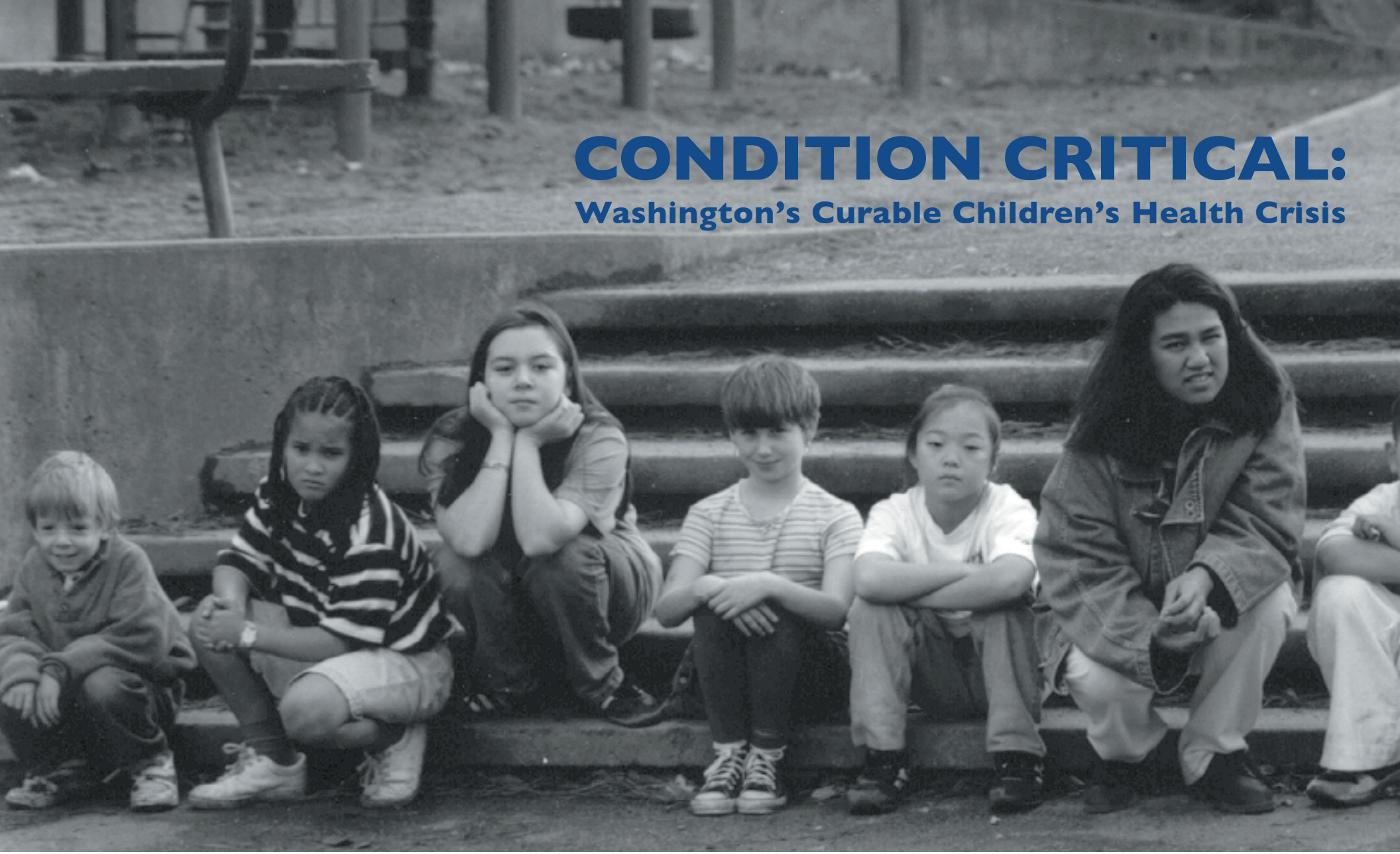

CONDITION CRITICAL:

Washington's Curable Children's Health Crisis

CHILDREN'S ALLIANCE

December 2004

CHILDREN'S ALLIANCE

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Executive Summary

Between 2002 and 2004, Washington fell from being a nationwide leader in providing children with health insurance coverage to being no better than average. An estimated 62,000 children lost publicly funded health coverage in less than two years and are likely going without any regular health care during the critical growing years of their lives.

The tens of thousands of children who lack regular medical care are far more likely to miss school, less ready to learn, and more likely to go to the emergency room for such manageable conditions as asthma and for ear infections that didn't have to happen.

But what happens to a child affects the rest of us, too. Hospitals and clinics are seeing more and more uninsured patients. Many are stretched to provide needed care and must make choices including layoffs and eliminating services. Parents are missing more days of work caring for their sick children for longer periods of time and are making hard choices about jobs based on whether or not those jobs will provide health care for their children.

Through interviews with Washington families as well as an examination of current data and research, this report documents the impact that the state's rising uninsurance rate is having on children and their families.

Among the key findings:

- Administrative barriers to Medicaid coverage alone—including more requirements and more frequent renewals—have resulted in approximately 50,000 children losing Medicaid.

- Another 17,500 children statewide lost health care coverage when a state program for immigrant children was eliminated in late 2002.

- More than $1 million has been spent on new administrative requirements—money that could have been used to insure eligible children.

- Children of color and children from rural communities have been disproportionately affected by policy changes that limit access to publicly funded health care programs.

- Many low-income working families in Washington, faced with the additional difficulty of getting and keeping medical insurance for their children, are opting to wait until a child gets sick—a strategy that may result in expensive emergency room visits and hospital stays.

- The Department of Health reports that Washington state hospitals have seen an overall growth rate of more than 50 percent in the amount of uncompensated care they provided from March 2003 to March 2004.

- Community health clinics—charged with providing care regardless of a patient's ability to pay—have seen an 18 percent increase, to 38 percent total, in the number of uninsured clients walking through their doors.

Faced with the mounting costs—both fiscal and moral—of allowing so many children to go uninsured, state policy makers must re-examine the wisdom of some of the changes to public health programs made in the past three years.

Specifically, the Children's Alliance recommends:

- **Roll back administrative barriers to Medicaid coverage introduced over the past two years, including restoring 12-month eligibility and continuous eligibility, in the Medicaid and State Children's Health Insurance Program.**

- **Reinstitute coverage to immigrants through restoration of the Medicaid look-alike program eliminated in 2002 and identify a secure source of state-only funding for the program.**

- **Identify a realistic, "middle ground" form of income verification and ensure that it is applied consistently across the state.**

- **Reinvest in outreach work to identify and enroll eligible children.**

- **Reexamine the possibility of federal waivers that would allow Washington to use State Children's Health Insurance dollars to provide health coverage to low-income parents.**

Introduction

Throughout the 1990s, Washington State was a nationwide leader in making health insurance accesssible to nearly all children. Washington's Basic Health Plan, investments in federal/state programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) and a commitment to outreach pushed Washington's uninsurance rate for children down to 4.5 percent in 2002.

Washington was particularly successful in making sure that children had a source of regular and preventive healthcare, a critical component of a child's health and development. Policymakers recognized that the small investment needed to provide this coverage was not only the right thing for children, but was far less expensive than treating children in the hospital or emergency room for conditions that could have been picked up or treated with regular care. Insuring children is cost-effective; while children constitute 64 percent of those served by Medicaid, they account for less than 25 percent of state healthcare expenditures. Policymakers' commitment to children's health made it possible to build an infrastructure that could address the healthcare needs of nearly every child who lacked another source of health coverage.

However, the state's decade-long progress on this issue came to a screeching halt during the state budget shortfall in 2002. Policymakers who had previously lauded the state's growing child health care enrollment as a wise investment now recast it as a fiscal burden.

We began this report in the summer of 2003 in response to the passage of a new state budget that enacted numerous administrative barriers expected to leave close to 24,000 people, including 18,000 children, without health care coverage. These administrative changes came on top of newly adopted monthly Medicaid premiums, scheduled to begin in January 2004, that were expected to leave an additional 20,000 children without Medicaid coverage, and the termination of a long-standing program that had provided coverage to immigrant children ineligible for Medicaid. Twenty-eight thousand immigrants who had been covered under this program, 97 percent of them children, were given the option of transferring their enrollment to the more costly Basic Health Plan; today approximately 17,500 of these children are without coverage.

Cumulatively these changes, implemented in less than one year's time, threatened to

"I can't afford to take (my son) to the hospital, so I don't allow him to do anything that might cause him to get sick. We have some of his old inhalers at home and he uses those."

—Spokane mother of three who earns too much to quality for state programs, but not enough to buy insurance. Her 15-year-old son has asthma.

leave close to 60,000 children without a source of health insurance, even though many were living in families with at least one working family member.

Who are these children, and how are they and their families coping? The Children's Alliance began interviewing families about their experiences with Washington's health care programs and how they were dealing with the changing landscape in January 2004.

After interviewing dozens of families, we have learned that most parents, if not all, are fully aware of the importance of having access to health care services for their children and what it means for their children's success in the future. Parents often make considerable sacrifices for the health and well-being of their children, including going without health insurance of their own in order to pay for their children's coverage.

We've also learned, however, that when combined with other obstacles like job insecurity and inadequate food and housing, constantly changing enrollment and eligibility requirements discourage families from pressing on in the fight to find or keep coverage for their children. In some cases, dealing with the difficulty of enrolling in the programs slips off the radar until there is a health emergency in the family. Crises like these can lead to costly and preventable emergency room visits, hospitalizations, and even financial ruin.

Our interviews with families have given us a unique chance to document their perspective on the new health care landscape and how they are coping with it. Our hope is that their stories will help illuminate the human consequences of these policy changes. In this report we also document the administrative and fiscal consequences—both intended and unintended—of policymakers' reversal of past health care commitments. Rising numbers of uninsured children have significant ramifications for the health care system that all Washingtonians depend on to meet our health care needs.

1991-2002: A Period of Progress in Children's Health Care Coverage

Throughout the 1990s, Washington adopted numerous policy changes to grapple with the growing numbers of uninsured children in the state. These efforts can be grouped broadly as those that expanded eligibility and those that simplified the administrative requirements to apply for and renew coverage.

Washington's Children's Medicaid Program:

Expanding Eligibility and Investing in Outreach

Efforts to expand coverage for children in Washington began in 1991, when the state began providing state-funded health insurance to children up to age 18 who were ineligible for Medicaid but whose family income was below 100 percent of the Federal Poverty Level (FPL).* This program was called the Children's Health Program and mostly met the health care needs of undocumented immigrant children.

The second major expansion to health care programs for children occurred in 1994, when Washington began providing Medicaid coverage to children under age 19 whose family income was at or below 200 percent FPL. The final expansion to public health care programs was the adoption of the State Children's Health Insurance Program (SCHIP) in 1999. SCHIP provides the same scope of coverage as Medicaid to children under age 19 whose family income is between 200 percent FPL and 250 percent FPL and requires modest monthly premiums. While these expansions helped to improve access to publicly funded healthcare programs, they did little to make sure that eligible people enrolled in such programs.

Removing Barriers to Coverage. Beginning in the 1990s, many states began making more subtle policy changes to their state Medicaid programs to increase program participation and ease the administrative requirements for families trying to apply for and retain coverage.

*The Federal Poverty Level (FPL) in 2004 is defined as annual income of $18,850 or less for a family of four. 200 percent of FPL is $37,700 and 250 percent is $47,125.

FAMILY STORIES

The Kerrs: Living on the Edge

Celia Kerr and her three children are living proof that many of us are only one pink slip away from needing help to keep our children insured. After 17 years at the same company, Celia's husband lost his job – the same job that had long kept the family firmly entrenched in the middle class. At the same time, the family also lost relatively generous medical benefits that allowed them to choose their own doctors and kept co-pays and deductibles low. "The worst part of all this has been the loss of benefits," Celia said. "We don't know how long it will be before we get them back."

The parents have maintained coverage for themselves by paying into COBRA at a cost of $622 per month, and their three children are now covered through Molina Health Care, one of the Medicaid managed care plans. As a result, two of their children had to change doctors. One child with chronic asthma was granted an exemption to stay with the pediatrician who had managed her condition since its onset. At least they had publicly funded health care to fall back on for their children when the family suddenly found themselves needing it.

Celia's husband continues to look for full-time work. In the meantime, though, both parents have cobbled together part-time work. Celia sings in the Seattle Opera chorus, is an on-call substitute teacher's assistant for her local school district and is a vendor at the local community market. Her husband has a part-time job playing bass and has pulled together some teaching work. None of these jobs provides medical benefits.

The family has less income and at the same time must cover a far greater proportion of their medical care. The parents now must shoulder 20 percent of their medical expenses in addition to paying a $20-per-visit co-payment. Dental and vision coverage are a thing of the past.

Earlier this year Celia had a breast cancer scare that required a biopsy. The out-of-pocket cost for this procedure was more than $600.

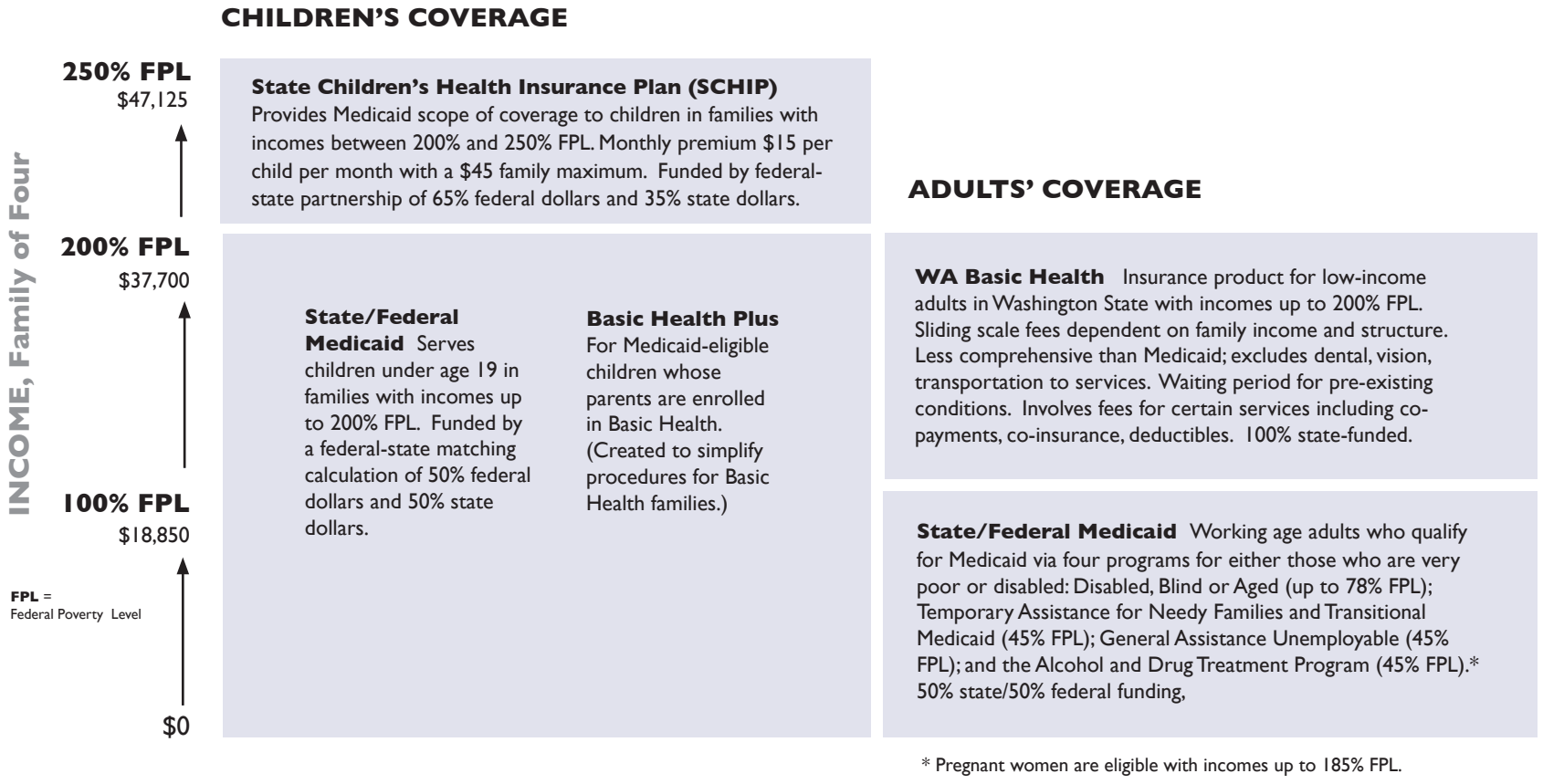
Celia does not have cancer, but she's deeply concerned about her family's future health care needs. "Having insurance should not be tied to having a job," she said. "We are the richest country in the world. We should all have health care."

Many of these changes were a response to research showing that those who were eligible for these programs were often either unaware of the program or were deterred by the administrative difficulties involved in applying.[1] More research showed that as administrative barriers were streamlined, participation in the programs grew.

Easing Asset and Income Determination Rules. In 1992, Washington began streamlining children's enrollment in Medicaid by eliminating the asset test, which had required families to prove that they did not have any assets valued at more than $1000 before being deemed eligible. In 1999, recognizing that irregular jobs, lack of pay stubs, or fear of jeopardizing their employment often made it hard for low-income families to supply proof of income, the state began allowing families to simply declare their income without pay stubs, tax returns, employer letters or other forms of documentation. Caseworkers then verified family income using employment security data, as well as phone calls to families and employers.

Extending the Eligibility Period. Also in 1999, Washington extended the eligibility period for children enrolled in Medicaid from six to twelve months to decrease the amount of "churning," or cycling on and off the program, that occurs because of attrition at recertification. A significant number of families who drop off the program at recertification return to the

Subsidized Health Coverage Available to Children and Families in Washington, 2004



* Pregnant women are eligible with incomes up to 185% FPL.

FAMILY STORIES

The Langstons: working family

The Langstons (not their real name) are among those families who struggle to maintain health care coverage for their children because they're self-employed. Dad runs his own marine sanitation business, and mom stays home raising their three children, aged 5, 9 and 13. Teresa got her children on the publicly funded State Children's Health Insurance Plan (SCHIP) four years ago. She took her children to the public health department in North King County to have them immunized, and an outreach worker told her about the program and helped her complete an application. Teresa sent the first page of her family's tax return, and with one phone call her children were covered for a year.

That's how it was; today is a very different story.

New rules implemented in 2003 require recertification every six months, and include a new and complicated self-employment form that doesn't really address the family's situation.

Teresa thought she was helping when she also sent in the first page of the family's income tax return and a profit and loss statement. Instead, she received a letter stating that her family must "spend down" their income by $12,000 before their children could re-qualify for SCHIP.

Teresa got on the phone with the state to try to clear things up. She ended up talking to someone who could not access her record, although the person agreed that a mistake had been made in the denial of coverage. A supervisor was supposed to contact her within 24 hours.

Teresa waited for a call that was never returned. When she tried again one week later, she was told the data she sent had been input incorrectly.

It took four months to resolve the Langstons' case—four months during which the children had no health insurance—all because of the bureaucratic problems created by complicated changes that have overwhelmed many local service offices.

program within a three-month period; research has shown that extension of the eligibility period helps to eliminate churning, which in turn saves administrative dollars and improves continuity of care.[2, 3]

Allowing 12-Month Continuous Eligibility. Finally, as part of the change to a longer certification period in 1999, the state adopted a provision called "twelve-month continuous eligibility." Under continuous eligibility, states consider a child eligible for the duration of the eligibility period regardless of a change in family income during that time. This provision allows for the fluctuations in family income due to seasonal work or overtime pay that are so common in low-income jobs and also makes certain that children are not left uninsured if a family member gets a job but does not have dependent coverage. Moreover, continuous eligibility helps to lower administrative costs and recognizes the value of continuity of care.

Getting the Word Out: Investing in Outreach. The importance of outreach in identifying and enrolling children in health coverage was noted by President Bush when accepting his party's nomination for President this past summer. He said, "In a new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for the government's health insurance programs."

Washington and its local communities recognized this need beginning in the

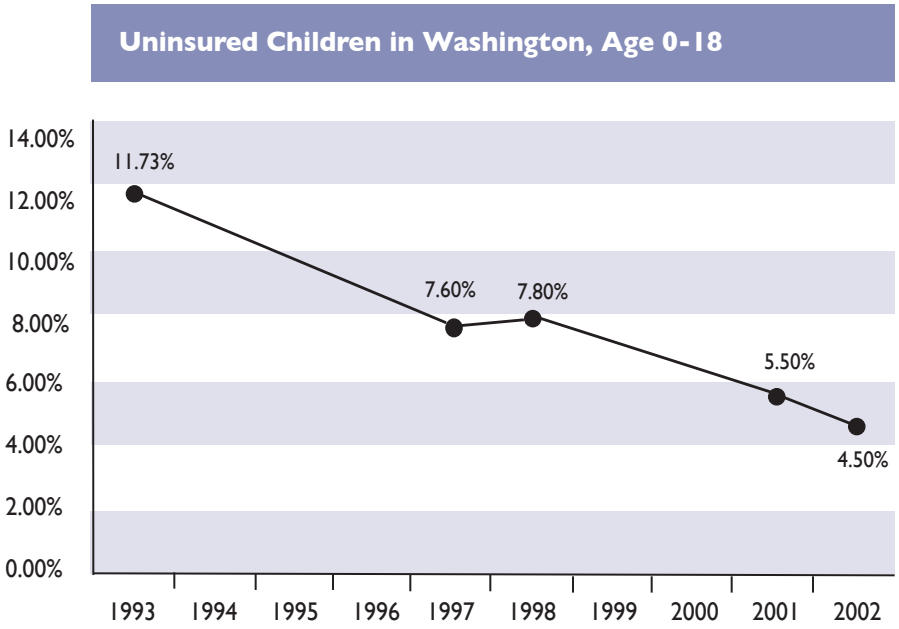
late 1990s with efforts like *kids.health.2001* in King County and *Spokane for Kids 2001* in Spokane County. Outreach work was at its peak during this time because of a provision in the 1997 welfare reform legislation that increased the amount of federal dollars available for this work. At that time, significant funding administered by the state allowed local outreach projects and/or health departments to obtain a 90 percent match from the federal government if they contributed 10 percent to fund these activities. At the peak of the statewide outreach campaign, there were funded projects in all of the 39 counties in Washington helping to identify and enroll eligible children in Medicaid and SCHIP.

Through these projects, outreach workers actively sought out new enrollees at schools, community centers and gatherings, social service organizations and clinics and other health care facilities. In addition, a statewide communications campaign called Healthy Kids Now! used billboards, bus ads, radio and newspaper ads to increase public awareness of these programs. Healthy Kids Now! also operates a 1-800 hotline number (1-877-KIDS-NOW) for parents to call to receive more information about enrolling their children. The success of these local outreach projects and the statewide communications efforts was evident in a sharp rise in the number of children with health insurance in Washington, which peaked at 95.5 percent in 2002.

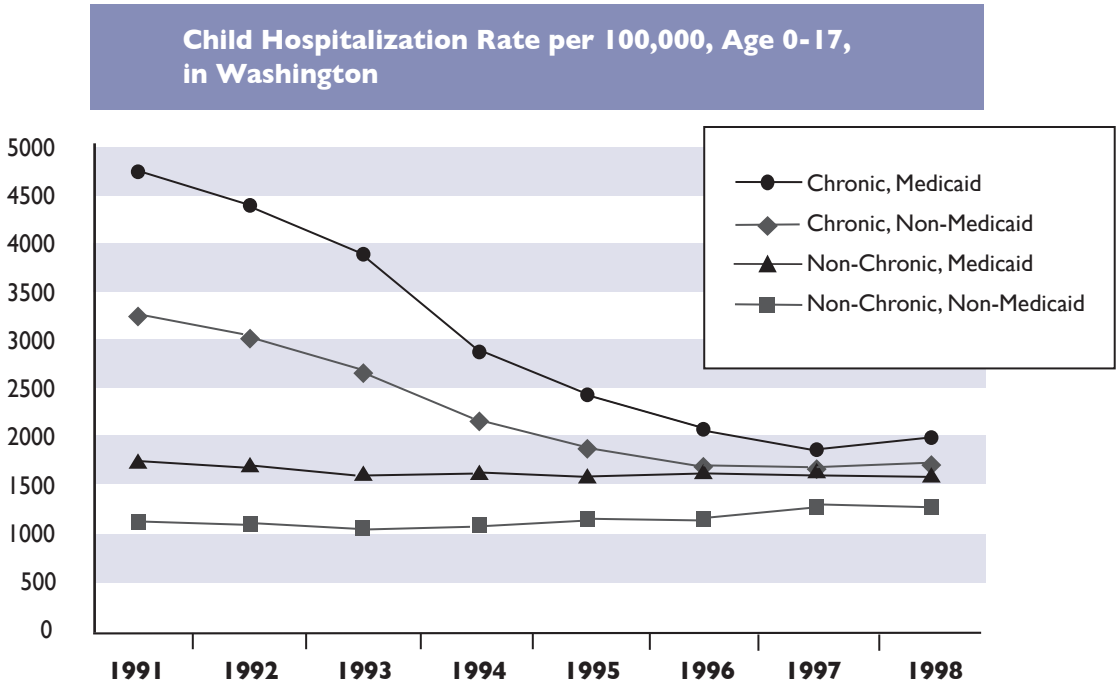
Changes Produced Better Results for Kids

Because of these moves to expand eligibility levels and streamline administrative requirements, by 2001 it was estimated that 97 percent of Washington children eligible for Medicaid or SCHIP were enrolled. More importantly, the number of uninsured children in Washington had dropped to a ten-year low according the Washington State Population Survey[4] (see chart below).

In addition to increasing enrollment, one of the goals of simplifying administrative requirements for Medicaid was to increase retention in the program. Many studies have found that administrative barriers to enrollment renewal, rather than ineligibility, are the main causes of disenrollment from Medicaid and SCHIP. Moreover, these barriers contribute to "churning" or cycling in and out of the program, which compromises continuity of care. Children who have insurance are more likely to have



Source: 1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000v5M, 2002v4M Washington State Population Survey



Data Sources: Chronic Condition Classification: NACHRI-3M CCCHC, 12/96; excludes Newborn Risk. Hospitalization Discharge Data: Washington State Dept. of Health, Office of Hospital & Patient Data Systems.

"America's children must also have a healthy start in life. . . . We will not allow a lack of attention, or information, to stand between these children and the health care they need."

—President George W. Bush

a regular physician and dentist that they see for care,[5] have fewer unmet health care needs, have fewer delays in getting care when it is necessary, and are more likely to have had well-child visits than children who are uninsured.[6] Reducing churn and ensuring continuity of care have been associated with reductions in emergency room visits and preventable hospitalizations because they improve access to primary care services and proper use of the health care delivery structure.[7]

The chart at left demonstrates that as Washington's Medicaid program expanded eligibility and streamlined administrative policies throughout the 1990s, the rate of hospitalizations for children in Medicaid declined. In fact, the rate declined so significantly that it mimicked the rate of hospitalizations for children with private health coverage.[8] This table was taken from a study conducted in 2002 regarding the effects of Medicaid expansions on the rate of childhood hospitalizations. The study concluded that statewide commitments to increasing access to health insurance and improving management of chronic conditions led to a decline in the rate of hospitalizations and a decline in repeated hospitalizations for children.

2003: Reversing Direction, Losing Ground

By 2001, approximately 600,000 children were enrolled in the state's health care programs, including Medicaid and SCHIP. However, the increasing enrollment in these programs soon became a target for policy makers facing huge budget deficits in the 2003 Legislative Session. In addition, state audits conducted in 2001 and 2002 had identified flaws in the methods the Department of Social and Health Services (DSHS) employed to verify income, and had suggested more stringent verification guidelines. While the audit provided legitimate reasons for improving program integrity in the Medicaid program, the changes that were made by the legislature far exceeded the recommendations made by the state auditor.

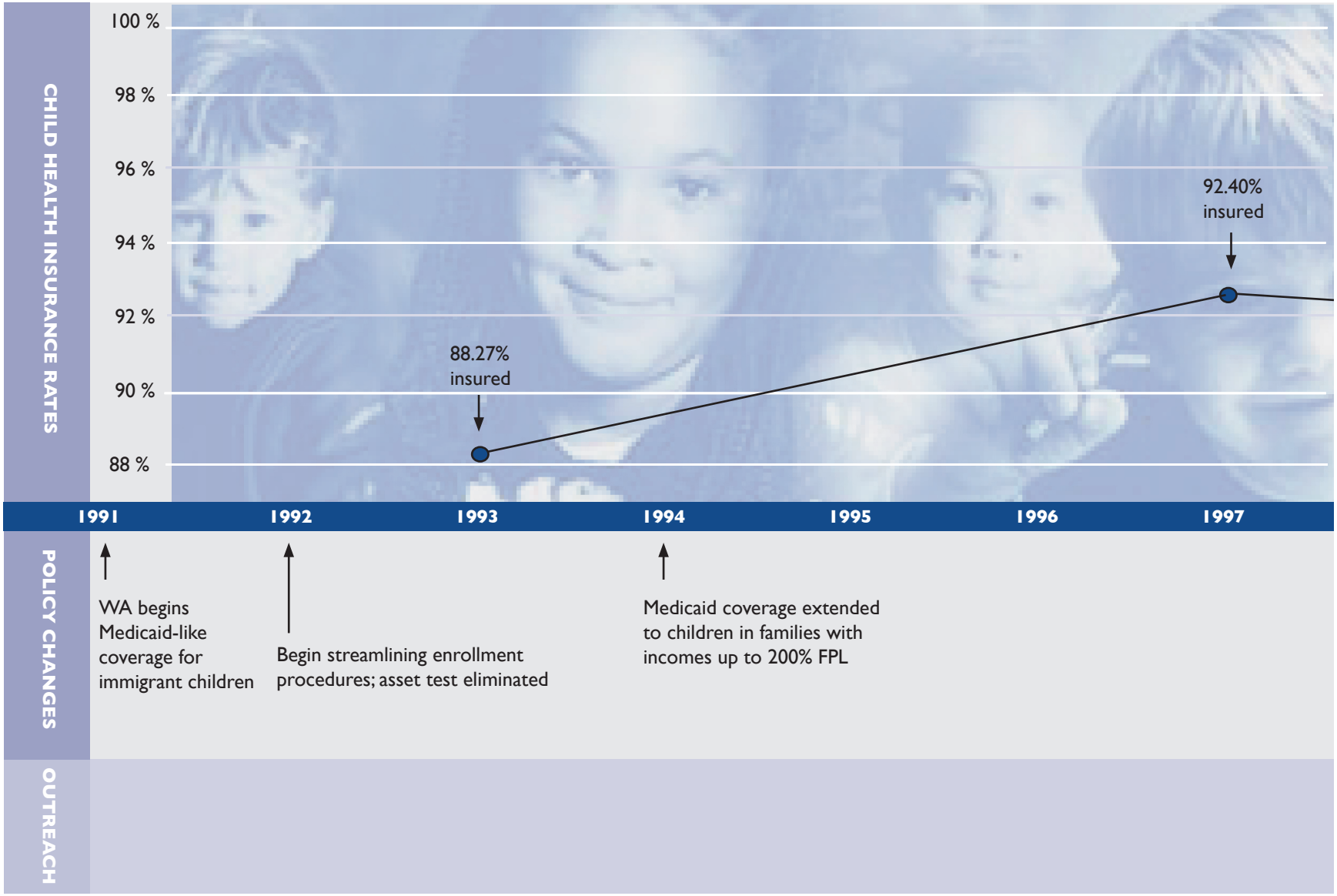
By April 2003, the avenues that had been cleared throughout the 1990s to help families obtain health care coverage for their children were either closed off or had become riddled with administrative roadblocks designed to reduce the caseload.

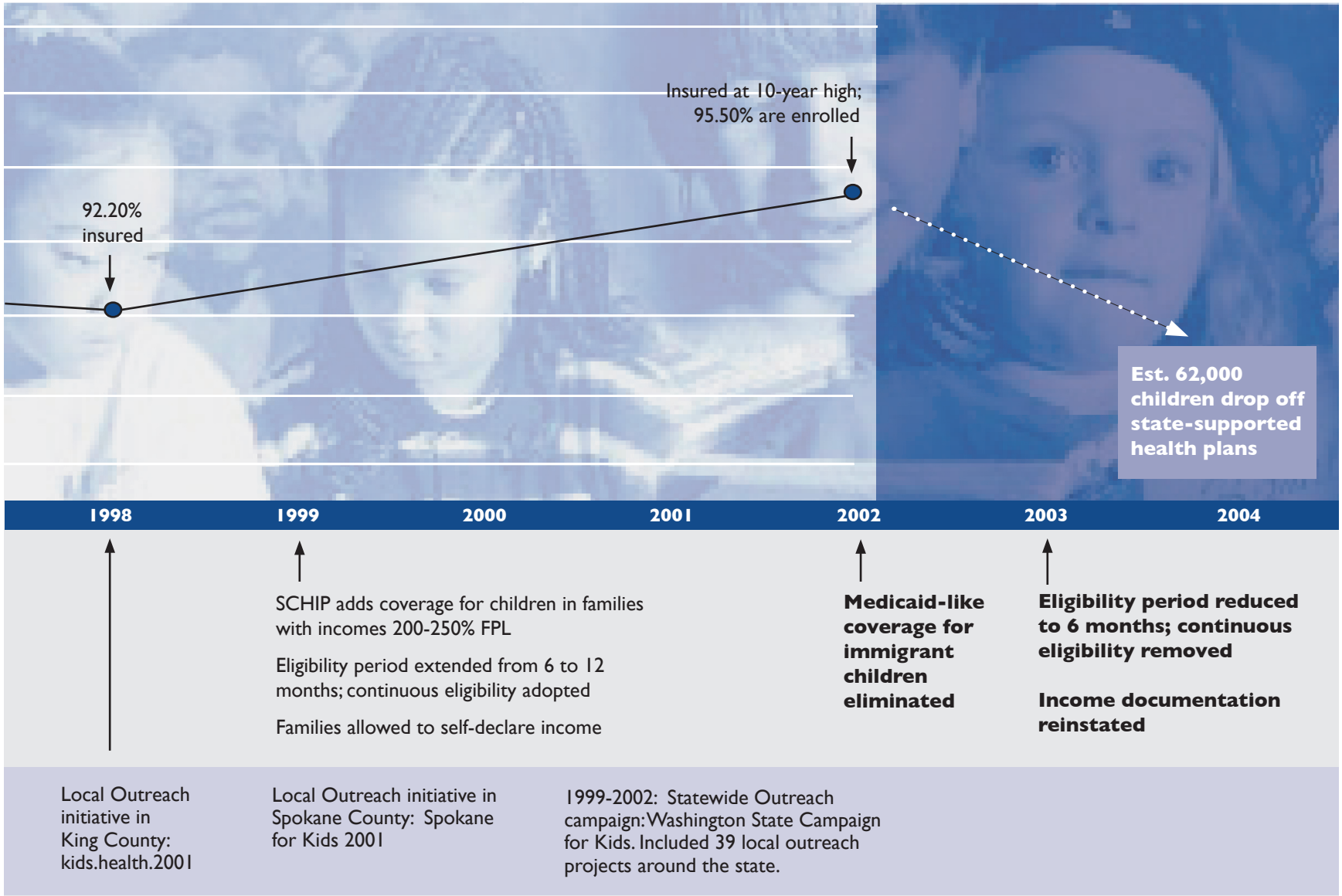
All of these administrative roadblocks were simply reversions to administrative processes that had been in place years before, notwithstanding a body of growing research making clear that these earlier practices had hindered eligible people from applying. In response to state audits and looming budget deficits, policymakers made a major turn backwards in children's health.

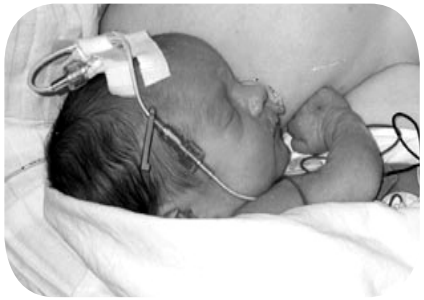
Income Documentation Requirement Reinstated. Instead of allowing families to simply declare their income on the application, today the rules require Medicaid applicants and enrollees to prove their income through pay stubs, tax returns, an employer letter or other documentation that verifies income. Many families who are dependent on these programs are operating in survival mode; they are often highly mobile, working odd jobs or paid in cash. Obtaining this type of documentation can threaten job security, and acts as a deterrent to seeking coverage. Moreover, the implementation of these requirements is inconsistent across the state, making it more difficult for families to apply. Faced with immediate needs for food and housing, some families put off getting coverage for a healthy child, which may not seem relevant until the child is injured or gets sick.

Eligibility Periods Shortened. Under the policies adopted in 2003, the enrollment period for coverage has been shortened from 12 to 6 months. This means that

Policy changes, outreach, and child health insurance rates, 1991-2004




Insured at 10-year high;
95.50% are enrolled
92.20%
insured
Est. 62,000
children drop off
state-supported
health plans
1998
1999
2000
2001
2002
2003
2004
SCHIP adds coverage for children in families with incomes 200-250% FPL
Eligibility period extended from 6 to 12 months; continuous eligibility adopted
Families allowed to self-declare income
Medicaid-like coverage for immigrant children eliminated
Eligibility period reduced to 6 months; continuous eligibility removed
Income documentation reinstated
Local Outreach initiative in King County: kids.health.2001
Local Outreach initiative in Spokane County: Spokane for Kids 2001
1999-2002: Statewide Outreach campaign: Washington State Campaign for Kids. Included 39 local outreach projects around the state.



instead of submitting paperwork to the state once a year, families are now required to do so twice a year. According to research on Washington's Medicaid program, approximately 20 percent of those reviewed for eligibility each month do not complete the renewal process and end up losing coverage.[9] Other states have noted disenrollment rates during the review process for Medicaid and SCHIP as high as 50 percent[10].

Washington demonstrated in the 1990s that a longer, 12-month eligibility period improved enrollment and retention simply by requiring families to fill out paperwork only once a year. By reverting to a 6-month eligibility period, the state has doubled the likelihood that clients will lose coverage simply because they did not complete the renewal process.

Continuous Eligibility Eliminated. Finally, children are no longer considered eligible for the duration of the eligibility period if there is a monthly change in the family's income between reviews. Instead, families are now required to immediately report to the state any change in income of $100 or more, even if this a seasonal fluctuation or due to overtime pay. Without the earlier assurance of continuous eligibility, families must now face a potential loss of health coverage for their children when obtaining new employment that does not include benefits for the first few months on the job.

Impacts of Administrative Changes

The administrative changes described above were part of the budget assumptions in the State's 2003 Supplemental Budget and the 2003-2005 Biennial Budget. Also included in the budget details were state estimates of how many people would lose coverage because of these new administrative roadblocks.

According to the state's Budget Detail, the changes were expected to result in approximately 4,800 (1.9 percent) fewer persons enrolled in publicly-funded medical assistance in Fiscal Year 2004, and approximately 19,000 (3.4 percent) fewer persons receiving assistance in Fiscal Year 2005. [11, 12]

Large Numbers of Children Losing Coverage. Data show that budget estimates of coverage loss have already been exceeded. In the Budget Detail, the majority of coverage loss was expected to occur in the second year of the biennium, from June 2004 through June 2005, because of the programming time necessary to fully implement the six-month eligibility period.[13] However, in the first year of implementation alone, the number of children who have lost coverage is already double the number estimated for the full two-year biennium.

Between April 2003 and September 2004, more than 50,000 children lost Medicaid

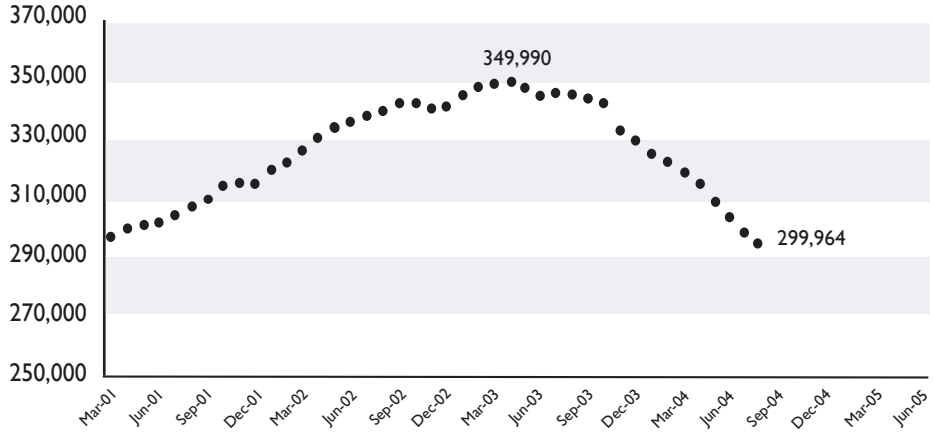
coverage (see chart at right). Although the state's SCHIP program has seen a caseload increase of about 5,000 children, there are still 45,000 children who have lost publicly funded health care, the majority of whom are likely uninsured today.

Since 2002, when the Washington State Population Survey documented an uninsurance rate of 4.5 percent for children aged 0-18, thousands more children have likely joined the ranks of the uninsured due to budget cuts that have either eliminated programs or put new administrative requirements in place for getting coverage.

Additional increases in uninsured children likely. Four sources of data point to the likelihood that Washington will see a large increase in the number of uninsured children, largely as a result of the 2003 budget changes.

Hospital data from the Washington State Department of Health[14] show a marked increase in the number of uninsured patients in the last year. According to the Department of Health, Washington hospitals saw an overall growth rate of 52.2 percent for uncompensated care for the year ending March 31, 2004. This is the highest growth rate seen since 1992. The data also show that uncompensated care accounted for 3.7 percent of total billed charges for Washington state hospitals, the highest rate since March 1992. The increasing amount of uncompensated care has grown so substantially that it makes it difficult for hospitals to continue serving patients. One hospital in Spokane recently made headlines when it announced a layoff of 174 staff because of the rising costs of uncompensated care.[15]

Children's Medicaid Caseload in Washington



Source: Washington State Caseload Forecast Council. Medicaid Other Children program provides medical services to children under 200 percent of the Federal Poverty Level (FPL) who are not eligible for Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).

FAMILY STORIES

The Stockmans: children's health lost in red tape

Brian Stockman, now 4 years old, was born prematurely. Early on he had two incidents of Respiratory Syncytial Virus, or RSV, a respiratory virus. As a result, Brian needs a nebulizer for breathing treatments and expensive prescription medications. With his special health needs, it has been important for him to stay with a regular family doctor.

Even though Brian's father Eric works full time and earns more than $36,000 a year, he can't afford health insurance for himself or his wife. It's a risk the couple has had to take. Their children, though, are a different story. The Stockmans (not their real name) have done their best to make sure their three children have health care coverage.

The family has long relied on Medicaid and the State Children's Insurance Program (SCHIP) to make sure their children are cared for. That got a lot harder when new administrative hoops were added in 2003, saddling the family with more paperwork and overloading state staff responsible for processing the coverage forms.

Recertification went from yearly to once every six months. The Stockmans did their best to comply, but were met with a tangle of red tape.

"I was asked to verify the family income and so I completed that paper work and returned it," Sally Stockman said. "I did this twice. Both times I was told it was not received."

In the meantime, the Stockman children lost their medical coverage.

It didn't take long for a high fever and a head gash to land the Stockman children in the emergency room—care they couldn't afford.

In the end, a hospital social worker helped push the Stockmans' paperwork through and—eight months later—their children are finally back on the SCHIP program.

The increase in the number of uninsured is also evident in data from the community and migrant health clinics in Washington (see table on facing page). Washington's community and migrant health centers provide cost-effective primary care services and a medical home to patients regardless of their ability to pay. The number of uninsured patients seen at the community and migrant health centers across the state of Washington has been increasing steadily. In 2003, uninsured patients comprised 38 percent of the patients at Washington's community and migrant health centers. This is an 18 percent increase from the year before. At the same time, the number of insured patients dropped 4 percent.

A third reason for expecting a rise in the number of uninsured in Washington is the decreasing availability of employer-based health insurance and the financial difficulty of purchasing individual health plans. A recent report published by Washington State Insurance Commissioner Mike Kreidler[16] blamed rising health insurance premiums for employers and unions in part on health providers' shifting their costs for the increasing burden of uncompensated care to those with private health coverage. Because of this shift, health insurance premiums have risen significantly between 1999 and 2003, making it more difficult for employers to continue providing coverage to their employees or for individuals to purchase it on their own. The Kaiser Family

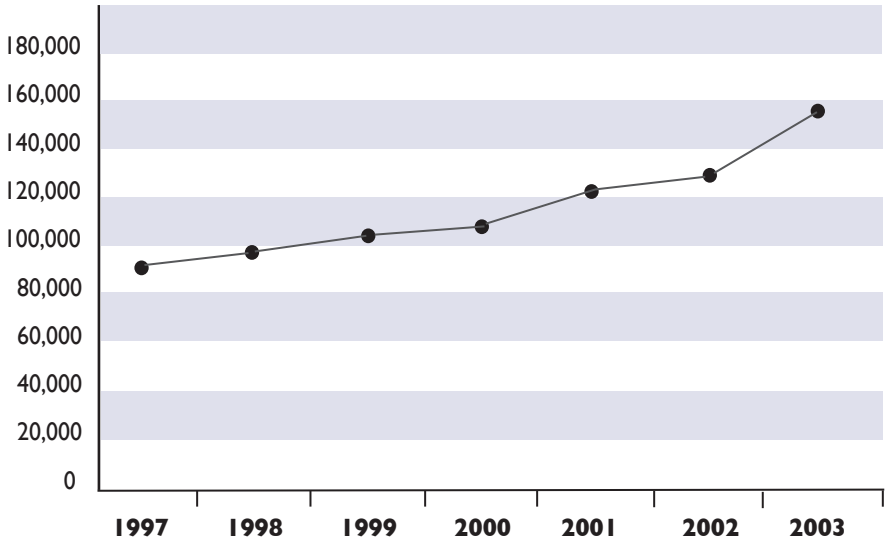
Foundation reported that in 2003, premiums for individual insurance rose by 23.7 percent, premiums for small group market rates increased by 16.6 percent, and premiums for large group coverage increased by 19.1 percent. Because of these rate increases, between 2000 and 2002, rates of employer- and union-sponsored coverage dropped from 63.8 percent to 61.8 percent, and individual coverage dropped from 5.6 percent to 4.1 percent. These findings are echoed in the national data that show that the percentage of all workers receiving health-coverage from their employer dropped from 65 percent in 2001 to 61 percent in 2004.[17]

Finally, recently released Census Data on low income children show an increase from 4.1 percent to 5.2 percent between 2002 and 2003 in the number of uninsured children in Washington State. This is most likely a reflection of the number of children who have lost Medicaid in the last year, since children who are eligible for this program live in families with incomes up to this level.

Paying More, Getting Less

By reintroducing administrative barriers, the state expected to save significant dollars as the Medicaid and SCHIP caseload dropped. However, there are two questions worth exploring to better understand whether of not this goal has truly been met:

Number of Uninsured Patients at Washington's Community Health Centers, 1997-2003



Source: Data collected by the Washington Health Care Authority for Community Health Services grantees. Includes data from the 22 Washington Association of Community and Migrant Health Center members. Received from Community Health Network of Washington, August 10, 2004.

(1) Who saves money? And (2), what are the costs of these savings? A recent report from the Health Policy Analysis Program at the University of Washington points out that "reducing average enrollment through increased barriers to retention is an inefficient way to save state dollars because such policies add to administrative costs and lead to higher health care expenditures after individuals return to Medicaid."[18]

Lack of Preventive Care Drives Up Emergency and Hospitalization Costs. One of the major consequences of children not having health insurance, whether private or public, is the increased cost associated with preventable emergency room visits and hospitalizations. Children may visit the emergency room for an easily treated ear infection, or for much more serious conditions that require a stay in the hospital. Either way, costs of emergency room visits and hospitalization quickly surpass the small amount it costs to provide Medicaid coverage for an entire year.

The table at left gives some examples of the mean hospitalization costs for common childhood conditions that in many cases can be prevented with access to regular medical and dental care. In all cases, it costs significantly less to provide Medicaid coverage for an entire year than to pay for one typical stay in the hospital for these conditions. The costs of such uninsured hospitalizations are absorbed by local hospitals and communities.

Mean Costs of Hospitalization for Preventable Illnesses in Washington, 2002

Diagnosis	**Mean Cost per Hospitalization** (2002 data)	**Total Annual Cost of Medicaid Coverage Per Child** (state share 50%)
Ear, nose, and throat infections	$3,920	$1,700 ($850)
Bronchitis and asthma	$3,056	
Diabetes	$3,498	
Dental-related hospitalizations (mainly tooth decay)	$3,714	
Depression	$4,402	

Data obtained from the Washington State Hospital Association, September 30, 2004 and diagnoses determined as "ambulatory sensitive" by John Neff, MD; i.e., diagnoses for conditions that are considered treatable or preventable with regular care in a physician's office.

More Stringent Eligibility Requirements Drive Up Processing Costs. By requiring renewals twice yearly rather than once yearly, the state doubled the number of times a caseworker must process Medicaid information for clients. Moreover, individual renewals and applications now take longer to process because caseworkers must make certain that documentation has been submitted to verify an applicant's income. When the required documentation is not included, the application or renewal must be pended until it is received. Also time-consuming for caseworkers are the varied income documentation requirements for different DSHS programs.

In a recent study conducted by the University of Washington's Health Policy Analysis Program, one Community Service Office reported that following the change to six-month recertification, the average proportion of their total work hours that caseworkers spend on renewals has increased from about 25 to 30 percent to 50 percent.[19] To conduct the more frequent eligibility reviews, the 2003-2005 budget allotted the Economic Services Division within DSHS an additional 96 full-time employees at the cost of $5.8 million in state dollars.[20]

However, adding these additional FTEs in the original budget was not enough to handle the significant increases in workload at the CSOs. In Fall 2003, a backlog in processing eligibility reviews developed, culminating in more than 10,000 children dropping off the Medicaid rolls because staff were unable to process the reviews in a timely manner. Early in 2004, DSHS authorized an additional 68 temporary FTEs for a 6-month period to assist in eliminating the backlog, at a cost of approximately $850,000 in additional state dollars.

In early August 2004, the Community Service Offices were asked to submit "phase-out" plans for these temporary workers, but conversations with regional CSO staff in September 2004[21] tell us that the backlogs are growing again, with the possibility that yet more children could experience breaks in their coverage.

FAMILY STORIES

Sheri: sacrificing wages to keep a daughter covered

Sheri's daughter has had two cancer scares in her 16 years. Sheri relies on the state's publicly funded Medicaid program (also called Healthy Options) to make sure her daughter gets the care she needs.

But, now this mom from the Olympic Peninsula is in a bind that faces many of those living near the border of what is considered a "low-income" wage.

Earlier this year, Sheri's boss, a chiropractor who can't afford to offer health insurance to his tiny staff, gave her raise. When she went from $10 and hour to $13 and hour, Sheri's daughter became ineligible for the state program. So, Sheri's scaling back her hours to make sure her child, who has serious medical concerns, remains covered.

"I will do what I can, and I will get the tests that my child needs," Sheri said.

A recent study in the journal Health Affairs[22] confirms that increasing administrative barriers is a false economy. The study showed that a reduction in administrative barriers actually decreased enrollment costs by 40 percent in the New York City area.

Following September 11, 2001, the city experienced problems with Medicaid computer systems and had difficulty enrolling the thousands of people affected by the tragedy in a timely fashion. In response, officials quickly developed a one-page application requiring only proof of identify as documentation. Income eligibility was then verified through cross-checking existing databases including the Internal Revenue Service and the state's Temporary Assistance for Needy Families data.

These streamlined procedures allowed workers to quickly enroll applicants. They also significantly decreased the average cost of enrollment in New York's state-funded health care plans. This is attributable to the fact that the average monthly cost per enrollee drops by 30 percent in the second six months of enrollment, according to a study by Leighton Ku and Donna Cohen Ross.[23] Moreover, when patients are dropped from the program and then return, there are additional administrative costs to the state and health plans to re-enroll them.

Lost Federal Revenue and Economic Impact. Another result of cutting state dollars from the state's Medicaid program is the significant loss of federal dollars being spent in Washington. Because Medicaid is funded through a state/federal matching structure, every time the state decides to reduce its costs by lowering the caseload, the state loses the federal matching funds that could have been spent here.
In Washington, the Medicaid matching rate is a 50/50 split; for every one dollar cut from the state budget, one dollar in federal

FAMILY STORIES

The Petersons: Tough Trade-offs/Parents Doing Without

How do families manage health care when they are uninsured? Mothers go without their medicines and fathers simply do not go to the doctor at all. This is the sad but true reality for one family living in Winthrop.

Meet Dave and Nancy Peterson (not their real names), who have two children, aged 5 and 13.

Dave is employed at a resort that is one of the largest employers in the community, but to cover the family on his employer's health plan would cost $800 per month—more than the family can afford. Nancy, too, works full time, but her employer's health coverage is also prohibitively expensive.

The Petersons have their children covered through Basic Health Plus, which is the same as Medicaid, but the parents have decided to go without.

Nancy has asthma and epilepsy. Because she can't afford all of the prescribed medications, she picks what she believes are the most important ones.

This is a family with two parents who work full time. But health insurance remains out of reach.

matching funds is lost. As those federal dollars are lost, the state also foregoes the economic activity those dollars could have produced in jobs and services in Washington's local communities.

Families USA, a national health care advocacy group, has estimated that for every $1 million cut from Washington's Medicaid program, $2 million is lost in business activity, 19 jobs are lost and $776,000 is lost in salaries and wages. The total state and federal dollar amount cut from Washington's Medicaid program when the 2003 administrative changes were made was approximately $25 million ($12.5 million state). Using the Families USA model, the cost of implementing these cuts translates into $52 million in lost business activity, 446 lost jobs and $19.4 million in lost salaries and wages.[24]

Other "Hidden" Cuts to Washington's Healthcare Programs for Children

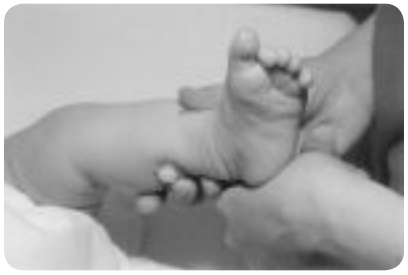
In this section, we highlight some other policy changes that are likely combining with the eligibility changes discussed above to create a more hostile environment for families seeking information and health coverage for themselves and their children.

Programs for Immigrants Eliminated. Late in the 2002 Legislative Session, policymakers eliminated three state-funded programs for individuals whose immigration status prevented them from qualifying for Medicaid. These programs were fully state-funded and, although not technically part of Medicaid, provided the same benefits as Medicaid and were administered by the Medical Assistance Administration, as are Medicaid and SCHIP. These programs served over 28,000 people, 97 percent of whom were children.

When the programs were eliminated, spaces for those losing coverage were created in Washington's Basic Health Program, a program initially designed to serve adults. This offer, while an attempt to ensure continued coverage for this population, was not automatic and was also a shift to an inappropriate health care program for the population. Because of Basic Health's numerous administrative and cost-sharing requirements, only about half of those who were cut off the Medical Assistance program were able to enroll, and the number has steadily declined since its peak in November 2002. As of August 1, 2004, only **6,530** immigrant children or their parents had Basic Health coverage.

Disproportionate Effects on Children of Color and Children in Rural Communities. When cuts are made to publicly funded health care programs, it is children of color and children living in rural communities that have the most to lose.

Research has shown that when parents also have health insurance, their children are much more likely to get the benefit of the coverage that they have.



Children of color are more likely than white children to live in families with incomes below the Federal Poverty Line and thus to be eligible for and enrolled in Medicaid. The Kaiser Family Foundation reported that in 2003, 12 percent of white children in Washington lived below the poverty line compared with 23 percent of African American children and 30 percent of Hispanic children[25]. This same report noted that non-elderly Medicaid recipients in Washington were 14 percent white, 31 percent African American and 26 percent Hispanic.

Because children of color are more likely than white children to rely on Medicaid for their health insurance, when cuts make enrollment and retention more difficult, these are the children that stand to lose the most. Moreover, when cuts are made to eliminate programs such as the three state-funded health care programs for immigrants in 2002, children of color are the clear target.

Children living in rural communities in Washington are also more likely to be covered by Medicaid, SCHIP or Basic Health and are more likely to be affected when changes are made that make enrollment and retention more difficult for families. Data from the 2002 Washington State Population Survey[26] show that a higher percentage of children living in rural counties children were insured by publicly funded health insurance than children living in urban counties. For example, in King County 32.7 percent of children were covered by publicly funded health insurance, compared with 56.6 percent of children living in counties in Eastern Washington.[27]

Though the numbers of children affected may seem small, the disproportionate effect of the recent cuts on children living in these counties is clearly documented. (See the appendix for full county details.) The counties that saw the highest percentage of children lose coverage were Wahkiakum (53.3 percent, 73 children), Lincoln (39.6 percent, 197 children), Skamania (39.10 percent, 279 children), San Juan (37.8 percent, 281 children) and Clallam (23.9 percent, 990 children).

Health Coverage for Parents Less Affordable. In our interviews with families, it became clear that many parents were making every sacrifice possible for the sake of their children's health coverage, including going without coverage for themselves. This has serious consequences for children's health. While providing coverage directly to children is an essential step, by itself it does not guarantee that children will actually get the care they need. Research has shown that when parents also have health insurance, their children are much more likely to get the benefit of the coverage that they have.[28]

Basic Health was, in part, a response to this problem, providing health insurance to adults with incomes up to 200 percent of the poverty level. However, because of state budget deficits, in recent years Basic Health has instituted program changes and increased fees that have made it difficult for families to sustain. Enrollment in the plan has declined from 100,000 with a significant waiting list in January 2004, to 90,000 with open enrollment as of October 2004.

Before the budget deficit in 2002, Washington State had applied for and was ultimately denied a federal waiver that would have allowed the state to use unspent SCHIP dollars to cover parents in Basic Health. It may not be out of the question for the state to go back and reattempt such a waiver proposal. Our interviews with families point to this as a critical need.

Decline in outreach. Outreach work in Washington has declined since 2002, when significant federal matching funds expired. While statewide communications acitivities such as the Healthy Kids Now! hotline and materials are still in operation, much of the local outreach work has either been significantly scaled back or completely eliminated, because of the lack of funding.

Conclusion

Administrative changes made to Washington's Medicaid program have resulted in tens of thousands of children losing health coverage. The impacts of the loss, though, are only now becoming clear. Families faced with a renewal process that rivals filing a tax return every six months are being "hassled" off the public health insurance rolls. In one year alone, more than 50,000 children have been pushed off the Medicaid program and it is unlikely that they are covered today. Combined with the 17,500 immigrant children who have lost coverage as a result of outright program elimination, close to 62,000 children are without a regular source of health insurance or the health care access that accompanies it. Fiscally, this has created an unsustainable scenario for the health care system in our state. As the number of uninsured rises, it becomes more and more difficult for hospitals, clinics and providers to stay afloat.

As a state, we must re-consider these budget-driven decisions in light of the individual and system-wide impacts that are emerging. Are we really comfortable with tens of thousands of children losing health care coverage, leaving them without preventive care? Are we ready to accept the consequences of illnesses that don't get addressed until costly charity hospital care is the only treatment option? Are we really better off when hospitals and clinics can't absorb the ever-rising number of uninsured families seeking their help?

Based on the research and interviews contained in this report alone, the answer is that we are not better off. This is an experiment in caseload reduction that has produced unintended consequences of an unanticipated magnitude.

On the following page, we outline a number of policy steps we recommend legislators take to address the growing children's uninsurance crisis in Washington. The true cost of implementing these changes is far less than the eventual costs of denying medical care to tens of thousands of our state's children. We know that these children will be left behind because they will miss more days of school, because they will not be ready to learn, and because they will not be given one of the basic tools they need and deserve to succeed. However, there is cause for hope, because there are clear solutions and evidence that it can be done. Our state was once the leader in implementing these solutions, and can be once again. The evidence to support these policy changes is mounting; what is needed now is the political will to carry them out.

Policy Recommendations

It is critical that we reduce the rising uninsurance rate in this state. To restore coverage to the tens of thousands of children who have fallen off the public insurance rolls in the past few years, we recommend that the state adopt the following policy changes:

- **Reinstitute coverage to immigrants through restoration of the Medicaid look-alike program eliminated in 2002 and identify a secure source of state-only funding for the program.**
- **Restore the 12-month eligibility period for Medicaid and SCHIP.**
- **Restore continuous eligibility for Children's Medicaid and SCHIP.**
- **Identify a "middle ground" for income verification that is realistic for families while maintaining program integrity. For example, instead of requiring families to submit pay stubs and other paper materials to verify income, allow families to record their income on application and recertification forms, and empower caseworkers to use other means to verify income including employment security data and calling employers directly. This should be combined with a rigorous audit plan to assure program integrity.**
- **Reinvest in outreach work to identify and enroll eligible children.**
- **Resubmit federal waiver proposals that would allow the state to use unspent Children's Health Insurance Program dollars to cover parents of Medicaid-eligible children.**

Appendix A

Footnotes

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Appendix B

County Caseload Decline

Decline in Child Medicaid Enrollment by County, April 2003 - July 2004				
County	**April 2003**	**July 2004**	**Change since April 2003**	**% Change**
Adams	2,578	2,422	-156	-6.1%
Asotin	1,489	1,387	-102	-6.9%
Benton	9,292	8,497	-795	-8.6%
Chelan*	8,394	8,303	-91	-1.1%
Clallam	4,140	3,150	-990	-23.9%
Clark	21,541	18,602	-2,939	-13.6%
Columbia	161	167	6	3.7%
Cowlitz	6,523	5,327	-1,196	-18.3%
Douglas*	1,276	273	-1,003	-78.6%
Ferry	798	715	-83	-10.4%
Franklin	6,969	6,415	-554	-7.9%
Garfield	44	35	-9	-20.5%
Grant	8,983	7,554	-1,429	-15.9%
Grays Harbor	5,048	3,854	-1,194	-23.7%
Island	2,487	1,982	-505	-20.3%
Jefferson	1,494	1,287	-207	-13.9%
King	68,832	60,439	-8,393	-12.2%
Kitsap	10,247	8,325	-1,922	-18.8%
Kittitas	1,891	1,613	-278	-14.7%
Klickitat	1,707	1,355	-352	-20.6%

NOTE: During this period caseloads were shifted between Chelan and Douglas counties—the two counties should be summed together.

Decline in Child Medicaid Enrollment by County, cont'd.

County	April 2003	July 2004	Change since April 2003	% Change
Lewis	6,030	4,679	-1,351	-22.4%
Lincoln	497	300	-197	-39.6%
Mason	3,368	2,838	-530	-15.7%
Okanogan	4,972	4,381	-591	-11.9%
Pacific	1,176	1,045	-131	-11.1%
Pend Oreille	941	805	-136	-14.5%
Pierce	39,074	33,103	-5,971	-15.3%
San Juan	743	462	-281	-37.8%
Skagit	8,794	7,718	-1,076	-12.2%
Skamania	714	435	-279	-39.1%
Snohomish	31,057	26,586	-4,471	-14.4%
Spokane	29,285	25,268	-4,017	-13.7%
Stevens	3,654	3,017	-637	-17.4%
Thurston	10,652	8,716	-1,936	-18.2%
Wahkiakum	137	64	-73	-53.3%
Walla Walla	4,199	3,599	-600	-14.3%
Whatcom	10,931	9,233	-1,698	-15.5%
Whitman	1,584	1,364	-220	-13.9%
Yakima	27,961	24,894	-3,067	-11.0%
TOTAL	**349,663**	**300,209**	**-49,454**	**-14.1%**

SOURCE: Washington Staet Medical Assistance Administration, 2004.

Appendix C

Glossary of Terms

State Children's Health Insurance Plan (SCHIP) Provides Medicaid scope of coverage to children in families with incomes between 200 percent and 250 percent of the Federal Poverty Level and requires a monthly premium $15 per child per month with a $45 family maximum. Funded by federal-state partnership of 65 percent federal dollars and 35 percent state dollars.

Medicaid Medicaid is a publicly funded healthcare program that serves children and others in Washington up to age 19 in families with incomes up to 200 percent of the Federal Poverty Level. Funded by a federal-state matching calculation of 50 percent federal dollars and 50 percent state dollars.

Basic Health Health plan designed to cover low-income adults in Washington State. Covers mostly adults and some children. Does not have the same scope of coverage as Medicaid and SCHIP. Covers people with incomes up to 200 percent with a sliding scale of fees dependent on family income and structure. This program is funded completely by state dollars. Does not provide dental, vision, transportation to services. Also includes a waiting period for pre-existing conditions. Involves fees including monthly premiums, co-payments, co-insurance and deductibles.

Basic Health Plus Subset of the Basic Health Plan that is for children who are in families up to 200 percent the Federal Poverty Level. Children receive the same coverage as they would in the Medicaid program and they are covered through the Medicaid funding stream of federal/state dollars. These children are theoretically considered Medicaid children by the state but are served by the Basic Health Plan to simplify procedures for children with parents enrolled in the Basic Health Plan.

Fee-for-Service A system of for reimbursing physicians in which doctors are paid a fee for each service performed.

Healthy Options The name of the Medicaid managed care program for the state. The majority of those enrolled in Medicaid and SCHIP are in a managed care plans that contract with the state to provide coverage.

Charity Care Hospital charges not paid by patients who are unable to pay.

Uncompensated Care A combination of charity care and bad debt expenses.

CHILDREN'S ALLIANCE

A Voice for Washington's Children, Youth & Families

The Children's Alliance is a non-profit, non-partisan child advocacy organization with over 128 organizational and 4,500 individual members throughout Washington State. We champion public policies and practices that deliver the essentials that kids need to thrive—confidence, stability, health, and safety. The Children's Alliance advocates on issues such as: foster care, childcare and early learning, health, hunger, juvenile justice, school nutrition, child abuse and state revenue.

To sign up for email alerts and updates from the Children's Alliance, go to: http://www.childrenshub.org/calliance/home.html. Choose Children's Health under "Policy Issues" for regular updates on children's health issues.

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