An Urban Institute Program to Assess Changing Social Policies

Health Policy for Low-Income People in Washington

Len Nichols
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State Reports

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**About the Series**

*Assessing the New Federalism* is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments, along with changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation’s population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the
dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-recourse safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of Assessing the New Federalism will include studies of the variation in policy choices made by different states.
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Highlights of the Report

Washington is proud of its long tradition of guaranteeing access to health care for most working and nonworking residents. Its Medicaid program is more generous than most in terms of income eligibility and the set of benefits covered. Washington is pragmatic about its service generosity, however: Medicaid benefits paid per beneficiary are slightly lower than average. Washington also supports a number of state-only health programs, including a large, subsidized health insurance program targeted specifically to the working poor and near poor. In addition, Washington has implemented health insurance reforms designed to improve access and affordability in both the group and the individual markets. Finally, Washington is in the forefront of using organized state purchasing leverage and regulatory authority to establish standards and to monitor health plan quality performance as the health care system evolves.

By virtue of these efforts, Washington’s rate of health insurance coverage of the nonelderly is high by national standards, and the state also compares favorably across a broad array of health status and outcomes indicators. These measures reflect generous Medicaid eligibility and successful outreach, the non-Medicaid health insurance subsidy program, a strong economy and a higher than average degree of private coverage, and a well-functioning health care safety net for the remaining uninsured.

Summary of Findings

Washington has been a leader in trying to fashion a bipartisan path to universal coverage and health reform at the state level. In 1993, it passed comprehensive legislation with employer mandates and substantial insurance reforms,
among other politically controversial techniques for achieving universal coverage and health care cost control. In 1995, the employer mandate/universal coverage core of that law was repealed, but important elements remained in place and are now being implemented. Preceding and remaining steadfast throughout that debate was Washington’s commitment to low-income populations. Medicaid eligibility for children and the non-Medicaid health insurance subsidy program for the working poor were both expanded considerably.

In some ways, state politics and important participants in the health care system are still reacting to the passage of comprehensive reform and the abrupt retreat from its implementation. The health and fiscal policy issues inherent to this debate figured prominently in both the 1994 and the 1996 elections, when Washington voters expressed a preference for a more limited role for government by electing a Republican majority, first in the House (1994) and then in the Senate (1996). The political reversal was not complete, however, as the newly elected governor is a Democrat. Perhaps more important, the preference for smaller government was concretely expressed through a ballot referendum that passed in 1994. Initiative 601 constrains the rate of growth of total state spending out of the general fund to inflation plus population growth. It remains to be seen exactly how this will affect health programs specifically, but it is clear that recent historical growth rates, especially for Medicaid but also for other health programs, cannot be sustained if the 601 constraints are to be satisfied across the board. Still, the new Washington legislature passed financial protections for many immigrants whose benefits were cut by federal welfare reform in a continuation of their bipartisan progressive tradition.

Many states are looking to newly discovered market efficiencies to help reconcile health policy goals with fiscal constraints. Although Washington did not originally set out to save Medicaid money through managed care, that has now become an important goal. Washington’s Medicaid program has proceeded on schedule with its pre-comprehensive reform plans to shift nondisabled adults and children into managed care plans (around 400,000 beneficiaries). It currently plans to move the disabled population (another 70,000) into managed care by 1999.

The non-Medicaid health insurance subsidy program, the Basic Health Plan, has 195,000 enrollees, 130,000 of whom are receiving subsidies from the state alone. The state maintains a strong preference for keeping this program state-only and not Medicaid. The program operates on managed competition principles (e.g., standard benefit packages, enrollees pay the marginal cost of a higher than average cost plan) and contracts with practically all of the managed care plans used by Medicaid and the public employees health benefits plan. The Basic Health Plan, through coordination with the state Medicaid agency, also provides a seamless web of coverage to families with women and children who may become Medicaid eligible because of health status or income fluctuations. All told, the state of Washington purchases health care plans or services for over 20 percent of the total population. Thus, total state leverage over managed care plans and the ultimate shape of the health care delivery system is considerable.
Other State Activity in Health Policy

Insurance Reforms

Washington has preserved and implemented the bulk of the insurance reforms that passed in 1993. Most are targeted at access and affordability of coverage for the small-group and individual markets, but there are also benefit mandates and limits on preexisting condition exclusions that apply to plans of all sizes (except the self-insured). The Washington employer-sponsored health insurance market is a bit larger than average nationwide, covering two-thirds of the under-65 population. The group reforms appear to be working reasonably well, but the individual market is undergoing some turmoil because carriers are embroiled in disputes with the insurance commissioner over premium increases. This market is being watched very closely. The consequences could spill over into the Basic Health Plan, since anyone can purchase insurance there (although there are income limits above which purchasers receive no state subsidy). Washington’s individual health insurance market is also larger than average but still covers only about 8 percent of the total nonelderly population.

Long-Term Care

Washington has relatively high long-term care expenditures per elderly recipient. The state places a high priority on enabling the elderly to avoid nursing homes if possible, for both political and fiscal reasons. The state uses Medicaid home and community-based waiver programs to provide nursing options to long-term care recipients. Still, two-thirds of the overall long-term care budget is devoted to nursing homes, and so the state continues searching for innovative alternatives for this type of care.

Mental Health and Developmental Disabilities

Three principles underlie state policy for those with serious mental illness or developmental disabilities: community-based care, managed care, and maximized federal support. Washington has been more successful than most states in deinstitutionalizing mentally ill and developmentally disabled persons and delivering care in community settings. Enrollment in a capitated Regional Support Network is required for Medicaid beneficiaries to receive most outpatient mental health services. Federal Medicaid disproportionate share hospital funding is particularly important to Washington’s overall delivery of mental health services.

Public Health

The state Department of Health carries out a broad range of activities, from traditional population-oriented activities to direct services. Two large block grants and 63 categorical grants provide federal support for Washington’s public health programs. Most funds and considerable (although monitored) discretion are transferred to local health departments, which are typically orga-
nized along county or multicounty lines. The expansion of Medicaid and the Basic Health Plan have reduced the need for local health departments to provide direct health services to the poor, but many still do, and many coordinate with the state Medicaid agency to maximize the draw of federal funds.

**Challenges for the Future**

With a strong economy; above-average commitments to funding the poor, near-poor, and safety net providers; and a low overall uninsurance rate, Washington’s health system is currently quite strong. The major challenges for the future are similar to those faced elsewhere: Can Medicaid save enough from managed care and other market-based efficiencies to avoid enrollment or benefit cuts? Can the health care safety net survive aggressive market competition and state budget constraints? Will funding for Basic Health Plan expansions be forthcoming or will the current waiting list be allowed to grow? Will insurance reforms help most small groups and individuals purchase and keep private insurance? Will organized purchasers, public and private alike, be able to ensure that high-quality health care is delivered in the managed care settings of the future? All these areas will require constant vigilance and may call for policy intervention in the next few years.
Thumbnail Sketch of Washington

Sociodemographic

Washington is the eighteenth largest state in the United States, with a population of 5.3 million (table 1). It has lower than average elderly and young populations, but its overall population has been growing at more than twice the national rate since 1990, suggesting that immigration of working-age adults is the primary factor behind Washington’s recent population growth. Washington has about the same percentage of its population living in urban areas (78.4 percent) as the nation as a whole. Washington’s racial mix is disproportionately white, 86.8 percent versus 72.6 percent for the nation, with much smaller than average black and Hispanic populations. It does have a larger than average proportion of “non-Hispanic other” (7.7 percent vs. 4.2 percent for the United States), largely of Asian, Pacific Islander, and Native American origin.

Economic

Washington has a slightly higher per capita income and lower poverty rates than average (table 1). Both the employment rate and the unemployment rate are higher than the nation’s, reflecting a population with a higher than average proportion of working-age adults. Recent growth in per capita income has been on a par with the nation, but growth in total personal income has been much higher, suggesting that the Washington economy has been creating average wage jobs faster than the nation overall for the past five years.

Currently, the Washington economy is very strong. The unemployment rate fell from 9.5 percent in January 1993 to 6.4 percent in December 1996. Over
### Table 1  State Characteristics

<table>
<thead>
<tr>
<th>Sociodemographic</th>
<th>Washington</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1994-95)a (in thousands)</td>
<td>5,301</td>
<td>260,202</td>
</tr>
<tr>
<td>Percent under 18 (1994–95)a</td>
<td>25.9%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Percent 65+ (1994–95)a</td>
<td>10.4%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Percent Hispanic (1994–95)a</td>
<td>3.0%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Black (1994–95)a</td>
<td>2.4%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Percent Non-Hispanic White (1994–95)a</td>
<td>86.8%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Other (1994–95)a</td>
<td>7.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Percent Noncitizen Immigrant (1996)*</td>
<td>4.3%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Population Growth (1990–95)b</td>
<td>21.6%</td>
<td>21.8%</td>
</tr>
<tr>
<td>Economic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Capita Income (1995)c</td>
<td>$23,774</td>
<td>$23,208</td>
</tr>
<tr>
<td>Percent Change in Per Capita Personal Income (1990–95)c,d</td>
<td>21.4%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Percent Change in Personal Income (1990–95)c,e</td>
<td>34.5%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Employment Rate (1996)f,g</td>
<td>64.4%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Unemployment Rate (1996)f</td>
<td>6.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Percent below Poverty (1994)h</td>
<td>12.6%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Percent Children below Poverty (1994)h</td>
<td>17.3%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Uninsured —Nonelderly (1994–95)a</td>
<td>12.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Percent Medicaid—Nonelderly (1994–95)a</td>
<td>12.3%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Percent Employer Sponsored—Nonelderly (1994–95)a</td>
<td>66.6%</td>
<td>66.1%</td>
</tr>
<tr>
<td>Percent Other Health Insurance—Nonelderly (1994–95)a</td>
<td>8.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Smokers among Adult Population (1993)</td>
<td>22.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Low Birth-Weight Births (&lt;2,500 g) (1994)a</td>
<td>5.3%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)i</td>
<td>4.7</td>
<td>7.6</td>
</tr>
<tr>
<td>Premature Death Rate (Years Lost per 1,000) (1993)n,n</td>
<td>43.7</td>
<td>54.4</td>
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<tr>
<td>Violent Crimes per 100,000 (1995)i</td>
<td>484.3</td>
<td>684.6</td>
</tr>
<tr>
<td>AIDS Cases Reported per 100,000 (1995)j</td>
<td>16.4</td>
<td>27.8</td>
</tr>
<tr>
<td>Political</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governor’s Affiliation (1996)a</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Party Control of Senate (Upper) (1996)a</td>
<td>23D-26R</td>
<td></td>
</tr>
<tr>
<td>Party Control of House (Lower) (1996)a</td>
<td>42D-56R</td>
<td></td>
</tr>
</tbody>
</table>

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e. Personal contributions for social insurance are not included in personal income.


g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996 where 1994 is the center year) edited using the Urban Institute’s TRIM2 microsimulation model.

i. “Other” includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.


n. Race-adjusted data, National Center for Health Statistics, 1993 data.


the same period, the unemployment rate dropped from 7.1 percent to 4.4 percent in Seattle. Thus, Seattle’s economy is even stronger than the state’s as a whole. Much of this strength comes from Boeing (aerospace) and Microsoft (computer software), which are doing very well. General economic growth has increased the total resource base available for private and public purposes throughout Washington.

Political

Washington is one of the few states with a long progressive tradition that does not also have a state income tax. Therefore, it relies on state sales and state property taxes. It has also become relatively adept at obtaining federal funding, both for federal purposes, which contributes to Washington’s economic base (defense) and to pursue state goals (social and infrastructure spending). The political climate could be described as socially liberal and fiscally conservative. Washington’s congressional delegation has been relatively prominent (Henry Jackson, Tom Foley) and largely Democratic over the past 30 years, as has been control of the state legislature and governor’s mansion. Recently, however, Republicans have achieved a majority in both state houses (26–23 in the Senate and 56–42 in the House), and the congressional delegation has become majority Republican as well. The political reversal was not complete, however, as the newly elected governor, Gary Locke, is a Democrat. While fiscal restraint is now a high priority, the recent legislative session did not reverse any major initiative or commitment in health care that the state has undertaken over the past few years. In fact, in response to federal welfare reform, the legislature appropriated state funds to replace lost federal support of some benefits for some populations (discussed below).

Perhaps because of the progressive tradition without a state income tax, there appears to be a consensus that bipartisan cooperation and agreement are essential. This pragmatism has permeated both parties and the state’s bureaucracy, and it engenders bipartisan support for the public programs that are in place. Another way of saying this is that political leadership in Washington state politics on both sides of the aisle has been relatively moderate ideologically, compared with that observed at the national level in recent years. Washington saw brinksmanship and sustained vetoes in the spring of 1997, but no major shifts in policy have occurred yet.
Setting the Policy Context

Overview of Health Policy Agenda

Policymakers, the public, and the health care industry are still defining how far they want to retreat from the ambitious goals enacted in 1993. That year Washington expanded on its traditional commitment to health care access by seeking universal coverage through employer mandates and household subsidies, cost control through managed care, and a thoroughly reorganized health insurance market. These reforms were controversial at the time, and most Washington leaders expected the federal government to follow soon with similar reforms and subsidies. At the same time, Medicaid eligibility for children was liberalized considerably (up to 200 percent of poverty), Washington began moving most Medicaid recipients into managed care plans, and additional funding was provided to expand enrollment in the Basic Health Plan (BHP). The state developed a public health improvement plan (PHIP) that promised to move local health departments out of direct service provision (assuming universal coverage) and into a renewed focus on core public health concerns.\(^2\)

The elections of 1994, in which the Republicans took control of the House and reduced the Democratic margin in the Senate to one vote, reflected a far less expansive view of the proper role of government. In 1995 and 1996, much of the 1993 law was repealed, including the commitment to universal coverage and employer mandates. Substantial insurance reforms were retained, however (guaranteed issue, limits on preexisting condition restrictions, portability, modified community rating for small groups, guaranteed access to all types of licensed providers,\(^3\) state approval of premium increases), so that Washington remains among the nation’s leaders in overall health insurance reforms. Health plans and providers had already prepared for the anticipated implementation of
comprehensive reforms by the time they were repealed, and the movement to
Medicaid managed care and organized state health insurance purchasing strate-
gies continued. These policies and responses were all designed to increase the
cost-effectiveness of health care in Washington within reformed insurance mar-
kets, and they have set in motion market forces that are not likely to be reversed.
To some, the universal coverage goals contemplated during 1993–94 remain a
benchmark against which current policy is judged. To everyone, health care
markets in Washington have been permanently altered in the past four years.

The structure of and commitment to existing programs serving low-income
populations were retained in 1995–96 as well. In some ways, there is now more
state policy emphasis on serving the poor and the working poor than there
would have been had universal coverage and managed competition reforms
gone into effect. In that event, considerable bureaucratic resources and political
capital would have been devoted to helping the vast majority of already insured
middle-class citizens adjust to the brave new world of thoroughly managed
competition, necessarily emphasizing health plan and provider choice and
quality more than basic cost and access issues.

The policy outlook for the immediate future is dominated by two issues:
impending budget constraints and rising concern about quality of care. A bal-
lot initiative passed in 1994 (Initiative 601) limits the growth rate in state
expenditures financed out of the general fund to the sum of population growth
and inflation beginning July 1, 1995 (roughly 4 percent per year in the 1995–97
biennium). Since state Medicaid spending has been growing at about 8 per-
cent per year, this constraint could require hard choices between enrollment
declines and service reductions. While the state has resisted cutting Medicaid,
there is general recognition that, in the long term, Medicaid spending growth
must be curtailed. The state’s major non-Medicaid, heavily subsidized coverage
expansion program, BHP, has attracted enough enrollment to exhaust the rev-
eneue sources currently dedicated to it, and the waiting list for enrollment is
large and growing. Competition for state resources promises to be sharper in the
years to come than it has been in the recent past, although it is not certain that
health care will be relatively harder hit than other areas. Overall, Initiative 601
represents a departure from Washington’s long-standing tradition of expand-
ing social service spending along with economic growth.

In addition to new budget constraints, maintaining the quality of health care
in Washington is high on many officials’ agendas. Different players are devising
ways to use state regulatory and purchasing powers to institutionalize and stan-
dardize health plan accountability for both private and public payors. Managed
care in Washington, while long present, has recently grown rapidly, and many
employees and dependents are encountering restrictions on provider choice or
strong financial incentives to use specific network providers for the first time.
With that exposure has come a recognition of the value in standardizing
provider network adequacy requirements, outcomes and satisfaction report-
ing, and quality assurance procedures across all health plans and newly emerg-
ing risk-bearing entities. This evolving effort includes numerous state govern-
ment agencies, providers, consumers, and employer/purchasers. Three agencies currently coordinate health plan reporting requirements and site visits to health plans serving state clients, and will plan joint procurement and quality improvement efforts for managed care services in the future. Given the scientific complexity of obtaining and interpreting quality measurements and the huge financial stakes, quality-of-care issues are unlikely to be resolved soon and without controversy.

Washington has established some of the most generous policies of all the states in terms of immigrant eligibility for Medicaid and other programs under welfare reform. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) bars new immigrants from Medicaid for their first five years in the country and gives states new options for determining immigrants’ eligibility for Medicaid. In the Spring of 1997, the Washington legislature passed and the new governor signed legislation that enables all new legal immigrants to receive state-funded Medicaid benefits during the federal five-year bar, after they meet a one-year state residency requirement. Washington has also adopted the federal option to provide coverage to legal immigrants in the United States prior to the passage of PRWORA and to new immigrants following the five-year bar. In addition, Washington is creating a state-funded program to replace legal immigrants’ food stamp benefits lost as a result of the federal welfare reforms. Apparently, passage of these state provisions was facilitated somewhat by the fact that new state expenditures in response to federal program changes do not count against Initiative 601 spending limits.

State Health and Health Care Indicators

Washington has a high rate of health insurance coverage by national standards and compares favorably across a broad array of health status and outcomes indicators. The relatively low uninsurance rate (12.9 percent of the nonelderly population [see table 1]) is largely attributable to a higher percentage of private coverage than in other states, although Washington’s Medicaid program is relatively generous toward the near-poor (those between 100 percent and 200 percent of poverty) and the state-only subsidized plan (BHP) targets this population as well. Reflecting both underlying sociodemographics and relatively broad access to care, Washington state has lower than average rates of teen pregnancy, low birth weight, infant mortality, and premature death as well as low incidences of both AIDS and tuberculosis.

Health Care Spending and Coverage

Medicaid spending in Washington was $3 billion in 1995, about half of which was financed by the federal government. On a per enrollee basis, Washington spends 8 percent less than the national average. Medicaid spending has been growing faster than other components of state spending recently,
increasing from 9 percent to 13 percent of state general fund expenditures between 1990 and 1995 (table 2). The primary reason for expenditure growth has been enrollment expansions. Washington has also pursued a very effective Medicaid maximization strategy, substituting federal dollars for state dollars in many areas. The federal share of medical assistance payments increased from 46 percent in FY 1986 to 56 percent in FY 1996, and the federal share of mental health spending went from 16 percent to 45 percent over that same period. Today about 12.3 percent of the nonelderly population and 57.9 percent of the poor are insured through Medicaid. Overall, roughly 15 percent of the population has state-subsidized health insurance, mostly through Medicaid or the Basic Health Plan.

Table 2  Washington Spending by Category, 1990 and 1995 ($ in Millions)

<table>
<thead>
<tr>
<th>Program</th>
<th>State General-Fund Expenditures(^a)</th>
<th>Expenditure(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual</td>
<td>Growth</td>
</tr>
<tr>
<td>Total</td>
<td>$6,171</td>
<td>$8,809</td>
</tr>
<tr>
<td>Medicaid(^c,d)</td>
<td>555</td>
<td>1,183</td>
</tr>
<tr>
<td>% of Total</td>
<td>(9.0)</td>
<td>(13.4)</td>
</tr>
<tr>
<td>Corrections</td>
<td>249</td>
<td>352</td>
</tr>
<tr>
<td>% of Total</td>
<td>(4.0)</td>
<td>(4.0)</td>
</tr>
<tr>
<td>K-12 Education</td>
<td>2,826</td>
<td>3,986</td>
</tr>
<tr>
<td>% of Total</td>
<td>(45.8)</td>
<td>(45.2)</td>
</tr>
<tr>
<td>AFDC</td>
<td>171</td>
<td>244</td>
</tr>
<tr>
<td>% of Total</td>
<td>(2.8)</td>
<td>(2.8)</td>
</tr>
<tr>
<td>Higher Education</td>
<td>925</td>
<td>951</td>
</tr>
<tr>
<td>% of Total</td>
<td>(15.0)</td>
<td>(10.8)</td>
</tr>
<tr>
<td>Miscellaneous(^e)</td>
<td>1,445</td>
<td>2,093</td>
</tr>
<tr>
<td>% of Total</td>
<td>(23.4)</td>
<td>(23.8)</td>
</tr>
</tbody>
</table>


a. State spending refers to general-fund expenditures plus other state fund spending for K-12 education.
b. Total spending for each category includes the general fund, other state funds, 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. Massachusetts did not report these provider payments to NASBO.
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 includes all remaining state expenditures (i.e., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.
The Department of Social and Health Services (DSHS) is an umbrella human services agency established in 1970 that houses both Medicaid and the majority of the state’s health service programs. DSHS accounts for 25 percent of the state general-fund spending, and the secretary of DSHS has cabinet status. DSHS administrations and their shares of the 1995–97 DSHS operating budget, including federal funding, include the following: Children’s Services, 5.7 percent; Juvenile Rehabilitation, 1.7 percent; Aging and Adult Services, 15.7 percent; Medical Assistance (mostly Medicaid), 35.5 percent; Health and Rehabilitation (includes mental health), 18.6 percent; Economic Services (e.g., Aid to Families with Dependent Children [AFDC]), 21.2 percent; and Management Services, 1.6 percent. The Aging and Adult Services Administration (AASA) administers long-term care services for the aged in Medicaid and related aging programs.

The Health Care Authority (HCA), whose administrator also has cabinet status, has administrative responsibility for the state’s own program for the low-income uninsured, the Basic Health Plan (BHP). This program interacts with Medicaid in important ways—creating a seamless coverage web for pregnant women and children, for example. The HCA also runs the state employee health insurance program, and a number of synergies (e.g., health plan requirements and audits) are achieved because the HCA purchases health insurance on behalf of different populations. Overall, the HCA accounts for about 1 percent of state spending from all sources.

The Department of Health, a relatively new agency whose secretary also has cabinet status, has authority over population-based services and some direct
services provided through the local public health departments. The Department of Health is also involved with the monitoring of DSHS/Medicaid health plans. The Department of Health accounts for 1.3 percent of total state spending from all sources.

**Medicaid**

The Medicaid budget in Washington state is split across several subunits of DSHS:

- Medical Assistance Administration, or MAA (53 percent of total Medicaid funds), administers the medical care component of Medicaid and related insurance programs.
- Aging and Adult Services Administration (24 percent) administers long-term care services for the aged in Medicaid and related aging programs.
- Mental Health Division (11 percent) administers community mental health and residential and institutional mental health services, including disproportionate share hospital (DSH) payments to mental health hospitals.
- Developmental Disabilities Division (9 percent) administers residential, community-based, and institutional developmental disabilities services.
- Other (3 percent) includes Children and Family Services, Alcohol and Substance Abuse, Central Administration, and Veterans Affairs.

Table 2 examines spending on Medicaid and other services that are financed from the state’s general fund as well as total spending from general, other state, and federal funds. Table 2 shows that Medicaid is the fastest-growing spending category, but K–12 education still makes up a far larger portion of the state budget. Since 1990, Medicaid has replaced higher education as the second-largest state expenditure by growing more than 16 percent per year. Because of its relatively high federal matching rate, Medicaid represents a larger percentage of total spending (federal and state funds) than of general fund spending. Given the relative constancy of the other shares, one can infer from table 2 that increased Medicaid spending has been partially financed with moneys that might otherwise have gone to support education or lower taxes.

Table 3 shows that Medicaid spending in Washington has been growing a bit faster than in the rest of the nation in the 1990s: 28 percent during 1990–92, compared with the U.S. average of 27 percent, and 13 percent during 1992–95, compared with 10 percent. The most recent faster-than-average growth has been the result of increased DSH payments, acute care spending on the under-65 population (especially children), and long-term care services for the elderly. Administrative costs have increased dramatically faster than the national average as well. Table 3 also shows that Washington has slightly more acute care spending (and less long-term care spending) as a percentage of total service expenditures (62 percent) than the nation as a whole (60 percent).
### Table 3  Medicaid Expenditures by Eligibility Group and Type of Service, Washington and United States ($ in Millions)

<table>
<thead>
<tr>
<th></th>
<th>Washington</th>
<th>Average Annual Growth</th>
<th>United States</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$1,299.0</td>
<td>$2,115.6</td>
<td>$3,033.7</td>
<td>27.6%</td>
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<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits by Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits by Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

**Source:** The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
<table>
<thead>
<tr>
<th>By Group</th>
<th>Washington</th>
<th>United States</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$2,253</td>
<td>$2,670</td>
<td>$2,933</td>
<td>8.8%</td>
<td>3.2%</td>
<td>$2,397</td>
<td>$2,729</td>
<td>$3,202</td>
<td>6.7%</td>
</tr>
<tr>
<td>Elderly</td>
<td>$7,755</td>
<td>$9,171</td>
<td>$10,653</td>
<td>8.7%</td>
<td>5.1%</td>
<td>$6,839</td>
<td>$8,422</td>
<td>$9,738</td>
<td>11.0%</td>
</tr>
<tr>
<td>Cash</td>
<td>3,531</td>
<td>4,328</td>
<td>4,607</td>
<td>10.7%</td>
<td>2.1%</td>
<td>3,329</td>
<td>4,017</td>
<td>4,818</td>
<td>9.8%</td>
</tr>
<tr>
<td>Noncash</td>
<td>10,048</td>
<td>11,694</td>
<td>14,373</td>
<td>7.9%</td>
<td>7.1%</td>
<td>10,377</td>
<td>12,192</td>
<td>13,521</td>
<td>8.4%</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$6,889</td>
<td>$8,092</td>
<td>$8,525</td>
<td>8.4%</td>
<td>1.8%</td>
<td>$6,378</td>
<td>$7,320</td>
<td>$8,022</td>
<td>7.1%</td>
</tr>
<tr>
<td>Cash</td>
<td>5,520</td>
<td>6,611</td>
<td>7,490</td>
<td>9.4%</td>
<td>4.2%</td>
<td>4,969</td>
<td>5,927</td>
<td>6,686</td>
<td>9.2%</td>
</tr>
<tr>
<td>Noncash</td>
<td>12,302</td>
<td>14,639</td>
<td>13,301</td>
<td>9.1%</td>
<td>-3.1%</td>
<td>12,047</td>
<td>12,574</td>
<td>12,660</td>
<td>2.2%</td>
</tr>
<tr>
<td>Adults</td>
<td>$1,396</td>
<td>$1,825</td>
<td>$2,044</td>
<td>14.3%</td>
<td>3.9%</td>
<td>$1,301</td>
<td>$1,518</td>
<td>$1,728</td>
<td>8.0%</td>
</tr>
<tr>
<td>Children</td>
<td>$632</td>
<td>$752</td>
<td>$1,014</td>
<td>9.1%</td>
<td>10.5%</td>
<td>$770</td>
<td>$931</td>
<td>$1,178</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

*Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.*
Table 4 illustrates that Medicaid spending per enrollee in Washington was 8 percent lower than the national average in 1995 and that it has grown more slowly per year than the national average since 1990 (5.4 percent vs. 6.0 percent). Overall spending per enrollee reflects the distribution of enrollee types as well as cost per enrollee of each type. Washington spends more than other states do per enrollee on the elderly, the blind and disabled, and nondisabled adults (mostly AFDC mothers and pregnant women ineligible for AFDC but eligible for Medicaid because of federal and state expansions). It spends less on children than the national average. These spending patterns reflect service-specific payment and utilization rates as well as benefit packages relative to other states.

Health Care Authority

The Health Care Authority administers the Basic Health Plan (BHP), which is an insurance program primarily aimed at uninsured lower-income working families. The BHP subsidizes individuals, families, or employers to purchase managed care plan coverage, with plans selected in a managed competition framework. Adults pay a minimum of $10 per month to join, and there is a sliding fee scale so that persons above 200 percent of the federal poverty level pay the full age-adjusted premium ($116 to $242 per month in 1996). Employers can sponsor BHP participation by their employees by paying $45 per month per worker. Persons over age 65 can join only if they are not eligible for Medicare coverage. Children under age 19 who are eligible for Medicaid may join BHP Plus, which essentially enrolls the children in Medicaid with no premium, although they are assigned to the same BHP health plan as their parents to enhance familiarity with providers and continuity of care. BHP is not an entitlement program, and funding levels are capped. In November 1996, the existing appropriation was exhausted, and as of December 1996, more than 60,000 people were on the waiting list. Funding for 8,000 more subsidized enrollees was appropriated during the 1997 legislative session.

Department of Health

The Washington State Department of Health carries out a broad scope of public health care activities, ranging from traditional population-oriented activities to direct services. The department consists of several divisions, including Epidemiology and Health Statistics; Environmental Health Programs; Public Health Laboratory; Health Systems Quality Assurance; and Community and Family Health, which administers, among other programs, maternal and child health services. The latter two divisions administer programs that are most relevant to the delivery of health care. Moreover, their budgets are the largest of all the divisions, with Health Systems Quality Assurance comprising 14 percent and Community and Family Health comprising 64 percent of the department’s 1995–97 appropriation.
The Department of Health is a relatively new agency, having been elevated to cabinet status only seven years ago. The intent of this change was to move public health issues more to the forefront, emphasizing health promotion and health protection.

**County Autonomy**

Over the past 30 years, local health departments in Washington, as in other states, have assumed some responsibility for providing clinical services to many of the uninsured, particularly mothers and children. More recently, however, most local health departments in the state have begun to shift their focus from the delivery of personal health services to core public health activities. A primary reason for this change is the expansion of Medicaid coverage for women and children and the institution of the BHP. Expanded coverage under these plans and enrollment of participants in managed care has gradually reduced the need for health departments to offer clinical services, such as well child care and prenatal care, to the poor. In a few cases, local health departments have been included in Medicaid managed care networks as primary care providers (e.g., Seattle-King County); but in general, the state merely requires that managed care plans “cooperate” with local health departments, for example, in ensuring that immunizations are provided on schedule.
Assessing the New Federalism

Washington has had a sustained commitment to social and health care safety nets through Medicaid and other state programs. The BHP and recent expansions of Medicaid eligibility for children are good examples of that continuing commitment. The decision to use the BHP—a state-only program—as the major vehicle to expand health insurance coverage to the low-income working population reflects a strong desire to avoid federal control and a willingness to use state funds to preserve that autonomy. Because of the strength of Washington’s economy and state policy choices, the percentage of nonelderly Washington residents who are uninsured has been lower than the national average for some time, and Washington’s health status indicators consistently rank among the top half of states in most categories.

At the same time, Washington is not immune to the current political emphasis on fiscal discipline and a reduced role for government. In terms of legislation, however, so far this has translated into scaling back some (but not all) of the ambitious universal reforms of 1993, rather than a reversal of Washington’s long-standing commitment to maintaining access to health care for its low-income residents. Initiative 601, the referendum on state budget spending that passed in 1994, is a departure from Washington’s tradition of expanding social service spending along with economic growth. But even here, the goal is to limit growth, not to achieve absolute reductions in spending.

Still, given recent health spending trends, especially regarding Medicaid, the hard choices required to satisfy the constraints imposed by Initiative 601 are much more on policymakers’ minds than New Federalism initiatives coming out of the federal government. The original Medicaid block grant formula proposed in 1995 would have hurt Washington relatively more than most states.
Washington would have been effectively penalized for having had a relatively strong economy, for having successfully pursued a Medicaid maximization strategy over the years, and for deciding to keep the BHP subsidy program a totally state-funded program. The formula was changed in subsequent proposals, and final passage of a Medicaid block grant was judged to be of sufficiently low probability (which continued to decline throughout the 104th Congress) that no serious contingency planning exercises were undertaken by state Medicaid officials. Of course, the prediction of no federal action turned out to be accurate.

Therefore, it is by no means clear how Washington will respond to federal Medicaid reform in the 105th Congress, especially given the 1996 election results in the state. On welfare reform, Washington’s traditional commitment to a social safety net was manifested, even by this more conservative legislature, through the appropriation of state funds to restore certain health and social support (food stamp) benefits for immigrants that might have been lost as a result of federal welfare reform. Since the Medicaid savings recently passed by the 105th Congress are sufficiently modest compared with both welfare reform and with the block grant and per capita cap proposals of the 104th Congress, it seems unlikely that federal policy will precipitate major changes in Washington’s Medicaid program in the near future. However, since cuts were made in the disproportionate share hospital (DSH) portion of Medicaid spending and since Washington effectively uses this money to finance a variety of state health spending, some programs might have to be curtailed, or additional nongeneral revenue state financing will have to be found.

Just as elsewhere, Washington Medicaid officials would enjoy increased flexibility that might come with federal Medicaid reform. Some were particularly interested in implementing a sliding scale premium or copayment schedule for Medicaid recipients who have incomes above the federal poverty level (thus making Medicaid more like BHP). They were also interested in repeal of the Boren amendment, which repeal did, in fact, pass in the 105th Congress. The Boren amendment propped up hospital and nursing home payment rates by providing a market-based standard against which to compare Medicaid payment levels in a federal court. Both of these reforms are viewed as dangerous by advocates for low-income populations, for either could reduce access if pushed too far.
Providing Third-Party Health Coverage for the Low-Income Population

A smaller percentage of the low-income population is uninsured in Washington than in the rest of the country (22.9 percent vs. 25.3 percent). This is the result of both generous optional Medicaid coverage for pregnant women and children and the Basic Health Plan’s targeting of the working low-income population.

Medicaid Eligibility and Enrollment Trends

Table 5 presents state data on trends in enrollment levels for Medicaid and other medical assistance programs (aside from BHP) from state FY 1990 to FY 1995 and projections for state FY 1996 and FY 1997 (compiled by legislative staff as of April 1996). These data are shown as the average number of monthly enrollees and are lower than levels in comparable federal reports, which are based on the number of enrollees who are ever on Medicaid in a given year (see table 6). The state and federal Medicaid statistics are otherwise broadly consistent. Both show that the number of Medicaid enrollees rose about 12–13 percent from 1990 to 1992 and 8–9 percent per year from 1992 to 1995 and that there was a particularly large increase in the number of non-AFDC children (called “other children” in table 5 and “noncash children” in table 6). From 1992 to 1995, Washington’s Medicaid enrollment levels grew about 3 percentage points faster than the national average rate, and the rate of growth for non-cash children in Washington was 2.6 times the national average rate (table 6). The major factor in this enrollment growth was the state’s 1994 expansion of...
### Table 5  Average Monthly Enrollment in Medicaid Assistance Programs

<table>
<thead>
<tr>
<th></th>
<th>Actual FY90</th>
<th>FY91</th>
<th>FY92</th>
<th>FY93</th>
<th>FY94</th>
<th>FY95</th>
<th>FY96</th>
<th>FY97</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>394,992</td>
<td>441,115</td>
<td>507,377</td>
<td>553,157</td>
<td>591,912</td>
<td>648,243</td>
<td>707,236</td>
<td>766,751</td>
</tr>
<tr>
<td><strong>Categorically Needy</strong></td>
<td>362,143</td>
<td>403,437</td>
<td>462,095</td>
<td>509,658</td>
<td>548,369</td>
<td>606,168</td>
<td>646,518</td>
<td>728,459</td>
</tr>
<tr>
<td>AFDC-R</td>
<td>208,108</td>
<td>219,197</td>
<td>230,746</td>
<td>238,151</td>
<td>244,365</td>
<td>245,168</td>
<td>242,159</td>
<td>242,797</td>
</tr>
<tr>
<td>AFDC-E</td>
<td>44,495</td>
<td>54,384</td>
<td>71,014</td>
<td>81,348</td>
<td>85,366</td>
<td>83,948</td>
<td>78,860</td>
<td>78,800</td>
</tr>
<tr>
<td>Aged</td>
<td>32,414</td>
<td>33,198</td>
<td>34,397</td>
<td>35,365</td>
<td>35,850</td>
<td>37,076</td>
<td>38,153</td>
<td>39,006</td>
</tr>
<tr>
<td>Disabled</td>
<td>53,103</td>
<td>58,834</td>
<td>67,904</td>
<td>77,335</td>
<td>85,432</td>
<td>91,607</td>
<td>97,748</td>
<td>103,554</td>
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<tr>
<td>Others—Women</td>
<td>23,755</td>
<td>37,383</td>
<td>14,201</td>
<td>15,734</td>
<td>17,836</td>
<td>18,186</td>
<td>18,515</td>
<td>18,818</td>
</tr>
<tr>
<td>Others—Children</td>
<td>—</td>
<td>—</td>
<td>42,669</td>
<td>59,511</td>
<td>76,583</td>
<td>126,290</td>
<td>166,571</td>
<td>240,411</td>
</tr>
<tr>
<td>QMB</td>
<td>266</td>
<td>441</td>
<td>1,164</td>
<td>2,214</td>
<td>2,937</td>
<td>3,893</td>
<td>4,512</td>
<td>5,073</td>
</tr>
<tr>
<td><strong>Medically Needy</strong></td>
<td>15,020</td>
<td>15,798</td>
<td>17,616</td>
<td>18,151</td>
<td>16,950</td>
<td>14,264</td>
<td>11,820</td>
<td>10,624</td>
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<tr>
<td>AFDC-R</td>
<td>5,397</td>
<td>5,229</td>
<td>4,802</td>
<td>4,791</td>
<td>3,852</td>
<td>2,698</td>
<td>928</td>
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<tr>
<td>AFDC-E</td>
<td>1,500</td>
<td>1,687</td>
<td>2,132</td>
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<td>1,960</td>
<td>1,182</td>
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<tr>
<td>Aged</td>
<td>4,188</td>
<td>4,469</td>
<td>5,169</td>
<td>5,192</td>
<td>4,747</td>
<td>4,718</td>
<td>4,720</td>
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</tr>
<tr>
<td>Disabled</td>
<td>3,341</td>
<td>3,911</td>
<td>4,752</td>
<td>5,246</td>
<td>5,514</td>
<td>5,507</td>
<td>5,699</td>
<td>5,819</td>
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<tr>
<td>Others—Women</td>
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<td>502</td>
<td>761</td>
<td>616</td>
<td>432</td>
<td>130</td>
<td>86</td>
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<tr>
<td><strong>State Only LT 18</strong></td>
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<td>3,227</td>
<td>11,127</td>
<td>10,911</td>
<td>12,360</td>
<td>12,792</td>
<td>13,221</td>
<td>13,622</td>
</tr>
<tr>
<td>GA-U</td>
<td>13,767</td>
<td>13,831</td>
<td>12,243</td>
<td>10,368</td>
<td>10,057</td>
<td>10,960</td>
<td>11,429</td>
<td>9,710</td>
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<tr>
<td>GA-U</td>
<td>7,110</td>
<td>11,221</td>
<td>11,081</td>
<td>9,617</td>
<td>7,729</td>
<td>7,610</td>
<td>8,384</td>
<td>8,880</td>
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<tr>
<td>ADATSA</td>
<td>2,546</td>
<td>2,750</td>
<td>2,626</td>
<td>2,639</td>
<td>2,447</td>
<td>2,576</td>
<td>2,549</td>
<td>2,600</td>
</tr>
<tr>
<td>Medically Indigent</td>
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<td>2,700</td>
<td>2,472</td>
<td>2,640</td>
<td>2,630</td>
<td>2,397</td>
<td>2,388</td>
<td>2,388</td>
</tr>
<tr>
<td>Refugees</td>
<td>1,650</td>
<td>2,122</td>
<td>1,824</td>
<td>1,429</td>
<td>1,546</td>
<td>1,662</td>
<td>1,860</td>
<td>1,948</td>
</tr>
</tbody>
</table>

Source: Data reported by the Budget Section, Medical Assistance Administration, Washington, April 23, 1996. Does not include enrollment of Basic Health Plan, which is under the Health Care Authority.
Table 6  Medicaid Enrollment by Eligibility Group, Washington and United States (Enrollment in Thousands)

<table>
<thead>
<tr>
<th></th>
<th>Washington</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enrollment</td>
<td>Average Annual Growth</td>
</tr>
<tr>
<td>Total</td>
<td>532.0</td>
<td>671.3</td>
</tr>
<tr>
<td>By Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>16.9</td>
<td>17.9</td>
</tr>
<tr>
<td>Noncash</td>
<td>31.1</td>
<td>34.3</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>65.2</td>
<td>89.0</td>
</tr>
<tr>
<td>Cash</td>
<td>52.0</td>
<td>72.5</td>
</tr>
<tr>
<td>Noncash</td>
<td>13.2</td>
<td>16.4</td>
</tr>
<tr>
<td>Adults</td>
<td>147.8</td>
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<tr>
<td>Cash</td>
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<td>120.2</td>
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<td>Noncash</td>
<td>46.1</td>
<td>62.2</td>
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<tr>
<td>Children</td>
<td>271.0</td>
<td>347.8</td>
</tr>
<tr>
<td>Cash</td>
<td>213.9</td>
<td>243.4</td>
</tr>
<tr>
<td>Noncash</td>
<td>57.2</td>
<td>104.4</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 data.
Medicaid eligibility for children under the age of 19 up to 200 percent of the federal poverty level, using a 1902(r)(2) state plan amendment. The expansion for children was enacted as part of the 1993 Health Services Act and is funded through the earmarked Health Services Account. The state has conducted active outreach to children.

The other explicit policy change was eliminating AFDC-related medically needy (not including the elderly or disabled medically needy) eligibility in January 1996. This was a legislative change made to reduce Medicaid spending; it was expected that most of these people would be able to enroll in BHP instead. Those already participating were grandfathered, so caseload levels will decline gradually.

Moderate increases in the number of aged and disabled cash assistance enrollees occurred between 1994 and 1996—2,000 aged and 13,000 disabled. The reasons for these increases were not clear. At least part of the reason might be that the state has actively been trying to identify General Assistance recipients who may be eligible for Supplemental Security Income (SSI) and, thus, Medicaid.

The state had no major welfare reform waivers in place at the time of the site visit. Major welfare reform legislation was debated in 1995 and 1996 but not passed until 1997, after federal legislation was enacted. AFDC caseloads (as reported under the AFDC program) declined slightly between 1994 and 1996, in part because the state’s overall economic condition improved over those two years.

Washington has relatively generous Medicaid eligibility limits, especially for pregnant women (up to 185 percent of the federal poverty level) and children under age 19 (up to 200 percent of the federal poverty level). The state’s AFDC and medically needy income criteria are also more generous than the national average. Moreover, the state extends family planning eligibility to poverty-related pregnant women for 12 months postpartum, as compared with the standard 60-day postpartum eligibility. To serve the aged and disabled, the state has both a medically needy program related to SSI and eligibility for people with incomes up to 300 percent of the SSI benefit level for those requiring institutionalized care. And, as mentioned in the long-term care section of this report, there are other programs for the aged and disabled.

**Other Medical Assistance Programs**

As shown in table 5, one sign of Washington’s dedication to health care for needy populations is the diversity of small medical care coverage programs, in addition to Medicaid and the BHP. Few, if any, states have so many “gap-filling” programs to serve special populations. The gap-filling programs include the following: (1) General Assistance-Unemployable (GA-U) and Alcoholism and Drug Abuse Treatment and Support Act (ADATSA) medical assistance programs,
which provide basic medical services to General Assistance clients; (2) Refugee Assistance, which provides Medicaid-type coverage to refugees; (3) the Medically Indigent program, which provides emergency reimbursement for uninsured people (not eligible for other programs) with high medical expenses incurred in hospitals (this is essentially an uncompensated care program for hospitals); and (4) the State Children’s Health Program, which provides Medicaid-type coverage to children under age 18 in households with incomes under the federal poverty level who are not otherwise eligible for Medicaid—essentially, undocumented alien children. The total number of people served in these programs is modest (28,000 in 1996) but was growing as of 1996. The GA-U program has recently assumed greater importance, since elderly and disabled immigrants who lose SSI benefits because of the federal welfare reform law will generally be eligible for GA-U cash assistance and medical coverage. While in principle these programs would be described as state funded, state officials acknowledge that they are largely funded by additional federal funds earned by the state’s disproportionate share hospital (DSH) program.

The Basic Health Plan

BHP participation has grown substantially since 1994 because of deliberate policy changes. Total participation more than doubled from 69,000 in July 1995 to 195,000 in December 1996. Prior to this increase, the state was concerned that BHP participation levels were much lower than expected (compared with estimates of the number of uninsured and relative to funds available in the Health Services Account), so it reduced premium levels to boost participation. This strategy was successful. However, the state particularly wanted to increase participation in employer-sponsored BHP plans, but it found that employers were slow to join. Washington based its budget appropriation on expectations that there would be about 100,000 individual members and 100,000 employer-sponsored members; the number of individual members is higher than expected but the number of employer-sponsored members (about 700) is much lower than hoped. Some hypothesize that this is because employers know they can let their workers join as individuals, which only costs a fully subsidized individual $10 per month, and incur no employer liability at all. In addition to making it easier for employers to offer employment-related health insurance, the state had planned on employer contributions reducing the necessity for state subsidy dollars.

The high ratio of individual to employer-sponsored members led to the exhaustion of appropriated BHP funds by the end of 1996. Still, the state did appropriate enough funds for 8,000 more enrollees in the 1997–99 biennium, and this expansion in a general time of fiscal retrenchment is a reflection of the bipartisan support the BHP has in Washington. Support for the BHP is wide because many lower-income working class people of all political persuasions are insured through it. And support is deep because it is not free to anyone—payments are based on a sliding scale for those who can pay more—and the plans are commercial plans with private enrollees. The total number of BHP

HEALTH POLICY FOR LOW-INCOME PEOPLE IN WASHINGTON
participants today is about 195,000, with 130,000 being subsidized by the state. The remainder represents individuals who pay the full premium (13,000) or children who are eligible for and financed by Medicaid (52,000).

**High-Risk Pool**

The state created a high-risk pool in 1987 that allows individuals denied coverage to buy standard policies at 150 percent of the average premium charged by the six largest carriers. All carriers, whether they sell in the individual market or not, are assessed in proportion to their total premium revenue to cover the losses in this high-risk pool. Since the 1994 expansions of the BHP, enrollment in the high-risk pool has dropped from more than 4,000 to fewer than 1,000 persons. Assessments average about $2,100 per high-risk enrollee; thus, about $2.1 million was assessed on total health insurance premiums sold in 1995 of over $4 billion. This amounted to less than 0.05 percent of commercial insurance business as a whole. The shift of former high-risk pool enrollees into the BHP has raised some concern about adverse selection effects there, but as of December 1996 there has been no directly attributable effect on BHP premiums.

**Insurance Reforms**

Private health insurance markets and regulations affect a large number of citizens. Table 7 reports three basic realities about health insurance coverage for the nonelderly in Washington and in the United States as a whole. First, there are more people between 100 and 200 percent of the federal poverty level (near-poor) than there are below it (poor). Second, more low-income (poor and near-poor) citizens in Washington and in the United States have private insurance than have Medicaid. Third, about a quarter of all low-income nonelderly individuals are uninsured. Since 85 percent of the uninsured have at least one worker in the family, most are likely to have access to at least one private group offering or to the individual market. Consequently, the rules that affect what types and under what conditions private group and nongroup insurance may be sold will directly affect the health insurance and health care access alternatives of most low-income people in Washington and in the United States as a whole.

While repealing the more ambitious elements of the 1993 law—for example, the employer mandate—the Washington legislature in 1995 and 1996 kept or strengthened some reforms: guaranteed issue for individuals and groups, a three-month limit on preexisting condition restrictions, group-to-group and group-to-individual portability, and modified community rating for small groups (smaller than 50). Each insurer in the individual and small-group markets must offer the BHP-model benefit package to all would-be purchasers. Carriers are required to reimburse enrollees for services rendered by any category of provider (e.g., naturopath or acupuncturist) as long as these services

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Assessing the New Federalism

HEALTH POLICY FOR LOW-INCOME PEOPLE IN WASHINGTON
are within their statutorily determined scope of practice and covered by the BHP package. Finally, the (elected) insurance commissioner retained the power to grant or deny premium rate increases in the individual and small-group markets. Overall, Washington is among the nation’s leaders in comprehensive health insurance reforms. Compared with the 1993 law, however, this still represents considerable retrenchment.

Recent estimates suggest that between 10 and 13 percent of Washington residents are uninsured. The Health Care Policy Board (HCPB) estimates that about 65 percent of residents are insured through private plans—57 percent through employer-based coverage and 8 percent through the individual market. Thirteen percent have Medicare as their primary coverage, 11 percent have Medicaid, almost 1 percent receive care from the Indian Health Service, and 0.7 percent are insured through the BHP. As many as half of those insured through employer-sponsored plans may be in self-funded plans and outside the reach of state regulators, although this estimate is unavoidably uncertain. Note that all of Washington’s new insurance rules affect the individual market and most affect the entire (not just the small-group) commercial group market. They do not affect the market for self-insured plans.

There are three types of health insurance carriers in Washington: health care service contractors (HCSCs), HMOs, and commercial indemnity insurers. HCSCs are Blue Cross or Blue Shield plans. There are now 22 HCSCs throughout Washington, with a combined market share that increased from 41 percent in 1993 to 50 percent of the commercial market in 1995. Preferred provider organizations (PPOs) are HCSCs’ most popular products in the private

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**Table 7 Health Insurance Coverage of the Nonelderly Population**

(population in thousands)

<table>
<thead>
<tr>
<th></th>
<th>Washington</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Below Poverty</td>
<td>100–200% of Poverty</td>
</tr>
<tr>
<td></td>
<td>Below Poverty</td>
<td>100–200% of Poverty</td>
</tr>
<tr>
<td>Population % of population in income class covered by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>20.4%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>57.9%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Employer Sponsored</td>
<td>13.2%</td>
<td>47.6%</td>
</tr>
<tr>
<td>Other</td>
<td>8.5%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Low income (&lt;200%) covered by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>322</td>
<td>19,351</td>
</tr>
<tr>
<td>Medicaid</td>
<td>526</td>
<td>26,081</td>
</tr>
<tr>
<td>Employer Sponsored</td>
<td>434</td>
<td>25,864</td>
</tr>
<tr>
<td>Other</td>
<td>122</td>
<td>5,111</td>
</tr>
</tbody>
</table>

Source: Two year concatenated March CPS files, 1995 and 1996. These files are edited by the Urban Institute Trim2 microsimulation model. Excludes those in families with active military members.

“Other” includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage. The vast majority of these persons are covered by private, individual market plans.
market. HCSCs also offer fully capitated products to Medicaid, BHP, and public employees.

HMOs are a separate licensed category of insurer in Washington. There were 10 HMOs operating in 1996, down from 14 in 1994. Group Health of Puget Sound is the largest (15 percent overall market share) and is one of the oldest staff-model HMOs in the country. A number of the newer HMOs are owned or controlled by indemnity insurers or by Blues plans. Most HMOs in Washington (7 of 10) offer products in the individual market as well as the group market. HMOs have about 32 percent of the commercial market.

Most pure indemnity insurers are disability insurers in Washington, selling with a life and disability insurance license. The Office of the Insurance Commissioner lists 16 “major” indemnity carriers in its current brochure for insurance purchasers. It is difficult to estimate their share of the market, since current reporting requirements allow them to combine the premiums of many products (disability, accidental death, Medicare supplements, long-term care) with comprehensive health insurance premiums. Most observers think they comprise less than 20 percent of the commercial health insurance market and that their share has been declining over time.

The small-group market appears to be working reasonably well in the wake of the reforms. Of course, 1996 was the first year of modified community rating, so perhaps more of an effect will be felt than is currently anticipated. The general level of competition among carriers appears to be high, partly because of favorable prices resulting from excess capacity in hospital beds and specialists, as exists in many other areas of the country. For HCSC and HMO products combined, commercial premiums per enrollee rose only 0.3 percent between 1994 and 1995. The HCPB surveyed small businesses (less than 50 employees) in 1996, and 63 percent reported no change in their premiums from the previous year when no reforms were in place. Seven percent dropped health insurance coverage, 29 percent had rate increases of 1 percent to 25 percent, and 1 percent had rate decreases.

Currently, by far the greatest concern about health insurance in Washington state is focused on the individual market. Carriers are worried about adverse selection, particularly in response to the new guaranteed issue requirements and limits on preexisting condition restrictions. Requests for rate increases have turned into protracted battles with the insurance commissioner. Tensions are always high in these cases, but these fights are intense by any standard. The insurance commissioner was recently reelected by a 52–48 margin, and her actions in the individual market were much discussed in a very hard-fought campaign. Threats to pull out of the individual market have been voiced, and some analysts are concerned that stability in this market may yet be a long way off.

The HCPB conducted a study of the individual market, which focused on the six largest carriers. The HCPB concluded that the carriers lost $58 mil-
lion on the individual market in 1995, compared with losing $21 million in the large-group market and making $22 million in the small-group market. Worried about the long-run stability of the individual market, the HCPB recommended that the state adopt mandatory reinsurance to stem the losses in this market.

Health Insurance Market Prospects

Washington uses managed competition theory and practice to advantage for the public employee and BHP programs. Aggressive competitive bidding for Medicaid capitation contracts may soon be the norm as well. Managed care is well established and accepted, although PPOs, not HMOs, appear to be the most popular products, judging by recent growth.

The perceived competitive need to keep premiums down explains the widespread concern over legislated benefit mandates (e.g., any category of provider, women’s direct access to specialists). Each plan fears the mandates will hurt them more than their competitors. In general, there is a sense that the really fierce competition has not begun yet, but the day of reckoning is widely perceived, at least by health plans, to be close at hand. By extension, the provider community is wary, for cutthroat health plan competition will only depress service prices more and increase the stringency of utilization controls. An interesting development that will be watched closely is that Boeing, long a self-insured employer, this year offered its workers a choice of a commercial HMO product and provided a strong financial incentive to select the HMO plan. This signals a belief that some commercial market products in Washington are proving at least as successful at containing costs as self-insured arrangements.

Many actors in Washington, in particular the Office of the Insurance Commissioner but also the Health Care Authority, Department of Social and Health Services, and Department of Health, are developing health plan quality standards and reporting requirements. Concerns over quality may very well be the mechanism to level the playing field of competition among different types of health plans. Quality reporting requirements may also be the path by which ERISA (self-funded) plans are brought back under the partial jurisdiction of state insurance regulators; for as managed care grows, concern about quality assurance and improvement, as well as physician incentives to undertreat, will grow as well, at least until quality reporting standards are institutionalized and accepted.
Managed care has long had a substantial presence in Washington with Group Health of Puget Sound, one of the first and largest staff-model HMOs in the country. HMOs as a group cover about one-third of the commercially insured population. Selective contracting is a standard competitive technique HMOs use to manage costs, and its use typically expands with growth in HMO market share. The provider community expects competitive pressures to be even more intense in the future and is preparing for that day through cost-reduction strategies, mergers, and alliance formation with complementary providers and health plans. This process has been accelerated by the need to construct partners to qualify for capitated Medicaid managed care contracts, especially for community health centers and teaching hospitals.

At the same time, the entry of for-profit hospital chains has been minimal, although rumors about negotiations with them abound. In general, there is considerable bracing for the expected shakeout to come.

Medicaid and state purchasing power generally have played an important catalytic role in the transformation of the Washington health care delivery system. The decision to move most Medicaid enrollees into managed care plans was made in the early 1990s, with implementation beginning in 1993; this change reflected a philosophical shift from “paternalism to purchaser.” Today, 380,000 Medicaid enrollees (of approximately 660,000 noninstitutionalized beneficiaries) are in fully capitated, closed-panel managed care organizations.
Another 195,000 Washington residents are insured through MCOs participating in the BHP. Finally, 225,000 public employees, dependents, and retirees are enrolled in MCOs through the state’s Public Employees Benefits Board, and 59,000 are enrolled in the state’s own self-insured PPO. Thus, more than 800,000 Washington residents are in more than 25 managed care plans purchased or administered by the state. This compares with approximately 3.7 million residents covered in the Washington commercial insurance market overall, and a total state population of 5.3 million. The state accounts for well over one-third of all of Washington’s considerable managed care enrollment; thus, its potential leverage over health plans and the ultimate shape of the health delivery system is considerable.

All health delivery systems are local, and Washington’s can be characterized as (1) the Seattle/Tacoma metropolitan area; (2) a few distinct mid-sized cities (Spokane, Olympia, Yakima, Walla Walla, Richland/Pasco/Kennewick); and (3) everywhere else. Outside the Seattle area, most communities have only one hospital, but three-quarters of the state’s population live in counties in which hospital competition is possible. Competition has been increasing in intensity lately, as in other markets around the country. Competition is often fiercest where there is an excess supply of hospital beds. While Washington has the second fewest beds per 1,000 persons in the nation, admission rates are very low and lengths of stay are short. Thus, although Seattle’s occupancy rates are slightly higher than the national average, many local observers consider that market to be in excess supply by about one-third.

As in many modern health care marketplaces, mergers among providers have occurred and may be increasing in Washington. Some mergers may reduce redundancies, increase clinical integration, and increase overall efficiency, while others are more likely to increase the market power of the merged entities and reduce competitive pressures in the long run. Mergers among hospitals and conversions of nonprofit hospitals to for-profit status, especially amid a systemwide drive toward cost efficiency, also raise questions about continued commitments to community-based uncompensated care, a vital element of the health care safety net anywhere there are large numbers of uninsured people.

In general, HCPB staff are satisfied that the Washington health service markets are competitive and that so far the operating joint ventures do not appear to be a vehicle for general price fixing. The state passed a nonprofit conversion process law in the spring of 1997. Nonprofit conversions are not a major issue yet, despite considerable speculation (and fear) that for-profit hospital chains are poised to make a major move in the Seattle market.

Medicaid Reimbursement for Inpatient Hospital Care

While most Medicaid beneficiaries, especially mothers and children, are in managed care plans, most Medicaid expenditures take place in fee-for-service (FFS) arrangements, on behalf of aged, blind, disabled, and other adults. Two
of the largest FFS expenditure categories are inpatient hospital and physician
care (25 percent and 12 percent of total medical assistance payments in FY
1995, respectively). We discuss them in turn.

Two factors affect inpatient hospital reimbursement for those under the FFS
system. First, a settlement agreement between the state and the Washington
State Hospital Association from a Boren amendment lawsuit in 1991 shapes
payment policies. Second, the state has a selective contracting system for hos-
pitals in many areas of the state. The state believes that its payment rates are
generally adequate relative to cost. While hospital representatives did not nec-
essarily concur, they did not protest vigorously either.

Medicaid uses three principal payment methods for inpatient hospitals:26
(1) a regular Diagnosis-Related Groups (DRG) system (called PPS-4), (2) a mod-
ified DRG system used for hospitals under the selective contracting system, and
(3) a ratio of cost to charges system used when the first two do not apply.27

The selective contracting system governs about 55 percent of hospital pay-
ments and applies to eight selective contracting areas of the state, which
include Seattle and most major cities. Thirty-one hospitals (of 90 nonfederal
community hospitals in the state) participate. Hospitals bid a DRG conversion
factor. Overall, the state estimates about 8 percent to 10 percent savings through
the selective contracting system but acknowledges that it could probably extract
more by accepting only the lowest bidders. Recent policy has been to refrain
from such aggressive purchasing behavior.

PPS-4 covers most of the hospitals outside the selective contracting sys-
tem. Per the Boren amendment settlement agreement, hospital-specific DRG
conversion factors are computed in a multistep fashion, which includes his-
torical cost data, including Medicaid costs, indirect medical education adjust-
ments, caps based on hospital “peer groups,” and outlier adjustments. Factors
are updated using the Data Resources Incorporated health care cost index.28
There is an additional outlier payment pool.

The ratio of cost to charges method is used for certain hospitals outside the
DRG system, or for procedures not included in the system. Hospitals paid this
way include out-of-state, military, and psychiatric hospitals, among others. A
few services—such as certain neonatal, AIDS-related, bone marrow transplant,
and chemical dependency/alcohol treatment—are also exempt from the DRG
system.

Data from the American Hospital Association (AHA) indicate that Medicaid
payments have improved greatly since the Boren amendment settlement,
although in 1993 they still appeared to average only 88 percent of costs in
Washington compared with 93 percent of costs nationally.29 The AHA data are
not perfect, particularly because of changes over time concerning provider taxes
and DSH programs, but they provide at least a rough view of Medicaid pay-
ments to hospitals. A representative from the state hospital association indi-
cated that the level of Medicaid payments was not viewed as a serious problem compared with major discounts that were being required in private health insurance. It seemed that recently negotiated private payment rates were still generally higher than Medicaid rates but occasionally fell below Medicaid levels. (Sometimes Medicaid rates have been used as benchmarks for negotiating private insurance rates, since the firms can point to Medicaid rates as rates previously accepted by the hospitals.) If the Boren amendment were repealed (which did occur), one state official felt that the state would probably try to reduce hospital rates slightly but not substantially. There is still a general reluctance to maximize leverage from state purchasing power, out of concern for the long-term consequences of reducing the number of provider participants in Medical Assistance Administration programs.

**Physician Reimbursement**

Since 1993, the state has used the Medicare Resource-Based Relative Value Scale to pay physicians on a fee-for-service basis, although the state does not use the Medicare conversion factors. Based on earlier analyses of 1993 rates, the state paid 89 percent of Medicare rates on average.

Updating the conversion factors is based on legislative fiat. The legislature sets “vendor payment” rate increases that apply across the board in a variety of areas, including home care or job training. In the 1995–97 biennium, the rate increase was 2 percent per year. MAA may deviate from these as long as rate changes average 2 percent. They have deliberately increased payments for OB/GYNs and pediatricians at a much higher rate (about 5 percent per annum), while other physicians’ rate increases were held below 2 percent. The state believes that Medicaid payments to OB/GYNs and pediatricians are now competitive with private payment rates.

The staff of the Washington State Medical Association consider Medicaid to be a poor payer and assert that fee-for-service payment levels are about 50 percent lower than private market levels. However, their larger concern is the growth of managed care in general and its implications for physicians.

**Disproportionate Share Hospital Payments**

Medicaid’s DSH program was designed to provide financial relief to hospitals that serve large numbers of low-income patients, on the theory that hospitals often lose money on them, even if they are covered by Medicaid. Specific payment formulas allow states to earn federal matching funds for DSH payments, and hospitals in turn can be at least partially reimbursed for delivering such care. Washington uses several Medicaid DSH programs to address various needs. In general, its goals have been to assist certain hospitals or to generate surplus funds for the state to support non-Medicaid medical services, including the state-only Medically Indigent and GA-U (General Assistance-
Unemployable medical assistance) programs. Table 8 presents national data on DSH expenditures for Washington and the United States from 1988 to 1995.

### Acute Care DSH Payments

Since 1990, there has been a “regular” DSH program that distributes $30 to $35 million per year to assist hospitals serving higher than average volumes of low-income or Medicaid patients. The state share of the payments comes from the general fund. Since 1992, this program has received a relatively small fraction of total DSH payments; in 1996, it constituted about one-tenth of all DSH payments.

There are three other acute care DSH programs (initiated in 1992 or 1993):

- The Medically Indigent program, which uses local funds (intergovernmental transfers) for the original state share of payments. The program payments are essentially uncompensated care payments for uninsured patients with high inpatient costs (there is a $2,000 deductible).
- The GA-U program, which also uses local funds for nonfederal payments. The surplus generated from federal funds in excess of those needed for some patients supports medical insurance for GA-U recipients.
- The Small Rural Hospital Assistance Program, which uses intergovernmental transfers from public rural hospitals to generate a federal match for DSH payments to rural hospitals.

These three programs totaled about $32 million in 1996, also about one-tenth of all DSH payments.

In 1992 and 1993, before the 1991 federal legislation that placed restrictions on the DSH program was fully implemented, the state also had four short-lived DSH programs: the Harborview Medical Center donation program, the Children’s/Mary Bridge donation program, a hospital settlement program (related to the 1991 Boren amendment lawsuit), and a Medicaid tax and dona-

<table>
<thead>
<tr>
<th>Year</th>
<th>Inpatient</th>
<th>Mental Health</th>
<th>Total</th>
<th>Growth</th>
<th>Washington Benefits</th>
<th>United States Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>11,149,608</td>
<td>—</td>
<td>11,149,608</td>
<td>—</td>
<td>1.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>1989</td>
<td>15,059,000</td>
<td>—</td>
<td>15,059,000</td>
<td>35%</td>
<td>1.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>1990</td>
<td>28,038,000</td>
<td>—</td>
<td>28,038,000</td>
<td>86%</td>
<td>2.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>1991</td>
<td>24,594,000</td>
<td>—</td>
<td>24,594,000</td>
<td>-12%</td>
<td>1.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>1992</td>
<td>173,197,000</td>
<td>57,732,000</td>
<td>230,929,000</td>
<td>839%</td>
<td>10.9%</td>
<td>14.7%</td>
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<td>1993</td>
<td>213,872,554</td>
<td>43,169,786</td>
<td>257,042,340</td>
<td>11%</td>
<td>10.7%</td>
<td>13.0%</td>
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<td>1994</td>
<td>264,696,110</td>
<td>44,176,803</td>
<td>308,872,913</td>
<td>20%</td>
<td>11.3%</td>
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</tr>
<tr>
<td>1995</td>
<td>171,725,815</td>
<td>176,233,324</td>
<td>347,959,139</td>
<td>13%</td>
<td>12.3%</td>
<td>12.6%</td>
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</table>
tion program. These programs were eventually declared to be in violation of federal DSH reform law, which banned donations, restricted the use of provider taxes, and limited federal DSH payments to 12 percent of the state’s medical assistance payments. Since 1993, the state has tried to ensure that it receives no less than the maximum allowed percentage and has created new programs to replace those declared invalid. This allows the state to continue helping certain public hospitals (especially Harborview, the largest public hospital in Seattle, and state psychiatric hospitals) and to maintain other programs with minimized net state dollars.

In 1996, the implementation of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) requirements created a new problem for the state’s DSH programs. Because DSH payments, under OBRA 93, cannot exceed hospitals’ documented losses on uncompensated care and Medicaid, the level of DSH funds that can be disbursed to some hospitals is curtailed.

The state believes that its DSH programs are legitimate, because they are primarily used to help targeted hospitals, such as Harborview, or to earn surpluses to fund other state medical assistance. Washington does not use DSH money for nonhealth purposes, as some states have been accused of doing. Yet some people in the state acknowledge that money is fungible, so that easing pressure on state health care spending ultimately helps other sectors of the state’s budget. While the new limits imposed by OBRA 93 will require some adjustments by the state, this is viewed as a manageable problem.

**Mental Health DSH Payments**

The Mental Health Division of the Department of Health and Social Services (DSHS) is responsible for all payments to three state-owned mental health hospitals (two adult hospitals and one pediatric hospital). MAA handles the relatively few DSH payments made to six private mental health hospitals in the state. There is some coordination of DSH payments between the two DSHS agencies, to ensure that the state obtains the maximum allowed federal payment.

The mental health DSH program began in 1992; the goal was to cover uncompensated care costs of state psychiatric hospitals. Total mental DSH payments were approximately $103 million in FY 1996 and a similar amount in 1997. These DSH payments go to the two adult mental health hospitals as single annual payments; the pediatric facility receives regular Medicaid payments. The level of DSH payments was much higher in 1995 (as shown in table 8), because OBRA 93 permitted, on a temporary basis, states to pay up to 200 percent of uncompensated care costs.

Overall, the three state mental hospitals have a 1996 budget of around $140 million, of which about $120 million is state and federal Medicaid funds and about $20 million is a combination of Medicare, patient collections, and private insurance (which includes Medicare deductibles and Medicaid spend-down). Thus, federal DSH funds have become very important to the state as a means
of covering well over half the total cost of the state mental health hospitals. Medicaid DSH payments are particularly important for adult mental health hospitals; their services were traditionally totally state funded before the Medicaid DSH program because federal law bars regular Medicaid coverage of mental health inpatient services in psychiatric hospitals for adults 22 to 64 years of age.

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**Medicaid Managed Care**

**History and Context**

Washington applied for and received a 1915(b) waiver to operate a Medicaid managed care demonstration in 1986. The demonstration project operated in three counties, with approximately 14,000 enrollees. Washington decided in 1992 to expand Medicaid managed care to all counties for the AFDC and pregnant women and children expansion groups. The original motivation behind the move to Medicaid managed care, which predated the comprehensive reform legislation of 1993, was to be able to cover more people cost-effectively, not to save money per se.

**Recent Policy**

Between 1992 and 1994, about 380,000 Medicaid enrollees were moved from fee-for-service coverage to fully capitated managed care plans. The initial concerns were how to prepare the clients for managed care rules and how to recruit enough managed care organizations (MCOs) to accept capitation for the Medicaid population, to ensure plan choice (a federal requirement and a policy goal of the MAA) and competition in each county. The name of the Medicaid managed care program—Healthy Options—signifies Washington’s emphasis on choice for enrollees.

To prepare enrollees, outreach meetings were held in each county. The state also devoted considerable effort to training caseworkers to prepare their clients for the gatekeeping and referral norms of capitated managed care. Medicaid managed care benefit fairs were held in each county at least three months before implementation.

Engendering capitation bids from an adequate number of MCOs in each county was an even larger concern and was addressed with three strategies. First, the state let it be known that premium bids as high as the traditional fee-for-service average cost would be acceptable. This reassured plans that extreme cost pressures would not be forthcoming, at least not until both the state and the MCOs had experience with managed care for the Medicaid population. In the absence of a risk-adjustment mechanism, this was probably necessary, at least initially, to elicit numerous willing bidders. The state did institute incentives for lower bids, but no plan was denied access if it bid the fee-for-service average, which was around $130 per month for the AFDC population in FY 1995. Second, the state used a three-year grace period granted by the Health Care
Financing Administration (HCFA) to avoid the requirement that no more than 25 percent of any health plan’s total enrollment be made up of Medicaid enrollees. And third, the state initially sold stop-loss insurance to new MCOs that formed for the purpose of bidding on Medicaid contracts.

The last two strategies allowed a number of community and migrant health centers to band together and satisfy the requirements for prepaid health plans, which permitted traditional providers for the low-income population to continue to serve that population even as the state converted to managed care. At this writing, there are 16 managed care vendors with 19 plans in the Healthy Options program, and at least two plans are in each of Washington’s 39 counties (the average is four). Currently, 90 percent of the state’s primary care providers participate in Healthy Options plans, soaccess would not appear to be a problem for Medicaid enrollees. If capitation rates are substantially cut in the future, of course, plans and providers may drop out, but that outcome is not anticipated at present.

**Benefit Package**

The Healthy Options benefit package is more generous than the Basic Health Plan benefit package: It includes dental and vision services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and transportation. Medicaid also pays for a number of services (e.g., inpatient mental health care, substance abuse services, interpreter services, and transplants) on a fee-for-service basis outside the Healthy Options plans. Adult mental health services are capitated and coordinated through Regional Support Networks. The state plans to include inpatient mental services in the capitated rate in 1997. Overall, the combined benefits package is quite generous.

**Enrollment**

The enrollment process is central to how effectively a Medicaid program reaches its target populations. Upon eligibility determination, two Healthy Options information packets are mailed to the beneficiary, with a two-week interval. If the client declines to submit a preference for a particular plan within a month of the first mailing, the Healthy Options program assigns that person to a plan. Plans with the lowest bids receive the most assignments. About 40 percent of all enrollees are assigned. This rate is perhaps inflated by children, new family members, and those who cycle in and out of Medicaid eligibility. About 15 percent of longer-term Medicaid enrollees are assigned. After assignment, enrollees have two weeks to select a different plan, and they can disenroll from or enroll in plans monthly. Still, the program observes relatively little plan switching.

Plans are not allowed to market directly to clients, although providers may advise patients about different plans. There is a toll-free enrollment phone line, and enrollment forms and counselors are available in 21 languages. Plans must
supply each member with a handbook that lists providers and facilities, including local “essential community providers.”

**Interaction with Other State Programs**

Children under age 19 in families eligible for BHP subsidies (incomes at or below 200 percent of the federal poverty level) are enrolled in BHP Plus, a Medicaid program. They remain members of their parents’ BHP health plan to preserve continuity of care and familiarity with providers. Medicaid simply pays the premium costs for these children. Also, pregnant women eligible for BHP subsidies are enrolled in Healthy Options plans, because the premium costs for these women will be shared with the federal government. This cross-enrollment requires coordination between MAA and the Health Care Authority. The agencies now use almost all the same vendors, and coordinate their site visits to the MCOs and MCO reporting requirements. A condition of being a BHP vendor is that one must bid for Medicaid contracts and supply BHP Plus products, although it is not clear that any health plans would avoid Medicaid without this constraint.

Some Medicaid clients have unique needs; these clients include homeless, illiterate, and non-English speaking persons. Contract decisions for 1996 favored plans with enhanced enrollee education and health promotion activities that address some of these unique needs. In addition, incorporating essential community providers into their provider networks earns plans points in the request-for-proposals process. Rural Health Clinics and Federally Qualified Health Centers that participate in Healthy Options receive cost-based reimbursement.

**Capitated Rate Setting**

Plans bid for Medicaid contracts, but until 1997 all or most bids were accepted. Rates are bid by eligibility group and adjusted by MAA for age and sex. Again, the state was originally more interested in building capacity to provide Medicaid managed care services than in saving money. And, in the absence of widely available, clinically meaningful, and auditable outcomes data, encouraging more than one plan per county may have been a wiser client protection strategy than a low-bidder-takes-all approach. In any event, the state made it clear that bids at the fee-for-service average cost level (for the Healthy Options population) were acceptable. Most bids were apparently at or near this level, based on historical claims data and actuarial projection techniques. As more of the Medicaid population has moved into managed care plans, the fee-for-service claims data that supported this benchmark calculation are no longer available or relevant. This, plus a strong legislative interest in saving money, has led Healthy Options to study a competitive bidding process. The Washington legislature commissioned a study that strongly recommended adoption of a low-bidder-take-all strategy and predicted that this could save Healthy Options 20 percent per enrollee within a few years. Most analysts
think 20 percent savings is unlikely without significant reductions in the Medicaid benefit package. Also, winner-take-all bidding could drive some plans out of business altogether, which could reduce competition in the long run. The state has not decided yet whether to adopt the recommendation.

**Quality**

Capitation generally, and the prospect of low-bidder-take-all capitation especially, has heightened concern about how effectively the state can monitor the quality of care delivered to Healthy Options enrollees. Medicaid has responded to this concern in a number of ways. First, the contract imposes certain outcomes reporting requirements on Healthy Options vendors, although not all plans have the information systems to permit full reporting yet. Healthy Options has brought Department of Health staff into the vendor proposal evaluation process to help sharpen the focus on quality of care issues. Healthy Options is conducting a provider survey to assess, among other things, the extent to which providers feel new financial arrangements are affecting decisions about care; it will use the results of this survey in negotiations with specific health plans. Healthy Options, BHP, and Department of Health personnel conduct joint, yearly health plan site visits to assess the quality of care. An Oregon clinical quality control firm has been retained to evaluate outcomes of Healthy Options plans in three areas: obstetrics, immunizations, and EPSDT. The overall results of an initial evaluation were fairly impressive, but there is still enough variance in outcomes for officials to be concerned. The Healthy Options program is an active participant in a very ambitious interagency quality assessment and improvement effort that will make recommendations about a common set of reporting requirements that would be required of all state vendors. This effort complements the rule drafting efforts under way at the Office of the Insurance Commissioner that would standardize network adequacy, quality assurance, and reporting requirements across all types of private health insurers in Washington.

**Medicaid Managed Care Issues for the Near Future**

Two issues are paramount. First, the state intends to move the SSI population into capitated health plans by 1998. (The original target date was 1996; it was pushed back because neither the state nor the vendors were ready.) This beneficiary group is much more complicated to serve than the AFDC/pregnant women and children population that now makes up the bulk of Washington’s Medicaid managed care enrollees. The state does have a managed care SSI demonstration project under way in Clark County. No doubt partly because of the considerable resources devoted to the Clark County experiment early on, it now has 75 percent voluntary selection and 25 percent assignment in its SSI managed care plans. Since vendors are naturally very concerned about adverse selection with the SSI population, the state wants to risk-adjust these contracts. Part of the reason for the postponement from 1996 to 1998 is to take the time to develop an effective risk-adjustment mechanism.
The second major issue for the future is cost containment. Initiative 601 now requires reductions in the rate of growth of spending out of the general fund. Medicaid managed care is a candidate for savings. Medicaid has the bargaining power to achieve some—perhaps significant—savings, at least of a one-time nature, by negotiating lower prices with managed care plans. Whether cost reductions can be sustained over many years by reducing the volume and intensity of services is a question many Medicaid managed care programs will be asking themselves in the next few years. What is clear is that there are costs to cost reductions. The first cost is that low-bidder-take-all strategies will limit the choice of plans in each area and will require a precision of quality monitoring that some doubt is feasible right now. This could jeopardize public acceptance of a strictly competitive strategy. Some officials would prefer to pursue a strategy of “cost reduction with a human face.” By that they mean that the state as a purchaser must be mindful that pieces of a health care delivery infrastructure that go bankrupt are not likely to come back. Since some of the high-cost pieces of that system are precisely those providers who have served the low-income and Medicaid populations faithfully over the years, the state should be careful about driving as hard a bargain as it arguably could in the near term. Whether this strategy will yield sufficient savings to satisfy the political forces calling for savings remains to be seen and probably depends on many forces outside the control of the Medicaid managed care program.
Delivering Health Care to
the Uninsured and
Low-Income Population

State and Local Public Health Departments

The Department of Health (DoH) consists of several divisions that carry out a broad scope of public health activities, ranging from traditional population-oriented activities to direct services. The total budget was $446 million in the 1995–97 biennium; the majority of the funding is for community and family health (64 percent), including the Women, Infants, and Children (WIC) program and Maternal and Child Health (MCH) programs, and for health systems quality assurance (14 percent). Overall, federal funds underwrite 53 percent of DoH programs and well over two-thirds of community and family health programs. The DoH receives 63 federal categorical and 2 federal block grants (Maternal and Child Health Services Block Grant and the Preventive Health and Health Services Block Grant). The single largest federal payment by far is for WIC: more than $130 million in the biennium. Most of these federal dollars, as well as state funds, are transferred to local health departments through a consolidated contract between the state and the local health departments.

Much of the work of the Washington State Department of Health, both program design and delivery, is carried out by the 36 local public health departments. Most are organized along county or multicounty geopolitical lines, but three are county-city health departments, including the Seattle-King County Health Department, which serves over 30 percent of the state’s population.
Almost half the state’s local health departments serve jurisdictions of less than 50,000 persons and have average annual budgets well under $1 million.

As important as state and federal pass-through grants are to local health departments (25 percent of the typical budget), in 1992–93, the largest single share of funding (34 percent) was from local tax revenue. Medicaid dollars, both federal and state, constituted another 8 percent of local health departments’ budgets, and direct (non-pass-through) federal grants accounted for 4 percent.35 Local health departments are expected to coordinate with the Medical Assistance Administration to maximize the draw of federal Medicaid matching funds. In some cases, local health departments must provide matching funds for Medicaid-eligible services.

Local health departments have for the past 30 years served as safety net providers in many communities, especially for uninsured or Medicaid-covered women and children. However, this has begun to change. Even though the legislative commitment to universal coverage was short-lived, the state remains committed to shifting the emphasis from local health department delivery of health services to the Public Health Improvement Plan (PHIP). This DoH initiative outlines 88 standards that local health departments must seek to fulfill, with a proposed six-year phase-in period. The standards fall into the categories of community health assessment, development of public health policy, ensuring community access to quality health care services, protecting the community against public health threats, and promoting health within the community. In the future, these standards will serve as the basis for contractual arrangements between the state and local jurisdictions (i.e., performance-based contracting). To support this effort for 1995–97, $15 million from the Health Services Account was earmarked for local health departments.

### Maternal and Child Health

The MCH program is one of the largest in the Division of Family and Community Health. In 1995, the budget was more than $25 million for the Maternal and Child Health Block Grant Program alone, which included programs for children with special health care needs, maternal and infant health, and child and adolescent health. Federal block grant funds increased by 23 percent (in nominal terms) from 1989 to 1995.36 Over this period, the state used Health Services Account funds (e.g., for a teen pregnancy project and immunization program) and Medicaid to minimize the drain on general fund revenues. The state qualifies for federal Medicaid dollars via intergovernmental transfers to local public health jurisdictions: State general fund money is passed through to health departments, which in turn expend it on Medicaid-eligible services and thereby qualify for a federal match. This is called leveraging state dollars or Medicaid maximization, depending on one’s point of view. Because of Medicaid expansions and BHP, the MCH program is funding fewer well-child clinics and is instead assuming monitoring and assessment responsibilities as well as case management of children with special health care needs, many of
whom will be enrolled in managed care when the SSI population is enrolled. The MCH program also provides some gap services not covered by Medicaid to children with special needs. In general, financial commitment to the MCH program has been bipartisan.

The Safety Net in Seattle

Safety net providers are institutions that, by statutory or self-defined mission, provide a significant amount of free care to uninsured or underinsured persons. Although Seattle-King County is a well-off community with a strong economy, it also has a large absolute need for subsidizing its health care safety net. Seattle-King County is a relatively high-income area with a relatively low poverty rate. But it has 30 percent of the state’s population, which includes 25 percent of the state’s poverty population, or 157,314 people in 1993. Seattle-King County also has the largest nonwhite population in the state, 18 percent overall, of which 11 percent are Asian and Pacific Islanders. Minorities and the low-income population (those with household incomes below 200 percent of the federal poverty level) are at the greatest risk of being uninsured and are most likely to need uncompensated medical care.

In Seattle, five hospitals, the local health department, and eight Federally Qualified Health Centers (FQHCs) provide a significant share of care to the low-income population and together form a safety net of health care services. Community, migrant, and homeless health clinics—FQHCs and FQHC lookalikes—provide many primary care services to the safety net population. FQHCs also serve very specific multicultural populations that some private providers and physicians may not serve as well. Unlike many other local health departments in the state, the Seattle-King County Health Department has maintained its role in providing primary care services, especially in low-access areas within King County.

Expansions in insurance coverage through the Medicaid and BHP programs have reduced the demand for free care from safety net providers all over Washington. As a result, the amount of services that they can provide has grown, and the safety net providers are considered either adequately financed or, at least, better off financially than in the past. Part of the safety net providers’ recent good fortune is a function of their ability to maintain or increase their share of the newly capitated public market.

Medicaid managed care has provided safety net providers with significant incentives to develop cost-effective managed care products or to affiliate themselves with organizations that provide managed care products. Interviewees indicated that the movement toward managed care forced providers to find new ways of internally managing care in a cost-effective manner, create networks of providers that can serve as a primary care referral base, establish health plans, or affiliate themselves with existing health plans.
While managed care is sometimes feared and loathed in the low-income advocate community, Medicaid and BHP managed care in Washington have helped efficient safety net providers in Seattle-King County that formed or joined Medicaid and BHP managed care plans because they are able to keep the residual. Capitation pays a fixed amount per person, which to date has been pegged to a fee-for-service average (for Medicaid), and the health plan is responsible for providing reasonable care for that fixed amount per person. But if services can be delivered for less than this payment, the health plan keeps the savings, the residual. Under fee-for-service payment, Medicaid would keep the savings from reduced utilization or lower provider payment rates. These savings can now be used by safety net providers that have formed their own health plans to finance additional services for the uninsured. But there are fewer uninsured persons than in the past, so the safety net providers, in general, are feeling less strained than they have in the past and less strained than many of their counterparts in other parts of the country.

Part of this lack of strain has to do with the virtual monopolies that Harborview has on trauma and some tertiary care and that Children’s has on all pediatric secondary and tertiary care, and the excellent reputations of both hospitals. At the same time, the community health centers in Seattle that joined together to bid for Medicaid and BHP contracts enjoy a client base that became insured with a capitated payment attached practically overnight. Financial success has clearly rewarded those safety net providers that established affiliations with specialists and hospitals. Overall, the safety net is financially stable, and while advocates indicate that there are some problems for very specific subgroups, access to care is adequate for the vast majority of Seattle’s low-income population.
Long-Term Care

The Elderly and Functionally Disabled

Long-term care services for the elderly and functionally disabled adults are administered by the Aging and Adult Services Administration (AASA) in the Department of Social and Health Services. As of fall 1996, AASA served more than 37,000 clients: 41 percent in nursing homes, 47 percent in their own homes, and 12 percent in community residential care. The agency’s 1995–97 budget is $1.58 billion, approximately half of which is derived from federal funds—primarily Medicaid. Over the past decade, “real” AASA expenditures have doubled, growing twice as fast as the total state budget, mostly because of increasing costs per person served. Two-thirds of AASA’s budget is allocated for nursing homes.

Despite the fact that growth of Medicaid long-term care costs has moderated, expenditures per elderly recipient remain high—$8,489 in 1995 versus $7,238 for the nation overall. Table 9 shows that Medicaid long-term care spending for the elderly is mostly for nursing home care: 93 percent versus 6 percent for home and community-based care. In contrast, 43 percent of Medicaid long-term care spending for the disabled is for home and community-based care versus only 16 percent for nursing home care.

The state continues to place a high priority on enabling the elderly and functionally disabled to avoid nursing homes if possible, both to respond to client preferences and to save public dollars. Overall, waiver programs are the state’s primary vehicle for providing nonfacility options to long-term care recipients. In 1994, 71 percent of Medicaid home and community-based care expenditures were on waivers, while the remainder paid for the optional services of personal care and home health. The state’s main Medicaid home and community-based care waiver—Community Options Program Entry System (COPES)—serves
Table 9  Medicaid Long-Term Care Expenditures by Eligibility Group, Washington and United States ($ in Millions)

<table>
<thead>
<tr>
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<th>Washington</th>
<th></th>
<th>United States</th>
<th></th>
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<tr>
<td>Long-Term Care Expenditures</td>
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<td>Total</td>
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<td>448.4</td>
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<td>ICFs/MR&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.9</td>
<td>6.7</td>
<td>6.9</td>
<td>348.9</td>
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<td>Mental Health</td>
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<td>0.2</td>
<td>1.1</td>
<td>973.0</td>
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Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

<sup>a</sup> Intermediate care facilities for the mentally retarded.
8,900 elderly and disabled recipients. COPES offers adult residential care, adult family home care, assisted living, personal care, and case management.45

There is some evidence that the shift away from nursing home care has reduced the state’s overall long-term care costs.46 It has certainly reduced the number of recipients who are in a nursing home and the number of nursing home beds (slightly), and increased the number of residential care facilities and home health agencies considerably.47 At the same time, the state is mindful of the need to remain steadfast in its pursuit of quality standards and care coordination. In particular, the state is trying to strengthen case management at the point of hospital discharge and further develop residential and nursing facility case management.

A rapid and sustained rate of growth of home care costs for the elderly and functionally disabled has led to some fears that the “woodwork effect”—more generous policies inducing people to seek home health services that they would not have sought if institutionalization were the only alternative to family care—will lead to high-cost growth. So far, there appear to be net savings, primarily because home and community-based services are much cheaper to provide—perhaps by as much as two-thirds—than nursing home stays.48 Still, conclusions regarding program savings remain debatable, and varying opinions are held by state officials and stakeholders.

The state’s goal is to further reduce its nursing home Medicaid census to 12,000 by July 2003.49 Partly due to certificate-of-need policies for nursing home beds (which raise barriers to entry and expansion of nursing home providers), Washington has been able to hold nursing home beds per 1,000 elderly to only 46 versus a national count of 53 beds per 1,000 elderly.50 At the same time, AASA’s assisted living caseload grew 106 percent.51 It should be noted that access to nursing home care, even for Medicaid patients, has apparently not presented a problem.

While Initiative 601 has led to talk of seriously restricting the growth of nursing home payment rates, they are currently viewed as at least adequate and perhaps generous vis à vis other states. Payment reform (shifting from simple cost-plus to case-mix adjusted fee-for-service payments) is scheduled for implementation in 1998. Selective contracting authority could also help the state place its clients in cost-effective institutions, but the authority has not yet been granted by the legislature. Other strategies, including the integration of acute and long-term care and the promotion of long-term care insurance, have been pursued, but both are in the early stages of development.

### Younger Persons With Disabilities

The Department of Social and Health Services houses the Division of Developmental Disabilities (DD) and the Division of Mental Health (MH). At least three broad approaches to delivering and financing services for the DD and MH populations are being pursued by the department: (1) community-based care, (2) managed care, and (3) maximized federal support. Perhaps the clear-
est indication of Washington’s strategy for the disabled is the increase of the ratio of Medicaid home and community spending on the blind and disabled to Medicaid Intermediate Care Facility for the Mentally Retarded (ICF-MR) spending on this same population: The ratio increased from 0.26 to 1.52 between 1990 and 1995. The impact of the state’s efforts is also apparent in the ongoing closure and downsizing of state institutions for persons with mental illness.

**Developmental Disabilities**

The Division of Developmental Disabilities operates and funds residential and other support services for more than 23,000 eligible clients, which represents an increase of nearly 3,000 since 1994. The fastest-growing segment of the population being served is children, a group that has increased at an average rate of 11 percent over the past five years. Overall DD caseload growth exceeds 7 percent, which exceeds Initiative 601 limits. The division is essentially an arm of the Medicaid program, as almost 43 percent of its budget is composed of federal matching funds.

Legislation was enacted that requires any savings from deinstitutionalization to revert to DD programs. The division has experienced difficulty moving rapidly ahead with deinstitutionalization, in part because of pressure from the strong state employees union that fears job losses and from advocates for the institutions. And state law prohibits moving clients out of an institution against their wishes. Nevertheless, because of the division’s reliance on Medicaid dollars to support ICF’s-MR, future reductions in the state’s Medicaid budget would inevitably speed up deinstitutionalization.

Federal effects on state DD policy are evident in the state’s service coverage: Washington has generously funded its three home and community-based waiver programs for the DD population, while those outside the waiver are not provided benefits that could potentially maintain them in their homes. These services include assistive technology and supported living, which do not qualify for a federal match payment. Still, Washington’s system of residential services reflects its commitment to placing persons in noninstitutional settings. In 1994, nearly two-thirds of persons in residential settings were in living arrangements with six or fewer beds, compared with only 47 percent for the United States. In 1992, only 40 percent of the state’s DD clients were in congregate care settings (including large state-owned facilities) compared with a national average of 76 percent. The majority of clients live in their own homes and receive personal assistance as needed or live in a “foster home” with a person or family unrelated to them.

**Mental Health**

The Division of Mental Health administers a system of care for adults and children who are seriously mentally ill or emotionally disturbed. The Division of MH is similar to the Division of DD in three main respects: (1) it operates as a branch of the state’s Medicaid program, (2) its service orientation is gradually shifting away from providing institutional care to providing community-
based outpatient care, and (3) managed care is playing an increasing role in the delivery of its services. In 1995, more than 90,000 persons were served through the division, up from 50,000 in 1990. Although the system was originally designed to serve adults, an increasing number of outpatient clients have been children—29 percent in 1995. Another 13 percent of clients were elderly.

In 1993, Washington ranked fourteenth in the nation in per capita expenditures on mental health. The state's ability to successfully draw down federal dollars via the Medicaid program has undoubtedly contributed to the increased spending. In 1985, the legislature instructed the Division of MH to maximize federal funding of mental health, and the division has since obtained federal matching funds for almost all its services. This has led to some substitution away from services and clients not covered by Medicaid, as state resources are required for matching payments. From 1988 to 1992, Medicaid spending on mental health care experienced an average annual growth of 49 percent compared with a 15 percent average annual growth for the nation. Between 1992 and 1994, mental health spending continued to climb at an average of 16 percent per year compared with a 3 percent decline for the nation.54

Washington has made significant strides in the treatment of mental illness in community settings. In 1993–95, the state spent 65 percent of its total state mental health program dollars on community mental health, compared with less than half for all states combined. Washington’s most recent budget goes even further, increasing community spending to 69 percent of total mental health expenditures. Community mental health spending includes outpatient care as well as supported housing and residential facilities. Most of the remaining state expenditures are for psychiatric hospitals.

Since 1992—when HCFA made it legal—Washington has used its state psychiatric hospitals to qualify for relatively large DSH payments. In 1992, DSH payments for mental health totaled $58 million; by 1995, DSH payments linked to mental health were $176 million. A portion of these DSH payments support the state psychiatric hospitals; 60 percent of state psychiatric hospital financing is derived from Medicaid, both DSH and other payments.57

Regional Support Networks and Managed Care

In 1989, Washington’s legislature enacted the Mental Health Reform Act, consolidating outpatient mental health services and granting responsibility for these services to 14 Regional Support Networks (RSNs) that serve one county or contiguous counties. RSNs frequently subcontract with private agencies to deliver services.

Beginning in 1993, the state, through a 1915(b) waiver, began a system of capitated managed care for outpatient mental health services for Medicaid-eligible individuals. Each of the RSNs was awarded the contract to serve as the mental health managed care plan for its region. Enrollment with an RSN is mandatory for all Medicaid beneficiaries, including those not currently man-
dated to enroll in managed care, for example, SSI recipients.\textsuperscript{58} The RSNs are responsible for all mental health services delivered to this population, with a few exceptions.

In addition to delivering capitated outpatient care, the RSNs also serve as gatekeepers for inpatient care, authorizing the use of state hospitals. Beginning in 1997, the state plans to incorporate inpatient psychiatric care for Medicaid beneficiaries into the RSN prepaid health plan, which requires an additional federal waiver.\textsuperscript{59} State psychiatric hospitals will not be included in the capitation arrangement since Medicaid reimbursement to these hospitals is restricted, as explained above in the DSH discussion.

Opinions vary regarding the effectiveness of RSNs in delivering capitated mental health services to Medicaid beneficiaries. Some Medicaid officials and patient advocates are concerned about the performance of RSNs. Advocates stated that movement toward managed care in mental health has been problematic; they noted that coordination of services has been difficult because of the involvement of many state agencies and vendors who are unfamiliar with the type of care needed for the mentally ill.

Washington's efforts to downsize its state mental hospitals have been propelled through the risk pool agreements it has established with RSNs. The state gives each RSN a target number of bed days it can use. If the RSN meets the target, it receives a percentage of the money saved for use on other programs. If it does not, the state imposes financial penalties. A target was also set for eliminating state psychiatric wards (the equivalent of 30 beds). Four wards have closed thus far, saving the state an estimated $7.5 million per ward, $2 million of which was returned to the RSNs. The impact of the changes is apparent in the declining hospital census. Division officials explained that the risk pool arrangement has not changed the number of short-term intensive stays; rather, it has decreased the number of long-term patients in residence in the hospitals.
Challenges for the Future

With plenty of good hospitals and physicians; a strong economy; above-average financial commitments to the poor, near-poor, and safety net providers; and a low overall uninsurance rate, Washington’s health care system is currently quite strong. The major challenges for the future are similar to those faced elsewhere, although the particulars vary: Can Medicaid save enough from managed care and other market-based efficiencies to avoid enrollment or benefit cuts? Can the health care safety net survive aggressive market competition and state budget constraints? Will organized purchasers, public and private alike, be able to ensure that high-quality health care is delivered in the managed health care settings of the future? All these areas will require constant vigilance and may call for policy intervention in the next few years.

Medicaid Savings

How much Medicaid savings is enough? This depends on two somewhat unrelated parameters: the underlying rate of increase in health care costs for the Medicaid population and the sustainability of the political commitment to the spirit of Initiative 601. The growth rate of health care costs is unlikely to be lower than that obtained in the private sector for the nonelderly population, and this minimum rate of growth is unknown. Treatment options for the Medicaid populations, especially the elderly and disabled, could progress in such a way as to lower or raise the minimum Medicaid cost growth rate. This means that however aggressively the state embraces winner-take-all competitive bidding strategies, selective contracting, and mandatory managed care, there is no guarantee that the underlying Medicaid cost growth rate will be less than population growth plus general inflation, as required by Initiative 601. If the
Medicaid rolls continue to grow faster than general population growth, the 601 constraints on aggregate state spending out of the general fund will likely force state policymakers to eventually consider reductions in Medicaid enrollment or benefit levels.

If the spirit of 601 is stronger than Washington’s traditional commitment to maintaining and expanding access to health care with economic growth, then cutbacks in the Medicaid program will occur. Most likely Washington would reduce benefits (such as adult dental care) as well as provider and health plan payment rates before reducing enrollment growth or enrollment, but the latter could occur if 601 remains in place long enough. If policymakers are unwilling to make these cuts in Medicaid growth, they must cut other programs or increase earmarked taxes (e.g., taxes on tobacco, alcohol, or health providers, which do not go into the general fund). There is no way to predict the exact outcome of this choice, for the world will surely look different in another couple of years after yet another election cycle and perhaps with a different economy. Still, at the present time, it is hard to imagine Washington cutting Medicaid very much. The response of state elected officials to federal welfare reform this spring (restoring benefits for immigrants) suggests the strength of the social consensus regarding low-income programs in Washington.

Federal Medicaid reform in the 105th Congress, especially DSH reforms, could pose a financing problem for a number of Washington state health programs. DSH funding is extraordinarily important to Washington’s mental health programs. State officials are clearly currently substituting federal dollars for state funds in many cases. Thus, nonfungible reductions in federal DSH monies, especially if specifically tied to mental health services, may force Washington to find other state financing sources or reduce services. More state resources may be feasible since Initiative 601 limits would not strictly apply in the case of federal policy changes. But it is not possible to predict how the state will respond to this scenario.

Safety Net Concerns

While the balance of any safety net is tenuous, at present the health care safety net in Seattle is strong. High Medicaid and Basic Health Plan (BHP) enrollment have provided solid funding sources. Community health centers that joined together to obtain Medicaid and BHP capitated contracts have become relatively efficient providers, and they allocate the savings created by that efficiency to services for the uninsured and underinsured. Also, the fraction of the population that is actually uninsured is relatively low in Seattle, a relatively high-income area with considerable philanthropic fund-raising capacity as well. Safety net hospitals such as Children’s and Harborview also benefit from unique marketing and quality advantages.

The first threat to this fine balance is genuinely fierce health plan competition. There is a widely perceived surplus of hospital beds and an oversupply
of physicians in Seattle. Medicaid is under increasing pressure to generate savings from managed care; it may soon stop paying so generously. At the same time, private employers are increasingly organized and aggressive purchasers of health insurance. This can only reduce payment rates, constraining the ability of providers to cross-subsidize care for the uninsured by charging the privately insured more than costs. This in turn will lead to potentially even stronger competition for Medicaid enrollees, which will make it easier to achieve Medicaid savings at provider expense. Finally, the legislature may be hard pressed to continue to finance BHP expansions: This year's funding for 8,000 new enrollees falls far short of the known waiting list. If the private individual insurance market does not stabilize and the small-group market does not remain stable as a result of the recent reforms, the BHP will become an even more popular choice for Washingtonians. Will the legislature return to its earlier commitment to expand coverage and appropriate money commensurate with waiting list growth over time? Without more financial resources from the state, the percentage of uninsured could increase, placing added pressure on safety net providers. These pressures will be greater, of course, if Medicaid is also cutting enrollment or enrollment growth.

Quality

The cost efficiencies of managed care mean that it is here to stay, but the degree of trust that was inherent, rightly or wrongly, in fee-for-service medicine has proved difficult to transfer: Thus the clamor for outcomes and process quality measurement, reporting, and accountability of health plans and managed care providers. The good news is that the state has been leading the way in this area for its own employees, BHP enrollees, and Medicaid managed care enrollees, and the private sector is learning that it can piggyback on state-induced information and reporting systems. The bad news is that, nationwide, the entire movement is in its infancy, especially for outpatient and chronic care. Organized purchasers, in particular Medicaid, are increasingly called upon to practice selective contracting before the science of clinical outcomes measurement can support refined criteria for selecting. The perceived relative performances of Medicaid, the Health Care Authority, and the private sector in monitoring and maintaining high-quality care over the next few years may have considerable influence on the types of health plans, purchasing strategies, and regulatory frameworks that survive in the long run, in Washington state and elsewhere.
Notes


2. Core public health functions include health promotion (e.g., health education) and community health protection (e.g., immunization, infectious disease surveillance and control, water purification, sewage treatment, inspection of food service operations, and environmental quality).

3. These include acupuncturists and naturopaths.

4. Department of Social and Health Services budget documents. State budget totals for medical assistance payments encompass more than Medicaid. They also cover some state-only programs such as general assistance and substance abuse treatment.

5. Table 7.

6. Health Care Policy Board (HCPB) estimates. The HCPB is appointed by the governor and the legislature to monitor, report, and make recommendations about health care policy issues facing Washington.


8. The state has a separate high-risk insurance pool that caps premiums at 150 percent of the standard rate. Subsidies are funded through a surcharge on insurers. In 1995, about 4,400 people were in the program. By 1997, fewer than 1,000 remained, and it is believed that many of these people are now in the BHP.

9. Not all of these people may have been eligible for subsidies.


11. This report uses the term “low-income” to mean those with income below 200 percent of the federal poverty level. The percentages were computed from the data in table 6.

12. The federal data derive from the HCFA-2082 report, as edited by The Urban Institute. The key difference is that people come on and off Medicaid during the course of a year, so that the number who are ever enrolled during a year is much higher than the level in any particular month. In addition, the state data correspond to the state fiscal year of July to June, compared with the October to September federal fiscal year, leading to small time-related discrepancies.

13. This includes children in BHP Plus, who are enrolled in Medicaid. It also includes unsubsidized enrollees and some special categories, such as home care workers enrolled in BHP. The number of subsidized regular members was 44,000 in July 1995 and 104,000 in July 1996.


16. All of these estimates came from the 1995 HCPB Annual Report.


21. OIC 1994–95 Annual Report data support the conclusion that the smaller indemnity insurers had about an 18 percent market share in 1995.


25. An MCO is not necessarily an HMO license holder but must satisfy the network adequacy, financial, and reporting requirements set by the Washington State Department of Social and Health Services.


27. These rates do not apply to the Medically Indigent and other small state-only programs, which provide much lower reimbursement levels. Taking into account the $2,000 deductible, state officials estimated that Medically Indigent payment rates were roughly 75 percent below Medicaid levels. In principle, the deductible means that the patient should be responsible for the first $2,000, but in practice it often means that the hospital must have an initial loss of $2,000 for the uninsured patient before any payment is made.

28. Data Resources Incorporated is a consulting and economic forecasting firm in Lexington, Massachusetts. Its indexes are widely used by governments and the private sector.


30. S. Norton.


32. All data in this paragraph are contained in the Department of Health budget documents, 1995–97.

33. Private agencies are also recipients of federal grant dollars via the DoH. These include Planned Parenthood, Children’s Hospital in Seattle, and WIC agencies.

34. For example, 81 percent of MCH funds are distributed to local organizations.


37. Per capita income in 1994 ($29,295) was 30 percent higher than the state average and 35 percent higher than the national average. U.S. Census Bureau, U.S. Department of Commerce.

38. In 1993 (the last year for which county figures are available), only 9 percent of King County residents had incomes below poverty, compared with 12 percent statewide (Census estimates). Today, Washington state has a 13.7 percent poverty rate, which still compares favorably to that of the nation as a whole at 15 percent (table 1).


40. Harborview Medical Center, Children’s Hospital, University of Washington Medical Center, Swedish Medical Center, and Providence Medical Center provide over $60 million in uncompensated care each year. Harborview provides twice as much as any other hospital, over $23 million in 1994.

41. Aging and Adult Services Administration (AASA) Progress Report: LTC Options for Adults and Seniors with Disabilities, Fall 1996.

42. AASA budget documents, 1995–97.

43. As reported in Final Bill Report: E2SHB 1908. See tables 3, 6, and 9 for additional budget and caseload information.

44. American Association of Retired Persons, Profiles of Long-Term Care Systems, 1996.

45. The state licenses three categories of residential alternatives to nursing homes: boarding homes (three or more persons in a “facility”); adult family homes (two to six persons in
“homes”); and assisted living (a combination of housing, health services, and assistance with personal care provided by a licensed boarding home in accordance with the assisted living services contract). The term “adult residential care” is a Medicaid reimbursement term rather than a licensure term and generally refers to care delivered in boarding homes.


48. AASA.

49. AASA Strategic Plan, July 1996.

50. Of the 29,000 nursing home beds in the state, 22,000 are in for-profit facilities. One-third of nursing homes are small and locally owned; however, national chains are purchasing many of these small facilities as well as in-state multifacility chains.

51. AASA Progress Report, Fall 1996.

52. Computed from data in table 9.


54. These expenditures do not include disproportionate share hospital payments.

55. Division of Mental Health Data; National Association of State Mental Health Program Directors Research Institute, Inc., Funding Sources and Expenditures of State Mental Health Agencies, FY 1993.

56. HCFA data.

57. Division of Mental Health materials. Note that state psychiatric hospitals cannot qualify for regular Medicaid payments for patients ages 22 to 64.

58. Populations exempted from enrolling with an RSN are residents of state-owned institutions and Native Americans who opt to receive care through the tribal health system.

59. The waiver—a second 1915(b) waiver—was submitted to HCFA in December 1996.


APPENDIX

List of People Interviewed

OLYMPIA

*Department of Social and Health Services*

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
<th>Name</th>
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<tbody>
<tr>
<td>Bobbe Andersen</td>
<td>Dave Dula</td>
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<td>Joan Bantz</td>
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<td>Tom Bedell</td>
<td>Roger Gantz</td>
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<td>Jane Beyer</td>
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<td>Ken Cameron</td>
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<td>Kathleen Connor</td>
<td>Judy McGinnis</td>
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<td>John Cordy</td>
<td>Wolfgang Opitz</td>
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*Health Care Authority*

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<tbody>
<tr>
<td>Gary Christenson</td>
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<tr>
<td>Vicki Wilson</td>
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*Department of Health*

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<tbody>
<tr>
<td>Joan Brewster</td>
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<tr>
<td>Georgia Britt</td>
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<td>Verne Gibbs</td>
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<td>Alice James</td>
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<td>Maxine Hayes</td>
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<tr>
<td>Lucy Phillips</td>
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<td>Jackson Williams</td>
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*Legislature*

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<tbody>
<tr>
<td>Representative Philip Dyer</td>
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<td>Senator Kevin Quigley</td>
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<td>Representative Mike Sherstad</td>
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<td>Don Sloma</td>
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<td>Tim Yowell</td>
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*Health Care Policy Board*

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<tr>
<td>Tom Ansart</td>
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<tr>
<td>Bernadine Dochnahl</td>
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<tr>
<td>Tom Hilyard</td>
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<td>Dwayne Thurman</td>
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Others
Sue Crystal Governor’s Office
John Conniff Department of Insurance

Provider Associations
Greg Vigdor Washington State Hospital Association
Len Eddinger Washington State Medical Association
Robert Perna Washington State Medical Association
Gerald Reilly Washington Health Care Association
Donna Cameron Home Care Association of Washington
Dennis Braddock Washington Primary Care Association

SEATTLE

Hospitals
Cheryl Ellsworth Children’s Hospital
John M. Neff Children’s Hospital
Kelly Wallace Children’s Hospital
Elise Chayet Harborview Medical Center
Peter Bigelow Sisters of Providence Hospital
Bruce Ferguson University Hospital

Community Health Centers
Dennis Braddock Community Health Plan of Washington
Karen Bosley Puget Sound Neighborhood Health Centers
Dorothy Wong International District Community Health Center

Health Department
Kathy Carson Seattle/King County Department of Public Health
Susan Oatis Seattle/King County Department of Public Health
Alonzo Plough Seattle/King County Department of Public Health

University Experts and Others
Robert Crittenden University of Washington/ Harborview
Aaron Katz University of Washington
James McIntire University of Washington
Richard Brandon University of Washington Kids Count
Sally Fox City of Seattle
Lonnie Johns-Brown Partnership for Washington’s Future
Tony Lee Freemont Public Association
Diane Sasne SEIU
Liz Schot Columbia Legal Services
About the Authors

_len Nichols_ is a principal research associate in the Urban Institute’s Health Policy Center. His recent work includes health insurance reform, Medicare reform, and medical savings accounts. Prior to joining the Health Policy Center, he was senior advisor for health policy at the Office of Management and Budget, and chair of the Economics Department at Wellesley College.

_Leighton Ku_ is a senior research associate in the Urban Institute’s Health Policy Center. Principal research interests include state health reform efforts and the financing of health care for low-income families. He has also spent many years investigating the response of American teenagers to the AIDS epidemic. He also teaches in the Public Policy program at George Washington University.

_Stephen Norton_ is a research associate at the Urban Institute’s Health Policy Center, where he specializes in research on the Medicaid program, maternal and child health and those institutions providing care to the medically indigent. He is the author of a number of articles on health care.

_Susan Wall_ is a research associate in the Urban Institute’s Health Policy Center. Previously she served as an analyst for the Physician Payment Review Commission. Her research has centered on access to care for low-income populations, including issues of health professional maldistribution, Medicaid managed care, and public health departments.
Errata

Several published *State Reports* and *Highlights* include an error in Table 1, “State Characteristics.” Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the *Assessing New Federalism* website.

Correct figures for 1996

<table>
<thead>
<tr>
<th>State</th>
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<tr>
<td>UNITED STATES</td>
<td>6.4%</td>
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<tr>
<td>Alabama</td>
<td>0.9%</td>
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<td>California</td>
<td>18.8%</td>
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<tr>
<td>Florida</td>
<td>10.0%</td>
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<tr>
<td>Massachusetts</td>
<td>5.4%</td>
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<tr>
<td>Michigan</td>
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<tr>
<td>Minnesota</td>
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<tr>
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<td>New Jersey</td>
<td>8.8%</td>
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<td>4.3%</td>
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<td>Wisconsin</td>
<td>2.1%</td>
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**Source:** Three-year average of the Current Population Survey (CPS) (March 1996-March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.

The error appears in the following publications:

State Reports:  
*Health Policy:* Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington
*Income Support and Social Services:* Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:
*Health Policy:* Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

*Income Support and Social Services:* Minnesota, Texas