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Health Policy for Low-Income People in Washington

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Washington is proud of its long tradition of guaranteeing access to health care for most residents. Its Medicaid program is more generous than most states' in terms of income eligibility and benefits, and it 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 small-group and the individual markets. For those who remain uninsured, most communities in the state appear to have a well-functioning safety net of health care providers. Finally, Washington is in the forefront of using organized state purchasing leverage and regulatory authority to establish quality standards for health plans and to monitor their performance as the health care system evolves.

Washington's health care system is quite strong as a result of a healthy economy; well-funded commitments to the poor, near-poor, and safety net providers; and a low overall uninsurance rate.

State Characteristics

Washington is the 18th-largest state and one of the fastest-growing. Its population increased at more than twice the national rate from 1990 to 1995, reaching 5.3 million people. The state's racial mix is disproportionately white—86.8 percent, compared with 72.6 percent for the nation. However, the state does have a larger-than-average proportion of "non-Hispanic other" (7.7 percent versus 4.2 percent for the United States), largely of Asian, Pacific Islander, and Native American origin (table 1).

The Washington economy is currently very strong. The unemployment rate fell from 8.4 percent in January 1993 to 5.8 percent in November 1996. Moreover, the increase in total personal income from 1990 to 1995 was 34.5 percent compared with 27.7 percent nationwide. The thriving aerospace and computer software industries are fueling part of the growth in the state's economy. Economic growth has increased the total resource base available for private and public purposes throughout Washington. It has also contributed to a lower-than-average poverty rate (12.6 percent versus 14.3 percent in the United States) (table 1).

Washington has a low rate of uninsurance by national standards (12.9 percent of the nonelderly population compared with 15.5 percent nationally) and compares favorably across a broad array of health status and out-

Table 1
State Characteristics

Sociodemographic	Washington	U. S.
Population (1994–95) (in thousands)	5,301	260,202
Percent under 18 (1994–95)	25.9%	26.8%
Percent 65+ (1994–95)	10.4%	12.1%
Percent Hispanic (1994–95)	3.0%	10.7%
Percent Non-Hispanic Black (1994–95)	2.4%	12.5%
Percent Non-Hispanic White (1994–95)	86.8%	72.6%
Percent Non-Hispanic Other (1994–95)	7.7%	4.2%
Percent Noncitizen Immigrant (1996)*	4.3%	6.4%
Percent Nonmetropolitan (1994–95)	21.6%	21.8%
Population Growth (1990–95)	11.6%	5.6%
Economic		
Per Capita Income (1995)	$23,774	$23,208
Percent Change in Per Capita Personal Income (1990–95)	21.4%	21.2%
Unemployment Rate (1996)	6.5%	5.4%
Percent below Poverty (1994)	12.6%	14.3%
Percent Children below Poverty (1994)	17.3%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	12.9%	15.5%
Percent Medicaid—Nonelderly (1994–95)	12.3%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	66.6%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	8.2%	6.2%
Smokers among Adult Population (1993)	22.5%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	5.3%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	4.7	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	43.7	54.4
Violent Crimes per 100,000 (1995)	484.3	684.6
AIDS Cases Reported per 100,000 (1995)	16.4	27.8

Source: Complete list of sources is available in *Health Policy for Low-Income People in Washington* (The Urban Institute, 1997).

* 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. Please note that these numbers have been corrected since the original printing of this report.

come indicators. Reflecting both underlying sociodemographics and relatively broad access to care, Washington has lower-than-average rates of teen pregnancy, low birth weight, infant mortality, and premature death (table 1).

Politics and Health Policy

Politically, Washington is unique in that it has a progressive tradition yet no state income tax; it relies instead on state sales and state property taxes. The political climate could be described as socially liberal and fiscally conservative. Displays of partisan ideology are relatively moderate, which seems to foster cooperation among lawmakers and state officials.

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-mandated coverage and substantial insurance reforms, among other politically controversial techniques for achieving universal coverage and health care cost control. In 1995, after the collapse of health care reform efforts at the national level, 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 state's own health insurance subsidy program for the working poor were both expanded considerably.

To some extent, 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 in the debate over universal coverage figured prominently in both the 1994 and the 1996 elections, when Washington voters expressed a preference for a more limited government role by providing Republicans with majorities, first in the House (1994) and then in the Senate (1996). The political reversal was not complete, however, as the newly elected governor, Gary Locke, 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 (roughly 4 percent per year in the 1995–97 biennium). 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.

Medicaid

Increasing from 9.0 percent to 13.4 percent of state general-fund expenditures between 1991 and 1995, Medicaid has been growing faster than any other component of Washington's state budget in recent years. As of 1995, the program ranked second only to K–12 education in terms of state general-fund spending and combined federal and state spending. Washington has 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 fiscal year (FY) 1986 to 56 percent in FY 1996. Medicaid spending in Washington, both federal and state shares, totaled $3 billion in 1995.

The rate of growth of Washington's Medicaid program, although somewhat greater than the national average throughout the 1990s, has declined substantially, from 27.6 per-

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Washington and United States
(Expenditures in Millions)

	Washington			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Total	**$3,033.7**	**27.6%**	**12.8%**	**$157,872.5**	**27.1%**	**9.9%**
Benefits						
Benefits by Service	$2,482.2	22.3%	11.5%	$133,434.6	18.8%	11.0%
Acute Care	1,547.8	26.8%	13.9%	79,438.5	22.1%	13.0%
Long-Term Care	934.4	16.6%	7.9%	53,996.1	14.8%	8.3%
Benefits by Group	$2,482.2	22.3%	11.5%	$133,434.6	18.8%	11.0%
Elderly	$607.2	13.3%	8.3%	$40,087.4	16.7%	8.1%
Acute Care	123.3	22.9%	9.6%	9,673.7	18.5%	11.9%
Long-Term Care	483.9	11.3%	8.0%	30,413.7	16.2%	7.0%
Blind and Disabled	$973.1	26.6%	10.6%	$51,379.4	17.7%	12.9%
Acute Care	547.5	31.1%	12.9%	29,760.7	22.8%	15.2%
Long-Term Care	425.7	22.1%	7.8%	21,618.7	12.3%	10.1%
Adults	$431.8	27.0%	9.1%	$16,556.9	20.4%	9.2%
Children	$470.0	23.6%	21.6%	$25,410.9	24.3%	13.3%
Disproportionate Share	$348.0	187.0%	14.6%	$18,988.4	261.5%	2.7%
Hospital Administration	$203.6	13.2%	30.1%	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: 1995 data for the United States are preliminary.

cent per year from 1990 to 1992 to 12.8 percent per year from 1992 to 1995 (table 2). The primary reason for Medicaid expenditure growth in Washington has been enrollment expansions, especially among noncash children (i.e., those whose families do not receive welfare payments) and the blind and disabled. Expenditures per enrollee have also risen in recent years. On a per enrollee basis, Washington spends more than the national average in every enrollment category except children (table 3).

Since at least 1990, acute care spending has risen more rapidly than long-term care spending in Washington's Medicaid program. This escalation has increased acute care's share of total service expenditures from 54 percent in 1990 to 62 percent in 1995 (versus the national average of 60 percent). Disproportionate share hospital (DSH) payments and administrative costs have also increased dramatically since 1990 (table 2).

Washington's Medicaid program insured 846,200 persons as of 1995. This represents about 12 percent of Washington's nonelderly population and 58 percent of its population below the federal poverty level (FPL). Washington has relatively generous Medicaid eligibility limits, especially for pregnant women (up to 185 percent of FPL) and children under age 19 (up to 200 percent of FPL). The state's Aid to Families with Dependent Children (AFDC) and medically needy income criteria are also more generous than the national average. To serve the aged and disabled, the state has a medically needy program, and it covers people with incomes of up to 300 percent of the Supplemental Security Income (SSI) benefit level who require institutionalized care.

While the state has been resistant to cutting Medicaid, there is general recognition that in the long term, Medicaid spending growth must be curtailed, particularly in light of Initiative 601. Enrolling beneficiaries in managed care plans is one tactic the state has pursued to help reconcile health policy goals with fiscal constraints. Washington's Medicaid program has proceeded on schedule with its plans to shift most noninstitutionalized adults and children into managed care plans (around 400,000 beneficiaries). The state plans to move the disabled population into managed care in 1999.

The Basic Health Plan and Other Programs

Washington's own health insurance program, the Basic Health Plan (BHP), offers subsidized managed care coverage to individuals, families, and employers. Primarily aimed at uninsured, low-income working families, the BHP had 195,000 enrollees in 1996. Enrollees pay a sliding-scale premium based on their income level. The program operates on managed competition principles (e.g., standard benefit package; 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 BHP provides a seamless web of coverage for women and children who may cycle in and out of Medicaid eligibility as a result of health status or income fluctuations. The state maintains a strong preference for keeping the BHP state-only and thus has not sought to qualify the program for federal Medicaid matching funds.

In establishing the 1995–97 budget for the BHP, the state anticipated that half the enrollees would be per-

Table 3
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Washington			United States		
		Average Annual Growth			Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Elderly						
Total expenditures on benefits (millions)	$607.2	13.3%	8.3%	$40,087.4	16.7%	8.1%
Enrollment (thousands)	57.0	4.2%	3.0%	4,116.6	5.1%	3.0%
Expenditures per enrollee	$10,6533.0	8.7%	5.1%	$9,738.0	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	$973.1	26.6%	10.6%	$51,379.4	17.7%	12.9%
Enrollment (thousands)	114.1	16.8%	8.7%	6,405.2	9.8%	9.5%
Expenditures per enrollee	$8,525.0	8.4%	1.8%	$8,022.0	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	$431.8	27.0%	9.1%	$16,556.9	20.4%	9.2%
Enrollment (thousands)	211.3	11.1%	5.0%	9,584.2	11.5%	4.6%
Expenditures per enrollee	$2,044.0	14.3%	3.9%	$1,728.0	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	$470.0	23.6%	21.6%	$25,410.9	24.3%	13.3%
Enrollment (thousands)	463.8	13.3%	10.1%	21,566.0	13.1%	4.8%
Expenditures per enrollee	$1,014.0	9.1%	10.5%	$1,178.0	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

sons whose employers paid their monthly share of the premium, a share that is higher than that paid by individual enrollees. However, relatively few employers have participated, which has reduced the expected amount of revenues supporting the program. The high ratio of individual to employer-sponsored members led to the exhaustion of appropriated funds by the end of 1996, and 60,000 people remained on the waiting list. The state appropriated enough funds for 8,000 more enrollees in the 1997–99 biennium, which, in a time of fiscal retrenchment, reflects the bipartisan support the BHP has in Washington.

Another indication of Washington's support for health care for needy populations is the diversity of small programs providing health care coverage. Few, if any, states have so many "gap-filling" programs to serve special populations. These programs include the following: (1) medical assistance programs for 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 with high medical expenses incurred in hospitals; and (4) the State Children's Health Program, which provides Medicaid-type coverage to children in households under FPL 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. Although in principle these programs would be described as state-funded, state officials acknowledged that the programs are largely supported by additional federal funds earned by the state's DSH program.

State Purchasing Power

Taking into account Medicaid, the BHP, and state employees, Washington purchases health care plans or services for more than 20 percent of the state population. Thus, total state leverage over managed care plans and the ultimate shape of the health care delivery system is considerable. Various players are devising ways to use state regulatory and purchasing powers to institutionalize and standardize health plan accountability to both private and public payers. Three state agencies currently coordinate plan reporting requirements and site visits to health plans serving state clients.

Insurance Reforms

Washington is among the nation's leaders in comprehensive health insurance reforms. Although it repealed the more ambitious elements of its 1993 health care reform law—for example, the employer mandate—it has preserved and implemented the bulk of the insurance reforms that passed. Most reforms 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 self-insured firms). The group reforms appear to be working reasonably well, but the individual market is undergoing some turmoil as carriers are embroiled in

disputes over premium increases with the insurance commissioner. If insurers begin to withdraw from this line of business, additional people will turn to the BHP, which could raise premiums if these individuals turn out to be sicker than average. How the individual market and BHP evolve and interact will be watched very closely.

Long-Term Care

Washington places a high priority on enabling the elderly and disabled to avoid nursing homes and other institutional settings if possible, both for fiscal reasons and because it is a popular policy. The state uses Medicaid home and community-based care waivers to provide nonfacility options to long-term care recipients. Still, two-thirds of the overall long-term care budget is devoted to nursing homes, so the state continues searching for innovative alternatives for this type of care.

Three principles underlie state policy for those with serious mental illness and developmental disabilities: community-based care, managed care, and maximized federal support. Washington has been more successful than many states in deinstitutionalizing mentally ill and developmentally disabled patients and in delivering care in community settings. Medicaid is a key source of funding for noninstitutional services, many of which are delivered through home and community-based care waivers for the developmentally disabled population and through capitated county- or multicounty-based Regional Support Networks for those beneficiaries with mental illness. Medicaid is important in the delivery of facility-based care as well. Federal DSH funds support a substantial portion of state psychiatric inpatient care. The state's Medicaid program also covers the optional service of intermediate care facilities for the mentally retarded. Although the state has continued its successful pursuit to lower the census in these institutions, its efforts have been slowed somewhat by resistance from the state employees union, whose members fear loss of jobs.

Public Health

The state Department of Health carries out a broad scope of activities, ranging from traditional public health services to direct personal health services. Numerous federal categorical and block grants provide support for Washington's public health programs, as do state and local appropriations. Most funds and considerable (although monitored) discretion are transferred to local health departments, which are typically organized along county or multicounty lines. The expansion of Medicaid and the BHP has reduced the need for local health departments to provide direct health services to the poor, but many still do. In providing these services, health departments generally coordinate with the state Medicaid agency to maximize the draw of federal funds.

Challenges for the Future

Washington's health care system is quite strong as a result of a healthy economy; well-funded commitments to the poor, near-poor, and safety net providers; and a low overall uninsurance rate. However, it is not immune to the policy and market challenges faced elsewhere. The major questions for the future that confront Washington are: 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 BHP 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 health care settings of the future? These areas will require constant vigilance and may call for policy interventions in the next few years.

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