

Recent Changes in Health Policy for Low-Income People in Washington

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Overview

Washington is a state with a strong history of progressive social policy. It has been a leader in health reform, with legislation in 1993 that included an employer mandate, an expansion of Medicaid coverage for low-income children and home and community-based coverage for the elderly and disabled, and a major effort to reform its individual and small group insurance markets. The state also expanded enrollment in its Basic Health Plan (BHP), an insurance program for low-income working families. In subsequent years, the state repealed several of these measures. It also enacted a ballot initiative I-601 that constrains state spending growth to inflation plus population increases, less than the rate of growth in per capita income. Today the state is struggling to maintain several of the advances in health coverage it made in the early 1990s.

Medicaid is a major item in the state budget, accounting for 17 percent of state spending (including spending from federal revenues). Medicaid spending is projected to increase by 11.6 percent per year between 2000 and 2003. This is attributable to projected enrollment growth of about 3.6 percent for Temporary Assistance for Needy Families (TANF) families, low-income children, and the aged, blind, and disabled. Managed care spending is expected to increase by about 11.5 percent per year. The state has aggressively controlled payment rates in the past year but realizes that rates will have to increase because of

rising costs faced by managed care plans. Prescription drugs are a major issue in the state, with expenditures expected to increase by about 17 percent per year between 2000 and 2003. Expenditures for hospital and physician care are expected to increase by about 10 percent per year due to a combination of increased enrollment, utilization, and payment rates.

Long-term care spending is not expected to place significant pressure on the budget and is seen as more controllable. Nursing home utilization has been falling as the state has moved more residents into community-based alternatives. Services provided through its Medicaid home and community-based waiver continue to increase. Because of its substantial expansion of long-term care services, the state does not anticipate that the *Olmstead* decision, which requires states to move individuals to community-based settings to the extent possible, will have a major impact.

In 2001 the state faced difficulty passing a budget for the 2002–2003 biennium, in part but not wholly because of health care spending increases. State spending, as noted above, is limited by an expenditure cap. In addition, because of tax cuts in recent years and the slowing of the economy, revenue growth has also been slow. In addition to expectations of rapid increases in health spending, in the November 2000 election voters passed two ballot initiatives to increase spending on teacher pay and to reduce class sizes. In response, the governor made a proposal for cuts in health care

Washington has gone from being a leader among states in health reform to a state struggling to maintain its existing coverage programs.

as well as in other spending. The senate and house passed budgets with alternative strategies that also affected health care. The health care cuts in the various proposals included reductions in dental and vision services in Medicaid, reductions in the BHP enrollment, increases in BHP premiums and copayments, and lower payments to hospitals for indigent care. These proposals were highly controversial and legislators were not able to pass a budget by the close of either the regular or the first emergency legislative session.

In the midst of the deadlock, state officials discovered a way to increase their upper payment limit, or ProShare program, that, as described below, brought in additional federal Medicaid revenues with little increase in state spending. As a result, a budget was passed and the cuts in health care spending were quite limited compared with the proposals that had been considered. There was a small cut in BHP enrollment and small increases in BHP copayments for prescription drugs. In the end, the cuts in BHP coverage will be more than offset by the growth in Medicaid rolls, including new coverage for the working disabled and women with breast and cervical cancer, though the composition of enrollees in the two programs is quite different. In addition, a ballot initiative was passed in November that allowed the state to increase its tobacco tax and use the proceeds to fund additional slots in the Basic Health Plan.

Washington clearly does not envision any significant further expansions of coverage, for example, through extending coverage to parents using Section 1931. The state is seeking a Section 1115 State Children's Health Insurance Program (SCHIP) demonstration waiver to restructure its Medicaid program and use its unspent SCHIP allotment to cover BHP parents through SCHIP. This would increase federal revenues more than expand coverage. Moreover, the maintaining of existing health coverage in the near future will be at the mercy of the budget process. Cuts in health care spending were avoided through tobacco settlement revenues in the 1999–2001 and 2001–2003 bienniums and by the new-found upper payment limit revenues in the 2001–2003 biennium. Thus, the state is essentially solving its budget problems and avoiding health care cuts with one-time "outside" revenues.

At the same time, the health care market in general is under stress. Health care providers in the state have been affected by several years of managed care growth in the private sector, controls on provider payment rates through Medicaid and the state employees' health benefits program, and more recently by Medicare cutbacks. While the greatest problems emanate from Medicare and private insurers, physicians and hospitals are adamant that state spending on health services needs to be increased. But this is inconsistent with the spending constraints imposed by I-601. As a result, the health system for low-income individuals seems to be in a fairly fragile state.

There are also concerns that the recession will lead to a drop-off in employer-sponsored the insurance, and that while Medicaid may pick up some of those losing coverage, there seems to be little willingness on the part of state legislators to further expand the fully state-funded BHP or to take advantage of the coverage options newly available from the federal government. Thus, an economic slowdown could pose significant problems in Washington for insurance coverage, an area where the state has been a national leader.

In the second year of the 2001–2003 biennium, Washington developed a \$1.3 billion deficit out of an approximately \$23 billion budget. The governor considered a range of options for reducing Medicaid spending. In the end, he proposed substantial cuts in reimbursement rates for both generic and brand name drugs and in nursing home reimbursement rates and elimination of interpreter services.

Motivation

The past five years have given states new opportunities in health policy for low-income people, yet also have put new pressures on policy formulation. Many developments increased state flexibility, including welfare reform and delinking of Medicaid from cash assistance, new funding for children's health insurance coverage under SCHIP, repeal of federal minimum standards for nursing home and hospital reimbursement that had con-

TABLE 1. Selected Washington Characteristics,

	Washington	United States
Population Characteristics		
Population (2000) (in thousands) ^a	5,894	281,422
Percent under age 18 (1999) ^a	25.7%	25.7%
Percent Hispanic (1999) ^b	6.5%	12.5%
Percent black (1999) ^b	3.5%	12.8%
Percent Asian (1999) ^b	5.8%	4.1%
Percent nonmetropolitan (1999) ^b	16.7%	20.3%
State Economic Characteristics		
Per capita income (2000) ^c	\$31,528	\$29,676
Percent change per capita income (1995–1999) ^d	16.4%	10.8%
Unemployment rate (2001) ^e	5.8%	4.5%
Family Profile		
Percent children in poverty (1998) ^f	12.7%	17.5%
Percent change children in poverty (1996–1998) ^f	–17.5%	–15.0%
Percent adults in poverty (1998) ^f	8.9%	11.2%
Percent change adults in poverty (1996–1998) ^f	–23.3%	–10.4%
Political		
Governor's affiliation (2001) ^g	Democrat	NA
Party composition of senate (2001) ^h	25D-24R	NA
Party composition of house (2001) ^h	49D-49R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC) ⁱ	78.5%	59.3%
1998 (TANF) ⁱ	72.8%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996 ^{i,k}	200%	124%
1998 ^{i,l}	200%	178%
2000 ^{i,m}	250%	205%

Table 1 notes begin on page 25.

strained states' control over Medicaid payments, and federal willingness to grant waivers under Medicaid (and now under SCHIP). Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support, which was believed to have been abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown and fears of recession. New pressures also arose from the Supreme Court's *Olmstead* decision that detailed a right to home and community-based services under the Americans with Disabilities Act, rapid growth in pharmaceutical spending, and the difficulties faced by Medicaid managed care. Political demands for public action arose from developments such as the rise in uninsurance, growth in private and public managed care, rising pharmaceutical costs, hospital fiscal woes, and from events specific to each state.

To examine how states have responded to both federal constraints and state flexibility during the last half decade, this study of Washington and 12 other states examines state priority setting and program operations in health policy affecting the low-income population.¹ Five major sets of issues are addressed in this set of reports. First, how have the political and fiscal circumstances of the state changed over the last several years? Second, has the state expanded public or private health insurance coverage, through Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has

access been affected by managed care plan withdrawals from Medicaid or backlash against plans by providers or beneficiaries? Fourth, how are states responding to their new freedom to set reimbursement rates, pressures to expand home and community-based services for disabled persons, and the labor shortage? Fifth, what other issues are prominent?

This report on Washington assesses changes and continuities in the last five years, building on an earlier baseline study.² Information came from in-person interviews on-site in early June 2001, supplemented by several telephone inquiries. Interviewees included state officials, provider associations, and other knowledgeable observers. Secondary sources included publicly available documents, newspapers, and Web sites. State officials were given the opportunity to comment on a draft, and changes were tracked through passage of the 2001–2003 biennium budget in July 2001.

Background

Demographics/Insurance Coverage

Washington is the 18th largest state in the nation with a population of 5.8 million and an area of 66,582 square miles. Geographically important is the state's east-west division by the Cascade Mountain Range. There are striking east-west political divisions as well. With several rivers descending from its mountains, Washington has had an inexpensive source of hydroelectric power that drew many manufacturers, such as Boeing, to the state.³ The population west of the mountains is relatively liberal, with a strong union history. A large portion of the population is concentrated in urban Seattle, also home to highly successful businesses such as Microsoft and Starbucks. Much of the land to the east is rural, producing wheat and apples, and the population is politically conservative. The state has 39 counties, of which many are rural. Compared with the national average, there are few racial minorities in Washington, although the state does have a significant Hispanic immigrant population working on the farms of eastern Washington and is home to 26 federally recognized Native American tribes. Both populations present state policymakers with unique health care challenges.

Per capita income in 2000 in Washington was slightly above the national average, \$31,528 versus \$29,676 (see table 1). However, mean income in Washington grew 5.6 percent faster than the national average between 1995 and 1999. While child poverty decreased at the same rate as in the rest of the nation, adult poverty fell 12.9 percent more than the national average between 1996 and 1998. Also, from 1996 to 2000 Washington consistently aided more poor children through cash assistance programs than the typical state.

Washington's uninsurance rate is lower than the national average; 6.5 versus 12.5 percent of children and 12.9 versus 16.3 percent of adults are uninsured (see table 2). Rates of employer-sponsored insurance are close to the national average for both those above and below 200 percent of the federal poverty level (FPL). For those above and below 200 percent of the FPL, the extent of public coverage is higher than average and has contributed significantly to lower uninsurance rates. The uninsurance rate for low-income children is 11.2 percent, versus 22.4 percent for the nation, with the state enrolling a higher percentage of low-income children in public coverage (42.2 percent) than the United States (35.2 percent). Among low-income adults, Medicaid or BHP covers 23.3 percent, versus the national average of 14.7 percent, leading to an uninsurance rate of 29.3 percent in Washington versus 34.9 percent for the nation.

Political Developments

Over the past eight years, Washington has become a more fiscally conservative state, with one of the nation's more stringent state expenditure caps. However, there is also a long history of social liberalism, which is surprising for a state with no income tax. The BHP, a state-only funded health insurance program for the working poor, is extremely popular, and even prior to the enactment of SCHIP, with a higher federal matching rate, the state provided Medicaid to children living at up to 200 percent of the FPL.⁴

TABLE 2. Health Insurance Coverage, by Family Income, Washington and the United States, 1999

	Children (Ages 0–18) ^a (%)		Adults (Ages 19–64) ^b (%)	
	Washington	United States	Washington	United States
Below 200% FPL				
Employer-sponsored	40.1	38.7	38.7	41.7
Medicaid/SCHIP/state	42.2	35.2	23.3	14.7
Other coverage	6.5	3.8	8.7	8.8
Uninsured	11.2	22.4	29.3	34.9
Above 200% FPL				
Employer-sponsored	83.5	85.3	82.0	83.7
Medicaid/SCHIP/state	6.0	3.8	2.1	1.1
Other coverage	6.2	4.9	7.5	5.8
Uninsured	4.3	6.0	8.4	9.4
All Incomes				
Employer-sponsored	69.9	66.7	72.6	72.3
Medicaid/SCHIP/state	17.3	16.4	6.7	4.8
Other coverage	6.3	4.5	7.8	6.6
Uninsured	6.5	12.5	12.9	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

FPL = federal poverty level

SCHIP = State Children's Health Insurance Program

Prior to the 1990s, there was a long history of Democratic legislative and gubernatorial control. Similar to most of the country, the 1994 election saw political power shift toward the Republicans. The Republicans gained control of the house in 1994 and the senate in 1995. The remainder of the 1990s saw changes in political control after several elections.⁵

Today, control over the senate is narrowly in the Democrats' hands, 25D-24R, and the house is split 49D-49R with shared control of the rules and chairmanships. In mid-July of this year, the legislature ended a historically long session, with three back-to-back special sessions,⁶ caused, at least in part, by political gridlock.

The Democratic governor, Gary Locke, who won reelection to his second term last year, replaced the retiring liberal Mike Lowry in 1996. Locke, the first Chinese-American governor in the United States, ran as a fiscal conservative centrist stressing education.⁷ Governor Locke has not emphasized health, making little mention of it in his 2000 and 2001 state of the state addresses and instead focusing on education, crime, transportation, water, and energy.⁸

State budgetary decisionmaking is heavily driven by ballot initiatives. Initiative 601, discussed in detail below, limits state spending. Initiative 695, passed in 1999, reduced state revenues from vehicle registration taxes. Two new initiatives, I-728 and I-732, required increased spending on education but provided no new revenue.

Market Developments

There is a great deal of concern about the health care market in Washington. Private managed care plans and public programs have placed increasing pressure on provider revenues. For state employees, Washington has used a managed competition model in which employees have to pay more if they chose a high-cost plan. As health care costs increased,

the legislature added funds to support state employees. But in general, rising costs mean employees will pay more and have incentives to avoid higher cost plans. Medicaid and BHP have been aggressive purchasers through their managed care programs. Historically, Washington has had low health care costs in comparison with other states. Medicare payment rates have also been low in the state, reflecting the state's low costs.

These factors have created significant financial pressure on providers. Physicians have become less willing to take risks and have been discussing unionization and strikes, demanding higher rates from managed care plans, and pulling out of public programs. Some physicians, reportedly, are leaving the state. Hospitals have the lowest margins they've had in many years; there could be problems with survival for some. Hospitals argue that costs and utilization are low by national standards and that there is little room for improvement. Much of this pressure has allegedly been affecting the safety net hospitals and their ability to provide care to the uninsured.

The state does have a medically indigent program for the uninsured and relatively rich disproportionate share hospital (DSH) programs, though the DSH program has been cut by the federal government. The state also benefits from relatively low uninsured rates. Even those hospitals that serve the poor are faced with relatively few uninsured. Medicaid rolls are projected to increase significantly faster than population growth, though the BHP is expected to contract somewhat.

Washington's efforts to reform its individual insurance market collapsed in 1998 and all the major plans refused to sell to new enrollees. The state enacted legislation in 2000 that partially resolved the problems in its individual market, and several insurers have reopened enrollment.⁹ The state has established a high-risk pool for those who fail a new health screening test but relatively few have joined the pool, raising concerns that the state has solved its private insurance market issues by excluding the sick. At the same time, there seems to be little appetite for any substantial increase in public coverage.

Fiscal Circumstances of the State

As shown in table 3, Medicaid is a significant component of the state budget. Some health spending is included in the "all other" category; for example, expenditures for health insurance for noncitizen children, public health programs, and state employee health benefits. Medicaid accounts for 15 percent of the state general funds and 17 percent of overall spending (which includes federal revenues). Medicaid expenditures are second only to K-12 education and are greater than spending on higher education. Expenditures on Medicaid have increased faster than most other expenditure items; the only significant exception is corrections. When federal funds are included, spending on higher education also increased faster than Medicaid in Washington. Transportation declined because of the movement of these expenditures out of the general fund between 1995 and 2000.

The state has had a strong economy throughout the 1990s. For example, per capita income grew by 16.4 percent between 1995 and 1999 versus 10.8 percent for the United States. Nonetheless, the state is consistently faced with budget crises as it attempts to enact its biennium operating budgets. While attempting to pass the 2002-2003 biennium budget, the 2001 legislative session became one of the longest in state history, with three back-to-back special sessions following the close of the regular session in April.

The perennial budget crises stem from a stringent expenditure cap, I-601, which was passed in 1994 and limits general fund spending growth to a three-year average of inflation and population growth.¹⁰ Additionally, if spending is held below the target the subsequent period's allowable growth rate is applied to the lower amount (i.e., rebasing). Moreover, the inflation rate that is used is based on the national implicit price deflator (IPD), which has tended to rise more slowly than the national consumer price index (CPI) as well as the Seattle CPI. While I-601 holds spending growth to inflation plus population growth, state revenues grow with productivity as well as inflation and population growth. Thus, in most years, including 1996 through 2000, state revenues have grown faster than

TABLE 3. Washington Spending by Category, 1995 and 2000 (\$ in Millions)

Program	State General-Fund Expenditures ^a				Total Expenditures ^b			
	Actual 1995	Estimated 2000	Annual Growth (%)		Actual 1995	Estimated 2000	Annual Growth (%)	
			WA	U.S.			WA	U.S.
Total	\$8,760	\$10,236	3	5	\$16,565	\$22,339	6	6
Medicaid^{c,d}	\$1,183	\$1,518	5	5	\$2,887	\$3,689	5	4
% of Total	14%	15%			17%	17%		
K-12 Education	\$3,937	\$4,644	3	7	\$4,354	\$5,335	4	7
% of Total	45%	45%			26%	24%		
Higher Education	\$951	\$1,228	5	5	\$2,029	\$3,488	11	5
% of Total	11%	12%			12%	16%		
Public Assistance	\$362	\$277	-5	-6	\$662	\$553	-4	-5
% of Total	4%	3%			4%	2%		
AFDC/TANF	\$244	\$189	-5	-9	\$516	\$462	-2	-7
% of Total	3%	2%			3%	2%		
Corrections	\$352	\$559	10	6	\$405	\$722	12	6
% of Total	4%	5%			2%	3%		
Transportation	\$49	\$6	-34	5	\$1,716	\$1,736	0	6
% of Total	1%	0%			10%	8%		
All Other^e	\$1,926	\$2,005	1	5	\$4,512	\$6,818	9	8
% of Total	22%	20%			27%	31%		

Source: National Association of State Budget Officers 1997. *1996 State Expenditure Report*. And 2000. *1999 State Expenditure Report*.

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

Note: Figures may not add to totals due to rounding.

the state's allowable spending, causing surpluses that are then deposited into a rainy day fund.¹¹

The expenditure cap has limited legislators' ability to budget more for the expansion of health and other social programs. While the spending cap has clearly been constraining, the problems facing the legislature have been manageable until recently for several reasons: (1) because of welfare reform Aid to Families with Dependent Children (AFDC) and Medicaid caseloads declined in the mid-1990s before beginning to rebound, (2) there have been lower rates of medical care inflation and the state has benefited from the impact of managed care on health care costs, (3) there has been a slow rate of salary growth for state employees, (4) there were new revenues from the tobacco settlement and ProShare payment programs which have allowed the state to fund some health spending outside of the general fund in the Health Services Account, and (5) contributions to the police and fire-fighter pension fund have slowed because of the stock market.¹²

This year's budget problems are tied to the cap but have also been precipitated by revenue shortfalls. The state does not have a personal income tax, but relies on property, sales, and business taxes for its general revenues, making the state's revenues highly susceptible to economic fluctuations. This year the state faced a downturn in its economy, water supply reduction due to a drought, an energy crisis, and an earthquake. These have caused

increases in emergency spending together with reducing revenues. For a variety of reasons that are described below, health care spending is expected to increase well above the rate of growth allowed by I-601. Finally, the two ballot initiatives requiring the state to decrease class sizes and increase teacher pay will also cause spending increases above the amount allowed by I-601.¹³

Because of the spending limit and the reduced pressure to spend, the legislature found itself in the mid-1990s economic boom with large unspendable state surpluses and enacted several tax cuts that, by 2001, reduced revenue intake to the spending limit.¹⁴ Therefore, this year as the economy slowed and the state was hit with the mix of problems mentioned above, the state found itself with a revenue problem for the first time since the spending cap was imposed.

Health care spending was an early target of the budget cutting. The limits imposed by I-601 affect spending out of the general fund, which includes the bulk of Medicaid spending. The general fund receives revenues from the sales tax, the business and occupation tax, and property taxes. Not all health care is funded out of the general fund. The Health Services Account (HSA) funds the BHP, the state share of Medicaid spending on children living below 200 percent of the poverty level, SCHIP, and the recently enacted Medicaid Buy-In and coverage for women with breast and cervical cancer, and some other smaller public health initiatives. Spending from the HSA is limited by its revenues. The HSA is funded by tobacco taxes, alcohol taxes, premium taxes on insurers, business and occupational taxes, hospitals, ProShare revenues, and tobacco settlement funds. Another major fund is transportation, which pays for road improvements and is funded by a gasoline tax.

Until legislation enacted in 2000, funds could not be transferred from the HSA to the general fund to allow the state to increase spending. In 2000 a revision of I-601 was enacted that said if a program or its revenues were transferred to the general fund the spending limit would increase.¹⁵ This allowed the state to move money from the HSA to the general fund and raise the spending limit. This has helped the state manage its budget and legally stay within I-601's parameters. In 2000 this allowed \$123 million of revenues from the tobacco settlement to be moved from the HSA to the general fund to solve that year's budget problems.

For the 2002–2003 biennium the state faced serious budget problems. Rising health care costs played a major role. State and employee health benefits were expected to increase in the next biennium by 12 percent to 14 percent per year and the BHP costs by 10 percent and perhaps more. Medicaid spending was expected to grow by about 10 percent per year because of increases in managed care rates and rising fee-for-service expenditures for the disabled, principally prescription drugs. Caseload growth is forecasted to be about 3 percent per year and per capita expenditures 7 percent per year. There were other needs outside of health care. State employees sought wage increases, and the two ballot initiatives that required reductions in class sizes and increased teacher pay added \$700 million–\$800 million during the biennium.

There was a general consensus that some cutting of health programs would be inevitable. The budget proposals of the governor, the senate, and the house were all different.¹⁶ All of the proposals incorporated increased spending from the general fund to be used for teacher pay, with reserves to be used to increase spending for school construction. The governor proposed to increase premiums and cost-sharing for the BHP, eliminate Medicaid vision coverage and cut dental care, and reduce reimbursement for care for the medically indigent in hospitals. The senate budget would have increased monthly premiums in BHP and imposed higher copayments for prescription drugs. The house budget would have cut the BHP to 100,000 persons (from 133,000) and increased BHP premiums and cost-sharing. The house would also have created a waiting list for SCHIP, cut emergency room spending on the uninsured, and reduced Medicaid dental services for adults. All would cap SCHIP enrollment and require state employees to pay a higher share of their health benefits. The proposed cuts in health care became extremely controversial and the state was unable to enact a budget.

The solution to the Washington budget dilemma came when state officials discovered a way to expand their upper payment limit, or ProShare, program. Upper payment limit programs work by increasing reimbursements to publicly operated hospitals and nursing homes, collecting the federal match on the higher rate, and having the facilities return a substantial share of the money to the state. The limit on reimbursement rates is set by how much Medicare would pay, thus the term “upper payment limit.” The state’s ProShare payments were made to 14 government-owned nursing homes. The state had been calculating the difference in Medicaid and Medicare upper payment limits for all 267 nursing homes. They used this sum to determine the amount of the enhanced payments that could be made to the 14 nursing homes which would return about half the money to the state. The Beneficiary Improvement and Protection Act enacted by the U.S. Congress in 2000 required states to calculate the difference between the Medicaid and Medicare upper payment limits for just the 14 nursing homes. There was a transition to the lower limits depending on how long the state had used the program; Washington has a three-year transition period, so eventually the use of this mechanism will be phased out.

In the midst of the budget deadlock, the state discovered that if they used the Resource Utilization Group System (RUGS) to calculate what the Medicare upper payment limit would have been, the limit could be increased. With the new methodology, the state would receive more than \$450 million new federal dollars in 2002 and 2003 and retroactive payments for 2000 and 2001. These funds increased the amount of revenue in the Health Services Account, which, because of the new provisions allowing funds to be transferred to the general fund, allowed the state to solve its budget problem.

Because of this newfound revenue and a willingness to use excess pension fund revenue, the house and senate agreed that there would be no cuts in Medicaid and that there would be an expansion of coverage for uninsured women with breast and cervical cancer, as well as for the working disabled through the newly enacted federal Ticket to Work program. Although the governor had proposed a cap on SCHIP enrollment, the final legislation eliminated the cap. The final legislation increased premiums for state employees; there was a consensus across party lines on these increases given that the premiums had not been adjusted for inflation for several years. The two cuts that were made reduced funding to 125,000 as opposed to 133,000 slots in the BHP and increased drug copayments in the BHP. Health care advocates were successful in putting forward a ballot initiative (I-773), which passed and will increase cigarette tax revenue for the Health Services Account and allow the state to expand BHP coverage by about 50,000 slots.

Medicaid Trends

Washington had 722,600 Medicaid enrollees in 1998 and spent over \$3.6 billion on the program. Table 4 provides HCFA data on Medicaid enrollment and spending for 1995 through 1998. The last year for which data was reported in a uniform manner for all states is 1998. More recent data provided by the state is also presented.

Between 1995 and 1998 Medicaid enrollment in Washington grew by 3.3 percent per year compared with an average national decline of 1 percent per year. The number of elderly beneficiaries grew by 4.7 percent per year in Washington while staying virtually constant in the United States as a whole. Most of this growth appears to be driven by non-cash enrollees (not shown). Since noncash enrollees are heavy users of prescription drugs and home care services, the rapid growth in noncash enrollees could be attributable to rising drug costs and to an increased number of elderly becoming eligible to use home care benefits. The number of blind and disabled beneficiaries grew at 1.9 percent per year, roughly half the rate of growth experienced in the rest of the United States.

There was an overall decline in adult enrollment (3.6 percent per year) but an increase in the enrollment of children (6.2 percent per year). Washington, like other states, experienced a substantial drop in cash assistance recipients from 1995 to 1998, 8.8 percent per year for adults and 11.2 percent for children. These are slightly lower than the rates of decline seen elsewhere in the nation. In Washington, only part of the drop in adult cash

TABLE 4. Medicaid Enrollment and Expenditures in Washington, 1998

	Washington, 1998			Average Annual Growth (%), 1995–1998					
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
	Washington	United States	Washington	United States	Washington	United States	Washington	United States	
Total Expenditures	\$3,622	-	-	6.1	3.9	-	-	-	-
Medical Services									
By Eligible Group	\$3,012	723	\$4,168	6.7	5.1	3.3	-1.0	3.2	6.1
Elderly	\$772	53	\$14,469	8.3	4.3	4.7	0.1	3.5	4.2
Blind and disabled	\$1,241	104	\$11,875	8.4	8.5	1.9	3.6	6.3	4.7
Adults	\$437	135	\$3,231	4.0	-1.4	-3.6	-4.4	7.9	3.1
Cash assistance	\$229	70	\$3,265	3.6	-10.4	-8.8	-14.9	13.6	5.3
Other enrollees	\$207	65	\$3,193	4.4	7.8	3.6	9.3	0.8	-1.4
Children	\$562	429	\$1,309	3.2	2.7	6.2	-1.5	-2.8	4.3
Cash assistance	\$218	137	\$1,585	-12.8	-8.8	-11.2	-12.2	-1.8	3.9
Other enrollees	\$345	292	\$1,179	23.4	12.4	21.5	9.8	1.5	2.4
By Type of Service	\$3,012	-	-	6.7	5.1	-	-	-	-
Acute care	\$1,803	-	-	5.2	4.0	-	-	-	-
Long-term care	\$1,209	-	-	9.0	6.5	-	-	-	-
DSH	\$333	-	-	-1.5	-7.3	-	-	-	-
Administration	\$278	-	-	10.9	8.5	-	-	-	-

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Notes: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare. "Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

Figures may not add to totals due to rounding.

enrollment was made up through increases in noncash enrollment. The number of adult cash enrollees dropped by 22.4 million while there were 6.6 million more adult noncash enrollees. On the other hand, there was a net increase in the number of children covered under Medicaid.¹⁷ This is due to the state's expansion of coverage of children living at up to 200 percent of the poverty level and the state's integration of Medicaid with the BHP. As a result, the drop in child cash enrollees was more than offset by the increase in noncash enrollment of children. There was a decline of 58,900 children from the cash assistance rolls but an increase of 129,300 noncash enrollees. While the number of noncash enrollees grew in other parts of the country, the rate of increase in noncash enrollees among children was nowhere near as rapid as it has been in Washington.

Total Medicaid spending grew by 6.1 percent per year between 1995 and 1998 as opposed to 3.9 percent in the United States. Acute care services grew by 5.2 percent per year in Washington and long-term care services by 9.0 percent per year in Washington, versus 4.0 percent and 6.5 percent, respectively, for the United States. The differences in growth between the state of Washington and the United States can be explained by enrollment growth. The growth in spending per enrollee was actually slower in Washington than in the nation, 3.2 percent per year in Washington versus 6.1 percent for the United States. There was a slight drop in spending for inpatient hospital, physician, lab, and X-ray services, but most of this is probably because of increased enrollment in managed care plans (where these services are not reported separately).¹⁸ Managed care spending increased by 10.7 percent per year, a high rate of growth but less than that seen elsewhere. The most notable change in long-term care spending is in home care, which increased by 24.3 percent in Washington versus 14.3 percent in the nation. Washington launched a major home and community-based waiver initiative during this period. The rates of spending growth in nursing facilities and intermediate care facilities for the mentally retarded were relatively low. Disproportionate share payments fell by 1.5 percent on average during the period.

Spending per enrollee in Washington in the aggregate is below the national average for both acute and long-term care services,¹⁹ but this tends to reflect the high proportion of adults and children relative to the blind, disabled, and elderly. Acute care and long-term care spending per enrollee for both the elderly and blind and disabled populations are greater than the U.S. average. Spending on nondisabled adults, principally acute care services, is also higher than the U.S. average, while spending on children is somewhat lower.

The Medical Assistance Administration (MAA) in Washington provided more recent data. The MAA pays for and includes in its data medical care expenditures for TANF populations; children living below 200 percent of the poverty level, including noncitizen children covered under state-only coverage; pregnant women living at up to 185 percent of the poverty level; acute care services for the aged, blind, and disabled; the medically needy; medical coverage for unemployed persons receiving General Assistance grant coverage; medically indigent coverage; and payments made to Medicare for eligible disabled and elderly patients. The Medical Assistance Administration expenditures do not include long-term care, mental health, or substance abuse. The data in table 5 are not comparable to the data in table 4.

Table 5 provides data on projected changes in enrollment and expenditures between 2000 and 2003. The MAA uses different enrollment categories than those in Table 4. Nonetheless, the data do allow us to understand projected trends. For the period 2000 to 2003 the state projects an increase in TANF enrollment over the period of 4.1 percent per year. This is seemingly due to both a rebound from the large drop following federal welfare reform and the slowing Washington economy. The number of aged, blind, and disabled enrollees is expected to grow by 3.4 percent, consistent with demographic projections and new enrollment projected to be generated by the state's large home and community-based waiver program. The number of pregnant women covered under Medicaid is not expected to increase. However, the number of covered children living below 200 percent of the poverty level is expected to grow by 5 percent per year. This is

largely attributable to the indirect effects on Medicaid enrollment from SCHIP applications as well as general outreach efforts conducted by the state and by localities and nonprofit organizations. Overall, enrollment is expected to increase by 3.6 percent per year.

Table 5 also shows that the state anticipates annual Medicaid expenditure growth of 11.6 percent from 2000 to 2003. Spending on the TANF population is expected to increase by 12 percent per year; on a per enrollee basis, growth is expected to be 7.6 percent per year, consistent with projected spending under the state's managed care program, Healthy Options (HO). Spending on the aged, blind, and disabled is projected to increase by 13.4 percent, or 9.7 percent on a per enrollee basis. The aged, blind, and disabled, including dual eligibles (eligible for both Medicare and Medicaid), account for 38 percent of MAA expenditures; of this 41 percent is on prescription drugs. For dual eligibles, prescription drugs are 70 percent of spending. For the aged, blind, and disabled who are not dual eligibles, 28 percent of spending is for prescription drugs. The high reliance on prescription drugs is important because these expenditures are projected to increase by 16.8 percent per year.²⁰ None of the aged, blind, and disabled are in Medicaid managed care; clearly, fee-for-service expenditure growth for this population is a major issue. Spending increases for other populations, on a per enrollee basis, are expected to grow by approximately 5 percent per year.

Health Insurance Coverage

The 1993 Health Reforms

The aftershocks of Washington's efforts to provide statewide universal health insurance in the early 1990s continue to affect health care policymaking in the state eight years later. Although many of the most ambitious 1993 Health Services Act reforms, including the employer mandate, were repealed several years later, other reforms—such as the expansion of the BHP, small group and individual market reforms, and the increased Medicaid eligibility threshold—significantly influence today's health insurance coverage issues.

One major goal of the 1993 reforms was to adequately provide health insurance to the state's working poor residents who often do not have access to employer-sponsored coverage. To accomplish this, the reforms expanded the BHP, a state-only funded health insurance program, from a small pilot project to a program that covered 60,000 individuals statewide by the end of 1995. Administered by the Health Care Authority (HCA), not the

TABLE 5. Projected Growth in Medicaid Enrollment and Expenditures

Eligibility Categories	Average Monthly Enrollees (in thousands)			Annual Expenditure (in millions)			Expenditures per Enrollee
	Active	Forecast	% change	Active	Forecast	% change	% change
TANF	256.7	281.9	4.1	492.9	694.2	12.0	7.6
Aged, Blind, and Disabled	149.0	165.1	3.4	746.1	1,091.6	13.4	9.7
Pregnant Women	21.8	22.0	0.3	177.4	209.4	5.6	5.3
Other Kids	278.5	315.9	5.0	331.2	444.0	10.1	4.9
Medically Needy	13.4	15.8	5.6	71.3	96.4	10.5	4.6
QMBs	4.5	5.0	3.5	1.3	1.7	9.3	5.6
Total	723.9	805.7	3.6	1,820.2	2,537.3	11.6	7.7

Data provided by the state of Washington Medical Assistance Administration.

Data do not include expenditures for long-term care services.

QMBs = Qualified Medicare beneficiaries

state's Medicaid agency, and funded through the state's Health Services Account, the BHP aims to provide health insurance to the low-income working population.²¹ The BHP provides a subsidy to families and individuals earning less than 200 percent of the FPL, with sliding scale-premiums starting as low as \$10 per month. Additionally, the 1993 reforms extended BHP availability to families and individuals earning over 200 percent of the FPL who could enroll without a subsidy but would bear the full cost of coverage. In 2001, about 130,000 people receive coverage through the BHP.

In the individual market, the 1993 health reforms granted protections, such as guaranteed issue, guaranteed renewability, portability, a three-month waiting period for preexisting conditions, and the elimination of individual underwriting.²² Additionally, the health insurance commissioner, an elected official, gained the authority to approve individual market rates. These changes led to adverse selection and rising costs that could not be fully passed on to consumers. Faced with rising costs and unable to increase premiums sufficiently, insurers eventually refused to sell new policies in the individual market.

To further increase coverage of Washington's poor, a third health reform expanded the Medicaid eligibility threshold. Beginning in 1994, Washington extended Medicaid coverage for children living at up to 200 percent of the FPL, which was one of the highest levels nationally at the time. This expansion would eventually reduce the state's receipt of SCHIP funding and shaped the development of its small SCHIP program.

The Basic Health Plan

The BHP is an insurance program aimed at uninsured, low-income working families.²³ It subsidizes coverage of adults and children living at up to 200 percent of the FPL and has allowed others to buy into the plans (unsubsidized), although, as discussed below, this group is now very small. The BHP is fully state funded, though coverage of most children is coordinated with Medicaid and the state receives federal matching funds for them. The BHP is not an entitlement program and its funding is limited by state appropriation. All enrollees pay some premiums and there have been waiting lists at times.

Since 1993, when the subsidized BHP was expanded and the nonsubsidized BHP was created, these two components of the BHP followed divergent courses. When the program was initiated, the two components were linked by the "106 percent rule." An insurer wanting to bid to offer insurance had to do so on both parts and could not charge more than 106 percent of the cost of subsidized BHP for nonsubsidized BHP.²⁴ By 1998, the failing individual insurance market caused adverse selection in nonsubsidized BHP, which dramatically increased costs. As a result, HCA delinked the subsidized and nonsubsidized bidding and pricing to protect subsidized BHP.

Following the separation, subsidized BHP has been successful. Until this year's budget crisis, the legislature maintained funding for 133,000 people.²⁵ Conversely, nonsubsidized BHP has felt the effects of adverse selection and resulting premium increases, and eventually its enrollment plummeted. Today, nonsubsidized BHP only exists in a few counties,²⁶ with approximately 1,400 enrollees.²⁷

Subsidized BHP. After expanding subsidized BHP across the state in 1993, enrollment had grown from 22,000 to 60,000 by 1995. Despite ending all advertising and outreach in 1996, when increased applications forced the creation of a waiting list, BHP continues to enroll as many people as funds permit, with the program's availability spread through word of mouth and by clinics and hospitals. The need for a waiting list was eliminated in May 1998 and it was not until early 2001 that applications again grew slightly faster than the attrition rate. A waiting list has not yet been necessary, as HCA officials temporarily solved the problem by slowing the application process, taking about a month between application and enrollment.

During the 1999–2001 biennium, the legislature approved a BHP budget that was expected to be sufficient to cover 133,000 subsidized BHP members. Because the average subsidized BHP enrollee is slightly older, and therefore more costly, the subsidized BHP enrolls around 130,000 people.

Of the 130,000 BHP regular subsidized enrollees, 101,375 individually pay their premiums, with the remainder receiving financial sponsorship from another source, such as an employer, clinic, or tribe.²⁸ In 1995, the legislature had hoped that by allowing employee sponsorship of BHP, they could increase BHP enrollment to 200,000 people with about one-half receiving financial support from an employer. Unfortunately, few employers enrolled primarily because it was much less expensive to join as individuals. Without the anticipated employer premium, funds were quickly exhausted, resulting in a significant reduction of the 200,000 figure to the current 130,000 level.

The figures above do not include Department of Social and Health Services (DSHS) funded home care workers or the children and pregnant women who are enrolled in BHP but funded through Medicaid. In 1996, home care and personal care workers funded by DSHS became eligible for subsidized BHP at reduced premiums. In 2001, 1,523 home care workers are enrolled. Additionally, children whose parents are BHP enrollees and pregnant women are eligible to enroll in BHP while being funded through Medicaid.

Although Medicaid eligibility does not preclude BHP enrollment, HCA officials coordinate enrollment of eligible children and pregnant women into Medicaid rather than BHP.²⁹ As the Medicaid threshold is 200 percent of the FPL, most children with BHP parents are Medicaid-eligible. To make this system “seamless,” the Medicaid-eligible children are enrolled in a program called BH Plus. BH Plus children receive a Medicaid benefit package with no cost-sharing and are funded with DSHS MAA dollars. However, they are enrolled not in Healthy Options (see the section on Medicaid Trends) but in the same BHP insurance plans as their parents. There are approximately 55,000 BH Plus children. Women in BHP who become pregnant, around 1,000 at any time, remain with BHP insurance plans but are temporarily transferred to Medicaid funding. BHP itself funds very few births.

Although BHP subsidizes individuals with a family income up to 200 percent of the FPL, 36 percent of regular subsidized enrollees earn less than 65 percent of the FPL. The enrollees who receive the greatest subsidies, those earning less than 125 percent of the FPL, compose three-quarters of the total subsidized population. HCA officials estimate that at least 85,000 of the subsidized enrollees are not eligible for Medicaid, often due to Medicaid’s assets test.³⁰ BHP does not have an assets test, so there are no restrictions on home or vehicle ownership.

Nonsubsidized BHP. The delinking of subsidized and nonsubsidized BHP pricing in 1998 sent the nonsubsidized program into a death spiral.³¹ Premium costs, which were no longer tied to the subsidized program, significantly increased. Healthy individuals able to find insurance elsewhere left nonsubsidized BHP, causing the insured pool to be smaller and sicker. This adverse risk selection forced January 1999 premiums to rise by 61 percent over the 1998 rates, and a large number of enrollees dropped coverage. Enrollment plunged again in January 2000 when HCA officials, attempting to preserve the subsidized market, did not require insurers to bid on both parts of BHP. Due to the high cost and few enrollees, most insurers opted not to bid on nonsubsidized BHP and nonsubsidized enrollment remained open in only a few counties. In 2001, there are only a little more than 1,400 people covered by nonsubsidized BHP.³²

BHP contracting with Managed Care. The provision of BHP services annually occurs through competitive contracting of insurance companies on a county-by-county basis. For subsidized coverage in 2001, BHP contracted with nine plans. At least two different plans are operating in 27 counties, and there is only one, the Community Health Plan of Washington, in 12 counties. From 1998 through 2001, BHP, Healthy Options, and state employee insurance used the same bidding mechanism and process, but insurers competed separately, allowing for differences in contracted insurers and service areas. For example, Kaiser and Regence were available only in BHP, not HO. The HCA does not negotiate rates for BH Plus children. By accepting a BHP contract, the insurer must accept the HO (or Medicaid) negotiated rate for the BH Plus children. For example, in 2001 Regence was excluded from HO; however, by contacting the BHP, it accepted the HO payment rates for BH Plus children.

Costs and Benefits. In 2000, it cost \$145.90 per month to insure a subsidized BHP enrollee.³³ The benefit package includes emergency care, hospital, office visits, preventive care, obstetrics and well-baby services, organ transplant, and chemical dependency or mental health treatment. There is also a prescription drug benefit. Drug copayments, recently increased in the final budget compromise, vary by type of drug, with a \$3 copayment for generics, \$7 for on-formulary brand names, and a 50 percent copayment for all off-formulary drugs. Vision, dental, and physical or occupational therapy are not included in the BHP package. There is a \$10 copayment for office visits, \$100 for hospital admissions, and \$50 for emergency room visits. Last year cost growth was 12 percent and officials are forecasting similar growth this year.

The Individual Market

The 1993 Health Services Act placed some of the nation's tightest regulations on the individual insurance market.³⁴ The most important changes were that the 1993 legislation mandated guaranteed issue and renewability and a three-month limit on waiting periods for preexisting conditions. It also required portability—that insurance be carried over from job to job. The insurance commissioner, an elected official, was authorized to approve premium increases.

Not surprisingly, guaranteed issue and a three-month waiting period for preexisting conditions proved to be an invitation to adverse selection and, combined with restrictions on premium increases, resulted in losses for health plans. Health plans responded by offering different benefit packages, some not including maternity care and prescription drug coverage. This segmentation of the market allowed the plans to reduce premiums to those not wanting those benefits but increase the cost of the plans with those benefits. These changes were not adequate to stop insurer losses.

By November 1998, only three plans (Premera Blue Cross, Regence Blue Shield, and Group Health Cooperative) remained in the market, and these only served roughly half of the counties.³⁵ Most of the counties in the rural eastern part of the state had no insurers. In December, Premera Blue Cross, which had 60 percent of the individual market, stopped selling new policies, blaming the effects of the insurance reforms.³⁶ By December 25, 1998, Group Health Cooperative and Regence Blue Shield also dropped out of the market.³⁷

Legislation enacted in 2000 extended preexisting condition waiting periods from three to nine months.³⁸ It also removed the commissioner's rate-making authority and required all comprehensive plans to offer maternity and drug benefits. It called for the development of a health care screening instrument intended to result in plans being able to screen out the 8 percent most costly applicants. This population was then to have access to the Washington State Health Insurance Plan (WSHIP), which provides a very comprehensive benefit package at premiums equal to 125 or 150 percent of individual market rates depending upon whether the WSHIP enrollee chooses a managed care or indemnity product. The legislation required a minimum 72 percent loss ratio. If the loss ratio fell below 72 percent, plans had to give a refund.

As a result of these changes carriers came back in, and there is now private coverage in all 39 counties, though in 10 rural counties there is only one plan. One concern is that rates in the individual market have not fallen much. Plans seem to have developed rates for the new enrollees based on their experiences with existing enrollees. Those who have stayed with individual coverage because of guaranteed renewal have gotten older and presumably are sicker. These rates are relatively high, and rates for new enrollees are averaging 80 percent of current premiums in the individual market.

Since the screening program began in January 2001, 21,683 individuals have been screened; 1,448 were rejected.³⁹ Of these, only 240 have enrolled in WSHIP. The remainder of WSHIP's 2,171 enrollees are those who have stayed in the pool even after it was closed to new enrollees. State officials are not sure why only 240 of the 1,448 rejected have signed up with the risk pool, but it is a considerable concern. Rates in the individual market have

remained high as indicated above. This could reflect the underlying rise in health care costs but also could reflect the absence of competition in the health care market.

State Children's Health Insurance Program (SCHIP)

Washington established a separate SCHIP program, called CHIP, for non-Medicaid-eligible children living between 200 and 250 percent of the poverty level. The state uses the Medicaid benefit package and charges copayments (\$5 for office visits) and premiums (\$10 per child per month premium; \$30 family maximum per month).

Medicaid and SCHIP, both administered under the DSHS MAA, have a joint Medicaid-SCHIP application with self-declaration of income.⁴⁰ The state has incorporated innovative mechanisms to ensure coverage of eligible individuals who apply. Both programs use the same income-counting methods, and an in-person interview is not required. This, along with their already high Medicaid eligibility levels, has resulted in a large Medicaid spillover effect, with 70 to 75 percent of those applying for SCHIP eligible for Medicaid. The state also has seen a significant growth in its Children's Health Program, which provides medical coverage to noncitizen children in households living below 100 percent of the poverty level.

Washington's SCHIP implementation occurred in 2000, later than most states. The state's reluctance to participate in SCHIP stemmed from its inability to obtain enhanced matching funds for children living below 200 percent of the FPL because they were already covered under Medicaid.⁴¹ Similar to Minnesota and Vermont, the state felt it was unfairly penalized by not receiving the enhanced SCHIP match for children eligible for Medicaid due to the 1993 reforms, which resulted in the state already covering children living at up to 200 percent of the poverty level by the time of the SCHIP legislation. As such, in 1997, SCHIP was viewed unfavorably and was not seen as a major funding source. In 1998, SCHIP bills were introduced, but never advanced from committee. By 1999, the state passed legislation to develop a Medicaid look-alike program with some cost-sharing for children living at 200–250 percent of the FPL.

Initially, the state used the same contract and the same type of bidding process as is used under Medicaid but had a separate bidding process for SCHIP. However, insurers had little interest in bidding for SCHIP because the target population was so small, and there were concerns over adverse selection. Consequently, SCHIP does not offer statewide managed care coverage, and about 50 percent of enrollees are fee-for-service. Beginning with the 2002 bidding, SCHIP and Medicaid children will be combined. Because the state did not receive SCHIP funding for children living below 200 percent of the poverty level, the state spent only \$2.2 million of the \$46.7 million FY 1999 allotment.

Other

The state established a children's health program (CHP) in 1990 with state funds. Soon thereafter the state expanded coverage under Medicaid using Section 1902(r)2 to children living below 200 percent of the poverty level. However, this Medicaid expansion did not include children who were not citizens. The state maintained the Children's Health Program to cover noncitizen children living at up to 100 percent of the FPL. There are now slightly more than 15,000 children covered under this program. Enrollment is expected to exceed 20,000 by 2003.⁴²

In late 2001 Washington also submitted a Section 1115 waiver proposal to CMS, which if granted would reduce outlays and increase federal matching funds. Under the waiver proposal the state would impose premiums on children and pregnant women with incomes above 100% of poverty, up to 5% of income, shift BHP parents into SCHIP, obtain the higher SCHIP match and make use of the state's SCHIP allotment. The state has asked for authority to impose cost sharing on optional services for all mandatory eligibles and on all nonpreventive services for optional groups, as well as authority to cap enrollment for all optional eligibility groups in Medicaid. It appears unlikely that CMS will approve this waiver in its current form.

Acute Care Issues

Managed Care

As of June 2000 there were 430,000 enrollees in the Healthy Options plan, Washington State's Medicaid managed care program. This is about 60 percent of Medicaid enrollees. Premiums paid to managed care plans were \$630.1 million in 2000 and were expected to increase to \$876.7 million in 2003, an increase of 11.5 percent per year. Per enrollee costs are expected to increase 8 percent per year.

Only TANF families and other nondisabled adults and children are in Medicaid managed care. Washington had attempted to enroll the Supplemental Security Income (SSI) population in managed care in eastern Washington. Managed care for the SSI population failed because of several factors, including a major withdrawal of health plan coverage in eastern Washington, a consolidation of health carriers, the fact that new enrollees entered with pent-up demand, and reportedly inadequate rates.⁴³ The experience led to widespread questioning of the managed care plan in general, particularly the adequacy of rates. The low Medicaid rates for the SSI population reportedly resulted in plans being more aggressive politically and in challenging rates on the general Healthy Options population.

In 1997 the state initiated a competitive bidding process. If plans were deemed qualified, they could continue to bid for coverage the next two years: 16 plans received contracts, 8 in Seattle. Plans were expected to submit new bids each year. The state was not aggressive in excluding plans and the rates were thought to be adequate, if not generous. In fact, in the Urban Institute's capitation rate survey, the rates in Washington were above average compared with those in the rest of the country.⁴⁴ Despite 7 percent increases in rates each year, plans reportedly lost money on the basis of the rates that were bid and/or negotiated in 1998 and 1999. In 2000 they negotiated a 12.9 percent rate increase.

Individuals who do not select plans are automatically assigned to one. Washington has auto-assigned these enrollees to the plans with the lowest bids. The lowest bidding plan gets 60 percent of the auto assignees, the second lowest 30 percent, and the third lowest 10 percent. The problem is that those who are auto-enrolled are thought to be difficult and high-cost beneficiaries. To compensate, the low bid plan submits a high bid with the result that another plan becomes the low bid plan, and consequently there is a large amount of shifting of enrollees between plans.

Plans were also strongly encouraged to contract with the BHP if they wanted to participate in HO. However, the BHP was having problems in the late 1990s that affected the attractiveness of the HO market. Following the collapse of the individual insurance market described above, plans began to leave the market and individuals who needed insurance began to enter the BHP. In 1996 the state closed its high-risk pool to new enrollees, many of whom also entered the BHP. Because of this adverse selection, the rates of plans participating in BHP became increasingly inadequate. In 2000 the state allowed plans to participate in Healthy Options without having to participate in the BHP.

Most of the plans in the Washington Medicaid managed care market are local; national plans have not made big inroads.⁴⁵ The dominant plans have been Group Health Cooperative of Puget Sound (now affiliated with Kaiser Permanente), Primera Blue Cross, and Regence Blue Shield. The other key plans are the Community Health Plan of Washington (organized by the community health centers) and Molina (which purchased QualMed).

In 2001 the state went through a new competitive bidding process and was able to achieve a much smaller increase in rates—the average rate increase was 3.5 percent in 2001 over 2000. In the previous three years it had been 7 percent, 7 percent, and 12 percent. However, as part of the competitive bidding process, Regence Blue Shield and Kaiser were excluded because of their high bids. Other plans dropped out of specific counties. The state believed that it would save \$90 million relative to what rates would have been. Out of 430,000 people enrolled in Healthy Options, 130,000 were reassigned because of the exclusion of these two plans and the exit of plans from several counties. The state

acknowledged that it had saved quite a lot of money and that 3.5 percent rate increases were not sustainable.

Plans in the state are facing great difficulties in attracting physicians, are having a much harder time negotiating with hospitals than in the past, and are facing higher drug costs. For at least the next several years, the state does not intend to use either a managed-competition model or its 2001 model. Instead, it will set rates to reflect an aggregate target rate of increase with adjustments for geographic differences in need. The state is also implementing a system that adjusts for risk borne by different plans as determined twice a year based on encounter data. Rates will no longer be determined by plans' bids but rather plans will choose whether or not to accept the state's risk-adjusted offer. For 2002–03 the rates will go up by 8 percent per year. Based on initial response from plans, this approach appears to have stabilized plan participation and expanded coverage. Regence will be returning, Group Health Cooperative will be expanding back into other counties, and other carriers are willing to expand into additional rural areas.

Prescription Drugs

Prescription drug costs are high and increasing rapidly in the state. The Medical Assistance Administration projects that drug spending will increase by 16.8 percent between 2000 and 2003 or about 13 percent over and above enrollment growth. The state reimburses pharmacists at 89 percent of the average wholesale price, more or less in line with policies in other states. The state participates in the federal drug rebate program, which provides the state with rebates from major manufacturers in exchange for offering all their drugs. In this year's legislative debate, the government sought to control drug spending by various means; most initiatives were defeated, attributed by many to heavy lobbying from drug manufacturers. The state sought authority to develop a prior authorization program for drugs with therapeutic equivalents, that is, all drugs in a class that are deemed equally efficient. The state would bargain and would identify drugs with the best price and require prior authorization for others. This was defeated. The legislature also did not adopt policies to reduce payments to pharmacists. However, the legislature directed MAA to achieve a 3 percent savings in program expenditures through various cost containment and utilization initiatives.

In response to the worsening economic outlook, in January 2002 the Administration has again proposed to cut drug reimbursement rates. There is also renewed interest in a joint formulary that would be used by state employees, BHP, and other non-Medicaid state purchasers. Physicians not accepting the formulary would be subject to extensive prior authorization. In the current fiscal environment opposition to this approach is weakening.

Hospital Payments

The hospital payment system is a diagnostic-related group–based system and rates have been increasing by about 5 percent per year. Hospital expenditures are expected to increase by 9.8 percent per year between 2000 and 2003.⁴⁶ Hospital margins are quite low in the state and hospitals are concerned about rates of payment. The state has reduced the burden on hospitals through its medically indigent program (for the uninsured) and its General Assistance for the Unemployed (GAU) program (a program for the temporarily disabled). Both pay hospital bills for people who are otherwise uninsured, though both programs pay hospitals less than their full costs. The state also has a relatively large DSH program. While this has been scaled back in recent years because of the Balanced Budget Act, it is targeted to those hospitals that provide a large amount of care through Medicaid. DSH payments are projected to fall from \$240 billion in 2000 to \$193.3 billion in 2003. Hospitals are greatly concerned about these reductions because they are on top of the larger pressures coming from Medicare and private payers.

Physician Payments

Physician payments are expected to increase from \$184.9 million in 2000 to \$247.9 million in 2003, or an annual rate of increase of 10.2 percent. The 10.2 percent reflects enrollment growth as well as rate increases and additional utilization—per capita physician expenditures are anticipated to increase about 6 percent per year. Since these are fee-for-service expenditures, this largely reflects the anticipated experience of the aged, blind, and disabled population. Medicaid rates are low relative to Medicare except for primary care services and maternity. For example, a recent report on primary care physicians conducted by the University of Washington concluded that Medicaid payment rates, both fee-for-service and through Healthy Options, averaged 86 percent of Medicare rates.⁴⁷ They also found that fee-for-service rates for services used by children averaged 92 percent of Medicare rates, while services more likely to be used by adults averaged 60 percent of Medicare rates.

Issues in Long-Term Care

Long-Term Care for the Elderly, Mentally Ill, and Developmentally Disabled

Washington has been known as a leader and innovator in long-term care services due to policy initiatives to shift Medicaid recipients out of nursing homes and expanded care options in community-based settings. Leaders in Washington continue to support and expand these shifts for the elderly and persons with mental illnesses and developmental disabilities. However, as new care settings, such as adult family homes, assisted living facilities, and board and care homes, take on a larger share of long-term care recipients, concern has grown about the quality of care given in these facilities and the level of regulation necessary to ensure quality. In addition to regulation of facilities, there are concerns regarding training standards and wage levels for aides working in community-based facilities.

In 1999, the Supreme Court ruled in *Olmstead v. L.C.* that inappropriate institutionalization was discriminatory against people with disabilities and illegal under the Americans with Disabilities Act. However, Washington began transitions to the community much earlier and the *Olmstead* decision is not viewed as having major consequences for the state. In 1993, Washington legislators enacted legislation promoting home and community-based care and mandated that nursing home residents with fewer needs be moved into community settings. The state has also limited the growth of nursing home services with certificate of need requirements.

Washington's long-term care system provides a diversity of services to the elderly and younger people with disabilities. The supply of institutional services and community-based services in Washington is far more balanced than the national average. In 1998 Washington had 285 nursing facilities housing 27,204 nursing home beds. This represented 41.7 beds per 1,000 people age 65 and over compared with the national average of 52.5 beds per 1,000 people age 65 and over. This relatively low supply of beds results from recent declines in nursing home beds over the past decade. The number of beds has decreased by 1,432 since 1989, with a significant portion of this decline occurring in recent years; 570 beds were lost between 1997 and 1998.⁴⁸

While the number of nursing home beds has decreased, the supply of nonmedical residential facilities, such as family homes, boarding homes, and assisted living facilities, has increased. In 1998 there were 32,080 beds in nonmedical facilities, representing an increase of 2,470 beds from 1997. There were 49.2 beds per 1,000 people aged 65 and over in non-medical residential facilities. This ratio is far greater than the national average of 25.5 beds per 1,000 people aged 65 and over.⁴⁹

Medicaid, including Washington's home and community-based waiver services, funds a significant portion of the long-term care received in the state. Of all nursing facility residents, 63 percent depend on Medicaid to pay for their care.⁵⁰ While the supply of nursing facility beds has declined in recent years, a large portion of total public expenditures on long-term care is still devoted to paying for care in nursing facilities. Of Washington's \$777

million spent on long-term care in fiscal year 2000, 61.7 percent of these funds was paid to nursing facilities, while the remaining 38 percent was spent on community-based services.⁵¹

Medicaid is a main payer of home and community-based services in Washington, indicating the significant role state funding priorities have had in shaping the long-term care system. Washington has two major Medicaid programs providing home and community-based services to the elderly and persons with disabilities: the Medicaid personal care benefit and the Community Options Program Entry System (COPEs), Washington's home and community-based services waiver. Washington also has a small state-funded program, the Chore program, that provides personal care and volunteer homemaker services to those with incomes and assets that exceed Medicaid eligibility levels.

Olmstead

The *Olmstead* decision affected long-term care policymakers across the nation in 1999, requiring that state long-term care programs make reasonable efforts to place Medicaid recipients in the least restrictive settings possible. Strictly enforced, this policy would require many states to restructure their long-term care system away from institutional settings in order to make more community services available. However, due to Washington's history of policies concentrating on home and community-based care, the *Olmstead* decision did not shift the state's policy direction.⁵² Washington has looked to community-based care as a route to decreasing long-term care costs since the early 1990s, especially with the pressure of cost-containment measures such as Initiative 601. Strong political support and funding of home and community-based services fueled the increasing numbers of adult family homes, boarding homes, and assisted-living facilities in the 1990s while restrictions on nursing home growth and payments constricted supply of institutional services.

Given the shifts in the long-term care system for the elderly and younger people with disabilities in recent years, it is unlikely that the *Olmstead* decision will significantly alter the state's policy direction. However, the state had made fewer efforts to revise the long-term care system for persons with developmental disabilities before *Olmstead*. Currently, there are fewer community services in place for this population, and large institutions still care for many individuals. In February 2001, Governor Locke proposed a plan to move residents out of psychiatric hospitals into community-based facilities by cutting \$32 million in funding for the hospitals over two years. Critics balked at the plan, asserting that community facilities do not currently have the capacity for such large transitions.⁵³ Some also question whether community services are adequate for individuals who are institutionalized because they have been deemed dangerous to themselves or other people.

Boren Amendment

The Balanced Budget Act (BBA) of 1997 repealed the Boren Amendment allowing states to design more flexible nursing home payment schemes that were no longer tied to quality standards. Washington has made some changes to its payment system since the enactment of the BBA in reaction to cost-containment strategies for nursing home expenditures enforced throughout the 1990s. Washington used a facility-specific prospective payment method beginning in 1980. A patient-specific case-mix system was implemented in 1999.⁵⁴ The payment systems seem to have slightly decreased the growth in nursing home expenditures over the years. The Washington Health Care Association reports that increases in payment rates since 1997 have been consistently lower than the increases allowed for inflation and population growth through Initiative 601.⁵⁵ While nursing home representatives have expressed frustration over low reimbursement levels, average payment rates of \$116 per day in 1998 were above the national average of \$96.⁵⁶ The problems the state faces are that (1) with declines in nursing home usage, acuity is increasing and (2) workforce shortages are forcing wage increases that ultimately need to be reflected in rates. While state officials believe the rate-setting system is sensitive to these issues, nursing home officials

argue that rate increases are not keeping up with cost growth and that Medicaid rates were only 81 percent of costs in 2000, falling from 95 percent in 1995.⁵⁷

Washington has limited the supply of nursing home beds in order to fulfill cost-containment goals for nursing facility services. Washington has required a certificate of need (CON) for nursing facilities since 1978. There also has been a CON requirement for the conversion of hospital beds to nursing home beds. Currently, the CON target ratio of beds to population is lower than the supply of beds in institutions. A bed-banking policy further limits the number of available nursing home beds by allowing nursing homes to sell the rights to beds when facilities close and providing incentives to convert nursing home beds into assisted-living beds. However, “banked” beds are still used in the calculations to determine the supply of nursing facility beds.

Washington, like the rest of the country, has struggled to fill the increasing number of positions available for long-term care providers due to a period of low unemployment rates combined with the low wages these workers typically receive. While a general shortage of registered nurses has made recruiting skilled staff difficult, attracting lower skilled aides has been an even more acute problem. One stakeholder reports that some nursing facilities have nearly complete turnover of aide staff in six months.⁵⁸ There were concerns that the problem of the shortage of aides could not be solved with current nursing home rates, and the legislature has been unwilling to make significant adjustments.

There have been concerns raised recently over the quality of care delivered to the elderly and people with disabilities. Much of these concerns have focused on home and community-based services, which have grown significantly in recent years, and stakeholders believe that quality assurance mechanisms have not been sufficient to regulate this new industry. Costs are tightly controlled, with limits on the hours of care provided, linked to patient assessments, and on hourly payment rates to independent providers and to home care agencies. There were concerns about the quality of care provided by low-paid home care workers. There were also concerns about the quality of care in assisted living facilities with personal care services provided by nonprofessionals with very little case management and little access to nurses.

Other Issues

Prescription Drugs for Seniors: The AWARDS Program

With the federal government slow to act on the politically difficult issue of prescription drug costs, states have begun to pass various forms of relief programs for seniors. Bypassing the legislature, the governor established the Washington State Alliance to Reduce Prescription Drug Spending, the “AWARDS” program, by executive order on August 24, 2000.⁵⁹ AWARDS is not a prescription drug insurance program, but a prescription drug “buyers’ club.” Similar in concept to SAM’s or Costco, seniors pay \$15 a year (or \$25 per family) to join the program and then may purchase reduced-price drugs as are already provided to state employees through Washington’s Uniform Medical Plan. Upon the program’s announcement, Governor Locke’s officials claimed seniors would see a 15 percent to 49 percent reduction in drug costs, with an estimated 15,800 participating seniors.⁶⁰

On January 5, 2001, the Coalition for Affordable Prescriptions for Seniors, a group mostly representing pharmacists, filed a motion to stop the implementation of the AWARDS rules as established by the Department of Health.⁶¹ The Coalition claimed that drug prices were not renegotiated with manufacturers prior to seniors entering the program, yet pharmacists continued to pay the same wholesale drug costs. Therefore, they argue, any “savings” seniors see would come solely from reducing pharmacists’ revenues, as seniors who used to pay full price were now granted discounts. In the motion, the Coalition made two claims. First, they claimed that the regulations passed did not follow the intent of the executive order, which explicitly stated that drug prices would be negotiated with manufacturers, and that no negotiations were planned. A judge denied this motion in mid-January, and at the beginning of March, the state began enrolling seniors. In its second claim, the Coalition challenged the Health Care Authority’s statutory authority

to implement the AWARDS program. On May 25, a state court judge agreed and struck down the program.

Patient Bill of Rights

The Washington Patient Bill of Rights has been touted by bipartisan government officials in Washington as a concrete step in an age of managed care toward creating a balance between providing quality health care and containing rising health care costs. It has also been lauded for its objective of shifting health care decision-making power from insurance carriers back into the hands of patients and doctors. As a result, the Patient Bill of Rights and its goals of managed care accountability and enrollee protection have generally received strong political support from both political parties and from grassroots activist organizations in the state of Washington.

The key concepts of the Patient Bill of Rights are insurance carrier accountability and patient protection.⁶² To achieve this, whenever a dispute arises over the potential denial of care in Washington, the bill makes provision for a speedy internal grievance process that is provided by the insurer and that conforms to standards set by the Washington State Office of Insurance Commissioner. Insurers are required to give consumers notice of any decision to deny, discontinue, or limit a health service. In addition, health insurers are held to the same standards of care and practice as doctors and other health care practitioners and can be held accountable for harm proven to be directly caused by a failure to follow this standard of care.⁶³ It is also the insurers' obligation to provide assistance for enrollees who want to file complaints and to investigate and resolve grievances in a timely manner.⁶⁴

Consumers who are ultimately denied specific services have the right to seek an independent third party review. In these cases the insurer must pay for the independent review, but enrollees have to first exhaust all internal complaint processes before requesting this review. At this stage, carriers have three days to provide all relevant information to the independent review organization, which has broad authority to review and override an insurance plan's medical necessity standards.⁶⁵ Although the decisions of the independent review are binding, if an enrollee remains unsatisfied, the Patient Bill of Rights provides consumers the option to sue their health insurers. This provision was perhaps one of the most contentious components of the bill. Insurance providers claimed that the potential increase in litigation would inevitably drive up insurance premiums for all enrollees and potentially increase the number of uninsured individuals in Washington.⁶⁶ Several key legislators successfully countered that these were "alarmist charges" that could not be proven with evidence from other states with similar legislation.

In an effort to facilitate informed decisions in the purchase of health insurance products, Washington's Patient Bill of Rights also makes provisions for the disclosure of health plan benefits, including exclusions. The bill requires that insurance carriers provide a copy of the drug formulary and policies regarding coverage of drugs, definition of medical necessity or other coverage criteria, explanation of benefits, privacy, grievance, and cost-sharing. Finally, a central component of Washington's Patient Bill of Rights is to ensure that enrollees must have adequate choice among health care providers. The insurance commissioner states that "adequate" will be "determined in part by both the geographic service area and the enrollee demographics."⁶⁷ Consumers are given the right to be referred to specialists when specialty care is warranted, and to obtain a second opinion. In addition, primary care providers must be permitted to continue seeing patients for up to 60 days following termination from a health care network.⁶⁸

Finally, the legislation has provisions that protect enrollees from unneeded invasions of their privacy. Health care carriers are prohibited from releasing personally identifiable health information unless it is authorized in writing, unless it is required for public health purposes, or unless it is covered by existing privacy laws applying to health information.

Conclusion

Washington will confront many difficult issues in the near future. It seems inevitable that health care spending through the state employees' plan, Medicaid, and the BHP will place ongoing pressure on the state budget. State spending will be limited by I-601, although the state recently has found ways of transferring funds from other sources to alleviate the constraints from I-601. But these transfers require new revenue sources. Thus state spending is also limited by the growth in state revenues, which in turn are dependent on the growth in the state's economy.

In the last two budget cycles the state solved its fiscal problems through tobacco settlement revenues and increased use of upper payment mechanisms. Neither of these will be available in the future to enhance state revenues. In the past budget cycle the state avoided significant cuts in the BHP; they may not be able to do so in the future. The state will be able to use new tobacco revenues to expand the BHP but is unlikely to enact further coverage expansions absent any new federal legislation. Washington has gone from being a leader among states in health reform to a state struggling to maintain its existing coverage programs.

The state faces other problems that have fiscal implications. Providers, primarily physicians but also hospitals, have been frustrated with years of constraints on rates through private managed care, Medicare and Medicaid policies, and the managed competition policies of the state employees' health plan and the BHP. Physicians are increasingly unwilling to accept risk and to participate in managed care plans. Hospitals have also been aggressive in seeking financial relief from the state. The state seems likely to face great difficulty in controlling costs through limits on managed care or fee-for-service payment rates.

The state will also have to confront the issues of shortages of nurses and home care workers. The problem is well-known in the state, but the legislature has not responded by increasing rates (the state is now proposing to reduce them) that would allow nursing homes and home care agencies to increase payment rates and alleviate workforce shortages. It is not clear how long this problem can be allowed to continue.

Finally, the state faces problems with its individual insurance market. Reforms enacted in the early 1990s led to adverse selection and the exit of plans from the individual market. It was the intent of the legislation that those people failing the screenings would join the state's high-risk pool. To date, most of those who have been screened out have not joined the pool. Thus, it seems that the state essentially solved its problems in the individual market by excluding the sickest. The state will eventually have to confront this issue. In sum, the state has been a leader in health reform but will face serious problems in the near future if it is to sustain its achievements.

Endnotes

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