substantially when adjusted for other factors.

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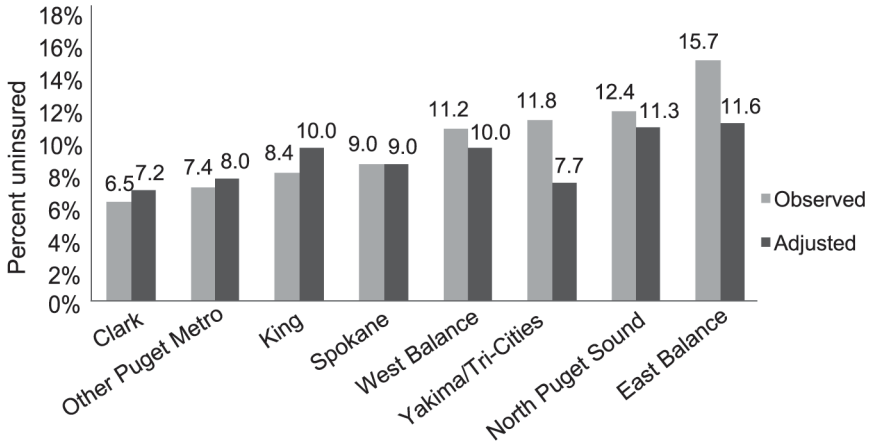
Figure 2-13. Percent Uninsured by Geographic Region, 2000



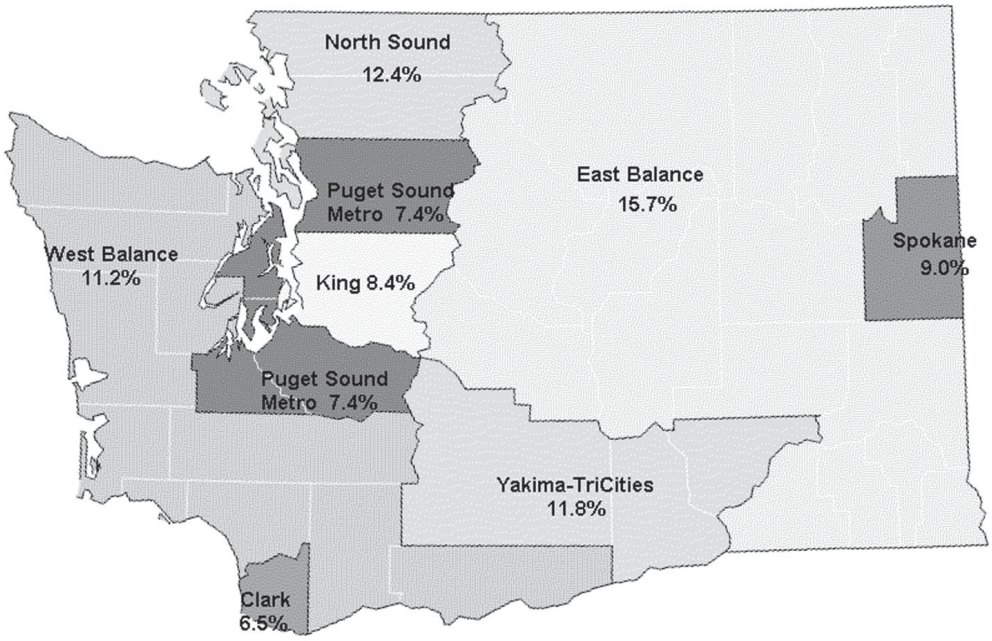
Source: Washington State Population Survey 2000. Data refer to the population under 65. Statistical adjustments are for health status, income, race/ethnicity, age, education, citizenship, and number of workers in a family.

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

The East Balance region (most of the rural eastern Washington counties) has the highest uninsured rate in Washington (15.7 percent). The lowest uninsured rate occurs in Clark County (6.5 percent). These regional differences diminish but remain after adjusting for other factors likely to affect rates of uninsured. After adjustment, uninsured rates for the West Balance, King County, North Puget, and East Balance regions are 10 percent or more.

The map below shows the unadjusted uninsured rates for the regions.

Figure 2-14. Percent Uninsured by Geographic Region, 2000



Source: Washington State Population Survey 2000. Data refer to the under 65 population.

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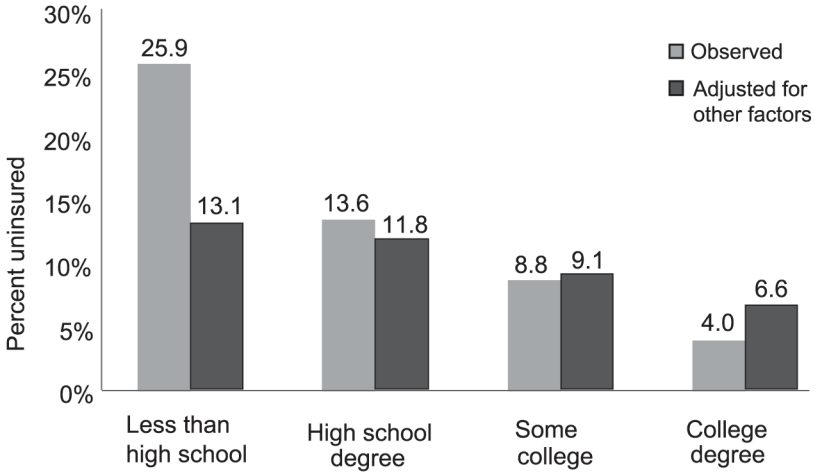
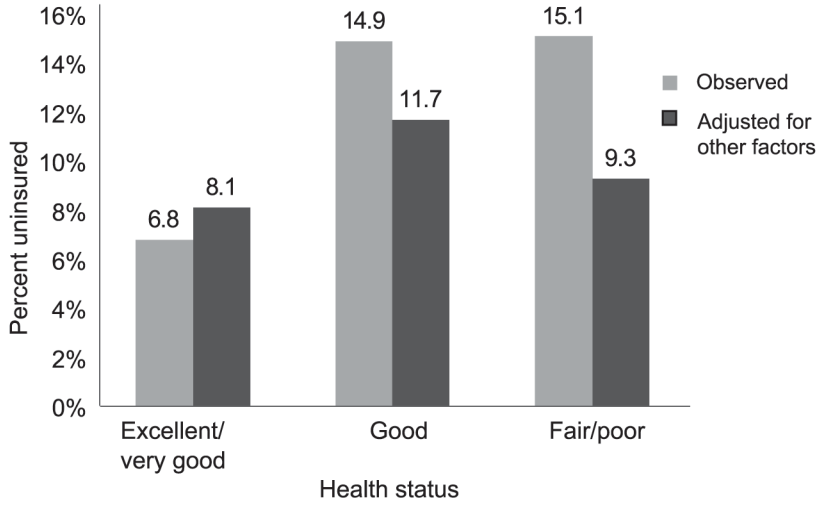
Figure 2-15. Percent of Adults Uninsured by Education, 2000



Source: Washington State Population Survey 2000. Data refer to adults aged 19-64. Statistical adjustments are for health status, region, income, race/ethnicity, age, citizenship, and number of workers in a family.

Adults (aged 19-64) with less education are more likely to be uninsured. Those with less than a high school education are the most likely to be uninsured (25.9 percent); those with a college degree are the least likely to be uninsured (4.0 percent). These differences diminish, but do not disappear, when income and other factors are taken into account.

Figure 2-16. Percent Uninsured by Self-Reported Health Status, 2000



Source: Washington State Population Survey 2000. Data refer to the population under 65. Statistical adjustments are for region, income, race/ethnicity, age, education, citizenship, and number of workers in a family.

The healthiest individuals are least likely to be uninsured. These differences shrink when adjusted for other factors.

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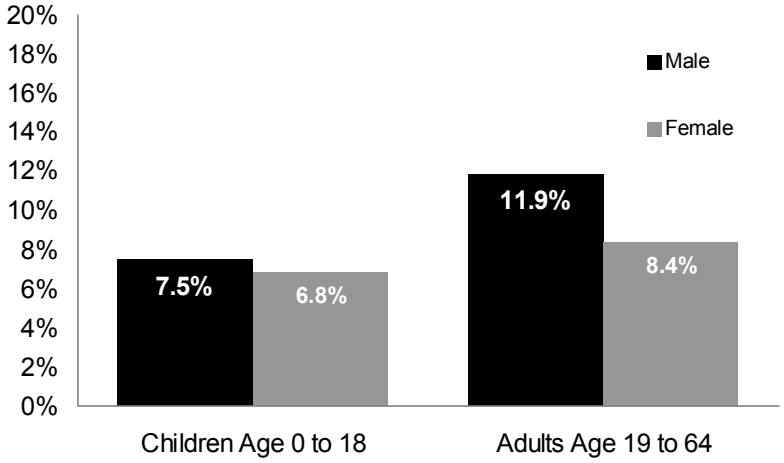
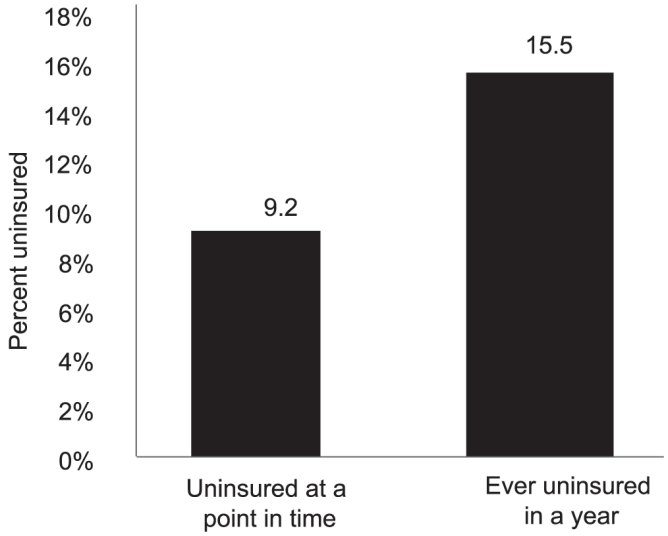
Figure 2-17. Uninsured Rates by Gender, Adults and Children, 2000



Source: 1998, 2000 Washington State Population Surveys.

Uninsured rates also vary by gender, with male adults and children more likely to be uninsured than female adults and children.

Figure 2-18. Percent Uninsured at One Point in Time vs. Ever Uninsured in the Prior 12 Months, 2000



Source: 1998, 2000 Washington State Population Surveys. Data refer to the population under 65.

The uninsured rate is nearly twice as high when measured over the course of a year compared to a single point in time, showing that for many people being uninsured is transitory. Therefore, policies to fill short-term gaps (such as for those recently losing an employer plan) may help many people who face a lack of insurance.

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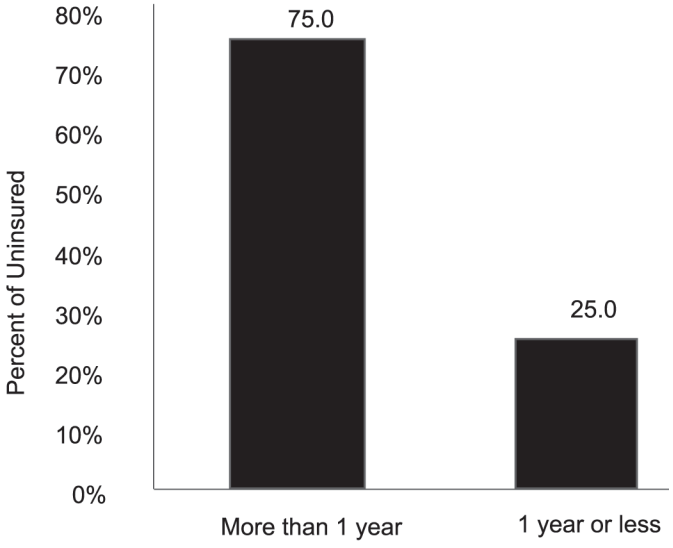
Figure 2-19. Distribution of Individuals Uninsured at One Point in Time, by Length of Time Without Insurance, 2000



Source: 2000 Washington State Population Surve; 1997 RWJF Washington Family Health Insurance Survey. Data refer to the population under 65.

However, three-quarters of those who were uninsured at a point in time have been uninsured for one year or more. This means that most of the uninsured are in long-term episodes of uninsurance. Consequently, policies designed to assist the short-term uninsured are unlikely to substantially reduce the overall uninsured rate.

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Chapter 3. The Role of the Family in the Insurance Status of Children

Introduction

This chapter examines the insurance coverage of children (aged 0-18) with a focus on how parental insurance status affects the insurance status of children. It also examines how the rate of uninsured children varies according to the gender and marital status of the head of the family. We also look at how families who do not insure all their children decide whom they will cover—examining factors such as health and age of children that are associated with the choice of whom to insure.

Children of insured parents are themselves overwhelmingly insured. Conversely, uninsured parents are much more likely to have uninsured children. And, three out of four uninsured children have uninsured parents. These patterns suggest that policies to insure adults may also be effective in insuring the remaining uninsured children. When families choose to insure only some of their children, they usually insure the youngest and the sickest children.

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Major Findings

Barriers to Coverage for Children:

- Two-thirds of children (aged 0-18) with uninsured parents are uninsured, but only 2 percent of children with insured parents are uninsured. In addition, three out of four (74 percent) uninsured children—almost 86,000 children—have uninsured parents. This suggests that new policies to expand coverage for children might focus on the family as a whole.
- Children aged 13 and older are more likely to be uninsured than younger children, even when adjusting for other factors such as parents' insurance status.
- About 60 percent of uninsured children are school age—about 73,000 uninsured children in 2000. Thus, the schools might be a focus for outreach efforts to insure children.
- Most uninsured children are in families where all children are uninsured. However, families that insure one or more of their children, but not all of them, tend to cover the youngest and less healthy children.

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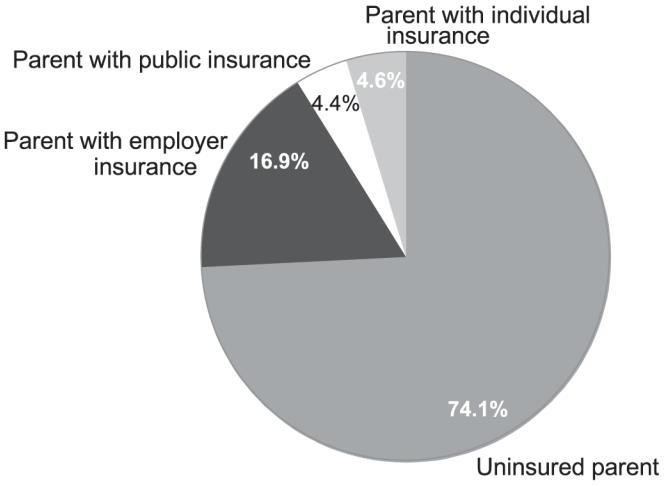
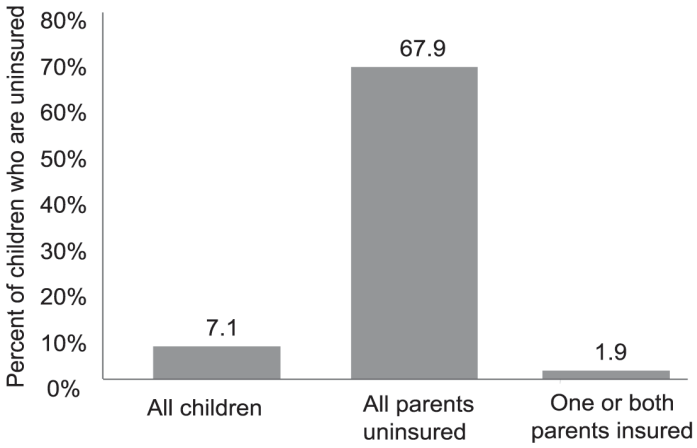
Figure 3-1. Distribution of Uninsured Children by Parent's Insurance Status, 2000



Source: 2000 Washington State Population Survey. Data refer to children aged 0-18.

A primary factor in predicting the insurance status of children is whether their parents are insured.* Almost three out of four uninsured children have uninsured parents.

Figure 3-2. Percent of Children Uninsured by Parent's Insurance Status, 2000



Source: 2000 Washington State Population Survey. Data refer to children aged 0-18.

Moreover, although 68 percent of children with uninsured parents are uninsured, only 2 percent of children with an insured parent are uninsured.

*Note: Our analyses in this paper categorize legal guardians of children (such as a grandparent) as parents.

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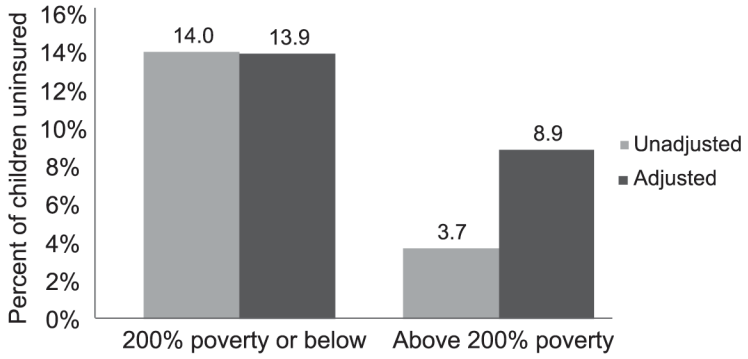
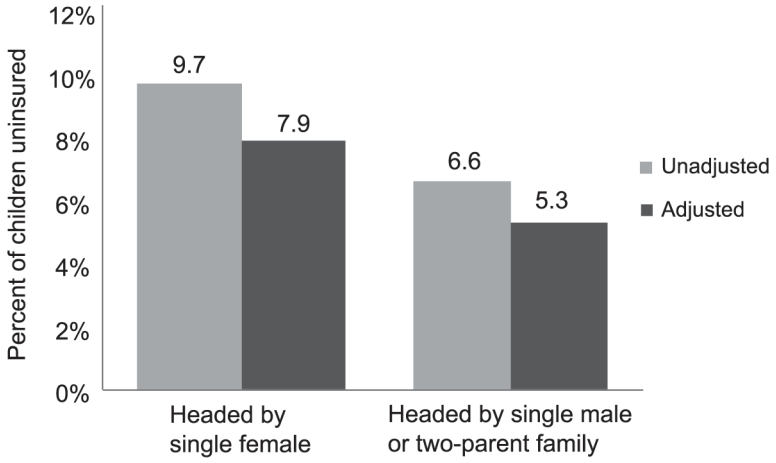
Figure 3-3. Percent of Children Uninsured, Above and Below 200 Percent of the Federal Poverty Level, 2000



Source: 2000 Washington State Population Survey. Statistical adjustments are for child's age, whether parent is a single female, and parents' insurance status. Data refer to children aged 0-18.

Children are more likely to be uninsured if their family's income is 200 percent FPL or lower, even after statistically adjusting for other factors likely to affect insurance rates.

Figure 3-4. Percent of Children Uninsured by Type of Family, 2000



Source: 2000 Washington State Population Survey. Statistical adjustments are for child's age, family income, and parents' insurance status. Data refer to children aged 0-18.

Children are also more likely to be uninsured if the family head is a single female. This is true even after adjusting for other characteristics, including parent's insurance status.

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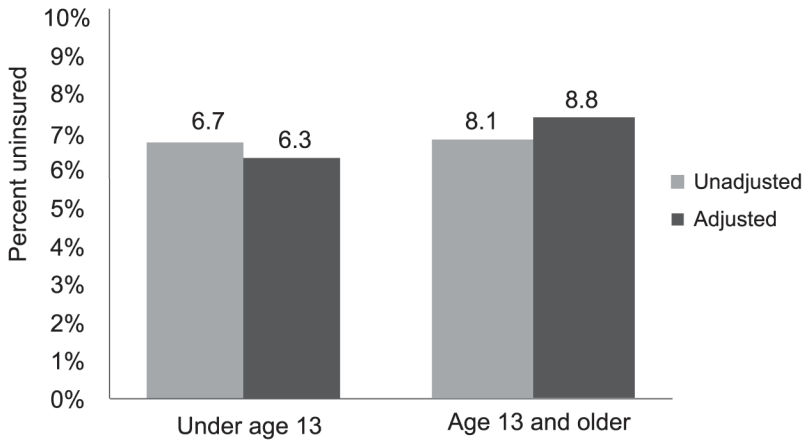
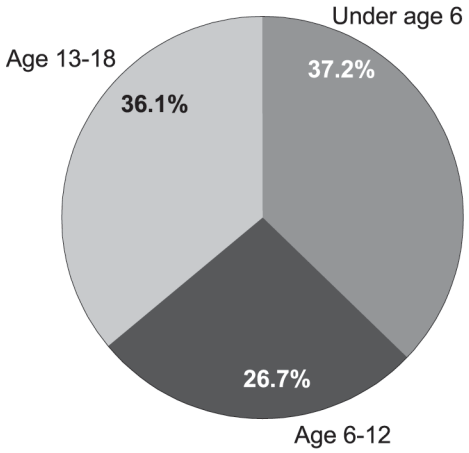
Figure 3-5. Percent of Uninsured Children by Age, 2000



Source: 2000 Washington State Population Survey. Statistical adjustments are for family income, whether parent is a single female, and parents' insurance status. Data refer to children aged 0-18.

Older children are more likely to be uninsured, even when adjusting for other factors, including parent's insurance status.

Figure 3-6. Distribution of Uninsured Children by Age, 2000



Source: 2000 Washington State Population Survey.

However, the number of uninsured children is relatively equally distributed among infants, preteen school-aged children, and teenagers. About 60 percent of uninsured children are school-aged children, so using the schools for outreach would target a majority of these uninsured children.

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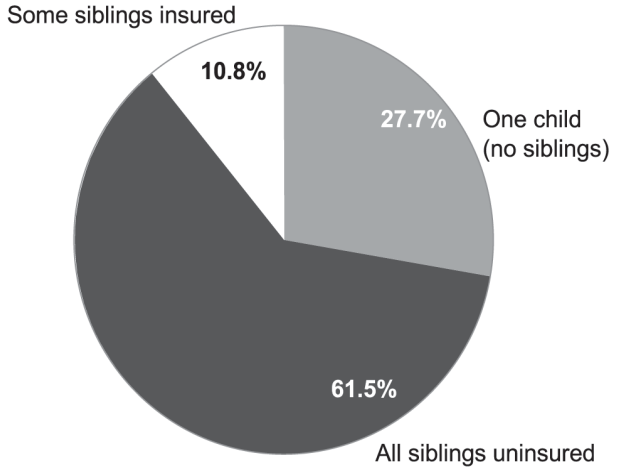
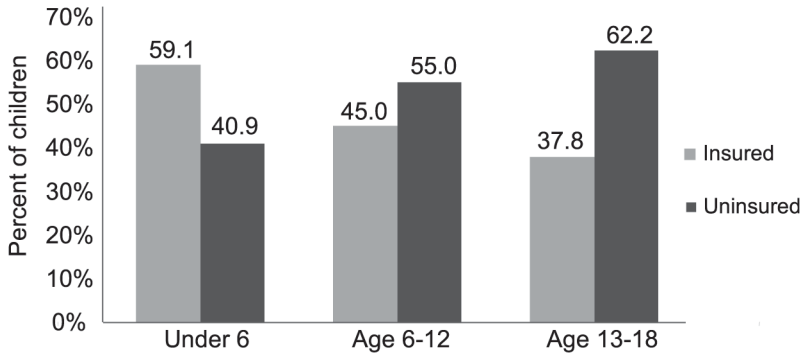
Figure 3-7. Distribution of Uninsured Children by Sibling's Insurance Status, 2000



Source: 2000 Washington State Population Survey. Data refer to children aged 0-18.

Most uninsured children are in families in which all children are uninsured.

Figure 3-8. Insurance Status of Children in Partially Insured Families by Age of Child, 2000



Source: 2000 Washington State Population Survey.

In families with only some children insured, the percent of uninsured children increases with the age of the children. In other words, families that do not insure all their children are more likely to insure the youngest children.

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Figure 3-9. Percent of Children Uninsured in Partially Insured Families by Health Status of Child, 2000

Source: 2000 Washington State Population Survey. Data refer to children aged 0-18.

In families with only some children insured, children who have better health are more likely to be uninsured. This suggests that families who do not insure all children may choose to leave the healthiest children uninsured.

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Chapter 4. Availability of Public and Private Insurance Coverage

Introduction

The two most prominent forms of insurance coverage in Washington are employment-based coverage and public insurance. This chapter examines factors that affect the availability of insurance coverage in these two sectors. The first section of the chapter briefly covers the role of public insurance programs in Washington, examining the range of programs, their intended recipients, and the eligibility procedures used for determining who can be enrolled in these programs. We examine primary eligibility pathways to public insurance for different segments of the population and identify factors likely to affect availability of insurance such as income, age, citizenship status, and medical condition. Availability of public insurance for children is quite broad (up to 250 percent of the federal poverty level), but availability of coverage for adults has been restricted by both enrollment caps in Basic Health and Medicaid rules limiting enrollment to adults with children. This chapter identifies hypothetical eligibility; the next chapter matches eligibility criteria of public programs with actual characteristics of individuals and families to measure actual access to public insurance among different segments of the population.

The second section of this chapter looks at the availability of private insurance in the employment-based market and identifies factors associated with the likelihood that workers are in a business that offers insurance to employees, including size of business, prevalence of seasonal employment, rates of unionization, and the prevalence of part-time, low-wage, female, and young workers in the business. The analysis focuses on workers only, not their dependents, and includes only workers under age 65. The section also includes estimates of how premiums faced by small employers affect the likelihood that insurance will be offered to employees. Chapter 5 goes beyond this analysis of the characteristics of employers or their workers to examine access to employment-based and other private insurance on an individual basis, measuring access to these forms of insurance among dependents as well as by the employed population.

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Major Findings

Availability of Public Programs

- Washington has numerous public insurance programs. whos eligibility varies according to factors such as age, income, family structure, and citizenship status.
- Programs for children are the most broadly available, with the combination of Medicaid and the Children's Health Insurance Program (CHIP) potentially making insurance available for all citizen children in families at or below 250 percent of the federal poverty level (FPL).
- Insurance for adults is less available to potential enrollees. Theoretically, the Basic Health program is open to all adults making up to 200 percent FPL, but enrollment caps have constrained enrollment to about 130,000 individuals.
- Other public programs exist that fill some of the coverage gaps for adults, but have very specialized eligibility requirements and are often restricted to those adults with very low income and a disability or specific health issue.

Availability of Private Coverage

- Most employees—about 80 percent—in Washington work for a business that offers coverage.
- Availability of coverage varies substantially by firm size. The availability gap is greatest for workers in businesses with fewer than 10 workers—only slightly more than half of these workers are in a company that offers insurance.
- Premium prices are related to whether coverage is offered by small businesses, suggesting that premium subsidies could have some effect in increasing the percent of employers offering insurance.
- But worker characteristics also matter, suggesting that lack of worker demand for coverage may also be a factor that affects employers' decisions to offer coverage. Characteristics associated with lower offer rates include high proportions of low-wage, young, and female employees.

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Part 1. Availability of Public Insurance in Washington

A wide variety of public insurance programs serve Washington residents. Various Medicaid programs make up the bulk of public program enrollment, with the two largest of these, TANF-related Medicaid and Children's Medicaid, together accounting for more than half a million enrollees. Medicaid programs are run by the state under federal guidelines and are funded by both federal and state dollars (at approximately a 50-50 ratio in Washington). Pregnancy Medical, also funded by Medicaid dollars, is the fourth largest program with more than 40,000 enrollees.

Some public programs are paid for solely with state dollars. The largest of these is Basic Health, but other state-only programs serve immigrants, those in substance abuse treatment, and very poor people without children. The following table shows the largest public health insurance programs in Washington, their target populations, and their enrollment for March 2000.

Public Program Eligibility

The three most important factors determining whether someone is eligible for public insurance, and if so which program they are eligible for, are age, income, and citizenship status. Other factors affecting enrollment include programmatic status (e.g., receiving Temporary Assistance for Needy Families (TANF) cash assistance, enrollment in Foster Care) and health condition (such as disability or need for substance abuse treatment).

Figure 4.1. Major Public Health Insurance Programs in Washington for the Low-Income Population

Name of Program	Population Targeted	Eligibility Limit as % of FPL*	Number Enrolled (Feb. 2002)
Children's Medicaid	Newborns and children under age 19	200%	312,621
Children's Health Insurance Program (CHIP)	Children under age 19 in families with incomes too high for Medicaid	250%	6,831
Foster Care	Foster children and adoptees under age 19	200%	15,351
TANF Medicaid (adults and children)	Children under age 19 and adults who care for them	45%	275,310
Children's Health Program	Children under age 18 who are non-U.S. citizens	100%	20,737
Refugee Assistance	Refugees granted asylum in the U.S.	49%	907
Basic Health (regular subsidized)	Low-income individuals/families not eligible for Medicare	200%	120,533
Medically Indigent	Low-income individuals not eligible for other medical programs	49%	2,072
General Assistance - Unemployable (GA-U)	Persons who are physically/mentally incapacitated and unemployable for > 90 days	45%	9,315
ADATSA	Persons incapacitated and unemployable due to drug/alcohol abuse	45%	3,670
Pregnancy Medical	Low-income pregnant women	185%	23,226
Family Planning	Medical coverage post-partum for women who received medical assistance during pregnancy	200%	67,602
Aged	Low-income individuals over 65	n/a*	61,307
Blind and Disabled	Blind and disabled people below federal and state income limits	n/a*	122,888

Source: Medical Assistance Administration, Health Care Authority

* Income is before-tax; some programs have an "income disregard" that reduces countable income (e.g., for income from work or for child care expenses). These modifications to the eligibility level are not reflected here.

** Income calculated using federal and state schedules that differ from the FPL.

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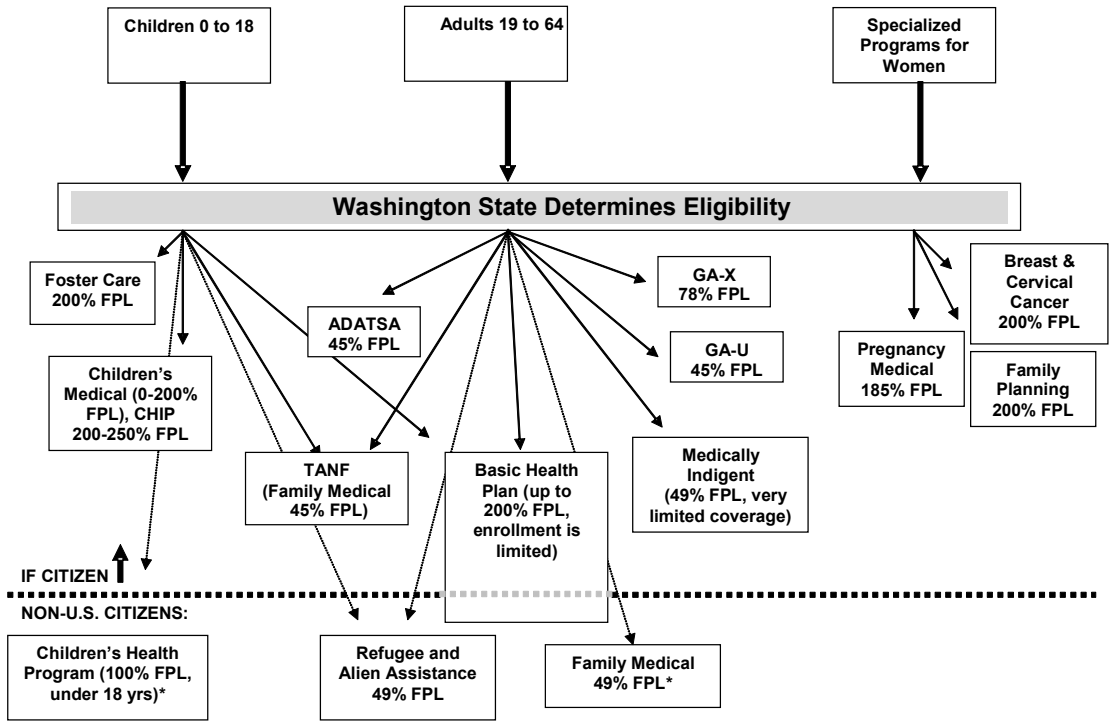
The following chart summarizes the major enrollment pathways in Washington's public programs for the population under 65. Some programs are exclusively for children, of which the Children's Medicaid program and the Children's Health Insurance Program (CHIP) are most generally available, with enrollment constrained only by citizenship status and family income level. Taken together, these programs are available to most of the state's children in households up to 250 percent FPL. Eligibility for the Foster Care program is determined by income and by enrollment in the Foster Care system. The Children's Health Program is a state-funded program for non-citizen children, with eligibility limited at 100 percent FPL. Children are only eligible for TANF Medicaid when they are part of families or households receiving TANF cash assistance.

The availability of public programs for adults is more complicated. Some of the programs are available only to adults who are caring for dependent children. TANF family assistance is available for those families with children who receive TANF cash assistance, and a similar program, Family Medical, serves those non-citizens not qualifying for TANF. The subsidized Basic Health program, a state-funded program providing access to adults regardless of the presence of children, provides coverage to those making up to 200 percent FPL. However, as we will see in Chapter 5, in practice enrollment caps have limited the availability of this program. Other programs serving adults are much more limited in scope and have narrow eligibility criteria.

Figure 4-2. Primary Eligibility Paths to Public Health Insurance in Washington for the Population Under 65



Income is before-tax; some programs have an "income disregard" that reduces countable income (e.g., for income from work or for child care expenses). These modifications to the eligibility level are not reflected here.

*Note: These programs are being phased out, with enrollees transferred to Basic Health.

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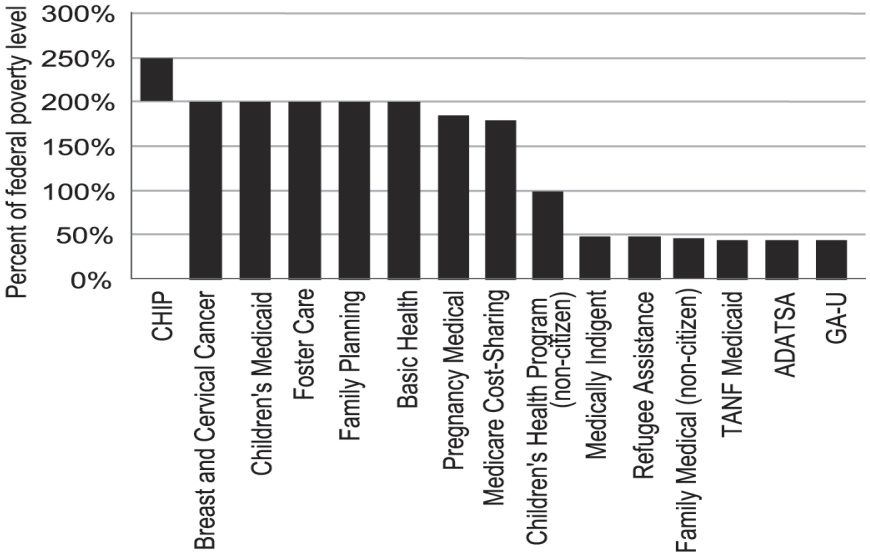
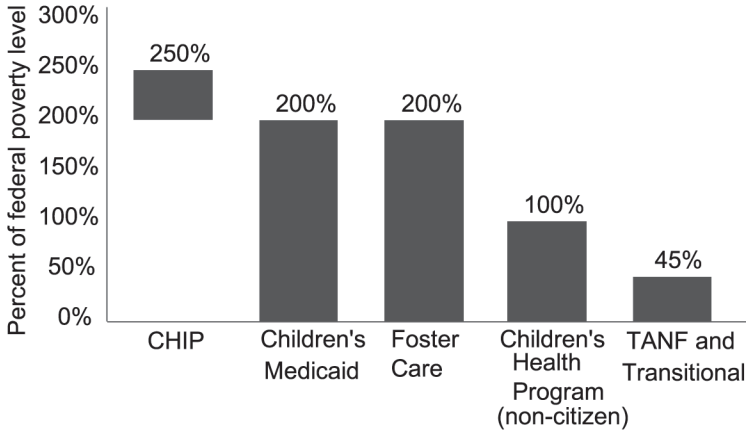
Figure 4-3. Washington Public Insurance Programs by Income Eligibility



Source: Medical Assistance Administration. Income is before-tax; some programs have an "income disregard" that reduces countable income (e.g., for income from work or for child care expenses). These modifications to the eligibility level are not reflected here. The Family Medical and Children's Health Programs for non-citizens are being phased out, with enrollees transferred to Basic Health.

The chart at left categorizes Washington programs solely by income eligibility cutoffs. Eligibility ranges from 45 percent to 250 percent FPL. Some populations face more difficulty than others in qualifying for insurance despite the existence of these myriad programs.

Figure 4-4. Washington Public Insurance Programs for Children by Income Eligibility



Source: Medical Assistance Administration. Income is before-tax; some programs have an "income disregard" that reduces countable income (e.g., for income from work or for child care expenses). These modifications to the eligibility level are not reflected here. The Children's Health Program for non-citizens is being phased out, with enrollees transferred to Basic Health.

Insurance for children is the most readily available, with relatively simple eligibility criteria. For U.S. citizens, a program exists for all children in families making up to 250 percent FPL. Non-citizen children are primarily limited to the Children's Health Program, which enrolls children in families making up to 100 percent FPL (although a few might qualify for Refugee Assistance).

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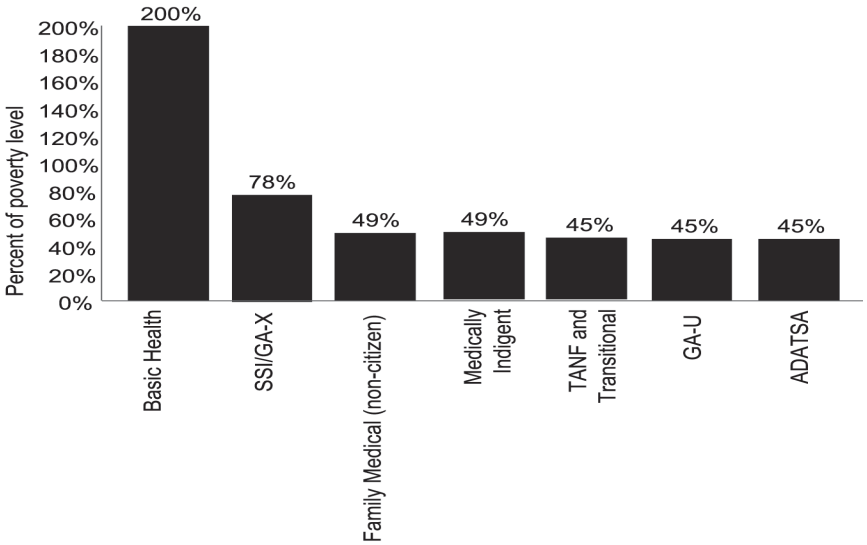
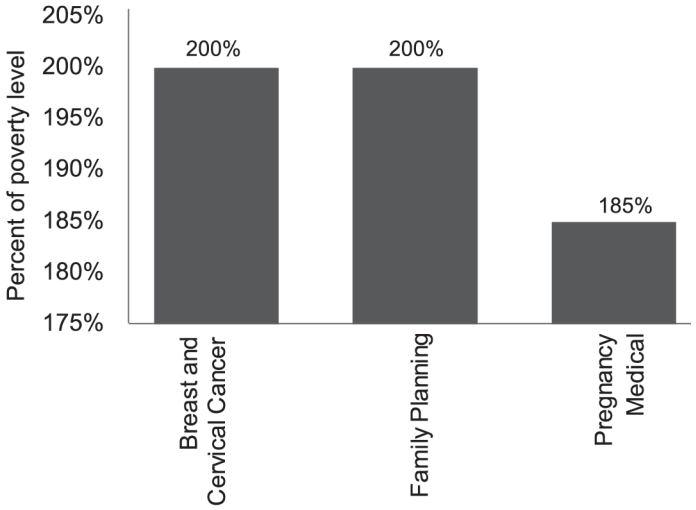
Figure 4-5. Washington Public Insurance Programs for Working-Age Adults by Income Eligibility



Source: Medical Assistance Administration; Health Care Authority. Income is before-tax; some programs have an "income disregard" that reduces countable income (e.g., for income from work or for child care expenses). These modifications to the eligibility level are not reflected here. The Family Medical program for non-citizens is being phased out, with enrollees transferred to Basic Health.

Washington State has achieved close to universal availability (if not access) for children, but qualifying for public insurance is much more difficult for working-age adults. Only those adults who have children and who are below the income limits for public assistance can receive TANF and Transitional Medicaid. Although Basic Health offers coverage to all adults making 200 percent FPL or less, enrollment caps driven by public program funding challenges have kept enrollment from exceeding about 130,000 individuals. (Chapter 5 documents the likely effect of different scenarios for eligibility expansion in Basic Health). The other programs shown here have very specialized eligibility criteria (e.g., disability or substance abuse) and have more restrictive income limits.

Figure 4-6. Washington Specialized Programs for Women and Families by Income Eligibility



Source: Medical Assistance Administration. Income is before-tax; some programs have an "income disregard" that reduces countable income (e.g., for income from work or for child care expenses). These modifications to the eligibility level are not reflected here.

Some additional specialized programs help to fill in some gaps in availability. Pregnancy Medical has greatly enhanced the availability of prenatal care. Family planning services are available to adults making up to 200 percent FPL. The Breast and Cervical Cancer Program also meets some specialized women's health needs, but enrollment is very small (fewer than 100 enrollees in February 2002).

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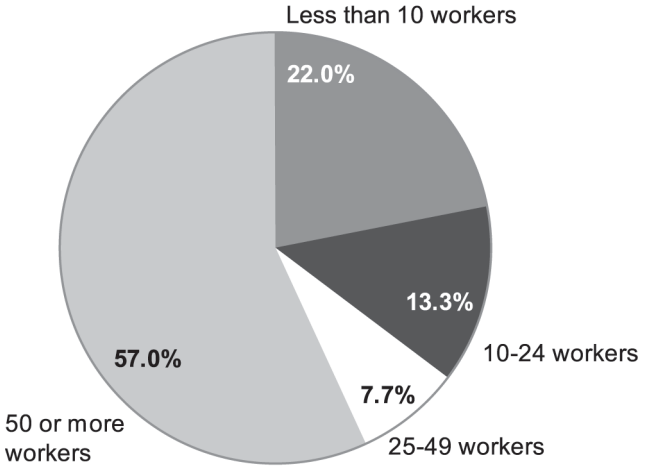
Part 2. Availability of Private Insurance in Washington

This section begins with a look at the distribution of workers aged 19-64 (not including their dependents) in Washington across types of businesses, so we know how many workers are included when we compare the insurance availability in different business types. Second, we examine the characteristics of businesses that are associated with the likelihood that insurance is offered as a benefit, including: size of business, because administrative costs of insurance are known to be higher in small business; whether a business has union workers, because unions negotiate for fringe benefits; whether a business is seasonal, because these employers gain less from investing in the health of workers; and, whether a business has numerous part-time workers, because insurance becomes a greater share of compensation and hence more costly. We also examine the effect of workforce composition, including factors known to affect demand for insurance, such as age and wage level of employees. In this chapter, we report the share of workers in firms that offer insurance; not all workers in these firms may qualify for that insurance, and some may choose not to enroll. Rates of enrollment in employer-sponsored insurance plans are examined in Chapter 5.

Figure 4-7. Distribution of Workers by Size of Business, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey.

Almost 60 percent of workers are in larger businesses (50 or more workers). But more than one in five is in a very small business with fewer than 10 workers.

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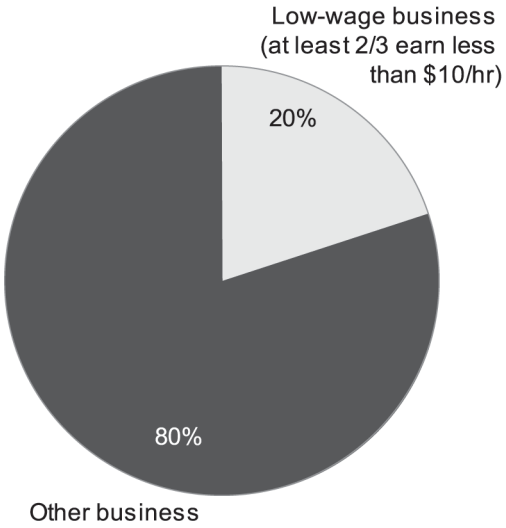
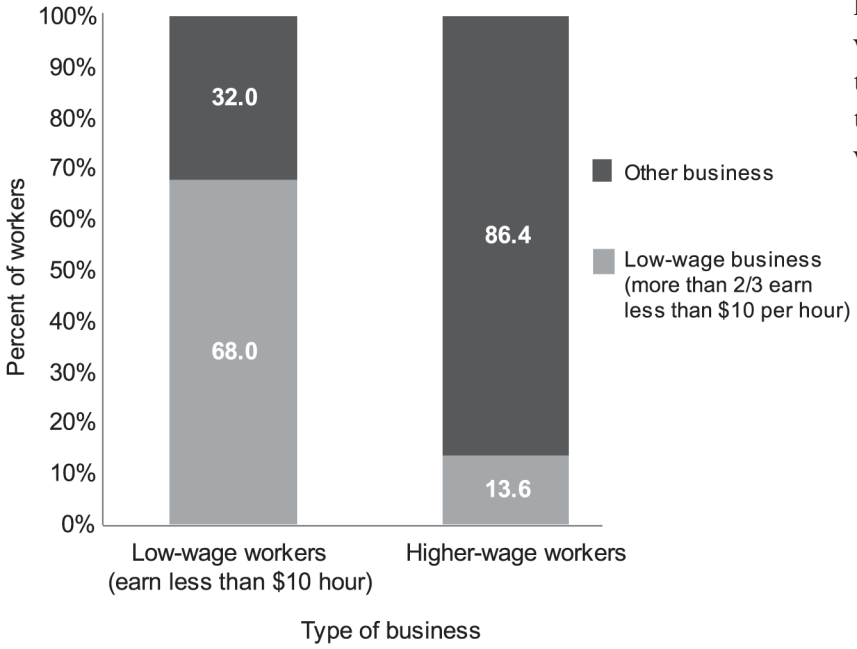
Figure 4-8. Distribution of Workers Between Low-Wage and Other Businesses, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey.

About 20 percent of workers are in businesses we define to be low-wage businesses—at least two-thirds of their workers earn less than $10 per hour.

Figure 4-9. Distribution of Low- and Higher-Wage Workers by Wage Characteristics of Business, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey.

Most low-wage workers are in low-wage businesses, and few higher-wage workers are in low-wage businesses. This concentration is important for policies that try to target low-wage workers through employers.

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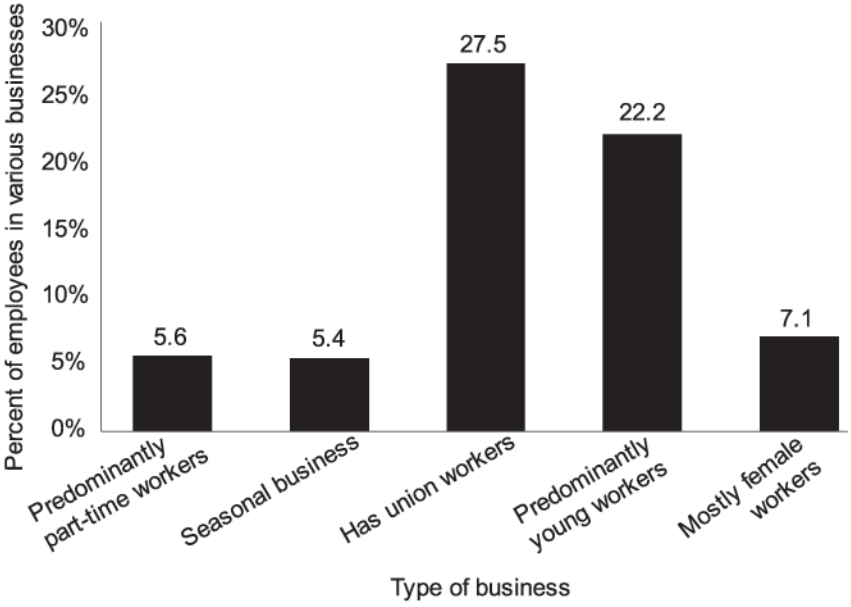
Figure 4-10. Percent of Workers by Type of Business, 2000



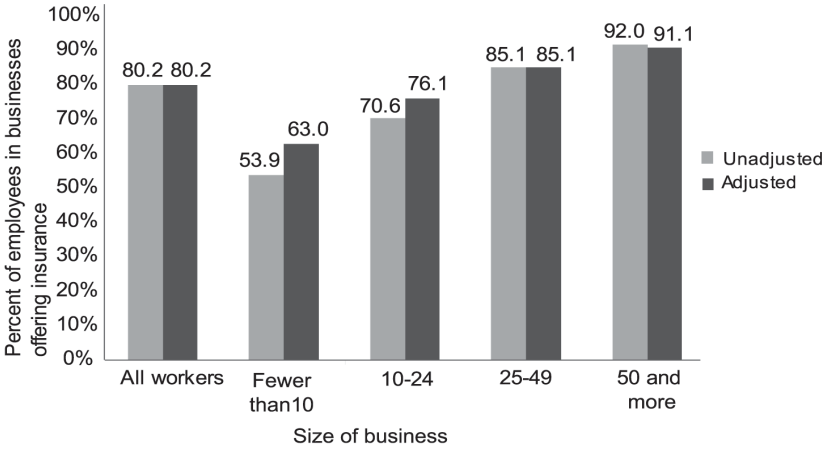
Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey.

Seasonal businesses have at least half of workers reported as seasonal or temporary. **Part-time** is defined as over half of employees working fewer than 20 hours per week. **Predominantly young** businesses have at least 30 percent of workers under age 30 and no workers over age 50. **Mostly female** businesses have 90 percent or more women workers. **Union businesses** have all or part of their workforce unionized.

Fewer than 10 percent of workers are in businesses that are seasonal, employ predominantly part-time workers, or have mostly female employees. More than one in four employees are in businesses that have some union employees. More than one in five workers are in businesses that have mostly young employees.

The characteristics of businesses often cluster together. Small businesses and low-wage businesses are more likely to have numerous part-time workers, young workers, and female workers and less likely to have union workers (see Appendix A. Methodology, Table A-1 for more information).

Figure 4-11. Percent of Employees in Firms Offering Health Insurance, All and by Size of Firm, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers including seasonality, unionization, and presence of young, female, low-wage, or part-time workers.

Note: As described in the methodology appendix, we have reweighted the employer survey in this chapter using the employee composition in 2000. Thus the figures are not directly comparable to the chart created from the 1997 survey shown in Chapter 1, which shows offer rates exactly as measured in the 1997 survey.

Workers in large businesses are substantially more likely to be offered coverage than workers in small businesses—only about 54 percent of workers in businesses with fewer than 10 workers have an employer that offers coverage, compared to 92 percent of workers in businesses with 50 or more employees. Large differences by size remain when we adjust for other factors that are related to both size and the likelihood of offering coverage.

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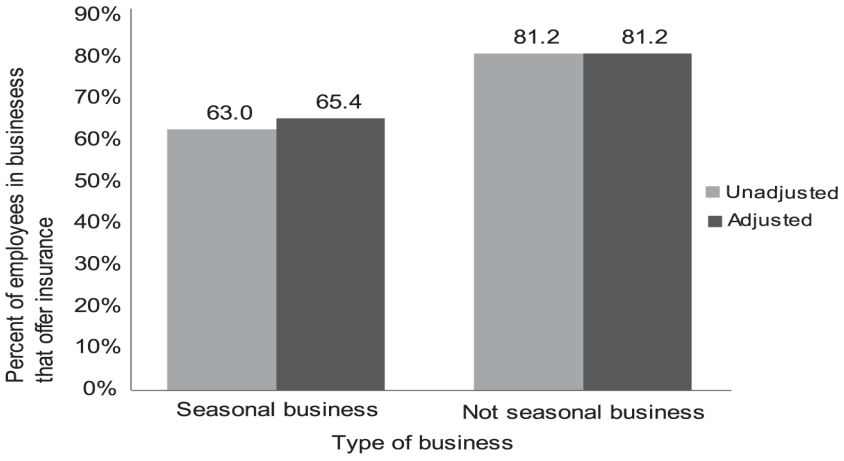
Figure 4-12. Employees in Businesses Offering Insurance, Seasonal and Non-Seasonal Business, 2000

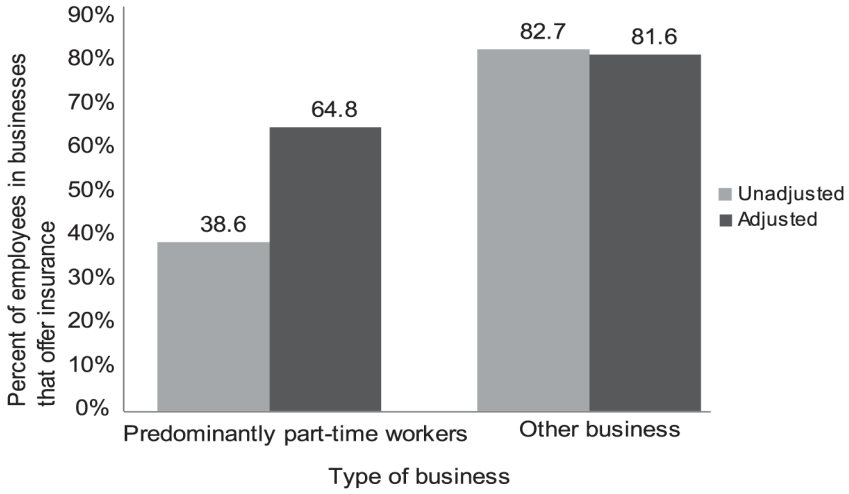


Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers including size of firm, unionization, and presence of young, female, low-wage, or part-time workers.

Seasonal businesses have at least half of workers reported as seasonal or temporary.

Workers in seasonal businesses are less likely to have an employer that offers insurance, even when we adjust for firm size, workers' wages, and other characteristics.

Figure 4-13. Employees in Businesses Offering Insurance, Part-Time and Other Businesses, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers including size of firm, seasonality, unionization, and presence of young, female, or low-wage workers.

Part-time is defined as over half of employees working fewer than 20 hours per week.

Businesses with a high percentage of part-time workers are also less likely to offer insurance. The effect of having a large share of part-time workers, however, is diminished after adjusting for other characteristics.

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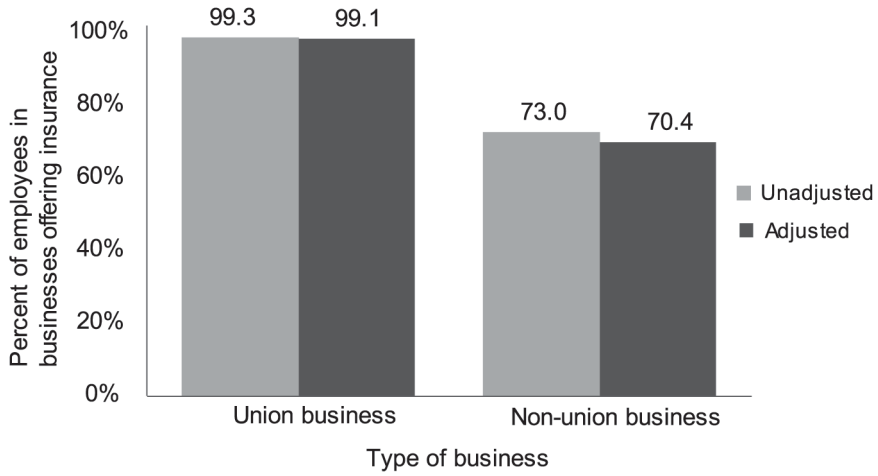
Figure 4-14. Employees in Businesses Offering Insurance, Union and Non-Union Businesses, 2000

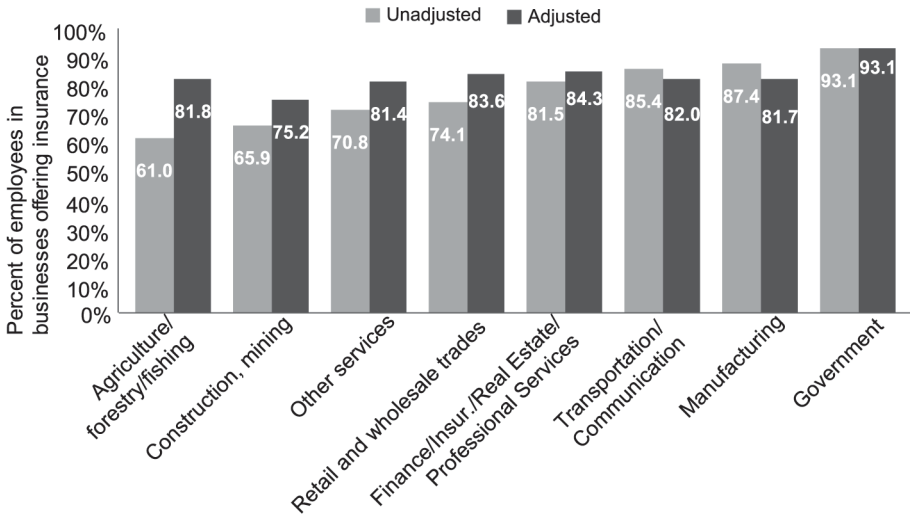


Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers including size of firm, seasonality, and presence of young, female, low-wage, or part-time workers.

Union businesses have all or part of their workforce unionized.

Close to 100 percent of workers in unionized firms in Washington have an employer who offers insurance, even after adjusting for other characteristics that affect the likelihood of offering insurance. For non-union firms, about 7 in 10 workers are in firms offering insurance.

Figure 4-15. Employees in Businesses Offering Insurance by Industry of Employment, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers including size of firm, seasonality, unionization, and presence of young, female, low-wage, and part-time workers.

Industries differ in the likelihood of offering insurance. Employees in local, state, or federal government positions are most likely to have an employer that offers insurance, and those in the agriculture, forestry, or fishing industries are the least likely. However, these differences are largely due to other characteristics that are associated with both industry and offering insurance (e.g., size of firm or seasonality), and the differences diminish after adjusting statistically for these characteristics.

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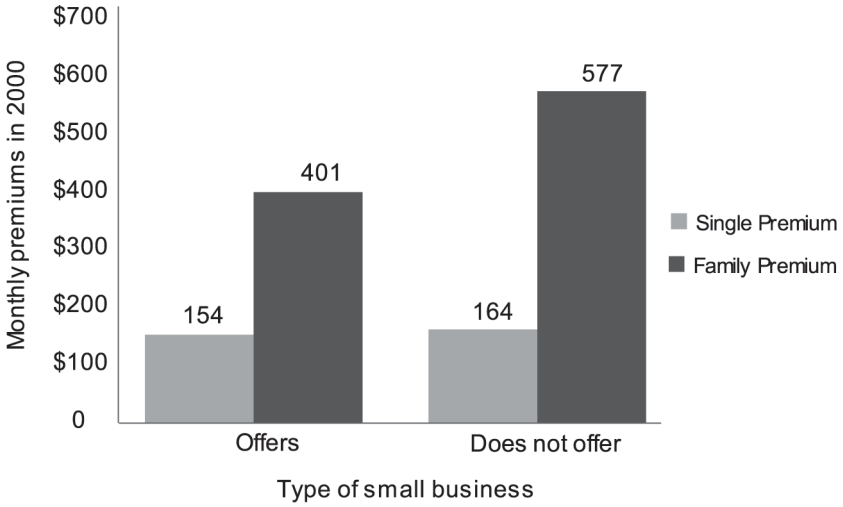
Figure 4-16. Monthly Premiums Paid by Small Firms That Offer Insurance and Predicted for Those That Do Not Offer, 2000

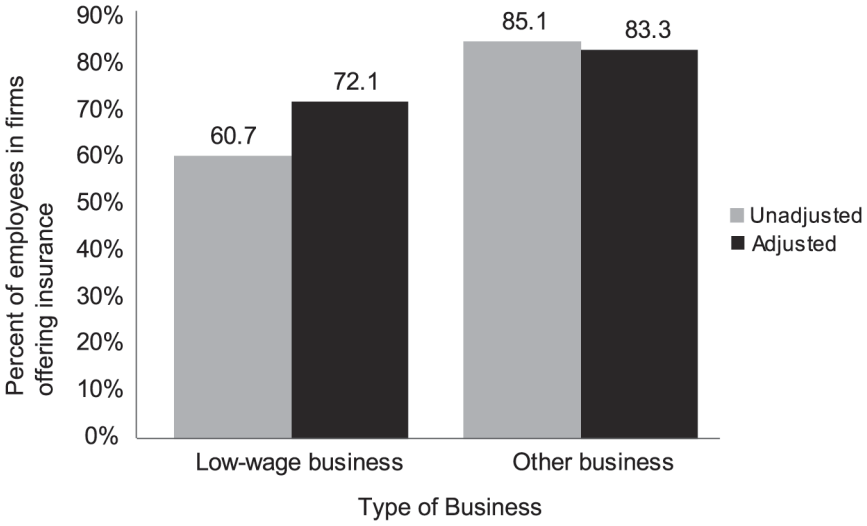


Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey.

Small firms are those with fewer than 50 employees.

Because the lack of availability of employer-sponsored insurance is primarily a problem for workers in small businesses (most large businesses do offer), policy discussions often center on how to encourage more small businesses to offer insurance. Price appears to be a factor in whether insurance is offered. The total (predicted) premiums that would have to be paid for insurance by small businesses (fewer than 50 workers) that do not now offer coverage are higher than the actual premiums paid by businesses that do offer insurance. (See Appendix A Methodology for a description of how we estimate premiums for employers not offering insurance.)

Figure 4-17. Employees in Businesses Offering Insurance by Predominant Wage Level of Business, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers, including size of firm, seasonality, unionization, and presence of young, female, and part-time workers.

Low-wage businesses are those in which more than two-thirds of workers make less than $10 per hour.

Characteristics of an employer's workers are also related to the likelihood that insurance is offered. Policies that focus only on the supply side—such as subsidies to get more employers to offer—therefore, may not have the intended effect. For example, workers in businesses with a large share of low-wage workers are less likely to have an employer that offers coverage. Such workers may be less likely to demand insurance, because they find premiums to be unaffordable.

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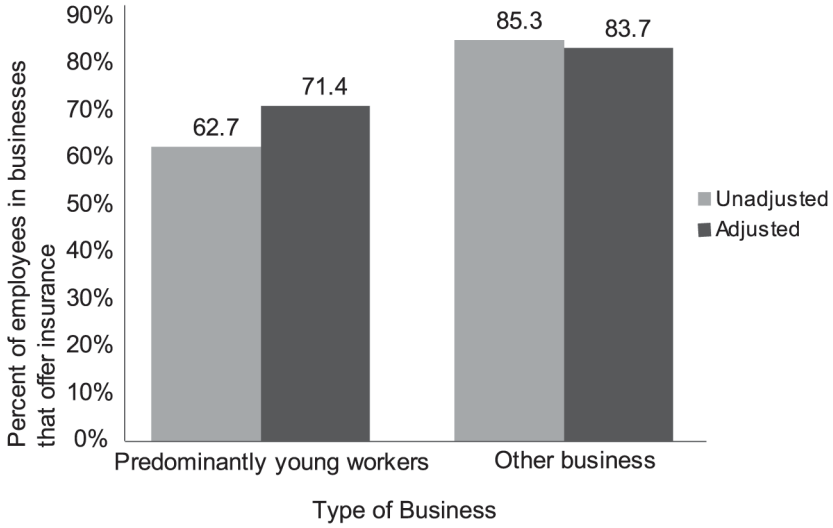
Figure 4-18. Employees in Businesses Offering Insurance, Firms with Predominantly Young Workers and Other Firms, 2000

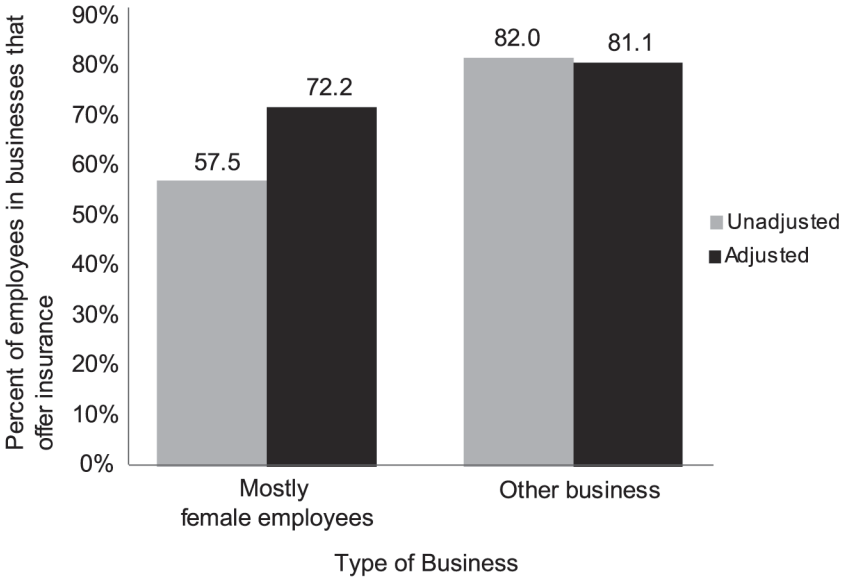


Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers, including size of firm, seasonality, unionization, and presence of female, low-wage, or part-time workers.

Predominantly young businesses have at least 30 percent of workers under age 30 and no workers over age 50.

Employees who work in businesses with a large share of young workers are less likely to have access to employment-based insurance plans.

Figure 4-19. Employees in Businesses Offering Insurance, Female-Dominated and Other Businesses, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Statistical adjustments are for characteristics likely to affect insurance offers, including size of firm, seasonality, unionization, and presence of young, low-wage, or part-time workers.

Mostly female businesses have 90 percent or more women workers.

A similar pattern appears for workers in firms with a large share of female workers, who are also less likely to have an employer that offers coverage. It has been hypothesized that some employers with a large number of employees with a working spouse may try to shift coverage to the other worker to save on their own compensation costs.*

* Dranove, D., Spier K.E., & Baker, L. (2000). Competition Among Employers Offering Health Insurance. *Journal of Health Economics*, 19, 121-140.

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Grant #1 P09 OA00002-01.

Chapter 5. Eligibility for Public and Private Insurance Coverage

Introduction

This chapter examines barriers to Washingtonians' access to both public and private insurance coverage. The first section examines barriers to access to public coverage. It begins by measuring actual enrollment of adults and children among those eligible for public programs. We also examine briefly how knowledge of public insurance options might affect enrollment. We then examine the accessibility of public insurance for uninsured adults and children under current public program funding and the effect on access of some hypothetical enrollment increases in Basic Health. We explore how eligibility varies for different segments of the population, such as adults with and without children, and among those with different health, family income, and labor force status. (For an explanation of how public program eligibility was determined, see the Appendix A. Methodology.)

We find that most uninsured children have access to public programs under current eligibility rules, but less than one-third of uninsured adults have access to these programs. This access would improve under expansions planned for Basic Health, and even more if Basic Health were fully funded.

The second section examines eligibility for private insurance. We examine uninsured rates among those with access to employment-based insurance and look at effects of employer premium contributions on the insurance status of employees and their dependents. We also examine patterns of uninsurance among the self-employed by income and health status, and the effect of recent job losses on the likelihood of being uninsured. This section briefly discusses the implications for possible efforts to expand private options for coverage.

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Major Findings

Eligibility for Public Insurance

- About one-third of adults eligible for public programs are enrolled in those programs, and about 37 percent of eligible children are enrolled. If we look just at the publicly eligible population not enrolled in private insurance, 68 percent of adults and 78 percent of children participate in public programs.
- Failure to participate among adults results partly from enrollment limits on Basic Health. But lack of information may also be a deterrent to participation in public programs, suggesting that more outreach may be needed.
- About 76 percent of uninsured children have access to public programs under current eligibility and funding, but fewer than one in three of their uninsured parents do. Access for uninsured, childless adults is even lower, at less than 10 percent.
- If Basic Health had no enrollment limits, allowing all adults at 200 percent of the federal poverty level (FPL) or below to enroll, only one in four uninsured adults would lack access to insurance.

Eligibility for Private Insurance

- Almost one in five of the uninsured are workers or dependents who are eligible for employer-sponsored coverage. However, among all of those eligible for employer coverage, only 2 percent are uninsured.
- Most workers and dependents who are eligible for coverage are insured, even if they are low income. Thus it will be difficult to target financial incentives to expand purchase of employer coverage among these workers.
- The self-employed and their dependents represent about one-third of the uninsured. Uninsured rates among this group are not strongly related to income, except for the highest income, despite federal tax subsidies that vary with income. This suggests that the planned phase-in of the full tax subsidy for the self-employed may not expand coverage significantly.
- About half of the uninsured do not have access to employer group coverage or to subsidies for the purchase of private coverage. Uninsured rates for these individuals are higher than for the population as a whole.
- About one-quarter of the uninsured do not have a current job, but almost half of these recently lost a job or are looking for work. Transitional coverage might benefit this population.

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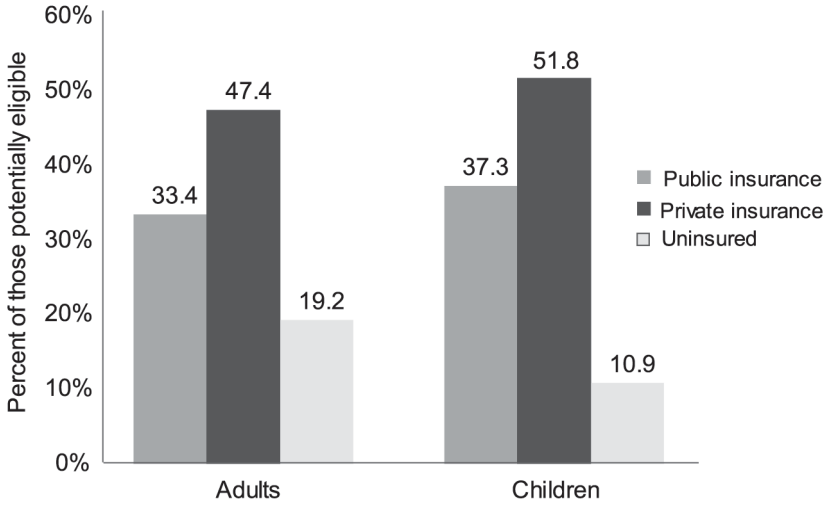
Part 1. Eligibility for Public Insurance Coverage

This section of the paper examines access to public coverage among the uninsured. We first report current enrollment in public programs among those potentially eligible. We examine available evidence for reasons why people who are eligible do not participate. We analyze access to public insurance, both under current eligibility rules and funding and under different scenarios for expansion (either planned or hypothetical). We also examine how factors such as health status are associated with access to public programs.

This section also includes information on the proportion of the population eligible for employer coverage. The next section examines in more detail patterns of eligibility for employer coverage.

Figure 5-1. Insurance Enrollment Among Those Potentially Eligible for Public Programs, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Among those adults potentially eligible for public programs—ignoring, for the moment, enrollment caps—about one-third are enrolled. For children, the proportion is slightly higher (37.3 percent). About half of those eligible for public coverage are enrolled in private insurance (either employer-sponsored or an individual plan). Among the potentially eligible, about one in five adults and one in ten children remains uninsured. (See Appendix A. Methodology for an explanation of how public program eligibility was determined.)

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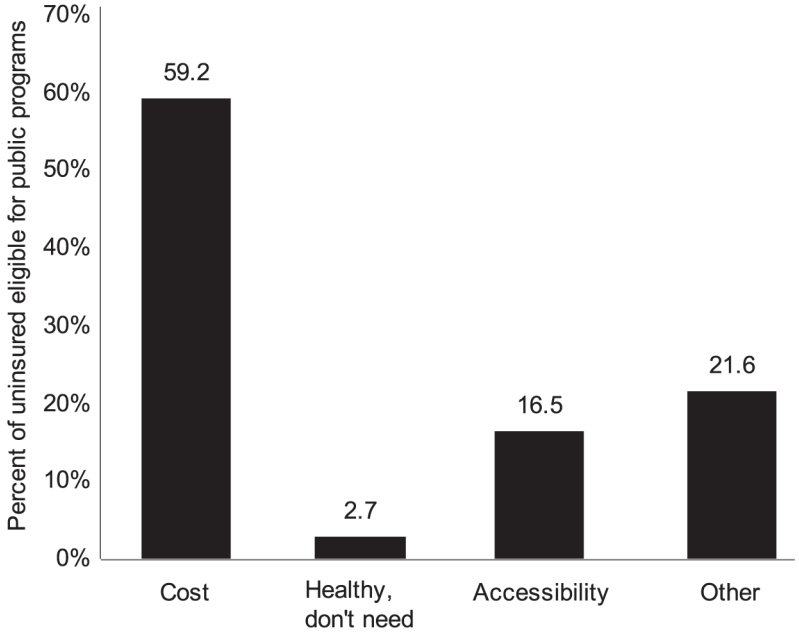
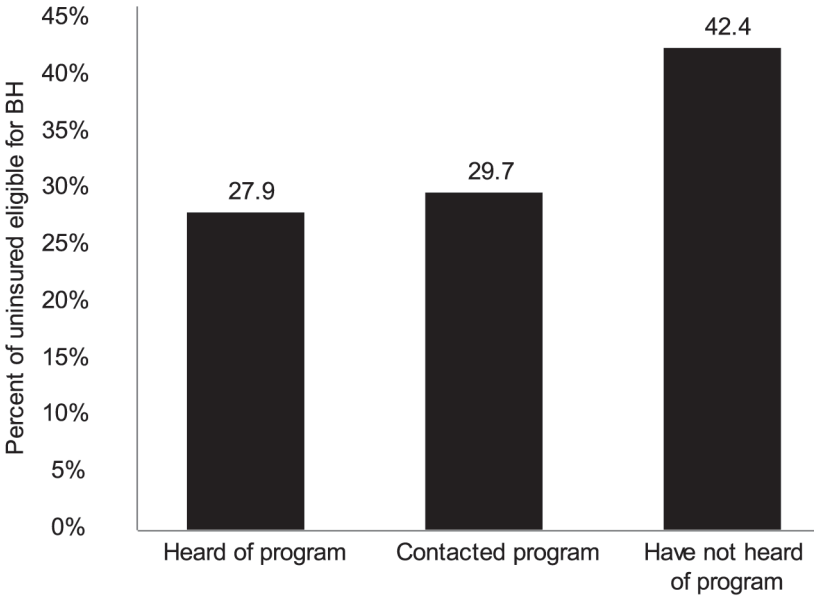
Figure 5-2. Reasons for Not Having Health Insurance Among Those Potentially Eligible for Public Programs, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Among those who are eligible for public coverage but remain uninsured, nearly 60 percent report that the cost of insurance is a deterrent.

Figure 5-3. Knowledge of Basic Health Among Uninsured People Potentially Eligible for Public Programs, 1997



Source: 1997 RWJF Washington Family Health Insurance Survey. Data refer to the population under 65.

A large share of uninsured people eligible for public programs report not knowing of the programs. In 1997, more than 40 percent of survey respondents had not heard of Basic Health. About 30 percent actually contacted the program, but did not enroll or were unable to enroll at the time. In 1999, a study by the Urban Institute found that half of Washingtonians had not heard of Medicaid or were unfamiliar with its eligibility rules.*

*Kenney, G, Haley, J. and Dubay, L. (May 2001). How Familiar Are Low-Income Parents with Medicaid and SCHIP? *New Federalism Series B*, No. B-42.

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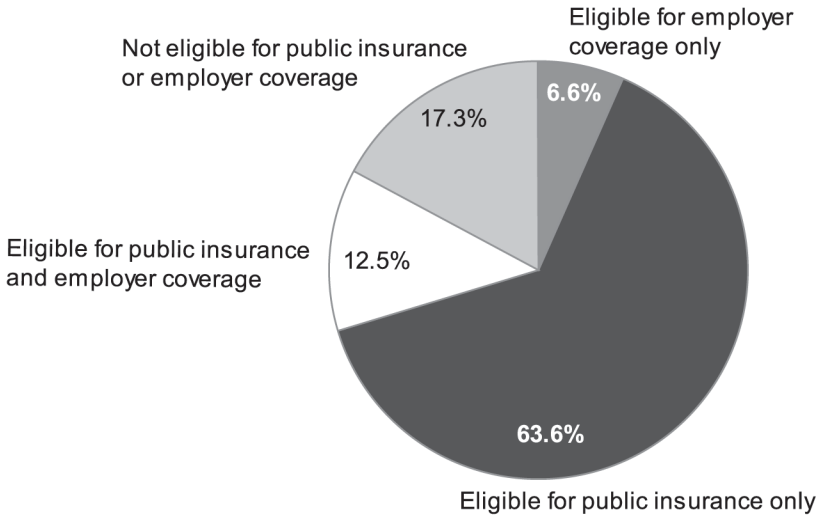
Grant #1 P09 OA00002-01.

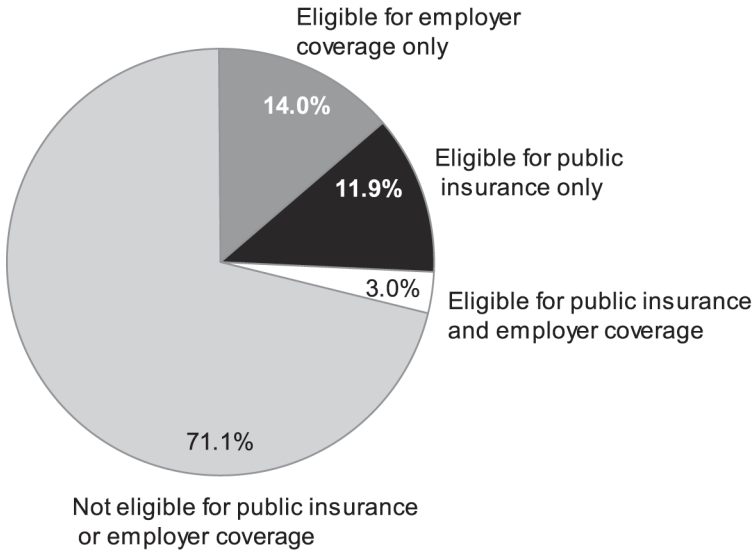
Figure 5-4. Eligibility for Insurance Among All Uninsured Children, 2000



Source: 2000 Washington State Population Survey. Data refer to children aged 0-18.

Most uninsured children have access to employer coverage or a public program—76 percent are eligible for public insurance, and only 17 percent are not eligible for either public or employer coverage.

Figure 5-5. Eligibility for Insurance Among All Uninsured Adults, 2000



Source: 1997 RWJF Washington Family Health Insurance Survey. Data refer to the population under 65.

However, under 2000 eligibility rules and program funding, most uninsured adults—71 percent—were not eligible for enrollment in public programs and do not have access to employer coverage. In 2000, no additional uninsured persons could be covered by Basic Health because of enrollment caps (except when an existing enrollee drops BH coverage, opening up a subsidized slot.).

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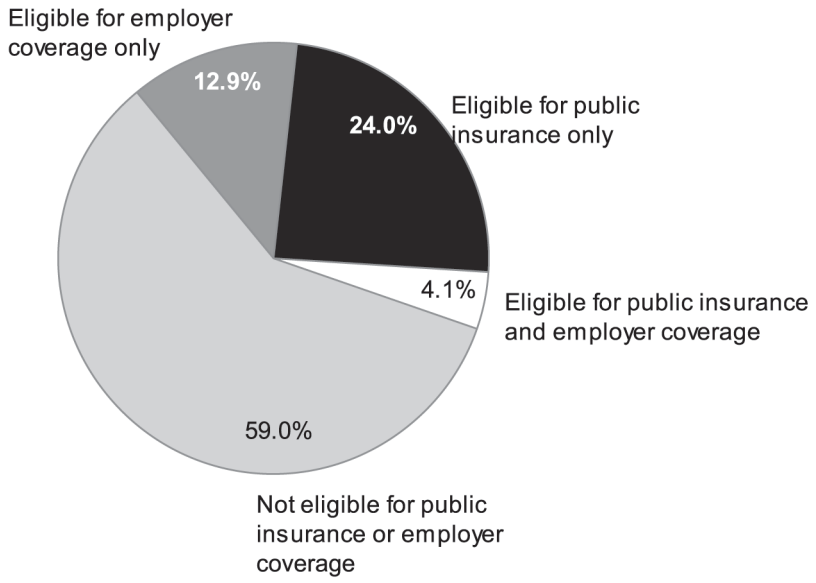
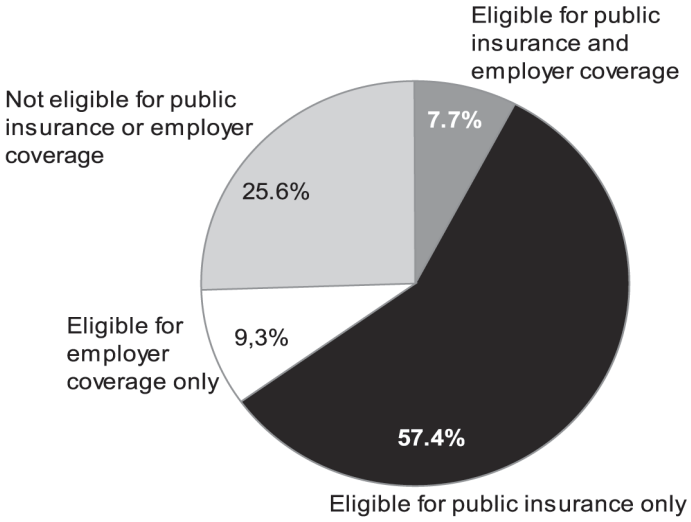
Figure 5-6. Eligibility for Insurance Among All Uninsured Adults with Basic Health Expanded by 50,000, Mid-2003



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

The proportion of uninsured adults not eligible for public or private insurance is anticipated to decrease as a result of Initiative 773, which increased the tobacco tax to expand Basic Health. If enrollment increased by 50,000, 59 percent would remain ineligible for public or employer coverage.*

Figure 5-7. Eligibility for Insurance Among All Uninsured Adults with No Enrollment Limitation in Basic Health, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

With no enrollment limits for Basic Health, a much smaller proportion of adults—26 percent—would not have access to public insurance or employer coverage.

* Note: The state budget adopted by the 2002 Legislature, which occurred after the analysis presented here was completed, eliminated public programs for immigrant children and adults, transferring enrollees in these programs to Basic Health. This would reduce the effect of the 50,000 expansion discussed here.

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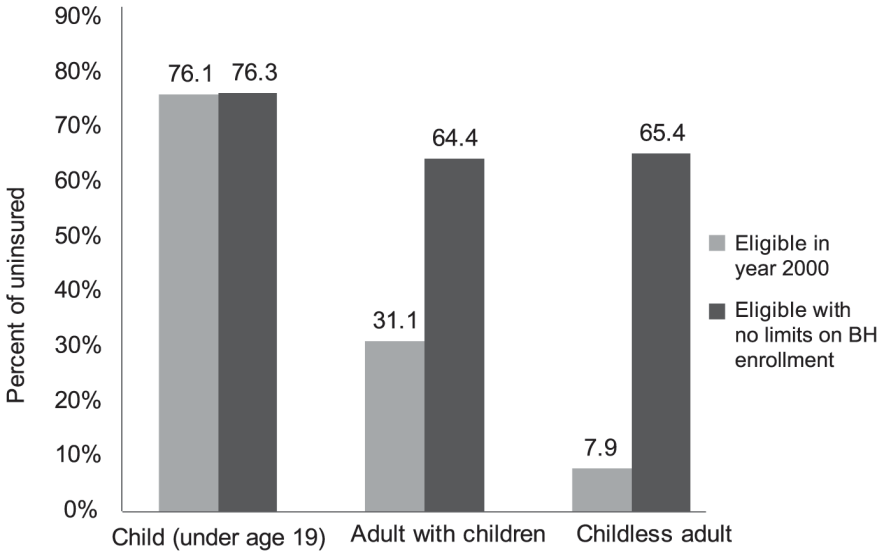
Grant #1 P09 OA00002-01.

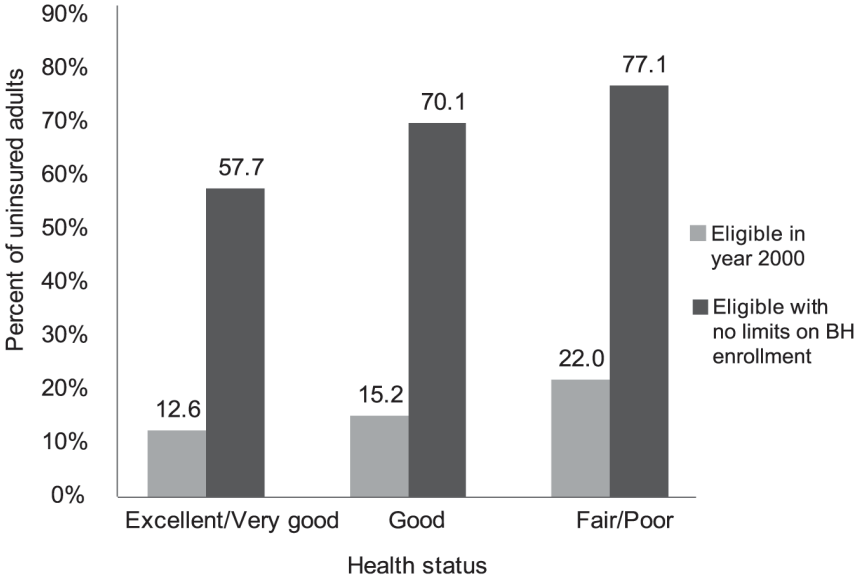
Figure 5-8. Eligibiliity for Public Insurance Among Uninsured Adults and Children, Year 2000 Eligibility, and with No Basic Health Enrollment Limits



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Uninsured single adults or childless couples are least likely to have access to public insurance. But two-thirds of uninsured parents do not have access to public coverage, and, as shown earlier, the insurance status of parents is a prime factor in children's coverage. This situation would improve substantially with full Basic Health funding.

Figure 5-9. Eligibiliity for Public Insurance for Uninsured Adults by Self-Reported Health Status



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

Uninsured adults in poorer health are more likely to be covered by public programs—in part because of eligibility related to health status and in part because of other factors associated with both health status and eligibility. Even so, less than one in four uninsured adults likely to incur substantial medical bills is eligible for public programs under current funding. With full funding of Basic Health, almost eight in ten of those in the poorest health would qualify for public coverage.

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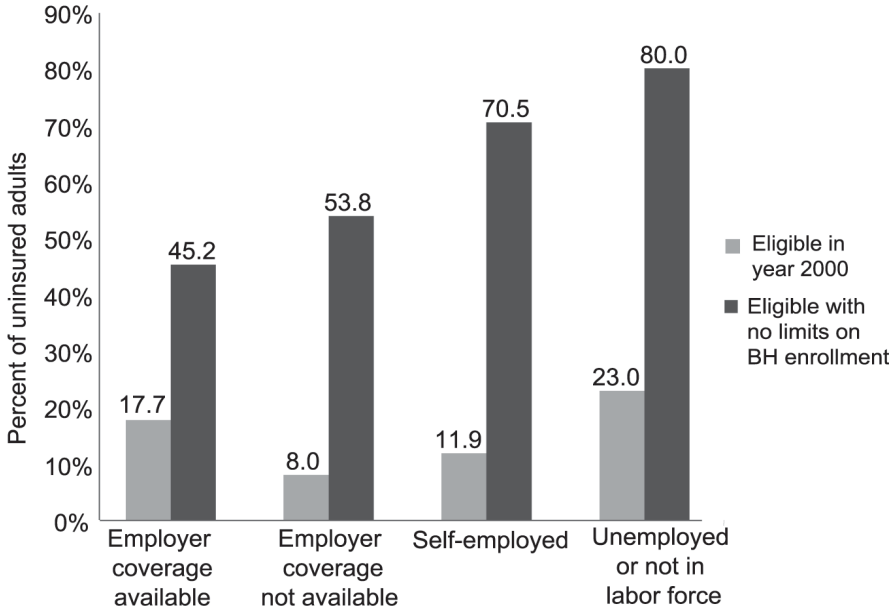
Grant #1 P09 OA00002-01.

Figure 5-10. Percent of Uninsured Adults Eligible for Public Programs, by Work Force Status and Access to Employer Coverage

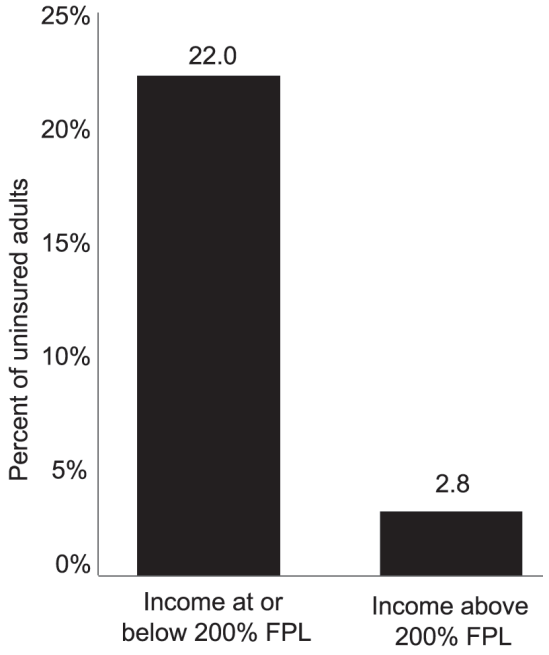


Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

Only a small proportion of uninsured adults without access to employer coverage or who are self-employed are eligible for public insurance. Access is better for the unemployed, but fewer than one in four is eligible.

Removing enrollment limits in Basic Health would improve access substantially for all these groups. Substitution of public for private insurance could be a problem among those eligible for employer insurance.

Figure 5-11. Eligibility for Public Programs for Uninsured Adults by Income Level, 2000



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

About one in five uninsured adults at or below 200 percent FPL is eligible for public coverage. With no enrollment limits for Basic Health this would increase to 100 percent, because all people at or below 200 percent FPL would be able to access public coverage.*

*Note: Some adults under age 65 and above 200 percent FPL are enrolled in public programs (e.g., Medicare's program for the disabled).

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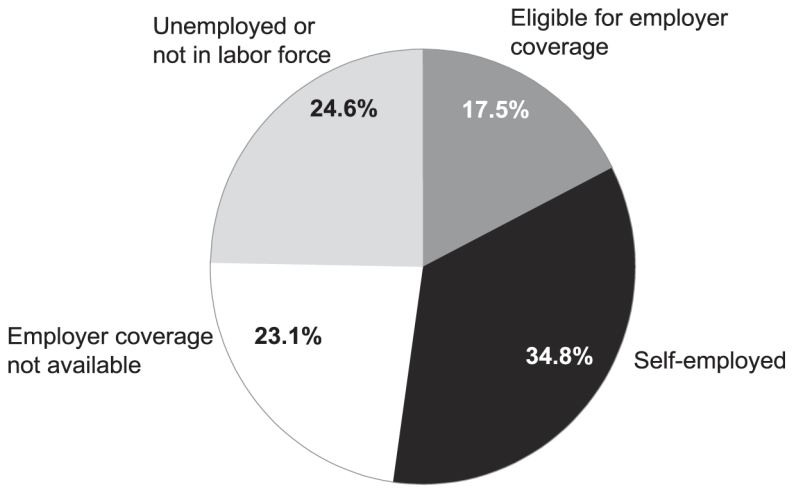
Part 2. Eligibility for Private Insurance Coverage

This section of the paper examines access to private coverage among the uninsured. This analysis includes both workers and their dependents. We look at how access varies by employment status, income, cost of employee or dependent coverage, and individual health status. This section also examines how self-employment affects access to insurance and what factors influence access among the self-employed.

Figure 5-12. Distribution of the Uninsured by Employment Status and Eligibility for Employer Coverage, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Almost one in five of the uninsured is a worker or dependent eligible for employer-sponsored coverage. More than one-third of the uninsured are self-employed or their dependents, despite federal tax subsidies that are available to help this group purchase private individual coverage. About half of the uninsured do not have access to group coverage or to tax-deductible individual market products available to the self-employed. Some small share of these persons might be eligible for COBRA transitional coverage.

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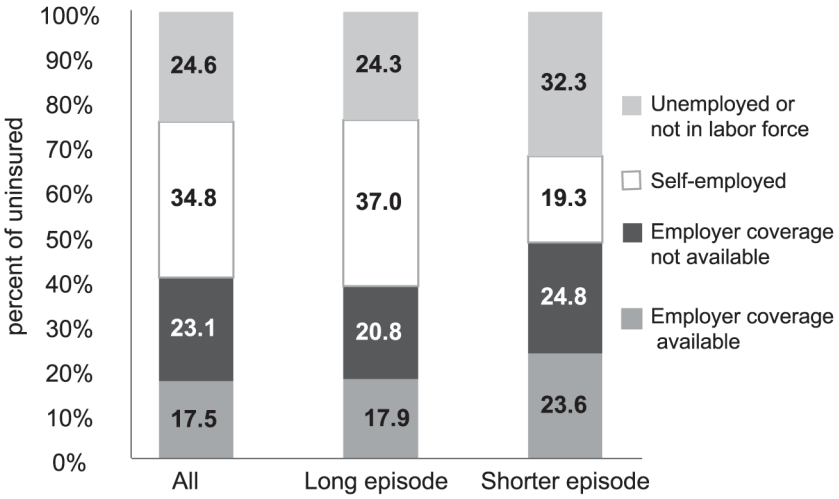
Figure 5-13. Employment Status and Eligibility for Employer Coverage Among the Uninsured by Insurance Duration, 2000

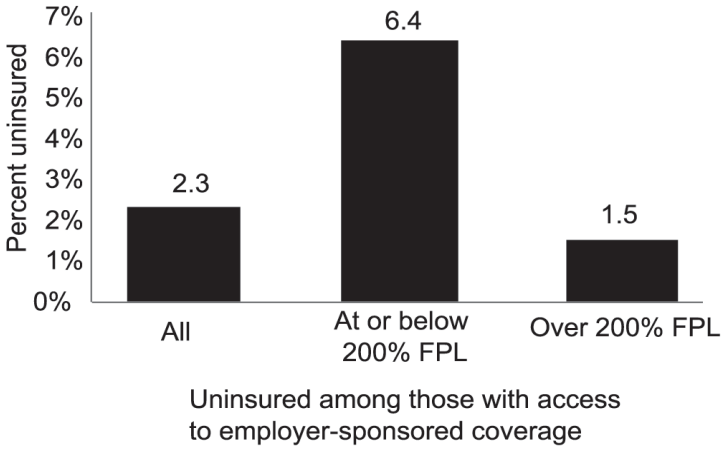


Source: 2000 Washington State Population Survey; 1997 RWJF Washington Family Health Insurance Survey. Data refer to the population under 65 .

Long episode: 1 year or more.
Shorter episiode: less than one year.

The work status of the uninsured varies according to whether they have been uninsured for a long or short period. The self-employed comprise a larger share of those uninsured for long episodes (one year or more). Those without a job comprise a larger share of the uninsured for short episodes (less than one year). The latter may be explained by the fact that new episodes of uninsurance tend to begin with the loss of an insured job.*

Figure 5-14. Percent Uninsured by Income Among People Eligible for Employer-Sponsored Insurance, 2000



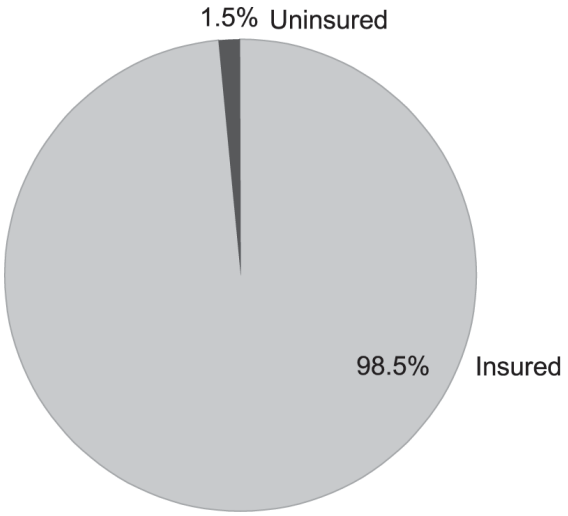
Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Although they account for one in five of the uninsured, only 2 percent of those who have access to employer-sponsored coverage are uninsured. Low uninsured rates are found for both low- and high-income families. Therefore, it will be difficult to design policies to expand coverage to the uninsured who work for an employer who offers coverage, even if low-income is one of the eligibility criteria.

*Glied, S.A. (Summer 2000). Challenges and Options for Increasing the Number of Americans With Health Insurance. *Inquiry*, 38, 90-105.

Funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration
Grant #1 P09 OA00002-01.

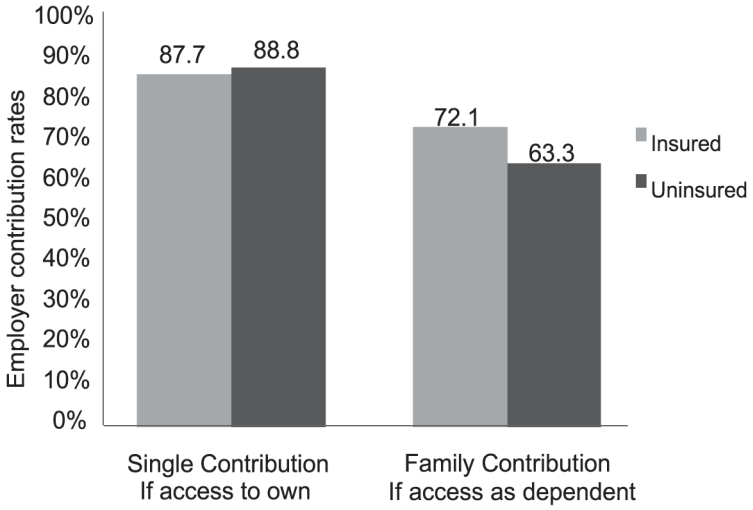
Figure 5-15. Insurance Status of Children with a Parent Enrolled in an Employer Plan with Family Coverage, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Data refer to the population under 65.

Among children whose parents are enrolled in employer plans that offer family coverage, 98.5 percent are insured. Also, virtually all—99.5 percent—of children whose parents are in employer-based plans are eligible for family coverage, according to the 2000 Washington State Population Survey.

Figure 5-16. Average Employer Contribution Rates for Single and Family Coverage, by Insured vs. Uninsured Status, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Data refer to the population under 65.

Uninsured rates are similar among employees eligible for coverage through their employer and persons eligible for employment-based insurance as dependents, according to our analysis of the 2000 Washington State Population Survey and the 1997 RWJF Employer Health Insurance Survey. When eligible for coverage through one's own employer, the uninsured and insured face similar contribution rates. However, uninsured dependents face lower employer contribution rates (and hence higher out-of-pocket premium payments) than the insured. This suggests that the cost of the employee share of the premium is a deterrent for some.

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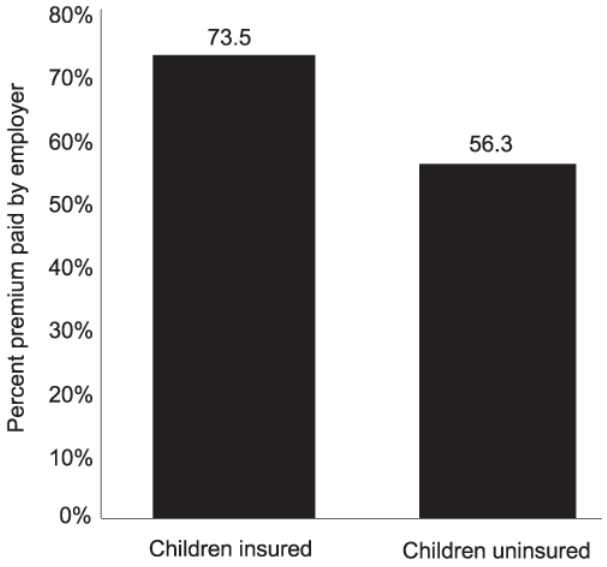
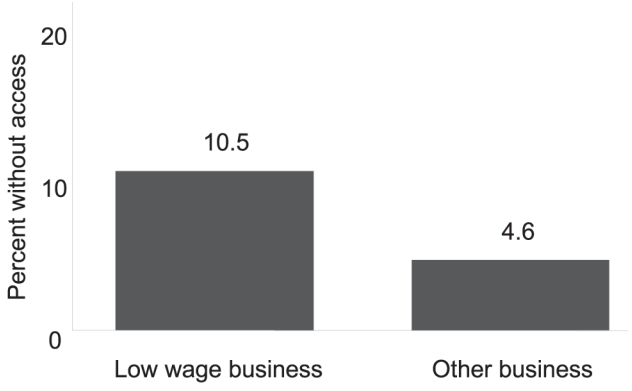
Figure 5-17. Employer Family Premium Contribution Rates for Insured and Uninsured Children, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Data refer to the population under 65.

Employer contribution rates for family coverage are much lower among uninsured children in comparison to insured children. This means that the family's out-of-pocket premium costs are higher for parents with uninsured children, suggesting that price is a factor when parents decide whether to insure their children.

Figure 5-18. Percent of Employees and Dependents Without Access to Employer Coverage, Low and Higher-Wage Businesses, 2000



Source: 2000 Washington State Population Survey; 1997 RWJF Employer Health Insurance Survey. Data refer to the population under 65.

Low-wage businesses are those in which at least two-thirds of employees earn less than $10 per hour.

Those who work in businesses with a large share of low-wage workers (and their dependents) are less likely to have access to coverage.

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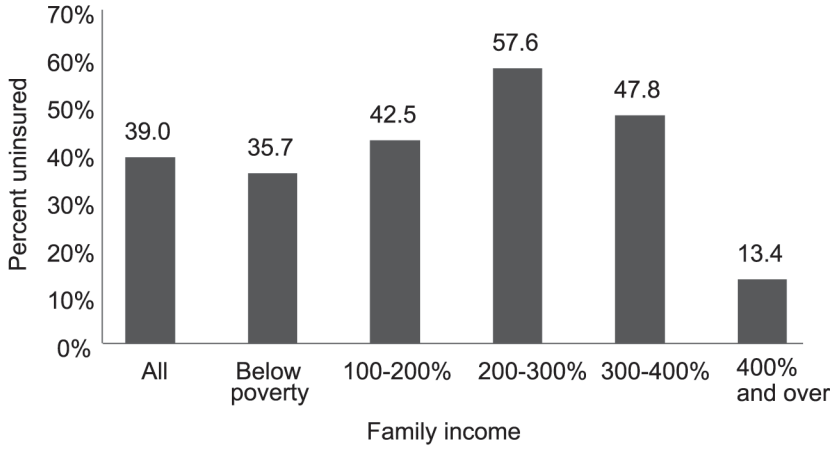
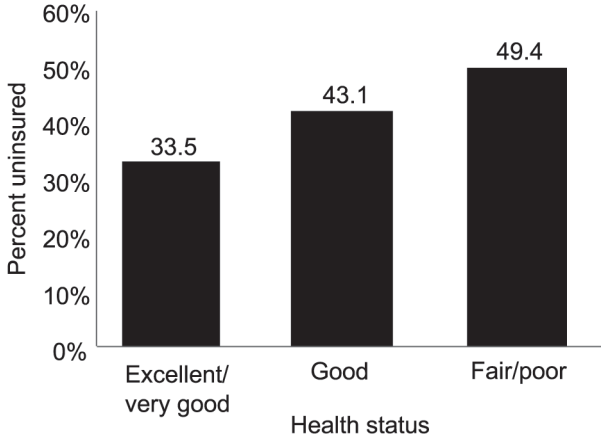
Figure 5-19. Percent Uninsured by Family Income for the Self-Employed and Dependents, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

The self-employed constitute a sizeable share of the uninsured—about one-third—although these workers and their dependents are only about 8 percent of the total population. About 39 percent of the self-employed are uninsured. Tax law permits these workers to deduct a portion of their health insurance premiums from taxable income (50 percent in the year 2000), even if they do not itemize deductions. Thus, the effective price of insurance falls with income. Surprisingly, uninsured rates among this group do not fall as income increases, except for the highest income group.

Figure 5-20. Percent Uninsured by Self-Reported Health Status for the Self-Employed and Dependents, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

The percentage of the self-employed and their dependents who are uninsured increases as health status decreases. This relationship suggests that underwriting in the individual market may be a factor, by making prices unaffordable for some.

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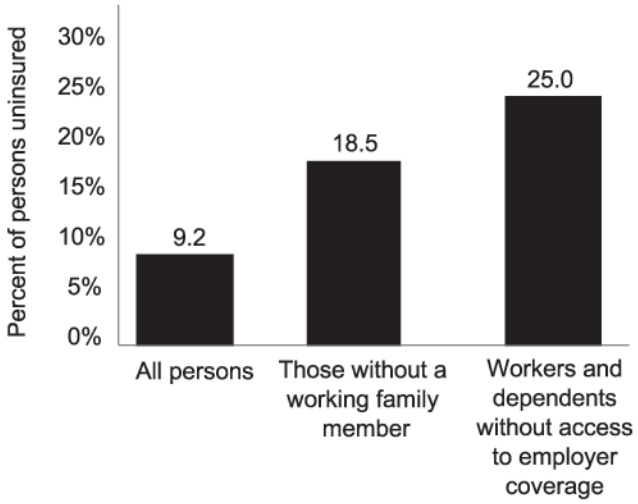
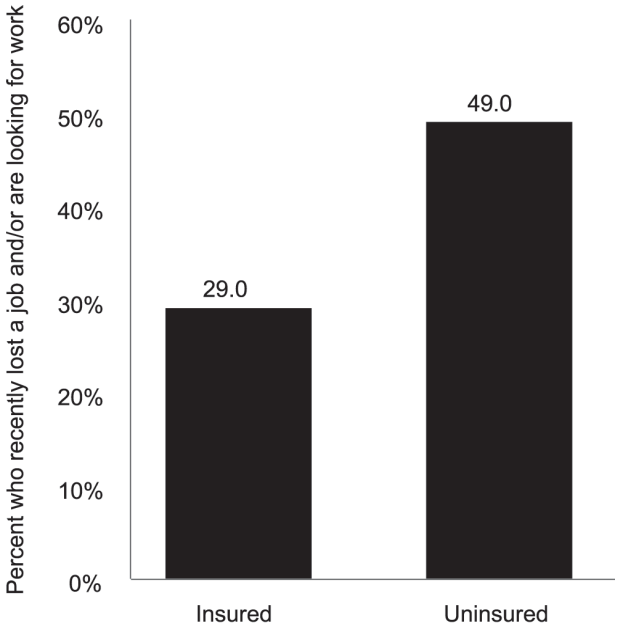
Figure 5-21. Percent Uninsured by Work Status of Family Members and Access to Employer Coverage, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Non-workers and workers who do not have access to employer coverage must either participate in public programs or purchase individual coverage. Few of them benefit from tax subsidies to purchase individual coverage and so must pay the full price of individual policies. As a result, uninsured rates among these groups are much higher than overall uninsured rates.

Figure 5-22. Percent with Recent Job Loss and/or Looking for Work Among Those Without a Working Family Member, by Insurance Status, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

About one-quarter of the uninsured are in families where no one is employed. Within this group of uninsured, almost one-half have a family member who recently lost a job or is currently looking for work. This is almost twice the rate as for insured people in families where no one works, suggesting that uninsurance may be a transitional state for those who recently became unemployed. As we saw earlier, this group of the uninsured is more likely to be uninsured in the short-term than are other groups. Hence transitional coverage may benefit this population if it is affordable and accessible.

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Chapter 6. Affordability of Public and Private Insurance Coverage

Introduction

Chapter 5 looked at access—are people eligible for public or private insurance? This chapter examines affordability: Is insurance available at a price affordable to those who are uninsured? We measure whether the family has income to pay the premium costs of available insurance options and expected out-of-pocket medical bills after taking into account resources required to pay for housing, food, and other necessities. (For an account of how this affordability analysis was conducted, see the Appendix A. Methodology. For a detailed analysis of the expenditures affecting a family's ability to afford insurance, please see Research Deliverable 3.3. *Income Adequacy and the Affordability of Health Insurance in Washington State.*) The chapter examines which segments of the uninsured population we estimate can afford coverage, given the public or private options available to them. It also looks at how funding levels of public programs affect the proportion of the uninsured population with access to affordable coverage and how health status affects affordability. We also look at how subsidies for public or private insurance premiums might affect affordability. The chapter compares access to affordable coverage for uninsured children, parents, and childless adults. We also examine how relationships with the labor market and the availability of employment-based plans affect affordability.

The affordability index does not tell us whether a family will actually purchase insurance, because it does not account for other family priorities, risk aversion, or attitudes about health insurance or health care. However, identifying groups that are most likely to lack affordable coverage should help in targeting insurance expansion policies.

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Major Findings

Affordability of Insurance

- About one in four adults at or below 200 percent of the federal poverty level (FPL) has access to affordable public or private coverage. With the elimination of enrollment limits in Basic Health, three out of four adults would have access to affordable coverage.
- More than half of all uninsured adults lack access to affordable public or private insurance coverage, but only one in ten children lacks affordable access.
- A 50 percent premium subsidy to public or private insurance premiums would expand access to affordable insurance only slightly, suggesting that financial subsidies to purchase private insurance would have modest effects.
- Only four in ten childless adults have access to affordable insurance, but two-thirds of parents do.
- For most (80 percent) of those with access to employer coverage, coverage is affordable.

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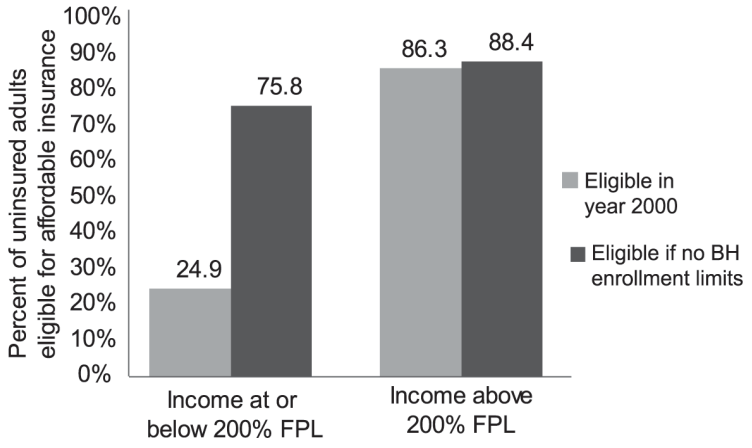
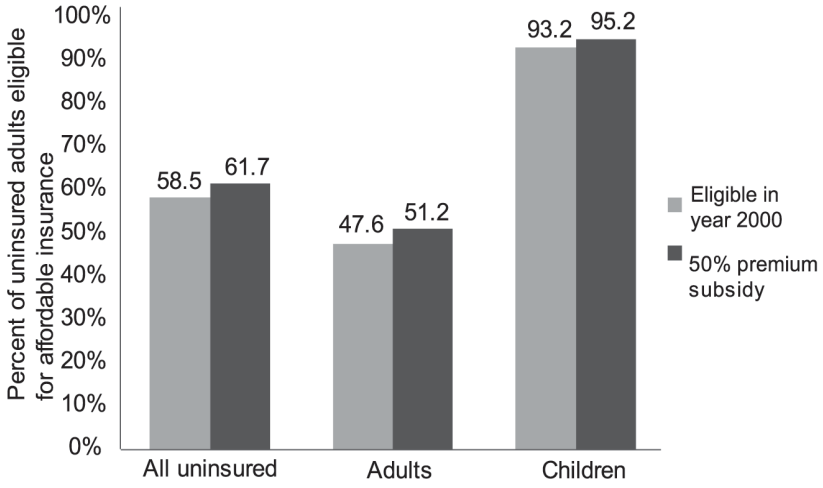
Figure 6-1. Eligibility for Affordable Public or Private Insurance Among Uninsured Adults by Income, Year 2000 and with no Basic Health Enrollment Limits



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

Access to affordable coverage varies by income, despite the existence of public insurance programs for the low income. Only one in four uninsured adults with income at or below 200 percent FPL has access to affordable insurance. This would substantially change with full funding of Basic Health that would make this program available to enrollment by all currently uninsured people at or below 200 percent FPL.

Figure 6-2. Eligibility for Affordable Public or Private Insurance, All Uninsured, Adults, and Children, Current and with 50 Percent Premium Subsidy, 2000



Source: 2000 Washington State Population Survey. Data refer to the population under 65.

Overall about 60 percent of the uninsured are eligible for affordable coverage. However, this varies substantially between adults and children, because most children are eligible for public programs. Conversely, fewer than half of uninsured adults have access to affordable coverage. A 50 percent subsidy to the cost of private insurance would improve this only slightly.*

* Note: The 50 percent premium is assumed to apply to families' out-of-pocket premium payments irrespective of the source of their coverage (i.e., includes family share of employer coverage, families' payments for individual coverage, and families' premium payments to public programs). Public program premiums included all applicable Basic Health premiums. The affordability index was recalculated after all family premium payments were reduced by 50 percent.

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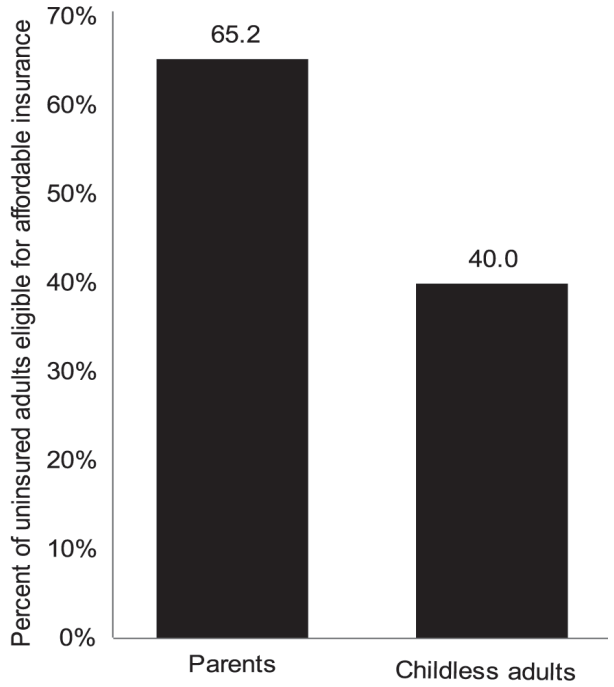
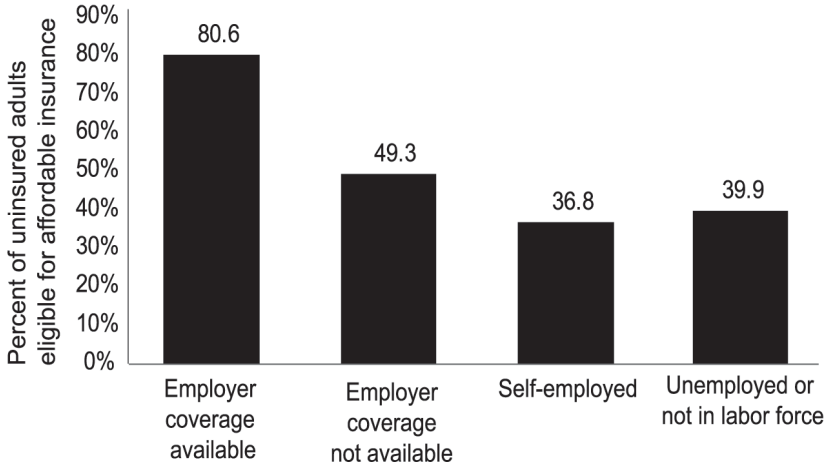
Figure 6-3. Eligibility for Affordable Public and Private Insurance Among Uninsured Parents and Childless Adults, 2000



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

Uninsured parents are more likely to have access to affordable coverage than are childless adults, in part due to public program eligibility rules.

Figure 6-4. Eligibility for Affordable Public and Private Insurance Among Uninsured Adults by Type of Private Coverage Available, 2000



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

Most uninsured adults who have employer coverage available are likely to be able to afford the coverage. Half or fewer uninsured adults in other situations have access to affordable coverage. This is also true for the self-employed even though they are eligible for subsidies through the tax system.

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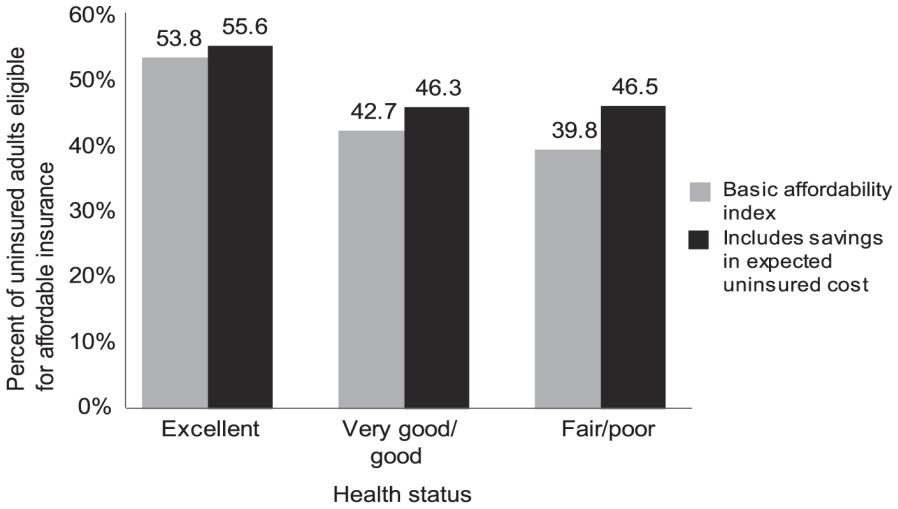
Figure 6-5. Eligibility for Affordable Public or Private Insurance Among Uninsured Adults by Self-Reported Health Status, 2000



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64.

Uninsured adults in poor health are least likely to have access to affordable health care coverage. This reflects higher prices of insurance for the very high-risk cases, and higher expected out-of-pocket expenditures. However, the affordability index does not take into account that insurance coverage effectively lowers overall medical expenditures among covered individuals by absorbing some of the costs of care. When we factor in these savings to our index, differences by health status are diminished.

(See Appendix A. Methodology for additional information on how we adjusted the affordability index to take into account savings in out-of-pocket costs.)

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Chapter 7. The Safety Net's Role in Serving the Uninsured in Washington

Introduction

Approximately 484,000 Washington residents under age 65 were uninsured in 2000. Although these individuals do not have health insurance, they may continue to need and seek health care. Access to providers may be more limited for the uninsured, but these residents do have places to go for care. The system of health care for the uninsured is known as the *safety net*. The safety net exists to some degree in all communities of the state, but access to the safety net is a central issue for uninsured individuals who seek health care.

This chapter examines the safety net in Washington and access to the safety net, which includes the number of safety net institutions, the volume of care provided by safety net providers, and the physical location of the safety net institutions. We also examine gaps that exist in the safety net, highlighting the areas of the state that may have a shortage of designated safety net providers.

Safety net providers are those health care providers that care for a disproportionate number of people who do not have the resources to pay for health care. Most doctors and hospitals serve this population and, taken together, may provide the bulk of charity care in the state. Safety net providers, however, have explicit missions to address the needs of the uninsured.* Safety net providers include some (especially sole community) hospitals, community and migrant health centers, and rural health centers.

The demand for safety net services in Washington is expected to increase due to the economic recession and growing unemployment. In October 2001, the United States Labor Department reported that Washington had the highest unemployment rate in the country, at 6.6 percent, and in January 2002 it had the second highest unemployment rate at 7.5 percent.† High unemployment rates tend to be correlated with higher rates of uninsurance. In Washington, the rate of the uninsurance is highest for people with no employed family members (see Chapter 2, page 25). Designated safety net providers will most likely absorb much of the increased demand for care from uninsured and unemployed residents of the state.

*Institute of Medicine. (2000). *America's Health Care Safety Net: Intact but Endangered*. Washington D.C.: National Academy Press.
†*Seattle Times*, November 21, 2002 and February 19, 2002.

Funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration
Grant #1 P09 OA00002-01.

Major Findings

Safety Net Capacity

The capacity of Washington's safety net to serve the uninsured population is strong, especially when compared to the safety net in other states. Washington ranks high among states in several research studies that sampled safety net resources. Long and Marquis* found that Washington, along with Florida and New York, ranked as one of the top 3 of 10 states in safety net capacity. Holahan and Spillman† found that Washington was in the top 4 of 13 states with the least vulnerable safety nets.

These studies differ in the implications of having a strong safety net. Long and Marquis reported that uninsured children visited health care providers with substantially higher frequency in states with a high safety net capacity. Holahan and Spillman found that no difference existed between the insured and the uninsured in the frequency with which they visited health care providers in states that had stronger and weaker safety nets.

This apparent variance is important for policy formulation. The Long and Marquis result suggests that expanding the safety net may be a way to increase access. The Holahan and Spillman finding suggests that expanding insurance, rather than expanding the safety net, may be a better way to improve access.

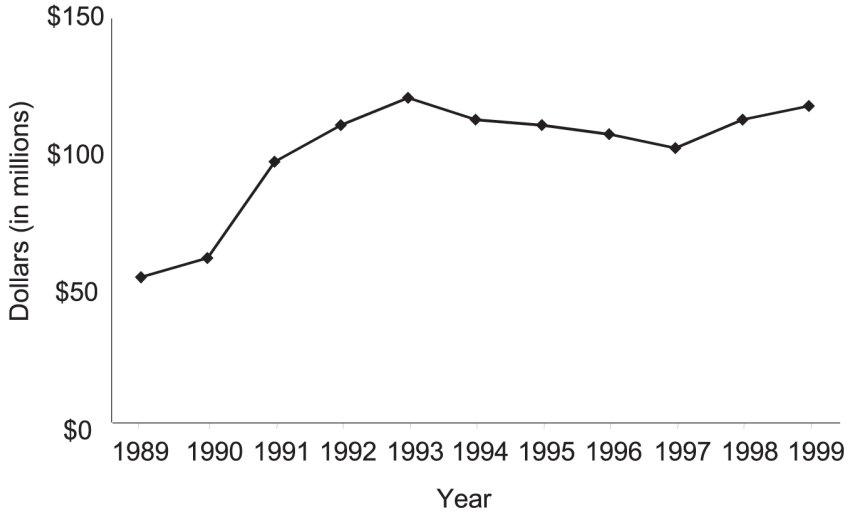
Delivery of Safety Net Care

- Relatively few hospitals provide most of the hospital charity care that is delivered in Washington. Nineteen of the 90 hospitals in the state provided 76 percent of all hospital charity care in 1999.
- Rural hospitals report less charity care as a percent of their total adjusted revenue than do urban hospitals. In 1999, rural hospitals contributed 1.5 percent of adjusted revenue (excluding Medicare and Medicaid) to charity care. Urban hospitals contributed 2.3 percent of adjusted revenue to charity care.
- The number of uninsured patients served by community and migrant health centers increased by more than 34 percent from 1992 to 2000. The uninsured dropped as a percentage of all patients seen by these community health centers from 39 percent to 29 percent during the same time period.

*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.

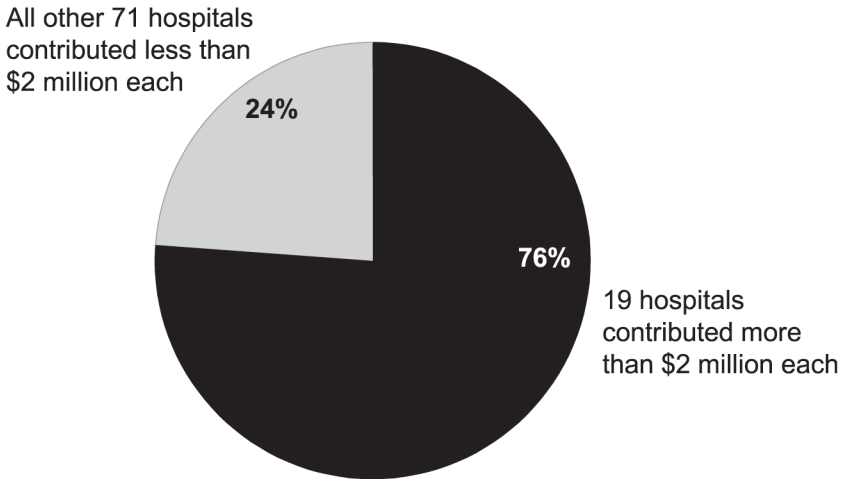
Funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration
Grant #1 P09 OA00002-01.

Figure 7-1. Hospital Charity Care Spending, 1989 to 1999



Source: Washington State Department of Health, Center for Health Statistics, 1999.

Figure 7-2. Total Hospital Charity Care Spending by Whether Hospital Contributes More or Less than $2 Million in Charity Care, 1999



Source: Washington State Department of Health, Center for Health Statistics, 1999.

Hospital Charity Care

Among all hospitals in Washington, spending for charity care increased during the 1990s. In 1989 hospitals contributed just over $50 million to charity care. By 1999 hospitals more than doubled the total amount. However, in the mid-1990s the amount of charity care stabilized and even declined slightly, perhaps due to expansion of Medicaid coverage for children and increased enrollment in Basic Health during this period.

The amount of charity care provided as a percent of adjusted revenue decreased by 1 percentage point from 1996 to 1999—from 3.2 percent to 2.2 percent. Adjusted revenue represents how much charity care is provided excluding Medicare and Medicaid revenues, which may give us a better sense of what hospitals contribute to charity care.

A majority of hospital charity care spending in Washington is accounted for by relatively few hospitals. Nineteen hospitals each provided more than $2 million of charity care in 1999. This amounted to 76 percent of all hospital charity care spending in the state. Harborview Medical Center alone provided more than 23 percent of total hospital charity care.

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Figure 7-3. Hospital Charity Care by Region

Hospital Charity Care by Region in Washington				
Charity Care as a Percent of Adjusted Revenue				
Hospital Region	**1996**	**1997**	**1998**	**1999**
King County	3.3	3.0	2.9	2.4
Central Washington	3.3	2.7	2.5	2.4
Southwest Washington	3.4	2.8	2.4	2.3
Puget Sound	2.8	2.2	1.8	1.8
Eastern Washington	3.3	2.2	2.2	1.8
Statewide	**3.2**	**2.6**	**2.5**	**2.2**

Source: Washington State Department of Health, Center for Health Statistics, 1999. Charity Care in Washington Hospitals.

From a regional perspective, hospitals in King County provide the greatest dollar amount of charity care. However, this picture changes considerably when Harborview Medical Center's $26.6 million is excluded. Then charity care in King County drops from 2.4 percent of adjusted revenue to 1.5 percent. Other King County hospitals provide charity care at levels comparable to rural hospitals.

Rural hospitals report less charity care, in proportion to their total adjusted revenue, than do urban hospitals. Overall, rural hospitals provided $8.8 million of charity care in 1999, amounting to 1.5 percent of adjusted revenue. Charity care for urban hospitals amounted to 2.3 percent of adjusted revenue.

Figure 7-4. Hospital Regions in Washington

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Community and Migrant Health Centers

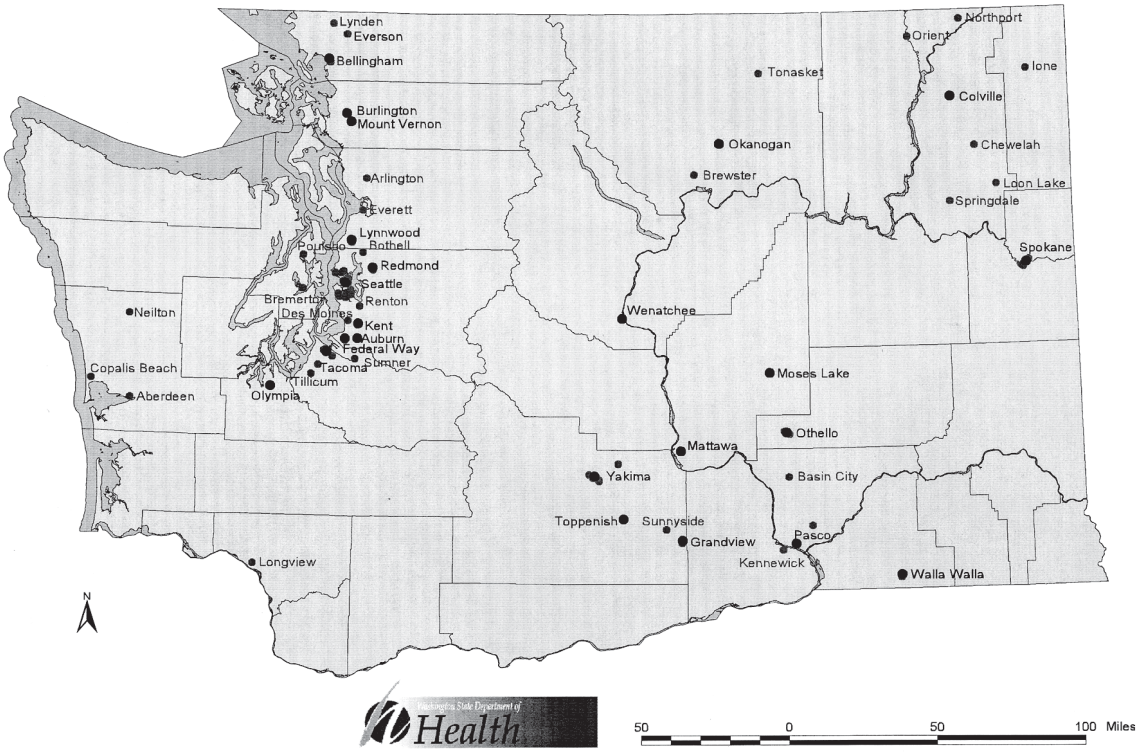
In 2000, the Washington Association of Community and Migrant Health Centers (WACMHC) reported that 21 community and migrant health centers operated 80 medical and 40 dental sites throughout the state as members of their organization. These community and migrant health centers provide comprehensive primary health care in both urban and rural areas. However, they tend to be located where the population clusters are largest, in the more urban areas. From the map below (Figure 7-5), we can see that the greatest concentration of community and migrant health centers is located along the I-5 corridor in the western part of the state.

Funding for Community Health Centers

Community health centers receive funding from multiple sources, the largest of which is payments by third-party payers such as Medicare, Medicaid, and private insurance. Another large source of income comes from grants received from federal, state, and local governmental agencies. These grants account for 26.7 percent of the total funding received by the clinics.

The Health Care Authority's Community Health Services grant program funds some of the community health centers in the state. In 2000, Community Health Services gave over $6 million to 29 not-for-profit community health centers with approximately 120 delivery sites throughout the state.*

Figure 7-5. Community and Migrant Health Centers and Dental Clinics, 2002



*Washington State Health Care Authority. (2001). Community Health Services 2000 Annual Report. Olympia, WA

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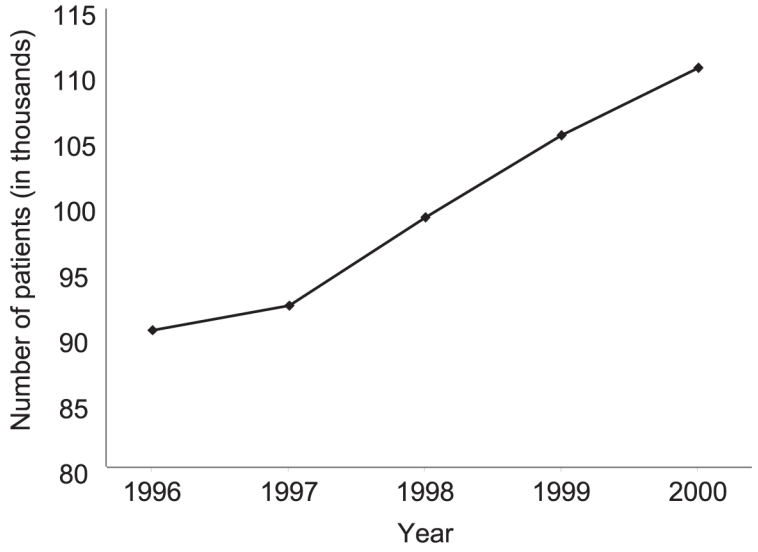
Figure 7-6. Uninsured Patients Served in Washington Community and Migrant Health Centers, 1996 to 2000

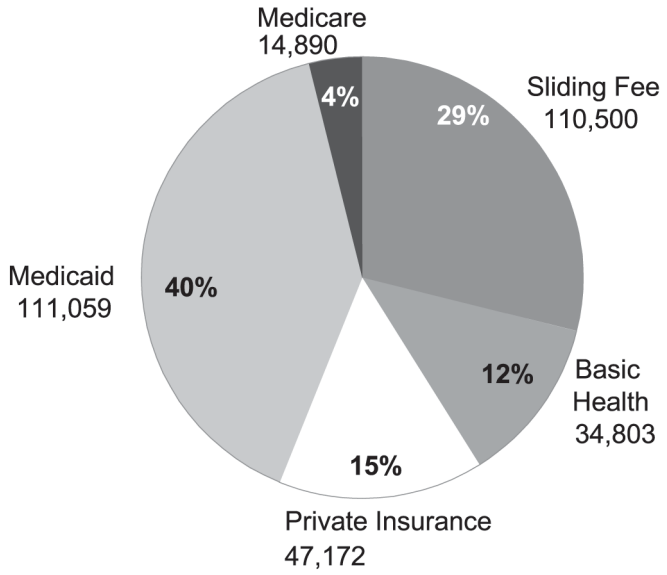


Source: Washington Association of Community and Migrant Health Centers, 2001.

Community and Migrant Health Center Charity Care

Among community and migrant health centers in Washington, the number of uninsured patients has increased by more than 34 percent since 1992, from 86,700 to 110,500 in 2000. However, uninsured patients as a percentage of all patients seen by these community health centers has decreased. In 1996, uninsured visits represented 39 percent of all patients; by 2000 this proportion had dropped to 29 percent of all patients.

Figure 7-7. Patients By Payment Source in Community and Migrant Health Centers, 2000



Source: Washington Association of Community and Migrant Health Centers, 2001.

The number of sliding-fee patients served by community and migrant health centers has increased by 15 percent since 1996, from 84,300 to 96,800 in 2000. As a payment source, sliding-fee clients, who are virtually all uninsured, represented 29 percent of all community and migrant health center patients in 2000. The only payment source that represents more of the patient base is Medicaid, at 40 percent.

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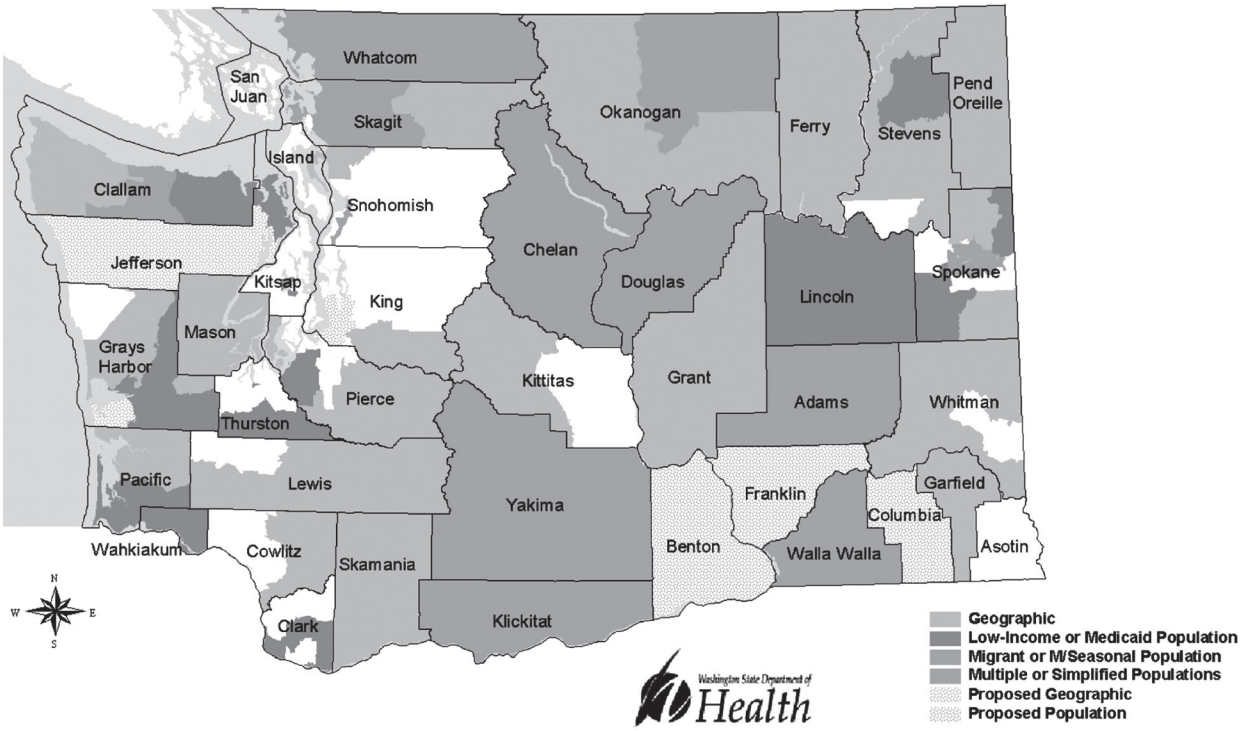
Health Professional Shortage Areas

The federal government designates areas of the state that have a shortage of primary care medical professionals and dental professionals as Health Professional Shortage Areas (HPSAs). HPSAs can be (1) An urban or rural area, (2) a population group, or (3) particular institutions that serve HPSA residents. In 1998, the Office of Community and Rural Health at the Washington State Department of Health estimated that federal shortage designations allowed local clinics, providers, and health jurisdictions to qualify for $35 to $50 million in federal funds through enhanced Medicare and Medicaid reimbursements.

HPSAs have become especially important since 1997 when the federal Balanced Budget Act allowed for the designation of private medical practices in Health Professional Shortage Areas as Rural Health Centers. The Office of Community and Rural Health has been very aggressive at getting HPSAs designated in Washington. As is evident from the map below (Figure 7-8), only a few areas of the state have not been designated as HPSAs; almost 90 percent of the state lies in a Health Professional Shortage Area.

Figure 7-8. Federally Designated Primary Health Care Shortage Areas in Washington, 2002



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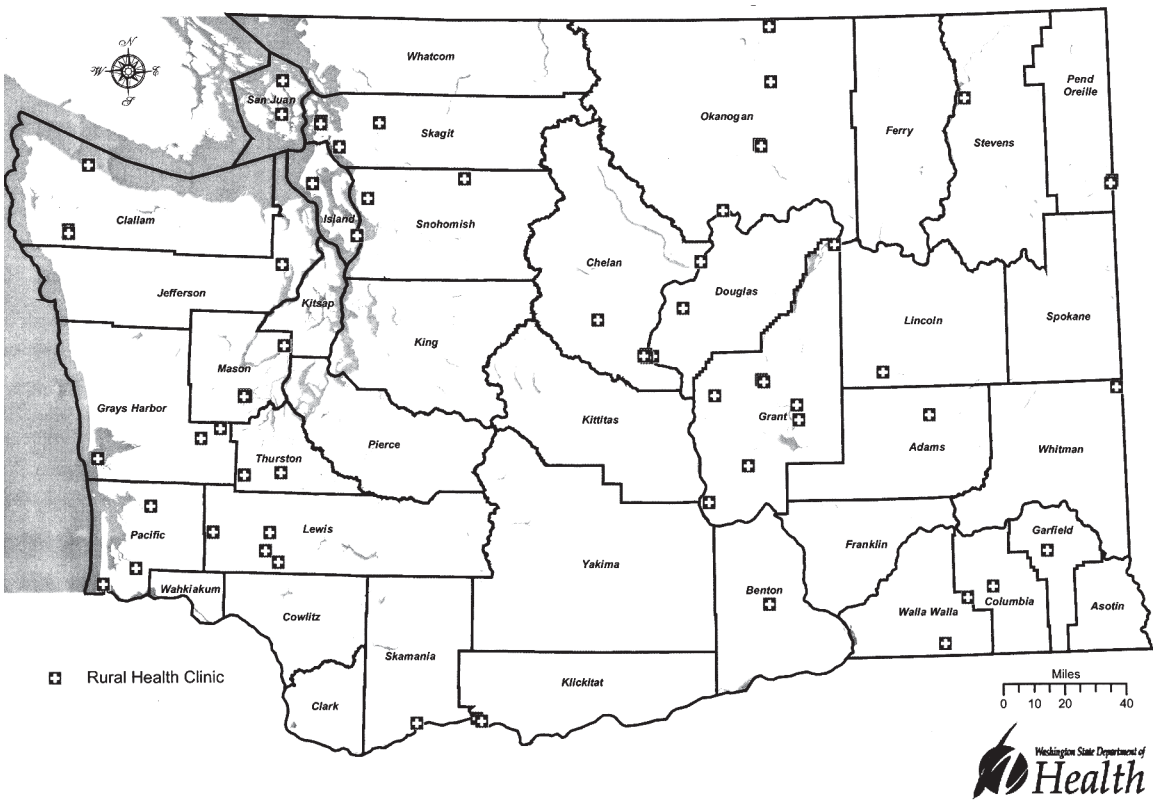
Rural Health Centers

The federal Centers for Medicare and Medicaid Services (CMS) designates clinics and private medical practices that provide primary care services to individuals in rural underserved areas as Rural Health Centers (RHCs). The designation means that the clinic or private practice will receive enhanced Medicare and Medicaid reimbursement. Initial eligibility requirements include: (1) location in an updated—within the past three years—Health Professional Shortage Area or Medically Underserved Area; and (2) location in a rural or non-urbanized area, according to the U.S. Census Bureau.

The volume of care provided by RHCs is unknown, because no centralized reporting structure exists. CMS does not require that RHCs see uninsured patients, offer a sliding-fee scale, or post the sliding-fee schedule even if one is offered. RHC status is becoming more and more important to clinics and doctors in rural areas. As Medicare payments have declined, many more providers have expressed interest in RHC designation. Washington has a total of 70 RHCs, and as many as 40 providers have expressed interest in certification by early 2002. From the map below (Figure 7-9), we can see that Rural Health Centers also tend to be focused along the I-5 corridor in the western part of the state.

Figure 7-9. Rural Health Centers in Washington, 2002



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Chapter 8. Conclusion: Gaps and Barriers in Coverage, and Implications for Policy

In this chapter we briefly recount some of the main findings of Research Deliverable 3.1 regarding the characteristics of the uninsured, and identify some main "lessons" for the design of policies that aim to fill remaining gaps in the insurance system in order to reduce the number of uninsured.

Gaps and Barriers

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 of the uninsured are important for designing policy solutions.

- They are primarily low-income. More than two-thirds are in families with income at or below 200 percent of the federal poverty level (FPL), accounting for 308,000 uninsured people. And these individuals are more than twice as likely to be uninsured as those above 200 percent FPL. This is consistent with our analysis of income adequacy, which indicates that families that can meet their basic living expenses and have enough money left over to pay for out-of-pocket health care costs frequently have incomes higher than 200 percent FPL. Below 200 percent FPL, families often do not have enough resources to pay for insurance.
- The majority (53 percent) of the uninsured are adults without children.
- Children account for 25 percent of the uninsured. The uninsured rate for children is lower than for adults as a result of recent public efforts to cover children, but 116,000 children still lack coverage. The overwhelming majority of these children also have uninsured parents.
- Most uninsured people (75 percent, or 365,000) are workers or their dependents. However, there is substantial diversity in the work situation of these individuals. Over three-quarters of this group do not have access to employer-sponsored coverage, about 31 percent work for an employer that does not offer coverage, and about 46 percent are self-employed. Families whose employer-based option is at small group rates must generally have incomes greater than 250 percent FPL—in some cases, more than 300 percent FPL—to purchase this coverage and still meet their basic living expenses.

These coverage gaps suggest that policies to reach the uninsured population must overcome a number of barriers.

- Affordability of coverage is likely to be the foremost problem given that the uninsured are concentrated among low-income individuals. The analysis of affordability confirms it is a significant barrier: more than 50 percent of uninsured adults lack access to affordable coverage.
- Many who lack access to affordable private coverage do not qualify for public programs. Childless adults are especially at risk, given public program eligibility rules.
- When families without dependents have enough income to cover basic living expenses, they are not eligible for Medicaid. In two of the counties we examined, families with two adults and no dependents are also not eligible for Basic Health if they have incomes high enough to meet their basic

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living expenses. Conversely, most families with dependents would be eligible for Basic Health, even with incomes high enough to meet their basic living expenses. Many of them are also eligible for Medicaid.

- Lack of full participation in public programs by those eligible suggests that not all barriers may be financial. Almost 20 percent of adults and more than 10 percent of children eligible for public programs are uninsured. Lack of knowledge of programs and their eligibility rules may be among the non-financial barriers.

- Lack of availability of family coverage may be a barrier to achieving a goal of insuring all children.

Policy Implications and Challenges

Most policy options to expand insurance that are under serious consideration by states or at the federal level are incremental in nature and can be classified in one of four major groups: options to build on the employer-based insurance system; policies to expand the voluntary purchase of individual coverage; public coverage expansions; and proposals that are aimed at specific population groups or at populations with specific needs—such as the uninsurable or those who have recently lost insurance after losing a job. Our analysis points to a number of challenges for designing effective incremental expansions.

- No one approach is likely to solve most of the problems; a combination of policies is likely to be necessary.

Policies to make existing employer-based coverage more affordable would apply to only about 20 percent of the uninsured. Policies to encourage more employers to offer coverage would potentially benefit only about 25 percent of the uninsured. Policies to help those in job transitions may benefit some uninsured, unemployed individuals, but they account for only about one-quarter of the uninsured population. Finally, public programs to provide coverage at no cost are likely to be necessary to reach the poorest of the uninsured—more than one-third of the uninsured have incomes below the federal poverty level.

- Effective targeting is a challenge in designing policies to expand the employment-based system.

One-fifth of the uninsured do not participate in offered employer-sponsored insurance programs, but only a very small minority of employees, even among low-income people who are offered coverage, fail to participate. Thus policies to increase take-up may benefit a large number of the currently insured, as well as the uninsured. Similarly, although businesses with primarily low-wage workers are much less likely to offer coverage than other businesses, still more than half of the former do offer coverage. Thus, policies to encourage employers of low-wage workers to offer coverage may benefit many employers who already offer insurance as a benefit. Policies that benefit the currently insured as well as those uninsured will cost more, but such policies would be more equitable as they would treat equally those in similar economic circumstances. Conversely, not all low-wage workers are in low-wage businesses, so these low-wage workers would not benefit from policies that were directed to workers of low-wage employers only.

- Substantial premium subsidies are likely to be necessary for the success of any approach.

We found that price appeared to be a factor in employee decisions not to enroll in employer plans, especially for dependents, and that price appears to be a deterrent to employers offering coverage.

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However, quite substantial differences in price have only modest effects on take-up and offer rates. Similarly, large differences in price for coverage resulting from the tax treatment of insurance for the self-employed have only modest effects on insurance rates for the self-employed. Moreover, even with a 50 percent subsidy of premiums for available coverage, about 40 percent of the uninsured would not have access to affordable public or private coverage.

- Expanded public program eligibility is likely to be necessary to close the gaps in coverage—especially, expansions in family coverage and for childless adults.

The insurance status of the parent is a key predictor in the insurance status of children; most uninsured children have uninsured parents. Policies to extend eligibility for public programs to parents may therefore be key to reducing the number of uninsured children. The largest group of the uninsured, childless adults, are currently ineligible for most public programs in the state.

- Administrative simplification, outreach, marketing, and other policy changes may be necessary to reach the uninsured through public programs.

Not all eligible individuals participate in public programs. Our analysis suggests that a large share of people may not be aware of existing programs. Other program features that make it difficult to access programs also may need to be redesigned to reach a goal of full coverage. Further research is needed to better understand these barriers.

- The uninsured population is best described as a flow rather than as a static pool. The changing nature of the uninsured populations poses a large number of challenges for effective policy design.

Our analysis has focused on the uninsured at a point in time, but many people move in and out of being uninsured. About 70 percent more people are uninsured at some time during the course of a year than are uninsured at a point in time. Many of these will have short-term gaps in insurance. However, the uninsured population at a point in time consists primarily of a large number of individuals who are chronically uninsured—about 75 percent will have been uninsured for one year or more. Thus, our analysis can say little about the special policy design issues associated with reaching those who have shorter episodes of insurance—such as issues of timing or the changes in circumstances that lead to these short spells. Analysis of this topic requires further research and longitudinal data.

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Appendices

Appendix A. Methodology

Appendix B. Data

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Appendix A: Methodology

Our profile of the uninsured and the analyses of coverage gaps and barriers to coverage are based primarily on data collected in the 2000 Washington State Population Survey (hereafter 2000 WSPS). The purpose of this appendix is to describe methods used to develop key constructs for our analysis that are not directly measured in the survey.

Matching to Other Surveys

We used three other surveys to impute important characteristics for our analyses that were not measured in the 2000 WSPS. These other surveys were the 1998 Washington State Population Survey (for a measure of any period of uninsurance during the year); the 1997 RWJF Washington Family Health Insurance Survey (for a measure of the length of the uninsurance spell in progress); and the 1997 RWJF Employer Health Insurance Survey (for detailed information about the offer of employer health insurance). The imputation involves matching observations in the 2000 WSPS and the host survey based on characteristics common to both.

The longitudinal insurance measures were imputed using a probit regression model that was estimated from the host data set to explain the characteristic in question. Two models were estimated—one for having any period of uninsurance during the year and one for having a spell of uninsurance for one year or more—each of the following form:

$$\text{Probability of having characteristic} = F(Xb),$$

where X denotes the explanatory variables, F is the cumulative normal distribution, and b are the coefficients estimated in fitting the model.

Explanatory variables in these regressions included: age, health status, poverty level, race/ethnicity, education, availability of employer-offered insurance, whether the primary earner was self-employed, and number of earners in the family. For each observation in the 2000 WSPS, we predicted the value of the characteristic as:

$$y = 1 \text{ if } F(Xb + m) > 0.5, \text{ and } y = 0 \text{ otherwise.}$$

The y values we impute take on the value 1 if the person was uninsured at any time in the last year and 1 if the current uninsurance spell has been in progress for a year or more. The X are the explanatory characteristics defined above, the b are the coefficients from the probit model, the m is drawn from a normal distribution with mean equal to 0 and variance equal to 1, and F is the standard cumulative normal distribution. This imputation is analogous to reweighting the host data to match the distribution of explanatory characteristics in the 2000 WSPS survey.

Because we wanted to study a number of characteristics about employer-sponsored insurance, we synthetically matched each worker in the 2000 WSPS to an employer in the 1997 RWJF Employer Health Insurance Survey. That is, rather than imputing characteristics of employer-sponsored insurance one by one, we attached all of the characteristics of a single employer to each worker. This process preserves the joint distribution of these characteristics. We assigned workers to employers based on industry, size of the business, the wage mix of the workforce and the business and the worker's wage, and information about whether the household survey respondent worked for an employer that offers

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insurance. Employers and workers were assigned to one of 20 industry/size groups. The industry groups were agriculture/forestry/fishing; construction/mining/manufacturing; trade; communications/transportation/utilities; finance/insurance/real estate; professional services; other services; local government; state government; and federal government. All industries except agriculture/forestry/fishing and the government groups were categorized by number of workers in the business: fewer than 10, 10-25, 26-50, and 51 or more. Each of these industry/size groups was classified by the wages of the workers in the business: low-wage businesses—those with two-thirds or more workers earning less than $10 per hour—and other businesses. A low-wage worker in the 2000 WSPS (i.e. one earning less than $10 per hour) was probabilistically assigned to an industry/size/type of business on the basis of the reported industry and size of his or her employer and the proportion of low-wage workers in this industry/size group that are employed by low-wage businesses. For example, if 80 percent of all low-wage workers in the "other service" industry who work for a business with fewer than 10 workers are in a low-wage business of this type, then the worker is assigned to a small, other service, low-wage business with probability of .8 and to a small, other service, higher-wage business with probability .2. Within the assigned type of businesses, random selections were made.

For some workers, we have information about whether the employer offers insurance, and we used this to create a subset of the sample including businesses to which a match might be made. For example, if there is a single worker in the family, we know that coverage is available if the worker has employer coverage or reports that it is available. In such case, we would assign the worker only to businesses that offer employer-sponsored insurance (and we recalculate the probability of working for a low-wage or higher-wage business to account for this subset). If there are two workers in the family, and the workers are covered by employer coverage or report that employer coverage is available, we know that at least one of the workers is employed by a business that offers coverage. We assume that a full-time worker at the larger of the businesses is offered coverage in this case and assign that worker to a business that offers employer-sponsored coverage. The other worker in the family can be assigned to a business that offers coverage or to one that does not. If the worker or workers in the family are full time workers and report that coverage is not available, we assume that the employer does not offer coverage and limit our assignment to these businesses. However, if the worker who does not have coverage available is a part-time worker, the worker can be assigned to an employer that offers coverage or one that does not.

The analysis of workers and their assigned employers can be thought of as reweighting the 1997 RWJF Employer Health Insurance Survey using employee weights derived from the 2000 WSPS survey. The distribution of workers according to characteristics of the business to which they are linked is shown in Table 1. We compared the distribution of employees by industry, low-wage versus other business, size of business, and whether insurance is offered by the business using these new weights and the employee weights from the 1997 RWJF Employer Health Insurance Survey. The results were not markedly different.

Eligibility for Public Programs

To analyze access to insurance for the uninsured, we identified uninsured persons who are eligible for public programs based on information in the 2000 WSPS. This coding represents an approximation and an abstraction from the complexity of eligibility rules; our coding is constrained by measures available in the survey. The rules we used for determining eligibility are as follows:

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For children age 18 or younger.

Medicaid: The child is eligible if he or she is a citizen or non-citizen resident in the U.S. five years or more, and adjusted family income is less than or equal to 200 percent of the federal poverty level. Adjusted family income is total family income less $90 per month per worker in the family less the costs of paid child care per month related to working expenses less child support payments (as reported in the survey). We approximate allowed deductions for child care costs by determining from the survey (1) whether the family reports making child care cost payments and (2) if there is a working adult. If yes, we deduct an amount of child care costs based on the age and county-specific child care cost standards from the Pearce Self-Sufficiency Standard (Pearce & Brooks, 2001).

Children's Health Program: The child is eligible if he or she is a non-citizen and resident less than five years and adjusted family income is less than or equal to 100 percent of the federal poverty level. Adjusted income is determined as described for Medicaid.

CHIP: The child is eligible if he or she is a citizen or non-citizen resident in the U.S. five years or more and adjusted family income is between 200 and 250 percent of the federal poverty level. Although CHIP is not an entitlement, our estimates are that current program funding would be sufficient to cover all uninsured children not otherwise eligible for a public program. Thus, our estimates of eligibility do not take into account capacity limits.

For adults.

Medicaid: The adult is eligible if there are children in the family and the adult is related to the child, the person is a citizen or non-citizen who has been a resident of the U.S. for five years or more, and adjusted family income is less than or equal to 45 percent of the federal poverty level. Adjusted family income is total family income less 50 percent of earned income less the costs of paid child care per month related to working expenses less child support payments.

State Family Assistance program: The adult is eligible if there are children in the family and the adult is related to the child, the person is a non-citizen who has been a resident of the U.S. for fewer than five years, and adjusted family income is less than or equal to 45 percent of the federal poverty level. Adjusted family income is as described for Medicaid adults.

SSI related programs/GA-U: The person is eligible if disabled, a citizen or non-citizen who has been a resident of the U.S. for five years or more, has own *earned* monthly income of less than $740 per month and own *unearned* monthly income of less than $591 per month in area 1 (King, Kitsap, Pierce, Snohomish, and Thurston counties) or $570 per month in area 2 (all counties except area 1). The incomes are as measured in the survey. We have operationalized *disabled* as reporting having a long-lasting condition such as blindness, deafness, or severe vision or hearing impairment or reporting having a condition that prevents the individual from working for pay.

Medicaid buy-in: The person is eligible if disabled, a citizen or non-citizen who has been a resident of the U.S. for five years or more, is working, has family income of less than 450 percent of poverty, and previously received SSI payments. *Disability* is operationalized as described above. As a proxy for previously receiving SSI payments, we use the indicator that the individual received TANF, GA, or SSI in 1999.

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For adults and children.

Basic Health (BH): Because BH was enrolled at capacity in 2000, we assumed that uninsured individuals did not have access to the program. However, we consider two alternative scenarios: removal of enrollment limits to permit all eligible uninsured persons to enroll in BH, and funding that would allow an additional 50,000 persons to enroll. For this latter case, we probabilistically designate uninsured adults and children who are not otherwise eligible for a public program to allow an additional 50,000 enrollments in BH to represent this scenario.

Estimating Adjusted Relationships

In many of our analyses we show the simple bivariate relationship between an outcome (such as having insurance) and a characteristic of the individual (such as age) and an adjusted relationship. The simple bivariate relationship shows the effect of the variable under study and all variables associated with it. For example, if older individuals are in poorer health and have lower incomes than younger persons, the bivariate relationship between having insurance and age would also reflect the effect of income on having insurance and the effect of health on having insurance. The adjusted relationship controls for all of the other variables to show the marginal effect of the characteristic under study, in this example, age. To do this, we fit dichotomous models (using logistic or probit regression) to explain the outcome of interest (for example, having insurance) as a function of all characteristics that we think are associated with it. That is, we fit a model of the form:

Probability of having characteristic = $F(Xb)$, or

Probability of having characteristic = $\exp(Xb)/(1 + \exp(Xb))$,

where X denotes the explanatory variables and b are the coefficients estimated in fitting the model. The F denotes the cumulative normal function used in fitting the probit model, the second equation is the form of the logit equation.

To measure the adjusted effect of a variable, say age, we use our fitted relationship to predict the outcome for everyone in the population as if they were all young, and we average these predictions to obtain an adjusted measure for the young. This shows what we expect the outcome would be if all the young had the same distribution of other characteristics (say income and health) as the population as a whole. We then predict the outcome for everyone in the population as if they were all old and average these predictions for the adjusted measure for the older population. Again, this shows the expected outcome for older persons if they all had the same distribution of characteristics of the population as a whole. The comparison of these two predicted average outcomes then shows the difference in the outcome for the young and old after controlling for all other factors.

We fit models to examine the adjusted effects of demographic characteristics on the probability of being uninsured among all persons (Chapter 2), of family characteristics on the probability that a child is uninsured (Chapter 3), and on the percent of workers in firms offering health insurance (Chapter 4). The variables that we control for to study the probability of being uninsured are: family income, race/ethnicity, age, citizenship, region of residence, number of workers in the family, health status, and education. The variables that we control for to study the role of family characteristics in whether the child is uninsured include: whether the parent is uninsured, whether the parent is a single female, the child's age, and the family income.* The explanatory variables that we control for in studying the

* We do not include race/ethnicity, region, citizenship, or work status of the parents, but rather, the effects of these variables are reflected in the role of the parent's insurance status on the child's state.

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probability that an employee is in a business that offers insurance include: size of firm, whether the business is seasonal, whether the firm employs predominantly part-time workers, whether the business has unionized workers, whether the business employs predominantly young workers, whether the business employs predominantly female workers, and whether the business employs predominantly low-wage workers.

Index of Access to Affordable Coverage

We developed an index of affordability for each sample person and family in the survey. The goal of this effort was to assess how many uninsured families have access to affordable coverage and the characteristics of the uninsured that do and do not have such access. Thus, this differs somewhat from the purpose of the affordability analysis, which measures the income needed for a typical family to afford various types of coverage in the state. Our procedures and assumptions in general, however, follow those described in the affordability analysis (See Research Deliverable 3.3, Income Adequacy and the Affordability of Health Insurance in Washington State). We modified some of the affordability analysis methods to incorporate specific information we had about each individual and family from the survey that cannot be accounted for in looking at an average, or typical, family. We detail these differences below.

We linked the Pearce Self-Sufficiency Standard (Pearce & Brooks, 2001) to each family in the 2000 WSPS survey based on the family composition and the county of residence. The Pearce standard is developed for 70 distinct family types based on the age and number of adults and the age and number of children in the family. The 70 types consider all possible family configurations with up to three children.* For families with more than three children, we calculated the marginal cost per child in each of the four age groups considered in the Pearce model (infant, preschooler, school age, teenage) based on the difference in cost for a two-adult family with two children in the age group and a two-adult family with one child in the age group. This marginal cost per child of a given age was then used to increment the standard to account for families with more than three children. We use the Pearce model to measure the family needs for all non-health related expenses. Because the 2000 WSPS survey was taken in 2000, we adjusted the Pearce standard from 2001 to 2000 dollars using the consumer price index for all urban areas.

Premium costs for the best (least cost) option available to the individual or family were then calculated as follows:

For those eligible for Medicaid, CHIP, GA-U of SSI-related programs, Children's Health Program, and State Family Assistance programs, the individual cost for insurance is set to zero.

For all other individuals, we establish a premium for the family based on the best (most affordable) option for each family member. For those eligible for BH, premiums are based on the sliding income scale for the lowest premium plan. We use the lowest premium plan, as was assumed in the analysis reported in Research Deliverable 3.3. However we account for the variation in BH premiums facing families at lower and higher income levels in our calculations by using income reported in the survey, and the BH premium schedule to calculate the cost for each person eligible for BH. Our analysis of the affordability index considers two BH funding scenarios: in one scenario enrollment is capped at

*In contrast, the analysis of income adequacy and affordability described in Research Deliverable 3.3 focused on 12 representative family types from the 70 used to calculate the self-sufficiency standard.

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current levels, and so those currently uninsured would be unable to join (and so are deemed ineligible). Thus, BH is not considered an option available to the uninsured, and so BH premiums are not considered in measuring the affordability index for the uninsured. In the other scenario, funding levels would accommodate all those who are nominally eligible, given the BH eligibility criteria, and so the BH premiums factor into the affordability index for the uninsured, if it represents the lowest cost plan available.

For those who have access to an employer health plan, we used the employee's share of the cost for self-only coverage or family coverage, as appropriate, using the required contributions from the 1997 RWJF Employer Health Insurance Survey and linking workers in the family to an employer (as described earlier). These premiums were adjusted to 2000 dollars, using the medical component of the consumer price index. We used this specific detail, rather than average costs for a small employer assumed in the analysis described in Research Deliverable 3.3, because we want to account for differences in premium costs and employer contribution shares across business sizes and industry.

For persons who are not eligible for a public insurance program and do not have access to employer-sponsored coverage, we used a premium schedule for the purchase of either individual insurance or WSHIP insurance. The premium schedules vary by the age and number of adults in the family purchasing in this market and by the size of the family and accord with the premiums for this program assumed in the affordability analysis. Persons reporting that they are in fair or poor health are given a WSHIP premium; others are given the individual market premium. Current tax law permits self-employed persons to deduct up to 50% (in 2000) of the cost of their individual health insurance premiums, even if they do not otherwise itemize deductions. This effectively lowers the price of insurance to .5*Premium+(1-marginal tax rate)*.5 Premium. We used information on marginal tax rates for single-person families and other families by level of total family income from the U.S. Statistical Abstract to make this adjustment for the premiums for self-employed persons and their family members.

To accord with the affordability analysis, we assumed three different health statuses, and we adopted levels of total spending and out-of-pocket spending that are consistent with the affordability analysis. The healthy in our analysis are those who report health status of excellent: they are assumed to have no medical care costs.* Those in average health are those reporting health status to be very good or good (this includes those whose health is the 40th to 90th percentiles of the distribution). The sick are those who report health to be fair or poor. We assume a total level of annual insured spending for health care services in 2001 dollars for those in average health as follows:

Under age 19: $1471

Age 19-25: $2254

Age 24-34: $2724

Age 35-44: $3165

Over age 44: $5494

* We limited the "healthy" to those reporting their health as excellent because about 40 percent of persons self-report excellent health. While the proportion of the population with no health expenses in a year (our definition of "healthy") is smaller than 40 percent, we do not have a more detailed set of health categories on which to base our three subgroups.

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These total spending assumptions accord with the out-of-pocket spending and cost-sharing assumptions for individual coverage in the affordability analysis. We assume the sick have total spending that is three times this level.* We adjust the 2001 dollars to 2000 dollars, using the medical component of the consumer price index for our affordability index for persons in the 2000 survey.

To determine out-of-pocket spending for those with access to employer coverage, we use measures of the actuarial value of the plan offered by the employer to which the workers in the family are linked. The actuarial values are measures that were developed for each plan offered by employers in the 1997 RWJF Employer Health Insurance Survey based on detailed information about the plan benefits. Again, we do this in order to take account of differences in benefits offered by large and small employers and across industries. The actuarial value is an estimate of the share of medical spending that would be reimbursed by the plan; the individual's out-of-pocket share is one minus the actuarial value. This latter share is then multiplied by spending to determine out-of-pocket payments for health services. For the person in average health, we use the actuarial value for the average person. For the sick person, we use the actuarial value for persons in the top 25 percent of the expenditure distribution in order to take into account a higher expected actuarial value as spending increases because of the lower weight of deductibles and because of out-of-pocket limits on spending.

For all other plans, we used the same assumptions employed in the affordability analysis described in Research Deliverable 3.3.

Our index of affordability is then measured as follows: For individuals eligible for Medicaid, CHIP, GA-U of SSI-related programs, Children's Health Program, and State Family Assistance programs who do not have premium payments or out-of-pocket cost sharing, the affordability index is set to 1. For all other persons, we compare the Pearce monthly requirements for non-health spending for the family plus the monthly family premium payments for the best option available to family members plus the average monthly out-of-pocket payments for all family members to the family's monthly income. If family income is greater than the monthly requirement for non-health spending and health spending, then the index is set to 1; otherwise, it is set to zero.

To illustrate the calculation for some prototype cases: suppose we have a married couple, both aged 35-44, living in Spokane County, with an annual income of 207 percent of the federal poverty level, or $24,000. The husband is employed and offered insurance for which he would have to contribute $300 per year for self-only coverage and $1000 per year for family coverage. Assume both are in excellent health. The least-cost health care option available to this family would be the employer plan. So the cost to the family for premiums annually is $1000 and the out-of-pocket cost for medical services is $0. The Pearce monthly requirement for non-health spending for this family is about $19,700. Thus, the requirements for non-health spending plus the health insurance premium payments and out-of-pocket medical services spending by the family equals $20,700, which is below the family income. Each person in the family receives an affordability index of 1.

Suppose instead that the wife is in poor health and the insurance policy has an out-of-pocket maximum for the year of $1000. In this case, premiums plus out-of-pocket health care spending for the year are $2000; but the requirements for health care and non-health care of $21,700 remain below the

* This assumption is based on actuarial consultation. In practice, this assumption does not affect our basic measure of the affordability index for most people since out-of-pocket spending for services by the sick will depend on the cap on spending in the lowest-cost health plan. It does enter our alternative calculation that accounts for what people would pay for services without insurance, described later.

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family income and the affordability index is 1.

Now assume that the husband's employer does not offer insurance. In this case the family must purchase in the individual insurance market. Since the wife is a high-risk person (her health is poor), her best option is WSHIP at an annual premium of $2170 (see the assumptions reported in Research Deliverable 3.3). Her out-of-pocket spending for medical care is $1500. The husband, however, can purchase individual insurance at an annual premium cost of $1728, and he incurs no expenditures for medical care services. Their health care spending needs are thus $5398 ($1500+$1728+$2170). In this case, the requirements for health and non-health spending of $25,098 ($19,700+$5398) exceed the family income of $24,000, and so the affordability index for each person is set to 0.

Finally, for this latter case, assume the wife is disabled with no earnings and no unearned income. She is eligible for insurance coverage through SSI-related programs. The husband can purchase individual coverage at a cost of $1728, as above, and has no out-of-pocket costs of care. Her index is set to 1, since we assign an insurance affordability index of 1 to all persons who have access to coverage at no premium and with no cost-sharing requirements. The requirements for health and non-health spending for the family are $21,428 ($19,700+$1728) and are below the family income of $24,000. Thus, the husband's affordability index is also set to 1.

The affordability index is not an index of likelihood of purchase because it does not account for other priorities of the family, risk aversion, or attitudes about health insurance or health care. Nonetheless, it does discriminate quite well between those who do and do not have coverage; among those who purchase insurance, 91.5 percent are measured to have access to affordable coverage. Among the uninsured, only 58.5 percent are measured to have access to affordable coverage (including public insurance).

The index looks at whether family income is sufficient to cover non-health care and health care resource requirements given the best insurance option. However, it does not take into account that individuals are likely to incur medical costs even without insurance, and so their direct payments for medical care may be lower with insurance; they may have more income left to pay for other needs. Therefore, we also looked at a variant of the index in which we measure the cost of insured health care as the premium less any savings in out-of-pocket spending from purchasing insurance. We then compared the Pearce standard for non-health care plus the cost of insured health care to the family income. This index requires a measure of expected payments for medical care if uninsured. To obtain this, we assumed that spending by the uninsured is 75 percent of insured spending; this is based on a large body of literature that looks at differences in use by the insured and uninsured. This literature obtains a wide range of estimates, but 75 percent represents a reasonable mid-range of the estimates. We also assumed that a family would not pay more than 25 percent of its income out-of-pocket for care, even if uninsured; if incurred expenditures exceed this amount, the family is assumed to seek charity care. In the aggregate, our conclusions are not very sensitive to the use of this alternative measure. Using the alternative measure, 61.4 percent of the uninsured have access to affordable coverage, in contrast to the 58.5 percent mentioned above. However, as we would expect, taking into account the savings in out-of-pocket payments in our measure does affect differences in affordability by health status, as reported in Chapter 6.

Estimating Supply Premiums for Workers not Offered Insurance

We are interested in looking at whether workers in businesses that do not offer health insurance face higher premiums for group coverage than workers in businesses that do offer coverage. We do not

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observe these premiums directly, but we can estimate the supply premium based on data about premiums paid for workers in businesses that do offer coverage and how those premiums vary with characteristics of the business and its workers. We assume that premiums are given by the relationship:

$$\text{Premium} = Z\,g + e.$$

If we know this relationship, we can then impute premiums that would have to be paid for workers in businesses that do not offer insurance.

However, because we only observe premiums for those who offer insurance, if we estimate this relationship on the data available to us, we must take into account the potential selection bias; the equation can not typically be consistently estimated using ordinary least squares. But consistent estimates of g can be obtained using the two-stage estimation procedure suggested by Heckman (1979). For the two-stage procedure, we first estimate the selection equation that distinguishes those who do and do not offer insurance as a probit model given by:

$$\Pr(\text{Offer Insurance}) = \Pr(X\,a + \text{Premium}\ b > u) = \Pr\,(X\,a + Z\,g\,b > h) = F\,(X\,a + Z\,g\,b),$$

where the X are characteristics that are assumed to directly affect the decision to offer insurance and the Z are characteristics that affect premiums (and some may also be in the X vector), u has the normal distribution and $h = u - b\,e$. Conditional on offering insurance and observing premiums, the premium equation is:

$$(\text{Premium}|\ \text{Offer Insurance}) = Z\,g - d\,[f(W)/F(W)] + v,$$

where $W = X\,a + Z\,g\,b$, $- d\,[f(W)/F(W)] = E(e|\text{Offer Insurance})$, $d = \text{cov}(eh)$, and $E(v)=0$. The two-stage estimation procedure involves fitting the reduced selection equation to obtain estimates of W, which are used along with the observed Z to estimate g and d in the premium equation. To estimate the equations, we assumed the following variables are in the X vector (that is, they directly affect the offer of insurance): industry, firm size, the age mix of workers, whether union employees, the gender composition of workers, the work hours composition of employees, whether a seasonal business, and the amount of turnover in the workforce. Characteristics assumed to affect premiums but not the offer include the number of years in business and whether ever denied coverage.

We then estimate predicted premiums for those not offering insurance as:

$$\text{Premium}\ |\ \text{Doesn't Offer Insurance} = Z\,g^* + d^*[f(W^*)/\{1-F(W^*)\}] + v,$$

where v is drawn from a normal distribution with mean 0 and variance and is estimated as the residual variance from fitting the premium equation. For a further discussion of this technique for estimating offer premiums, see Marquis & Louis (2001).

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Figure A-1. Distribution of Workers in Washington, 2000 by Characteristics of Business

Characteristic of business	All business	Low wage business (a)	Other business (b)	Small business (c)	Large business (d)
Size of firm					
Fewer than 10 workers	22.0	30.4	19.9	51.2	0.0
10-50	21.0	24.7	20.1	48.8	0.0
More than 50	57.0	44.9	60.0	0.0	100.0
Low-wage business	20.0	100.0	0.0	25.6	15.7
Other business	80.0	0.0	100.0	74.4	84.3
Employs mostly part-time workers (e)	5.6	11.3	4.2	7.5	4.3
Employs mostly full-time workers	94.4	88.7	95.8	92.5	95.7
Seasonal business (f)	5.4	9.4	4.4	4.7	5.8
Not seasonal	94.6	90.6	95.6	95.3	94.2
Has union workers	27.5	4.6	66.8	4.3	45.1
No union workers	72.5	95.4	33.2	95.7	54.9
Employs predominantly young workers (g)	22.3	41.5	17.5	27.4	18.5
Other business	77.7	58.5	82.5	72.6	81.5
Employs mostly female workers (h)	7.1	17.8	4.4	9.1	5.6
Other business	92.9	82.2	95.6	90.9	94.4

(a) at least 2/3 of workers earn less than $10 per hour
(b) fewer than 2/3 of workers earn less than $10 per hour
(c) 50 or fewer workers
(d) More than 50 workers
(e) at least half work fewer than 20 hours per week
(f) at least half of workers are temporary or seasonal
(g) more than 30 percent of workers are less than age 30, no workers older than 50
(h) at least 90 percent of workers are female

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Appendix B. Data

Figure B-1. Counts of Insured and Uninsured Persons Under 65 in Washington, 2000

(in thousands)			
Characteristic	**Uninsured**	**Insured**	**Total**
All persons under 65	484.4	4756.4	5240.8
Age of person			
Under 19	115.8	1503.7	1619.5
19-34	210.1	1059.5	1269.6
35-54	127.2	1692.3	1819.5
55-64	31.3	500.9	532.2
Family income			
100% FPL and below	164.7	578.6	743.3
101-200%	143.4	611.9	755.3
201-300%	71.5	712.1	783.6
301-400%	51.1	710.5	761.6
401% and higher	53.7	2143.3	2197.0
Race/ethnicity			
White, non-Hispanic	324.4	3854.5	4178.9
Black, non-Hispanic	18.6	172.2	190.8
Hispanic	87.0	298.5	385.5
American Indian/Alaska Native	35.5	91.6	127.1
Asian/Native Hawaiian	18.9	339.6	358.5
Citizen			
Citizen	423.6	4565.0	4988.6
Non-citizen	60.8	191.4	252.2
Gender			
Male	279.7	2377.1	2656.8
Female	204.7	2379.3	2584.0

Figure B-1 continued

Source: 2000 Washington State Population Survey.

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Figure B-1. Counts of Insured and Uninsured Persons Under 65 in Washington, 2000 (continued)

Characteristic	Uninsured	Insured	Total
Health status			
Excellent/very good	246.3	3401.1	3647.4
Good	180.8	1033.3	1214.1
Fair/poor	57.3	322.0	379.3
Number of workers in the family			
None	119.3	524.9	644.2
One	284.9	2183.6	2468.5
Two or more	80.2	2047.9	2128.1
Employment status of workers in family			
Unemployed or not in labor force	119.3	524.9	644.2
Have access to employer coverage	84.6	3632.3	3716.9
Employer coverage not available	111.9	335.8	447.7
Self-employed	168.6	263.4	432.0
Region			
Clark	20.5	294.0	314.5
Other Puget Metro	116.5	1457.6	1574.1
King	130.7	1427.8	1558.5
Spokane	32.8	332.8	365.6
West Balance	39.4	310.8	350.2
Yakima/Tri-Cities	44.1	328.3	372.4
North Puget	38.4	272.0	310.4
East Balance	62.0	333.1	395.1
Education (for persons 19 and older)			
Less than high school	81.3	232.4	313.7
High school degree	149.0	945.8	1094.8
Some college	91.4	946.8	1038.2
College degree	47.0	1127.7	1174.7

Source: 2000 Washington State Population Survey.

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Figure B-2. Counts of Insured and Uninsured Children in Washington, 2000

(in thousands)			
Characteristic	**Uninsured**	**Insured**	**Total**
All persons under age 19	115.8	1503.7	1619.5
Parent's insurance status			
Insured	30.0	1463.3	1493.3
Uninsured	85.8	40.4	126.2
Family Income			
200% FPL and below	76.0	465.9	541.9
Above 200% FPL	39.8	1037.8	1077.6
Age of child			
Under 6	43.1	490.5	533.6
6-11	30.9	461.3	492.2
12 or older	41.8	551.9	593.7
Family head			
Single female	28.9	268.1	297.0
Single male, or two-parent family	86.9	1235.6	1322.5

Source: 2000 Washington State Population Survey.

Figure B-3. Counts of Uninsured by Insurance Eligibility, Under Age 65 in Washington, 2000

(in thousands)	
Characteristic	**Number of uninsured**
Adults (19 and older)	
Eligible for public coverage	43.9
Eligible for employer coverage	51.4
Eligible for public and employer coverage	11.0
Not eligible for public or employer coverage	262.3
Total Adults	368.6
Children (under 19)	
Eligible for public coverage	73.7
Eligible for employer coverage	7.6
Eligible for public and employer coverage	14.5
Not eligible for public or employer coverage	20
Total Children	115.8

Source: 2000 Washington State Population Survey.

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