

**medicaid**  
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**Moving Immigrants from a Medicaid Look-Alike Program to  
Basic Health in Washington State: Early Observations**

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**May 2004**

# kaiser commission medicaid and the uninsured

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## I. INTRODUCTION AND SUMMARY OF FINDINGS

After a period of coverage expansions, budget crunches have prompted many states to begin cutting back on Medicaid and state-funded health insurance programs.<sup>1</sup> Washington State, formerly a leader in expanding public health insurance coverage, is among those states that have implemented cutbacks in enrollment and coverage, with much more extensive changes underway. This report examines the state's first significant coverage retrenchment—the elimination of programs for immigrant children and adults.

In 2002, the Washington State legislature eliminated three state-funded programs for individuals whose immigration status prevented them from qualifying for Medicaid. Although fully state-funded, and, thus, technically not part of the Medicaid program, the benefits provided were identical to those in Medicaid. Since these programs were separate from Medicaid, in this report, we refer to these immigrant benefits as Medical Assistance, an umbrella term used in Washington to refer both to Medicaid and similar state-funded programs.

This program elimination affected over 28,000 individuals, over 90 percent of whom were children; the rest were parents or other relatives caring for children. About two-thirds were of Hispanic origin, and more than 80 percent spoke a primary language other than English.

Rather than eliminating these individuals' eligibility for health coverage outright, the legislature instead set aside "slots" for them in the state's Basic Health program, a state-funded health insurance program with premiums, cost-sharing, and a more limited benefit package than Medicaid. To enroll, families had to complete the Basic Health application and pay the first month's premium (or have payment made on their behalf). Despite substantial efforts by public and private outreach workers and the involved state agencies, only about half of those terminated from the Medical Assistance programs for immigrants successfully enrolled in Basic Health during the first transitional months—October through December 2002. A large proportion of those who did enroll have not retained their coverage.

To assess the impact of the elimination of the Medical Assistance programs for immigrants, this report draws on analysis of administrative data from the state, key informant interviews, and a focus group and interviews with affected families. Since Washington's Basic Health program has similar attributes to some state Medicaid waiver programs and to some features proposed by various states as cost-control measures, the experience of the affected immigrants in Washington may be instructive.

### Major Findings

**Enrollment Losses.** Only about half of the original Medical Assistance population made the transition to Basic Health. Although some of those who lost their public coverage may have found private coverage, it is highly likely that most of the children and parents who did not make the transition became uninsured. For immigrants who did enroll in Basic Health, disenrollment rates were several times higher than they were in the Medical Assistance programs.

**Procedural Barriers to Enrollment.** The involved state agencies, the Medical Assistance Administration, which administered the immigrant programs, and the Health Care Authority, which administers Basic Health, were limited in their ability to seamlessly transfer enrollees from

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<sup>1</sup> Holahan J., Wiener J., Bovbjerg R., Ormond B., and Zuckerman S. The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets? Kaiser Commission on Medicaid and the Uninsured, January 2003.

one program to another because of statutory requirements and Basic Health enrollment rules. Because of the relatively complicated enrollment process, any number of barriers—confusion regarding the process, incorrect addresses, language difficulties, paperwork requirements, premium payment deadlines—may have led to a loss of coverage. These procedural barriers, combined with the upheaval in the programs and increased workload for both agencies during the transition period, were likely the largest causes of the low rates of transition to Basic Health.

**Affordability Concerns.** Individuals in the Medical Assistance programs were not required to pay any cost-sharing, but, once in Basic Health, they had monthly premiums and copayments for various services. Prior studies of Basic Health and the national literature indicate that low-income people are highly sensitive to price when deciding to pay for insurance. This study finds that Basic Health's premiums and copayments created affordability problems for many immigrant families involved in the transition. Premium payment procedures and amounts contributed to high rates of disenrollment from Basic Health after the immigrant population was first enrolled. Copayments for care were also a problem in some instances.

**Problems Resulting from a Narrow Scope of Coverage.** The Basic Health program provides adequate coverage for many families but has substantial gaps in coverage that compromise care for others. Although some families were able to make the transition smoothly and continue to receive appropriate care, others, especially those with special health care needs, encountered difficulties obtaining needed care. The Basic Health program's limited benefit package, which, unlike Medical Assistance, does not include medical equipment and supplies, speech and occupational therapies, vision, dental care, and other services, resulted in instances of delayed or denied care. Some enrollees needed treatments for life-threatening chronic illnesses that were not covered by Basic Health.

**Fewer Support Services.** The Basic Health program does not include the support services that were available through the Medical Assistance immigrant programs, such as medical interpretation services and non-emergency transportation. The absence of these supports made it hard for some families to access health care. People with limited English proficiency were sometimes reluctant or unable to make specialty appointments because they had no interpreter. In some parts of the state, problems associated with language difficulties were ameliorated because Basic Health insurance plans contract with safety net clinic providers with bilingual or multilingual staff. In some instances, families enrolled in Basic Health had transportation problems, especially for specialty services that were not available locally.

**Cost Shifting.** The transition process itself, and the resulting coverage gaps, required substantial resources from state agencies, county public health agencies, providers, and community organizations. As such, the transition resulted in a cost shift onto other private and public entities. The state legislature appropriated some short-term dollars for dental care and medical interpretation to help fill the gaps in coverage created by the transition. Some providers increased their provision of charity care for uncompensated services. Public health agencies provided staff resources for outreach or identified temporary funding sources to help pay for non-covered care for families involved in the transition. The Alien Emergency Medicaid program experienced a surge in use after the transition. All of these efforts resulted in a cost-shift from the Medical Assistance programs to other private and public entities and programs.

Washington's strong public and private safety net institutions (especially community health centers, public health agencies, advocacy organizations, and various organizations providing outreach to low-income populations) cushioned the negative effect of the changes to some degree by advocating with the state agencies, assisting with enrollment, troubleshooting

paperwork and documentation issues, and sometimes providing free care. These activities helped to increase the number of immigrants who enrolled in Basic Health and helped to maintain continuity of care.

## II. STUDY AND METHODS

This study gathered and analyzed information from an array of both quantitative and qualitative sources to examine the following questions:

- **The transition.** How many people made the transition from the Medical Assistance programs to Basic Health? What factors prevented Basic Health enrollment? What is the rate of disenrollment from Basic Health among those who made the transition? What are the factors that affect retention?
- **Affordability.** Are Basic Health premiums affordable to the affected population? Is the cost of care affordable to the population?
- **Access to appropriate care.** Are those who enrolled in Basic Health able to access necessary and appropriate care within the Basic Health program? What are the main barriers to accessing care?
- **Effects on providers and health organizations.** How have various organizations, including health plans, providers, county departments of health, and community-based health advocacy groups responded to and been affected by this transition?

The study employed a wide variety of methods, with an emphasis on those allowing for quick analysis of the early effects of these program changes. It includes quantitative analyses of data obtained from the two involved state agencies—the Washington State Medical Assistance Administration, which administers Medicaid and similar programs, and the Washington State Health Care Authority, which administers Basic Health. These data were used to measure the number of individuals who made the transition to Basic Health, profile the transition population, measure retention, and examine reasons for fluctuations in enrollment levels.

Qualitative research consisted of key informant interviews, a focus group, and a review of relevant reports and agency statements and information sheets. To provide background information for the project and identify key issues, we conducted 24 key informant interviews with outreach workers in eight Washington counties who had direct contact with the affected population. We also interviewed providers and health plan professionals to fill in factual gaps about the transition and its effect on children and providers.

We conducted interviews with nine adults whose children did not enroll in Basic Health in order to explore barriers to enrollment and other reasons that families were not enrolling. Interviews were conducted in the two dominant languages within the population (Spanish and English). We also conducted a Spanish language focus group of families whose children were able to enroll in Basic Health to gather information on the effects of the switch from the Medicaid look-alike coverage to Basic Health. In addition, we used data from an informal survey of public health nurses conducted by the Washington State Department of Health. This survey reported on the situation of a sample of immigrant children with special health care needs after the elimination of the three immigrant programs.

We designed our research to gather a broad scope of information rapidly to allow quick assessment of the early effects of these program changes. Although no single data source used in this project is entirely definitive regarding many of the questions asked, we looked for



consistent evidence from many different data and information sources in order to establish findings. However, although we are able to provide evidence regarding the major effects of these program changes, we cannot always provide a precise measure of the incidence of specific issues associated with the transition. For example, because of the impracticality of conducting a large survey of the affected group, given resource constraints and fluctuating addresses among the study population, we did not measure the population prevalence of barriers to enrollment or access to care that were identified through interviews, focus groups, and other qualitative methods. However, although we lack precise population-level estimates of the prevalence of certain situations or problems, the consistency of findings across many sources of information provides confidence regarding the validity of the findings.

### **III. BACKGROUND**

In this section we briefly review the recent history of programs and eligibility within Washington's public insurance system. We provide comparisons of the features of Medical Assistance programs, which include both Medicaid and Medicaid-like programs, and Basic Health, a state-funded program primarily for working adults not eligible for Medicaid. We also describe some demographic shifts that influenced the creation of special programs for immigrants.

A combination of accelerating medical inflation, legislative and initiative-driven tax cuts, and economic recession created the conditions for a shift from expansion to retrenchment in public insurance programs in Washington State. We review the reasons behind one of these rollbacks, the elimination of the Medical Assistance programs for immigrants and discuss some specifics of the transition to Basic Health. We also briefly review the literature relevant to understanding predicted or observed effects of the transition, including recent findings regarding affordability, enrollment retention, and immigrant access to health care.

#### **Public Programs in Washington: A Brief Overview**

Washington's public programs are administered within two agencies, the Health Care Authority, and the Department of Social and Health Services (DSHS). DSHS houses the state's Medicaid programs as well as a number of state-funded programs providing health care coverage to special populations. Within DSHS, the Medical Assistance Administration administers Medicaid and other similar programs, including the Medical Assistance programs for immigrants. Adults must meet very specific requirements in order to qualify for Medical Assistance. In addition to meeting income guidelines, they must generally either be caring for children or have a disability that makes them unable to work. By contrast, eligibility for children is much broader, with the majority of the state's children eligible for coverage if they meet income requirements.

The Health Care Authority administers health insurance programs for public employees and Basic Health. The state-funded Basic Health program began enrollment in 1989 as one of the nation's first programs to offer insurance to those not eligible for Medicaid.<sup>2</sup> Individuals with incomes at or below 200 percent of the Federal Poverty Level (FPL) are eligible for Basic Health.

Access to Washington public health insurance programs for low- and moderate-income families has generally expanded over the last decade and a half. In 1989, Medicaid income eligibility was increased from Aid to Families with Dependent Children grant levels (well below the FPL)

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<sup>2</sup> Technically, someone eligible for Medicaid whose income falls within Basic Health guidelines could choose to enroll in Basic Health instead of Medicaid. In practice, Basic Health has mostly served those not eligible for Medicaid.

to the FPL for children under the age of 8. In 1990 it was increased to 133 percent of FPL for ages 1 to 5. In 1991, all children were covered to 100 percent of FPL, including immigrant, non-citizen children who were ineligible for Medicaid.<sup>3</sup> In 1994, child coverage in Medicaid was expanded to 200 percent of FPL for all children through age 18.<sup>4,5</sup> Medicaid and state-funded Medical Assistance programs combined enrolled almost one million Washingtonians by 2000. Expanding enrollment in public programs was responsible for the steady decline in the uninsured rate from 12.2 percent in 1993 to 8.4 percent in 2000.<sup>6</sup>

In 2000, the state further expanded coverage for children by initiating its State Children's Health Insurance Program (SCHIP), a federal-state program for otherwise uninsured children between 200 and 250 percent of the FPL.<sup>7</sup> Washington's SCHIP program is separate from Medicaid, although its benefits are identical to Medicaid coverage.<sup>8</sup>

### **Public Health Coverage for Immigrants During the Expansion Period**

Programs to meet the needs of immigrant populations were, in part, a response to growth in the proportion of the population that is not native-born in Washington. Although the proportion of immigrants in the national population is increasing, the rate of increase is even higher in Washington, a coastal state with substantial ties to Asia and with substantial activity in industries such as agriculture and construction that attract and solicit workers from Mexico and Central America. According to U.S. Census data, between 1990 and 2000, the foreign-born population increased by 91 percent in Washington, compared to 57 percent nationally.

Recent immigration, and particularly non-citizen status, is strongly correlated with being uninsured. As recent national data show, 87 percent of the native-born population has coverage, compared to 67 percent of immigrants. Also, low-income immigrants are twice as likely to be uninsured as low-income citizens generally.<sup>9</sup> Although 82 percent of naturalized citizens have coverage, a rate approaching that of the native-born population, only 57 percent of non-citizens are covered.<sup>10</sup> Duration in the country also has an effect on insurance status, with those who have been in the country longest being more likely to have coverage: 82 percent of those who have been in the U.S. longer than 20 years have coverage, compared to 55 percent of those who have been in the U.S. less than 10 years.<sup>11</sup>

Washington responded to growing numbers of immigrants by expanding eligibility for public health coverage to these individuals. The 1991 and 1994 Medicaid expansions included immigrant children, first to 100 percent of FPL, then to 200 percent. After the 1996 federal welfare reform law limited immigrant eligibility for Medicaid, the Washington legislature passed a law confirming that those excluded from Medicaid, including parents, could receive state-funded

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<sup>3</sup> Washington State Medical Assistance Administration, "Historical Eligibility Changes," undated.

<sup>4</sup> Ibid.

<sup>5</sup> Children in the state-funded Basic Health program were provided with Medicaid coverage through Basic Health providers in a "Basic Health Plus" program started in 1994. This program is funded by Medicaid dollars.

<sup>6</sup> M. Susan Marquis, Mark Gardner, and Jennifer Phipps, *Targeting the Uninsured in Washington State*, report to the Washington State Office of Financial Management, State Planning Grant on Access to Health Insurance, April 2002.

<sup>7</sup> To be eligible for SCHIP, children must meet federal requirements for citizenship or immigrant status.

<sup>8</sup> Although many states started their SCHIP programs in 1998, Washington's SCHIP program was delayed until 2000 by the state legislature, which balked because SCHIP rules only provided funding for coverage expansions. This made the state ineligible for matching funds for its early expansion to 200 percent of the FPL. Recent changes in federal legislation now allow the state to receive matching funds for these expansions.

<sup>9</sup> Kaiser Commission on Medicaid and the Uninsured, *Immigrants Health Care Coverage and Access*, March 2001.

<sup>10</sup> Census 2000 data.

<sup>11</sup> Ibid.

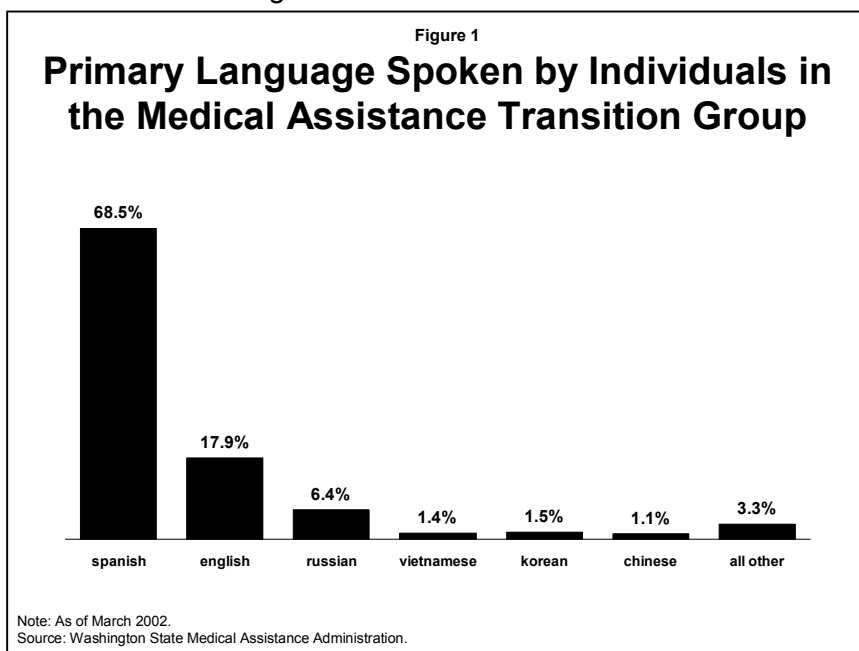
coverage. Washington was among 13 states that offered state-funded coverage to all excluded legal immigrants; they received benefits identical to Medicaid.<sup>12</sup> Despite Washington's efforts to cover recent and long-time immigrants, non-natives were still more likely to be uninsured. For example, in 1998, 15.3 percent of Washington children with at least one parent not born in the U.S. were uninsured, compared to 7.8 percent of all children in the state.<sup>13</sup>

## Overview of the Transition Group

As a result of these expansions in coverage through the 1990s, at the time the Medical Assistance programs for immigrants were eliminated in September 2002, coverage was available to children with family incomes below 200 percent of FPL and parents and relatives who otherwise qualified for Medicaid except for their immigration status. Pregnant women with incomes up to 185 percent of FPL were also covered.<sup>14</sup>

In late 2001, 73 percent of immigrant Medical Assistance enrollees were in a program for undocumented immigrant children and 16 percent were in programs for documented immigrant children not qualifying for Medicaid. The remaining were families with children enrolled in the State Family Assistance (SFA) program, a TANF look-alike program for legal immigrants not qualifying for federal benefits.<sup>15</sup>

Across these categories of eligibility, 93 percent of the enrollees were children. More than 80 percent primarily spoke a language other than English at home. Almost 70 percent spoke primarily Spanish and about 6 percent spoke Russian; remaining non-English languages included Asian languages such as Korean, Vietnamese, and Japanese (Figure 1).



<sup>12</sup> Kimberley Chin, Stacy Dean, and Kathy Patchan, *How Have States Responded to the Eligibility Restrictions on Legal Immigrant in Medicaid and SCHIP?*, Kaiser Commission on Medicaid and the Uninsured, June 26, 2002, p. 9.

<sup>13</sup> Health Policy Analysis Program, *Uninsured Children in Washington State, Findings from the 1998 State Population Survey*, April 2000, unpublished.

<sup>14</sup> Pregnant legal and undocumented immigrants qualify for a separate program, Pregnancy Medical, which was not directly affected by the program eliminations studied here. Washington State Medical Assistance Administration, "Identification: Who is in the transition population?", <http://fortress.wa.gov/dshs/maa/BasicHealthptransition/IdentWho.html#pregnantwomen>. However, a bill was recently enacted that caps funding for the immigrant portion of this pregnancy program and allows the state Medical Assistance agency to restrict enrollment if the budget targets are exceeded.

<sup>15</sup> Washington State Medical Assistance Administration, data on transition group, December 2001.

## The Transition Process

In 2002, the state legislature eliminated the Medical Assistance programs for immigrant children and families, directing that these individuals be offered enrollment in Basic Health instead.<sup>16</sup> This move was part of an effort to close the state's 2002 budget gap. However, the elimination of the immigrant programs and the transfer of the population to Basic Health was not designed to save costs by reducing enrollment. Instead, it was designed to tap into a new revenue stream made available to Basic Health by a tax increase on tobacco enacted by initiative in late 2001.<sup>17</sup> Because the initiative stipulated that the new money could only be used for new enrollment, the legislature decided to shift the immigrant population from Medical Assistance to Basic Health. Otherwise, the initiative would have required the money to be spent entirely on program expansion. (Later, the legislature decided, by a two-thirds vote, to suspend the initiative's requirements that the new tobacco dollars be used for program expansion, and instructed the Health Care Authority to reduce Basic Health enrollment to 100,000).<sup>18</sup>

The state began to send materials informing the affected families of the forthcoming elimination of the Medical Assistance coverage in mid-2002. The involved agencies conducted numerous mailings in an attempt to describe the program changes and get clients to initiate enrollment into Basic Health. One letter was sent by the Medical Assistance Administration to enrollees before the programs ended, informing them of the elimination of the programs and answering questions regarding the process of enrolling in Basic Health. The Health Care Authority sent postcards in June 2002, followed by applications, to more than 15,000 households informing them of the transition. The Medical Assistance Administration continued to send letters regarding the programs' termination to new clients who enrolled during the transition period but before the programs ended. In August 2002, the Medical Assistance Administration sent letters informing some enrollees that they met the five-year residency requirements to remain in Medicaid. The agency also sent a questionnaire to all others, at the urging of advocates, to give them an opportunity to demonstrate that they met the immigrant status criteria for Medicaid.<sup>19</sup>

The agencies adopted a number of measures in an attempt to ease the transition process and increase enrollment into Basic Health. The original deadline to transfer without the possibility of being placed on the existing Basic Health waiting list was October 1, 2002, the date the immigrant programs were slated to end. The Governor's office later instructed the agency to extend the deadline for transition without penalty to June 2003. The Health Care Authority also developed a shortened application for this population, although documentation of income from the IRS or a statement of inability to provide such documents was still required.<sup>20</sup>

Basic Health allowed non-citizens who initiated an application (returned a postcard or application) but did not complete it by October 1 to receive coverage for the months of October and November, pending receipt of premiums.<sup>21</sup> Basic Health also solicited donations from various organizations to pay the premiums for some applicants during the first two months of enrollment in order to assure completion of the enrollment process.

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<sup>16</sup> Even though State Family Assistance medical coverage was eliminated, the grant portion of that program was not changed.

<sup>17</sup> LAWS of 2002, ch. 2 § 1 (Initiative Measure No. 773, approved November 6, 2001)

<sup>18</sup> Ralph Thomas, "Adding up the winners and losers," *Seattle Times*, June 8, 2003

<sup>19</sup> Clients initially placed in these programs were not always thoroughly screened for Medicaid eligibility, and Medicaid status is subject to change over time.

<sup>20</sup> Washington State Health Care Authority, "Draft Work Product Deliberative Materials," November 20, 2002.

<sup>21</sup> Washington State Health Care Authority, "Expanded Enrollment Action Plan," July 2002.

A number of trainings, sponsored by the Health Care Authority, the Medical Assistance Administration, and the nonprofit organizations Northwest Health Law Advocates, Northwest Justice Project, and the Children’s Alliance were conducted for community-based organizations, clinics, and hospital staff to enhance their ability to assist the transition population. Some local agencies, such as Public Health—Seattle & King County, conducted additional trainings. The Health Care Authority set aside \$112,000 (including Medicaid administrative match) for training and support for outreach efforts by 13 organizations.<sup>22</sup>

### **Medical Assistance and Basic Health: A Brief Comparison**

There are a number of differences between Medical Assistance and Basic Health. Since Medical Assistance evolved as part of the safety net and provides benefits identical to Medicaid, it has many features designed to enhance coverage and care for vulnerable children and families. By contrast, Basic Health was conceived as a “basic” coverage package for the working poor, many of whom are not eligible for Medicaid or similar programs.

All Basic Health enrollees receive care through managed care plans, while the Medical Assistance immigrant populations received fee-for-service coverage. Basic Health includes various provisions to discourage adverse selection—that is, enrollment of those more likely to have higher medical expenses. These include “lock out” rules that apply to those not making required premium payments in a timely fashion and preexisting condition requirements for certain illnesses. These provisions were not part of Medical Assistance.

There are also differences in income eligibility between the programs. Basic Health covers families with incomes up to 200 percent of poverty, but its definitions of family are narrower than those used for Medicaid and Medical Assistance and, thus, more restrictive. Basic Health does not allow various “income disregards” for earned income that apply to Medicaid and Medical Assistance, again reducing the effective eligibility.<sup>23</sup> However, since the income distribution of the immigrant population is mostly below the poverty level, it is unlikely that Basic Health income limits affected substantial numbers of immigrant families.

Coverage under Basic Health is less comprehensive than Medical Assistance. Basic Health also provides fewer benefits with higher cost sharing than the average employment-based plan.<sup>24</sup> Certain conditions or services that were covered by Medical Assistance are not covered under Basic Health. These include most durable medical equipment, hearing aids, and services such as transportation to medical appointments. Basic Health offers limited pharmacy coverage and does not cover dental care or speech or occupational therapies.<sup>25</sup> Physical therapy is limited to rehabilitation after surgery. Other areas are covered but in a more limited fashion than they were covered through Medical Assistance; for example, eye exams are covered, but eyeglasses are not. Notably, because Basic Health was designed primarily for adults, coverage for some preventive services and for children with special health care needs is limited. Table 1 identifies some of the main differences in the benefits of the programs.

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<sup>22</sup> Ibid.

<sup>23</sup> Health Care Authority, “Draft Work Product Deliberative Materials,” November 20, 2002.

<sup>24</sup> Stan Dorn and Tanya Alteras, forthcoming report for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

<sup>25</sup> Gary Christenson, “Status Report: Washington Basic Health Plan,” presentation, November 18, 1998.

**Table 1**  
**Medical Assistance and Basic Health: Key Differences in Benefits**

Condition or service	Medical Assistance	Basic Health
Adult day health	Yes	No
Dental services	Yes	No
Dentures	Yes	No
Preventive Care for Children	Yes (and treatment of all conditions discovered during the exams)	Yes
Elective surgery	Yes	No
Eyeglasses and exams	Yes	Exams only
Hearing Aids	Yes	No
Medical equipment	Yes	No
Neurodevelopmental center visits	Yes	No
Nutrition therapy	Yes	No
Optometry	Yes	No
Organ Transplants	Yes	Limited
Orthodontia	Limited	No
Physical/occupation/speech therapy	Yes	Limited
Podiatry services	Yes	No
Private duty nursing	Limited	No
Prosthetic devices/mobility	Yes	No
School medical services	Yes	No
Enteral/parenteral nutrition	Yes	No
Transportation (non-ambulance)	Yes	No

Note: For Basic Health, "services in addition to those listed in the schedule of benefits may be provided at the sole discretion of the health plan through the health plan's medical management program if providing the service will result in a lower out of pocket cost to the health plan."

Source: Washington State Medical Assistance Administration (MAA), "MAA and Basic Health Benefit Comparison for Non-Citizen Transition Group," June 2002, and communication with MAA and Washington State Health Care Authority.

In addition to having more limited benefits than Medical Assistance, Basic Health requires beneficiaries to pay premiums and substantial cost sharing that were not part of Medical Assistance. For example, in 2003, minimum premiums per enrollee were \$10. Prescription drugs were covered, but there was a three-tier formulary designed to provide incentives for patients and providers to use the lowest-cost products. There was a \$3 copayment for some low-cost drugs and a \$7 copayment for other generic drugs and items such as contraceptives. However, beneficiaries needed to pay 50 percent of all costs for brand name drugs in a plan's formulary, even in cases where there were no generic equivalents on the market.<sup>26</sup> Table 2 summarizes the cost sharing in place in 2003.<sup>27</sup>

<sup>26</sup> Washington State Health Care Authority, *Appendix A: Schedule of Benefits, 2003 Basic Health Member Handbook*.

<sup>27</sup> This cost sharing increased substantially in January 2004 in response to a directive from the governor and legislative measures to restrain costs and enrollment growth, including 20 percent coinsurance for many services, a

**Table 2**  
**Basic Health Cost Sharing, 2002-2003\***

<b>Monthly Premiums</b>	\$10-\$158 per person, based on income, age, and health plan
<b>Copayments</b>	
Physician	\$10 per office visit (not including maternity care).
Hospital	\$100 per admission, with \$500 maximum per year per enrollee. No payment for readmission for same condition within 90 days or for maternity care.
Outpatient	\$25 per non-emergency admission or facility visit. No payment for readmission for same condition within 90 days or maternity care. \$50 for ER use unless resulting in an inpatient admission.
Lab and X-Ray	None
Ambulance	\$50. No copayment for transfer to contracting facility or for needed services.
Preventive Care	None
Maternity Care	None
Pharmacy	Three tier system, with copayments at \$3 and \$7 for the first two tiers, and 50 percent for brand name drugs in the health plan's formulary, even if no generic equivalent is available.

\*Basic Health cost sharing increased substantially in January 2004.

Source: Washington State Health Care Authority, *Appendix A: Schedule of Benefits, 2003 Basic Health Member Handbook*.

## **A Brief Review of Relevant Literature**

Despite efforts to increase enrollment of the immigrant group in Basic Health, enrollment rates were generally disappointing. A number of recent research reports, drawn both from Washington State and national studies, provide context useful in helping to explain why enrollment rates were so low. These studies discuss the impacts of cost-sharing and enrollment and reenrollment procedures on enrollment and retention. Other papers review the specifics of the health care access problems experienced by immigrants.

Extensive recent research has documented the costs of uninsurance to society and individuals.<sup>28</sup> A number of papers have also described many of the reasons people remain uninsured despite eligibility for Medicaid and SCHIP. Many researchers identify paperwork burdens and enrollment complexity as reasons for low enrollment rates. Since, in many respects, Medicaid enrollment is simpler than enrolling in Basic Health, these findings are relevant to that program as well. A national survey of low-income parents documented reasons that they either found enrollment processes difficult or were unable to complete the enrollment process. Among those who tried to enroll but were unable to complete the process, frequently cited barriers included "too hard to get required papers" (72%), "too confusing and complicated"

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\$10 minimum pharmaceutical charge, and a \$150 annual deductible. Minimum premiums have increased to \$17. Washington State Health Care Authority, "Basic Health Subsidized Benefits Summary," June 11, 2003.

<sup>28</sup> See the following publications by the Institute of Medicine: *Coverage Matters*, September 2001; *Care without Coverage: Too Little, Too Late*, May 2002; and *A Shared Destiny: Community Effects of Uninsurance*, March 2003.

(62%), and “materials not in my language” (46%). For eligible people who did not attempt to enroll, half cited “rules were too confusing/forms too complicated” as reasons for not applying.<sup>29</sup>

A review of New York’s experience with Disaster Relief Medicaid, a program adopted after Medicaid eligibility systems were impaired in the 9/11 disaster, showed that adopting a short application form, reducing documentation requirements, and providing substantial language assistance resulted in an upsurge in enrollment. However, after this temporary program ended, the process of transitioning newly enrolled people to regular Medicaid occasioned substantial confusion and created barriers to continued enrollment.<sup>30</sup>

A review of the application process for SCHIP in three states showed that, despite simplified application forms, one half to three quarters of applicants failed to complete the application process. Most of the coverage denials were caused by incomplete applications or those missing required documentation or verification, particularly of income.<sup>31</sup>

Research also documents how cost sharing can create barriers to enrollment and retention. The presence of premiums and premium increases reduce enrollment of low-income people in health insurance programs. A recent review of the national literature on cost sharing showed that even small premiums—one percent of a family’s income or \$13 per month for a family of three with income at the FPL—lowered enrollment by 16 percent. Premiums at three percent of family income—\$38 for a family of three with income at the FPL—could be expected to reduce enrollment by half.<sup>32</sup>

A 1997 examination of affordability in four states, including Washington, showed that enrollment in public programs dropped off markedly after premiums exceeded 3-4 percent of family income.<sup>33</sup> In an analysis of how cost affects Basic Health participation, Long and Marquis found that levels of monthly premiums have a significant effect on enrollment. For example, they found that a decline in average premiums from \$50 to \$25 resulted in a 4 percent increase in Basic Health enrollment, and a decline from \$25 to \$10 led to an additional 3 percent increase in participation.<sup>34</sup>

Dorn and Alteras also found a relationship between premiums and enrollment in Basic Health.<sup>35</sup> In a review of Basic Health enrollment changes since the program’s inception, the authors noted that changes in premium costs have been associated with changes in enrollment, although other changes in the program also often occurred simultaneously with premium changes. The authors also reviewed earlier studies that found a causal link between premiums and

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<sup>29</sup> Perry M, Kannel S. *Medicaid and Children: Overcoming Barriers to Enrollment*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2000.

<sup>30</sup> Michael Perry, *New York’s Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People*, Kaiser Commission on Medicaid and the Uninsured and United Hospital Fund, August 2002.

<sup>31</sup> Ian Hill and Amy Westpfahl Lutzky, *Getting In, Not Getting In, and Why: Understanding SCHIP Enrollment*, The Urban Institute, May 2003.

<sup>32</sup> Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid*, Center on Budget and Policy Priorities, May 7, 2003.

<sup>33</sup> Leighton Ku and Teresa A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*, Urban Institute, March 1, 1997

<sup>34</sup> Steven H. Long and M. Susan Marquis, “Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection,” *Inquiry*, Vol. 39, Fall 2002.

<sup>35</sup> Stan Dorn and Tanya Alteras, forthcoming report for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.



enrollment. For example, a study of the Basic Health pilot program in the early 1990s found that a \$5 increase in premiums for a family was associated with a 6 percent decline in enrollment.<sup>36</sup>

Another recent study looked at detailed family budgets in a number of representative counties in Washington to examine whether various families could afford the health insurance options available in their areas. According to the study, factors affecting affordability of health care include family type, county, coverage options, and health status of family members. The study found that a family needs to have an income at least at 100 percent of the FPL, and in many counties much higher, to be able to afford health care coverage costs along with other necessities, regardless of family type, coverage option, and level of health. Below this level, families were forced to trade basic necessities against one another.<sup>37</sup>

Sponsorship—a feature of Basic Health that allows clinics or community organizations to pay premiums on behalf of enrollees—alleviates affordability problems for some enrollees. Sponsorship programs recognize that the premiums for the program are unaffordable for some families. According to a recent review of Basic Health by Dorn and Alteras, financial sponsorship helps people enroll in and afford Basic Health. When comparing the demographics of enrollees who are sponsored with those who are not sponsored, the authors found that those who are sponsored are more likely to have incomes below 100 percent of FPL, to be non-white, to speak Spanish, to have less than a high-school education, to have fair or poor health, and to lack health insurance before enrolling in Basic Health.<sup>38</sup>

Recent reviews have also summarized findings that copayments significantly reduced the use of essential services and prescription drugs among those who were enrolled.<sup>39,40</sup> For example, even very small Medicaid copayments adopted in California reduced immunizations by 45 percent, Pap smears by 21.5 percent, and obstetrical care by 58 percent.<sup>41</sup>

Some recent research focuses specifically on the problems faced by immigrants and those with low English proficiency in gaining access to health care and insurance. For example, one survey-based study showed that children of immigrants were twice as likely to be uninsured, four times as likely to lack a usual source of care, and twice as likely to be in fair or poor health compared to the population of non-immigrant children.<sup>42</sup> A series of focus groups of Hispanic workers identified the high cost of health insurance, the availability of alternatives (such as clinics), language barriers, and immigration concerns as reasons for not enrolling in coverage and/or not receiving care.<sup>43</sup>

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<sup>36</sup> See Madden et al, 1995, “Voluntary public health insurance for low-income families: The decision to enroll” in *Journal of Health Politics, Policy, and Law*, 20(4): 955-972.

<sup>37</sup> Carolyn Watts and James Matthisen, *Income Adequacy and the Affordability of Health Insurance in Washington*, report prepared for the Office of Financial Management, State planning Grant, June 2002.

<sup>38</sup> Stan Dorn and Tanya Alteras, forthcoming report for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

<sup>39</sup> Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid*, Center on Budget and Policy Priorities, May 7, 2003.

<sup>40</sup> Julie Hudman and Molly O’Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003.

<sup>41</sup> Ibid.

<sup>42</sup> Randy Capps, *Hardship Among Children of Immigrants: Findings from the 1999 National Survey of America’s Families*, The Urban Institute, February 2001.

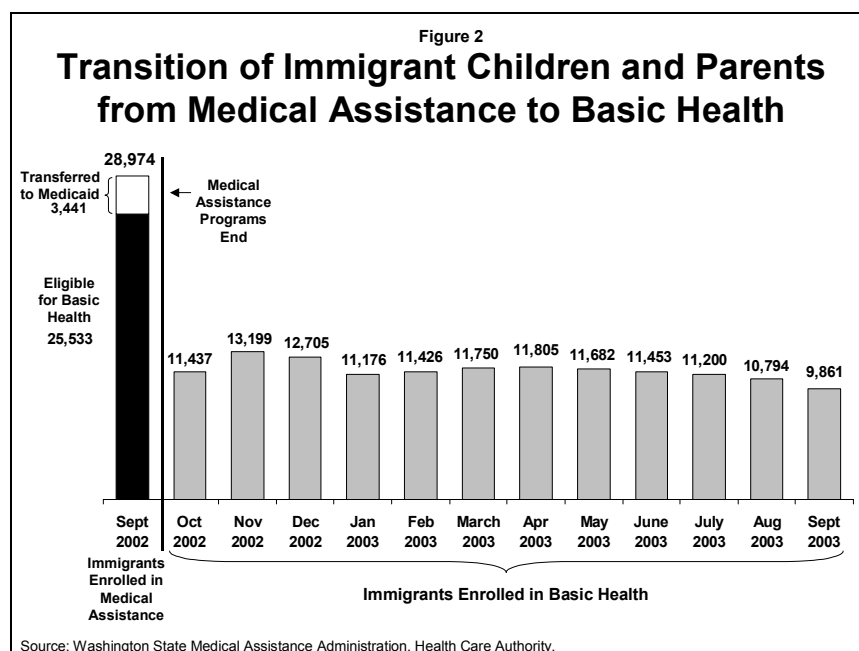
<sup>43</sup> Michael Perry, Susan Kannel, and Enrique Castillo, *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings*, The Commonwealth Fund, December 2000.

Language assistance is a key determinant in getting access to health care for some immigrants. For example, a national study of the uninsured compared those who needed and obtained translation assistance with those who needed translation but did not receive it at a hospital. Not surprisingly, those who needed and received interpretation were more satisfied with their care than those who did not receive interpretation but needed it. They were also more likely to understand medical instructions and to be asked if they needed help paying for their prescriptions or medical care.<sup>44</sup> Similarly, another recent review of problems experienced by Spanish-speaking Hispanics showed that almost half (45%) needed interpretation services when seeking medical care, but only half of these reported actually receiving it.<sup>45</sup>

#### IV. FINDINGS

##### Low Rates of Enrollment in Basic Health Among the Transition Group

One of the more dramatic effects of the elimination of the Medical Assistance immigrant programs was a substantial decline in insurance coverage among the population affected by these changes. At the height of enrollment in November 2002, just over half of those who lost eligibility for Medical Assistance were enrolled in Basic Health (Figure 2). Attrition after enrollment was also high. This section reviews these enrollment patterns. The subsequent section documents reasons for this relatively poor enrollment result.



At the time the Medical Assistance programs for immigrants ended, enrollment totaled 28,974.<sup>46</sup> Out of this population, 1,779 people were initially identified as eligible for regular Medicaid because they met federal residency requirements and were transferred to Medicaid before the

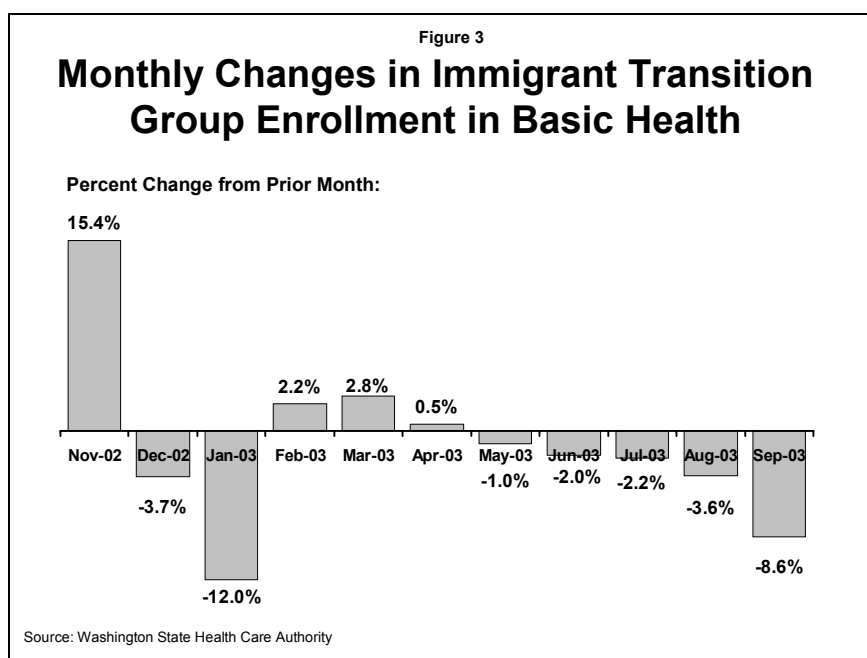
<sup>44</sup> Dennis Andrulis, Nanette Goodman and Carol Pryor, *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency*, The Access Project, April 2002.

<sup>45</sup> The Commonwealth Fund, "Uninsured Hispanics with Limited English Face Formidable Barriers to Health Care," News Release, The Commonwealth Fund, February 27, 2003.

<sup>46</sup> Washington State Health Care Authority, "Expanded Enrollment Action Plan, Overview of Implementation," July 2002.

immigrant programs ended. The Medical Assistance Administration, responding to concerns raised by advocates that this identification process was inadequate, sent questionnaires to families identified by agency staff and outreach workers as possibly Medicaid-eligible. As a result, an additional 1,662 individuals out of the original population were transferred to regular Medicaid between October and December 2002.

Of the 25,533 not eligible for Medicaid within the transition population, just over half (51.7 percent, or 13,199) had enrolled in Basic Health at peak enrollment in November 2002. The other 12,334 people (48.3 percent) did not make the transition and lost their insurance coverage during the first few months of transition, although additional immigrants were enrolled in subsequent months. From this high point, enrollment of this group in Basic Health dropped 3.7 percent in December and another 12 percent in January (Figure 3). These December and January drop-offs mostly reflected the programs' requirement that enrollees begin to pay premiums and complete application requirements to remain enrolled.



In succeeding months, enrollment began to creep up again as a result of outreach efforts and the resolution of procedural and documentation issues, reaching 11,805 by April 2003. This new total remained below the peak enrollment in November 2002, however. After April, a downward trend again appeared as a result of normal attrition and disenrollment among those unable to pay premiums or meet other requirements.

On average, 520 people lost insurance every month through July 2003, an attrition rate of 4.4 percent, or almost twice the average attrition rate of this population when enrolled in Medical Assistance.<sup>47</sup> More recently, exit rates increased, reaching 8.6 percent in September 2003.<sup>48</sup> This may reflect the effect of the Basic Health recertification process, which occurs after six

<sup>47</sup> Exit rates calculated from data provided by the Washington State Health Care Authority. Background exit rates are for the MAA "V" program, the largest program for immigrant children. Average monthly attrition for the July 2000-July 2002 period was 2.6 percent. Source: Washington State Office of Financial Management, CN Other Children (V program) Entry Exit Table.

<sup>48</sup> Calculated from enrollment data provided by the Washington State Health Care Authority.

months of enrollment.<sup>49</sup> These disenrollments were partially offset by new enrollees coming into Basic Health after gaps in coverage. As a result, 16,135 individuals received coverage for at least one month during this nine-month period.

## **Barriers to Enrollment and Retention**

Despite significant efforts made by the Medical Assistance Administration, the Health Care Authority, and community organizations to enhance enrollment of the transition group into Basic Health, barely half actually made the transition. An obvious reason these individuals lost insurance coverage is that they were not transferred directly into Basic Health from Medical Assistance but were instead offered the opportunity to enroll in “slots” that had been set aside for them. Under the legislation that eliminated the Medical Assistance programs, the Health Care Authority, which administers Basic Health, was not permitted to directly transfer the affected population from one program to another.<sup>50</sup> Instead, all enrollees had to comply with enrollment procedures and meet the program’s requirements. Although the Medical Assistance Administration and the Health Care Authority made various efforts to simplify and streamline the process, a number of enrollment barriers remained for individuals, including incorrect address information, language barriers, affordability concerns, trouble obtaining required documentation, and confusion about the process. A few of the families who did not transfer to Basic Health might have found other insurance but most have probably become uninsured.

Substantial disenrollment from Basic Health also occurred in the second and third months of the transition period. During the first two transition months, Medical Assistance Administration information was used to establish eligibility, and nonpayment of premiums did not result in disenrollment. After November 2002, applicants had to complete a full Basic Health application and pay premiums (including any premiums owed for prior coverage months) in order to remain enrolled.<sup>51</sup> (Some enrollees were “sponsored,” i.e. their premiums were paid by third parties such as clinics or community organizations; see below.) Inability to pay premiums and incomplete applications and/or documentation contributed to the drop-off in enrollment in December 2002 and January 2003.

We conducted research using a number of different information-gathering techniques to identify specific barriers that affected enrollment and retention. These barriers are reviewed below:

***Language and literacy issues.*** As previously described, the majority of parents in transition group families speak a primary language at home other than English. Our research revealed that language was a barrier for some during the transition process or after enrollment, depending in part on whether families had access to bilingual outreach workers or clinic staff. Access to properly translated documents were also a problem for some. Language factors were often combined with other factors that delayed or prevented enrollment.

If we examine data for a “before and after” picture of language composition, we see that limited-English-speaking households actually increased their share of the enrolled population, largely due to the higher percentage of Spanish speakers after the transition. Before the transition, 69 percent of enrollees in the immigrant programs were primarily Spanish-speaking, but 83 percent

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<sup>49</sup> The total potential population was limited by the way the transition group was defined and counted: only those formerly enrolled in Medical Assistance. However, it is likely that few, if any, additional immigrants not previously enrolled in Medical Assistance joined Basic Health during the period studied here since Basic Health entered a period of “managed enrollment” (waiting lists) during this period due to budget constraints and anticipated program cutbacks.

<sup>50</sup> Washington State Health Care Authority, “Draft Work Product Deliberative Materials,” November 20, 2002.

<sup>51</sup> Washington State Health Care Authority, “Expanded Enrollment Action Plan,” July 2002.

of those who made it to Basic Health by October 2002 spoke Spanish. The percentage speaking English as a primary language actually dropped, as did Russian speakers, while Korean and Vietnamese speakers increased.<sup>52</sup> This comparison tells us little about the independent effects of language, however, since a number of other variables may have been involved in the transition rates for various populations. For example, it is likely that Spanish-speaking people are among those enrollees with the best access to safety net organizations that provide language and enrollment assistance and sometimes premium sponsorship. Since there was significant evidence of the confusing nature of the Basic Health enrollment process (see below), the language composition of the Basic Health enrolled group may reflect ties to community groups or community clinics able to assist in the transition.

A set of interviews with Spanish-speaking families whose children did not make the transition did reveal evidence of language as a barrier, however. Most of the respondents received information about the transition in the mail. Only one respondent found the material to be simple to understand and follow. Some Spanish speakers received materials in Spanish, some received materials in Spanish and English (alternately), and others received just English letters. Some interviewees complained about receiving too much information, adding complexity and making the process harder to follow.

A focus group of Spanish-speaking parents of children who were able to enroll in Basic Health revealed little evidence of difficulties caused by language alone, although the group was conducted in a part of the state where bilingual staff in community and health organizations are plentiful. However, all of the respondents had sought some help from outreach workers, clinic staff, or the agency during the application process. A few respondents noted some difficulty in receiving information from the agency, with one noting a three-day delay in getting a return telephone message and another not able to get through at all.<sup>53</sup>

Even when the language was appropriate, families often had difficulty understanding procedures. According to some outreach workers we interviewed, literacy per se, and not just receiving materials in their native language, was a problem for some clients.<sup>54</sup> One outreach worker noted that it was a “big problem that the bills are in English, with only a small sidebar in Spanish. It didn’t match up, and so families didn’t understand that they needed to send two payments [reference to a requirement that initial enrollees who started the application process late in the cycle needed to send in two premium payments simultaneously]. They held one [payment] back and, so, may lose coverage.” In general, outreach workers thought that informing clients through the mail had limited effectiveness because of illiteracy, conflicting information, letters provided only in English, and because clients’ addresses change frequently. By contrast, radio, and word-of-mouth contacts with outreach workers and clinic staff often proved most effective in providing the correct information.

**Documentation requirements.** Some families had difficulty providing the documentation required to complete the Basic Health application. Basic Health requires families to verify their incomes through tax returns and recent pay history information.<sup>55</sup> However, tax return requirements can be waived if enrollees provide proof of nonfiling status and alternative verification of income.<sup>56</sup> By contrast, the Medical Assistance Administration allowed income to

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<sup>52</sup> Health Care Authority language data are incomplete, with 9.2 percent of families having no record for language spoken. These cases were excluded from the percentage reported here.

<sup>53</sup> Focus group of Basic Health enrollees.

<sup>54</sup> Interviews with outreach workers.

<sup>55</sup> Health Care Authority, “Draft Work Product Deliberative Materials,” November 20, 2002.

<sup>56</sup> Wash. Admin. Code 182-25-040(2)(a)

be determined by client declaration at the time of application unless claimed income appeared questionable to agency staff.<sup>57</sup> Basic Health also requires proof of street address, Social Security numbers for all members of a family, and documentation of all sources of other income. One parent interviewed for this project noted that, “There was always some requirement we didn’t meet, a piece of information we didn’t provide. Every time we thought we had complied with their requests there was something else missing.”<sup>58</sup>

Relatively simple transaction issues confounded some families attempting to enroll in Basic Health. Some families noted that frequent address changes increased problems in keeping up with documentation requirements, a problem also noted by outreach workers.<sup>59</sup> Problems were compounded in some instances by letters generated by the Department of Social and Health Services computer eligibility system indicating that some in the transition population were eligible for another year of Medical Assistance benefits.<sup>60</sup> These letters were generated as part of annual “eligibility reviews,” some of which occurred in the months preceding the programs’ elimination. According to outreach workers interviewed for this project, this created the false impression among some in the transition population that they could retain their coverage without applying to Basic Health. For example, one worker indicated that many Russian-speaking families chose not to enroll after receiving this letter, believing statements that the program would end were in error (or deliberately misleading).<sup>61</sup>

In short, various application and documentation requirements often worked in tandem with language and literacy issues to make enrollment more difficult for this population. According to one outreach worker,

“Dealing with Basic Health is very stressful for families. They can’t understand the information they get in the mail, even if it is in Spanish. They drag letters out when I do a home visit. When people call Basic Health, the line is busy; when they talk to a person, they are not nice. Clients are being asked to send in information over and over. Just miss one deadline, and they cut you off. If families do send in requested information, it takes six weeks for Basic Health to input. Families say, ‘It is not worth it. We can’t make them happy no matter what we send and then they want it over and over.’ Families give up, let coverage lapse, and go to the ER. ER docs are flown in. They don’t really know the community and don’t give good care.... I work harder than ever and make many more home visits. This transition is not going to save the state any money. Families can’t keep up.”<sup>62</sup>

**Affordability.** Affordability issues played a role in reducing enrollment within the transition population. According to the Health Care Authority, “...it has been a major challenge to help these individuals cope with the loss of a free health care program in exchange for a program with fewer benefits that requires payment of a monthly premium.”<sup>63</sup> Minimum monthly premiums for Basic Health increase along with family income and age of enrollee. Premiums may also increase if certain higher-cost plans are selected by enrollees. Premiums in 2003 ranged from \$10 per person (adults and children) at the lowest income levels in a low-cost plan to over \$150

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<sup>57</sup> Health Care Authority, “Draft Work Product Deliberative Materials,” November 20, 2002.

<sup>58</sup> Interviews with non-enrolled families.

<sup>59</sup> Interviews with non-enrolled families and with outreach workers, February 2003.

<sup>60</sup> Health Care Authority, “Draft Work Product Deliberative Materials,” November 20, 2002.

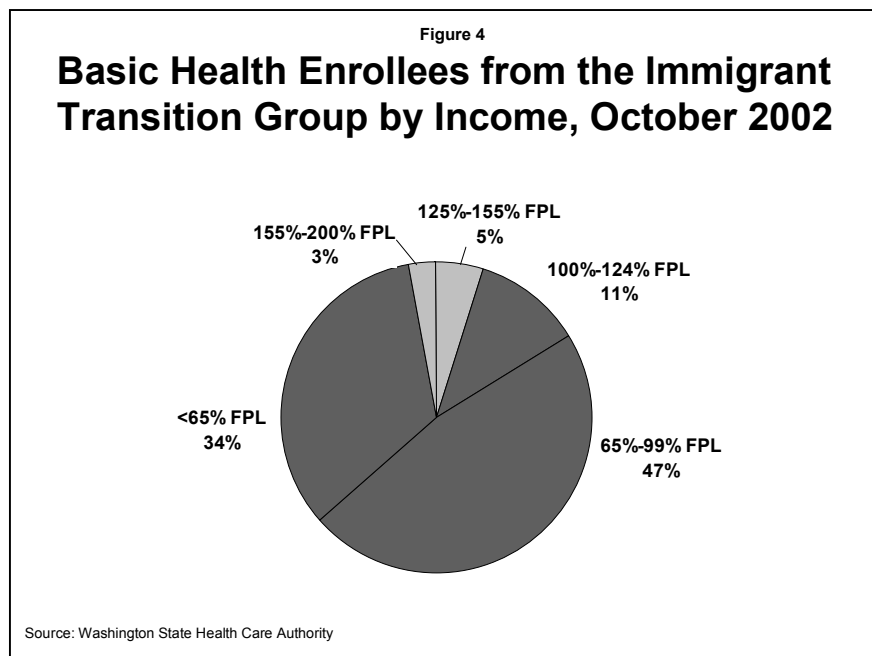
<sup>61</sup> Interviews with outreach workers.

<sup>62</sup> Interviews with outreach workers.

<sup>63</sup> Washington State Health Care Authority, information sheet on programs and issues, October 1, 2002.

per person for older adults at the highest income levels. (Costs can exceed \$200 per enrollee per month for older adults if certain high-cost health plans are chosen.) For example, a very low-income family with two adults under age 40 and three children would pay \$50 per month in premiums under the lowest-cost plan. At the highest income levels in 2003 (just under 200 percent of the FPL), the same family would pay \$252 per month if they were enrolled in the lowest cost plan.<sup>64</sup> (These amounts all increased in January 2004.)

Premiums increase more steeply for families above 125 percent of FPL. Most Basic Health enrollees (over 72 percent) have incomes below this threshold. Above this income level,



premium payments can consume between 2.2 percent and 6.9 percent of household income, even for an enrollee under the age of 40.<sup>65</sup> The concentration of enrollment at lower incomes is even more marked for the immigrant transition group, with 92 percent below the threshold of 125 percent of FPL in October 2003 (Figure 4). However, even though most enrollees from the immigrant transition group are subject to the lowest range of premiums, many still had difficulty affording them.

In open-ended interviews with enrollment outreach workers who work with the immigrant population, a number of respondents noted that the premiums were too expensive for their clients (and none stated they were affordable). According to one worker, “Some don’t have \$10 to pay...The rent dominates their lives. They don’t even try to rent on their own, but share with others and still don’t have enough to pay rent.”<sup>66</sup>

Information received from interviews with families revealed that some families were attempting to enroll children but not eligible adults because of the premium costs.<sup>67</sup> One participant said, “My priorities were getting medical coverage. I thought of cutting some other expenses in case it was necessary, even if my wife and I had to give up medical coverage for ourselves.”

In a focus group of Basic Health enrollees, many had affordability concerns, with some expressing doubt about whether they could remain in the program. According to one participant, “We get scared that if we don’t pay they will take away the plan. We have to find a

<sup>64</sup> Calculated from information in Health Care Authority, “How Much Will Basic Health Coverage Cost,” November 2002. Premiums are charged only for the first three children in a family.

<sup>65</sup> Stan Dorn and Tanya Alteras, forthcoming report for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

<sup>66</sup> Interviews with outreach workers.

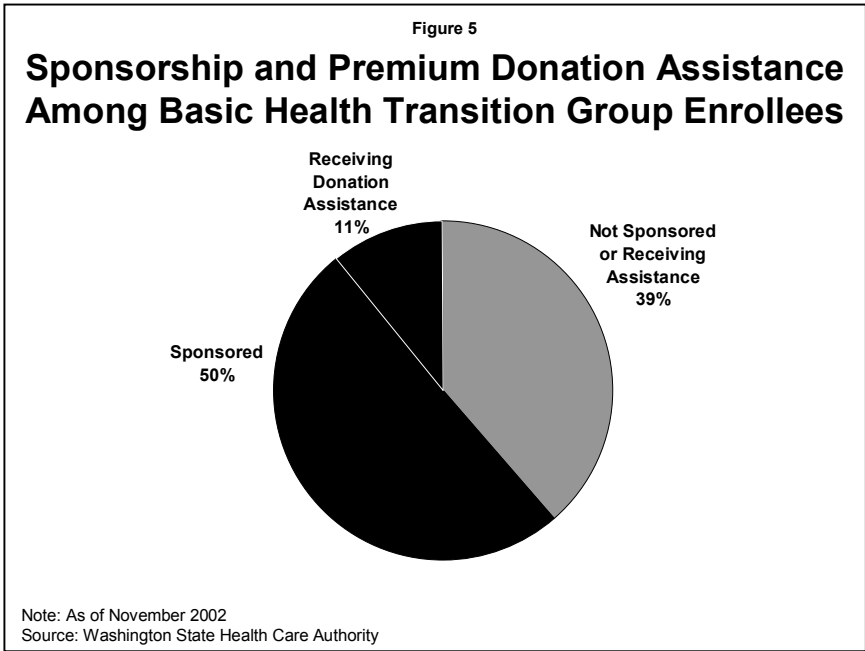
<sup>67</sup> Interviews with unenrolled families.

way.”<sup>68</sup> Fluctuating incomes for those in marginal jobs presented a problem for some. One respondent noted, “I work in the field. There are times you make good money and times you don’t even work. I told them that. It’s difficult to give them an exact income with each report if we don’t know...I got Basic Health because of my daughter’s health situation. I reported my income, and it was too high, and that was when they charged me \$90 roughly. Then I reported my income at a later time that was even lower and that’s when I got a bill for \$230...For me it’s better to terminate Basic Health and get another insurance.”

According to outreach workers, some families did not see the need to enroll because their children were healthy. They waited until they had a sick child to try to enroll. “My kids are healthy. I don’t want to pay for health care. I don’t need it.” Others felt that they had to pay for everything with Basic Health so they saw no need to purchase this insurance. For some families, the incentive to enroll in Basic Health may be reduced because they have access to community clinics, where care is available on a sliding-fee scale basis. This helps with access to primary care but may present problems when individuals require specialty care.<sup>69</sup>

Cost sharing at the point of service also impacts the affordability of insurance coverage, affecting the decision to enroll as well as retention. Many individuals we spoke with (family members, outreach workers, and health care providers) noted that cost-sharing creates a burden for many families. While cost-sharing may have a marginal effect on the decision to enroll, it may have a larger effect on retention and the ability to afford particular types of treatment. (The impact of cost sharing on access to care is discussed further below.)

Both sponsorship and a temporary donation program set up by the Health Care Authority helped some immigrants make the transition by assisting with premium costs. Sponsoring organizations also were likely to have staff, often with bilingual or multilingual skills, available to help families navigate the enrollment process. The Health Care Authority solicited donations from groups to assist in premium payments for the first two months of enrollment for those unable to obtain regular sponsorship.<sup>70</sup> In November 2002, half of the transition group who enrolled in Basic Health was sponsored, with an additional 11 percent receiving donations (Figure 5). However, these donations ended after two months, contributing to the enrollment declines seen in December and January.



<sup>68</sup> Focus group with enrolled families.

<sup>69</sup> Interviews with outreach workers.

<sup>70</sup> Washington State Health Care Authority, “Draft Work Product Deliberative Materials,” November 20, 2002.



Between November 2002 and June 2003, the number of sponsored enrollees increased slightly (by 3.3 percent). At the same time, total enrollment dropped so that the percent of enrollees sponsored increased from 50 percent to 60 percent of enrollment. It appears, therefore, that sponsorship contributes to enrollment stability among those able to obtain sponsorship.

About one in five outreach workers interviewed for this study mentioned lack of sponsorship as a barrier to clients enrolling. Although some workers were in areas with sufficient sponsorship slots for all who needed them, others saw clients who were in danger of losing sponsorship because agencies only offered short-term sponsorship. Others had clients with incomes above limits set by sponsors.<sup>71</sup> A number of respondents in a focus group conducted for this study were sponsored. Although some noted that the feature helped with affordability, many were unclear about how sponsorship worked, such as what costs the sponsor pays and what costs needed to be covered by the enrollee.<sup>72</sup>

During the transition, the Health Care Authority worked to increase the list of sponsorship organizations.<sup>73</sup> At the time the transition began, however, enrollees in 19 counties did not have any sponsors available to them.<sup>74</sup> (However, the counties with sponsorship tended to be those with the highest immigrant enrollment, helping to increase access to sponsorship.) In addition, the criteria for sponsorship vary according to the policy of each sponsoring agency, with eligibility varying substantially between 100 percent and 200 percent of the FPL.<sup>75</sup> Clients who exceed the sponsorship income limit lose eligibility for this assistance. Even when sponsors were available in a county, accessing this assistance may have required changing providers or traveling to reach the sponsoring clinic.<sup>76</sup> Also, some sponsors (especially providers) only sponsor a limited number of patients and have no additional slots for new enrollees. Therefore, although sponsorship is very important in increasing Basic Health affordability for immigrants and other enrollees, its ability to close the affordability gap is limited by geographic boundaries, enrollee income cutoffs, and the number of enrollees an agency will sponsor.

**Retention Issues.** For those who made the transition to Basic Health, staying enrolled appeared be challenging. Enrollees who perceived the program as too expensive or who had financial difficulties forcing them to prioritize expenses may have disenrolled themselves. There are also a number of procedural issues that intersect with affordability and that may affect retention. If a family misses two consecutive monthly payments, they are disenrolled and barred from reenrolling for one year.<sup>77</sup> Three payments missed in a year also results in disenrollment.<sup>78</sup> Changes in address could lead to enrollees missing mailings about premium payments and, thus, being dropped from coverage. Leaving the state for six months also results in disenrollment, which is a problem for some seasonal workers, as noted by the Health Care Authority.<sup>79</sup>

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<sup>71</sup> Interviews with outreach workers.

<sup>72</sup> Focus groups with Basic Health enrollees. Sponsors pay premiums but not co-payments.

<sup>73</sup> Health Care Authority, "Draft Work Product Deliberative Materials," November 20, 2002.

<sup>74</sup> The Children's Alliance, *Losing Ground: more children lose health coverage and essential services*, December 6, 2002

<sup>75</sup> Health Care Authority, Basic Health Sponsor Summary, 4-29-03.

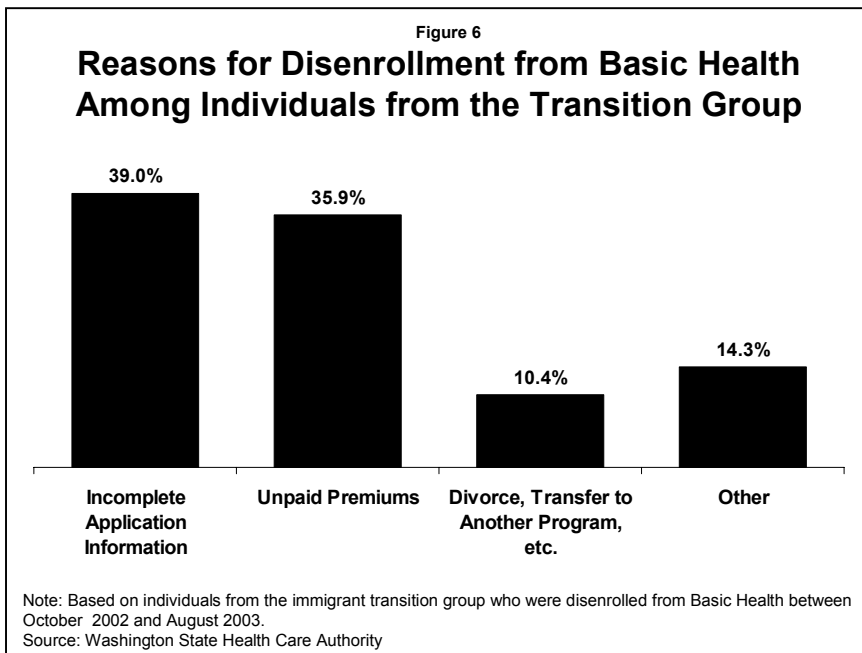
<sup>76</sup> Interviews with outreach workers.

<sup>77</sup> Washington Administrative Code 182-25-090(6),(7).

<sup>78</sup> Bills are generated six weeks prior to the coverage month and due on the 5<sup>th</sup> of the preceding month and are considered delinquent by around the 11<sup>th</sup>; however, enrollees are notified that if payment is received by a certain date they will retain coverage (the 22<sup>nd</sup> or 23<sup>rd</sup> for the first of the following month, depending on the length of the month). Source: Communication to HPAP from Health Care Authority.

<sup>79</sup> Washington State Health Care Authority, "Draft Work Product Deliberative Materials," November 20, 2002.

Figure 6 shows reasons for disenrollment among individuals from the transition group who were disenrolled from Basic Health at any time during the first 11 months of the transition. Application and documentation issues and affordability issues were by far the largest reasons for disenrollment, with 39 percent not fully completing some aspect of the application process and 36 percent not paying required premiums. Since these data do not capture the reasoning behind family decision-making regarding enrollment, it cannot be used to precisely measure the reasons families became disenrolled. For example, a family realizing it could not afford premiums might have stopped making an effort to finish an incomplete application and, thus, have been coded as failing to comply with the application process, rather than as unable to afford premiums. However, these data indicate that the two broad sets of reasons, taken as a whole, account for the vast majority of disenrollment.



Only limited data are available regarding long-term disenrollment as a result of agency rules designed to discourage adverse selection. Families are disenrolled for twelve months if they miss two consecutive payments or three payments in a year. A review by the Basic Health agency revealed that, of 7,225 immigrant families enrolled during the first six months of 2003, 763, or 10.6 percent, were disenrolled for two months for non-payment of premiums. Most of these cases would likely trigger the one-year bar against reenrollment.<sup>80</sup> Although the long-term effect of these enrollment rules could not be derived in the short time window of this research, it would appear that the rules contribute significantly to reducing average enrollment.

Verification of eligibility factors, including income, may also have an effect on retention. Clients who provide social security numbers and who appear in the state's Employment Security establishment survey or Labor and Industries database will be recertified annually as long as reported income is below eligibility limits. However, clients without social security numbers or who fail to appear in the databases used for verification are recertified every six months and must provide additional documentation.<sup>81</sup> Although we did not gather specific data on the effects of this increased documentation and frequency of reviews, initial patterns of disenrollment suggests that these requirements also reduce immigrants' retention of Basic Health.

<sup>80</sup> Information provided by the Washington State Health Care Authority, July 28, 2003.

<sup>81</sup> Washington State Health Care Authority, "Draft Work Product Deliberative Materials," November 20, 2002.

## Impact on Access to Health Care

Since coverage and support services are narrower in Basic Health than in Medical Assistance, we examined whether these coverage differences affect the availability and timeliness of care received by immigrants who were able to transition to Basic Health. We discovered evidence that some of the coverage differences have affected access to care. Many of these issues arose because a substantial number of children were moved from a program with comprehensive coverage to one with limited coverage for some pediatric disorders. In other cases, delays in enrollment, caused either by paperwork issues or being placed on the Basic Health waiting list, also created situations where needed health services went unmet.

We examined this issue through interviews with outreach workers and families, a focus group with families, and interviews with health plan and provider staff. We also obtained the results of an informal survey of public health nurses conducted by a nursing consultant with the state Department of Health, Children with Special Health Care Needs Program. Although this survey was not done scientifically and does not provide statistically valid results, it provides an overview of the range of problems experienced by the transition population and some examples of specific efforts to find alternate ways of getting children care that was no longer covered. The survey documented 44 cases in 9 counties where local public health professionals tried to locate health care services or financing of health care for immigrant children either unable to enroll in Basic Health or who were enrolled but had conditions not covered by Basic Health. Out of 44 cases, 11 were on the Basic Health wait list and 15 were enrolled in Basic Health but had conditions not covered by the program. Others were not on Basic Health for unspecified reasons or their Basic Health status was not specified.

Some of the most common ailments these 44 patients suffered, often in conjunction with other illnesses, were: cerebral palsy (10 cases), developmental delay (6 cases), Spina Bifida (3 cases), hearing problems (6 cases), and vision problems (5 cases). The cost of these uncovered services was substantial in many cases. For 11 patients whose care required regular treatments, costs for those treatments were estimated at close to \$500 per month. Among patients identified with one-time needs, costs ranged from \$40 for a vision evaluation to \$10,000 for heart surgery for a child with a heart condition. Most of these patients were enrolled in Basic Health but had conditions that were not covered. Other children, including the pediatric heart patient, may have had conditions covered by Basic Health but were unable to enroll.

***Children with Chronic Care Needs.*** Not surprisingly, the most serious problem we discovered was the reduction in coverage for health care problems faced by children with chronic conditions. Under the Medical Assistance programs, children with serious chronic conditions had been able to access more comprehensive benefits. By contrast, Basic Health excludes physical therapy for cerebral palsy, seizures, and other disorders, and enteral feeding tubes and supplements for children with palsy or severe digestive disorders.

Survey-based estimates conducted by CDC and reported by the group Family Voices, place the number of Washington children with special health care needs at 13.7 percent of the total child population.<sup>82</sup> Specific data on the prevalence of special health care needs within the immigrant population are lacking. Key informant interviews and interviews with outreach workers, health plan staff members, public health staff, and providers revealed numerous instances of coverage gaps for children within the immigrant transition group, indicating that these problems occurred

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<sup>82</sup> Family Voices, National Data on Children and Youth with Special Health Care Needs, available at: <http://www.familyvoices.org/drc/index.html>.

with some frequency. Interviews also identified various methods used by providers or family advocates to locate funds to pay for non-covered services. The extent to which such efforts have been able to close the gaps is unknown.

Many health professionals expressed concerns about Basic Health's limitations for this population. According to one health plan administrator, "Basic Health benefits are inadequate to keep some of these kids alive...I would love to see Basic Health begin to cover durable medical equipment and therapy."<sup>83</sup> Others we interviewed echoed these sentiments. A local public health official claimed that there is "...a pretty cumbersome process for assuring that kids have the bare minimum, such as tube feeding, formula, etc. Basic Health and the related health plans have been poorly responsive to concerns that have to do with life-dependent functions (like nutrition)."<sup>84</sup> A medical director of a health plan that participates in Basic Health noted limitations for both adults and children, "We are denying cases where physical therapy or reconstructive therapy are needed, and cardiac rehab after stroke is also not covered."<sup>85</sup>

A focus group conducted for this study also revealed some of the effects of Basic Health coverage gaps. For example, one participant mentioned that a problem had emerged in getting appropriate care for her daughter after enrolling in Basic Health, "I have a child with a cyst on her gums. They had to see her in Seattle. The doctor said it is probable the cyst comes back. I was taking her every three months for a check-up when they took the coupon away. Basic Health did not cover it, because they said it was a dental problem. But it was a cyst, and she needed checkups. I spoke to her doctor, and they said to call Seattle. They didn't see her, and she needs it."<sup>86</sup>

**Prescription Drug Copayments.** Basic Health requires enrollees to pay copayments for prescription drugs. The copayment amounts are tiered based on the type of prescription drug. Brand name drugs require the highest cost sharing—individuals have to pay 50 percent of the drug's cost for drugs that are in a plan's formulary and drugs not on that formulary are not covered at all. Although formularies have a role in helping to shape patient, provider, and pharmacy incentives toward lower-cost drugs, a problem may arise when there are no therapeutically equivalent generics. For example, according to an administrator at a health plan involved in Basic Health, "Patients who need drugs that are new on the market find themselves in quite a predicament. These are the more expensive drugs that have no generic equivalent – for example, anti-rejection transplant medications. Basic Health requires the enrollee to pay 50 percent of the cost. Many Basic Health enrollees cannot afford to pay these high monthly copays."<sup>87</sup>

Public health nurses provided some examples of cost-sharing issues surrounding drug coverage:

- A 13-year-old with end stage renal failure, who is not on the transplant list, needs dialysis and a growth hormone. The patient is enrolled in Basic Health but unable to pay the copay for dialysis and medication. The family is currently applying for Alien Emergency Medicaid.

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<sup>83</sup> Interviews with providers and health plans.

<sup>84</sup> Interviews with public health officials.

<sup>85</sup> Interviews with providers and health plans.

<sup>86</sup> Focus group with families on Basic Health.

<sup>87</sup> Interviews with providers and health plans.

- A 17-year-old with bipolar disorder and schizophrenia needs medication with estimated costs up to \$600/month, but Basic Health does not cover these medicines.<sup>88</sup>

According to one outreach worker, “Prescriptions are expensive. If a drug is not on the formulary, the costs can be from \$300-\$600 per month. The local clinic has asked [a local community organization] to pay for medications, and some pharmacies will give discounts.”<sup>89</sup> Focus group participants also expressed general concern over increased drug costs.<sup>90</sup>

In some cases, obtaining assistance with drug costs is made more difficult by enrollment in Basic Health. One plan administrator noted that pharmaceutical company “compassionate care” programs that provide free drugs to some low-income, uninsured people cannot be used when a person is insured through Basic Health.<sup>91</sup>

**Loss of Dental and Vision Coverage.** The transition population went from full coverage of routine dental care in Medical Assistance to no dental coverage in Basic Health. Focus group participants lamented the loss of dental care for their children.<sup>92</sup> In recognition that Basic Health does not cover dental care, the legislature appropriated \$3 million to the Health Care Authority to provide grants to community clinics for a combination of dental services and interpreters (for both dental and medical services).<sup>93</sup> Fourteen community clinics participated in this program. However, not all children from the transition group can access these services.

As one measure of the quantitative effect of the loss of dental coverage, one pediatric oral health organization that has several clinics around the state estimates that it provided services at its clinics to approximately 600 children from the immigrant population after their loss of coverage through Medical Assistance.<sup>94</sup> The money provided by the legislature to cover these types of services was set to expire by June 2003, but the 2003 legislature appropriated an additional \$6 million over two years for community clinics for those ineligible for Medicaid (including immigrants), to be used for a combination of dental care through these clinics and interpreter services for those who have no other source of interpreters.

The same oral health organization also goes into schools across the state to treat children who need dental services and estimated that it had seen about 350 immigrant children from the transition group through its school outreach program. These services were not funded by the state grants. Usually the families of these children cannot afford to pay for these services, and so the dental organization absorbs the expenses.<sup>95</sup>

Lack of coverage for vision equipment (glasses, contacts etc.) also has increased costs for families. A focus group participant noted, “My child who is disabled uses glasses, and that is not covered. The other day they broke, and we had to pay \$50.”

**Disruptions in Continuity of Providers.** In the fee-for-service Medical Assistance program, enrollees were free to receive care from any provider willing to accept their Medical Assistance coverage. Since all enrollment in Basic Health is through participating health plans, issues of

<sup>88</sup> Information provided by Washington State Department of Health informal survey of Public Health Nurses.

<sup>89</sup> Interviews with outreach workers.

<sup>90</sup> Focus group with families on Basic Health.

<sup>91</sup> Interviews with providers and health plans.

<sup>92</sup> Focus group with families on Basic Health.

<sup>93</sup> LAWS OF 2002, Ch. 371, 212(7).

<sup>94</sup> Interviews with providers and health plans.

<sup>95</sup> Ibid.

forced provider switching and possible barriers to care (e.g., access to specialists) arose. We discovered some instances of this in our interviews with providers, health plans, families, and outreach workers.

Interviews with families showed that some had experienced reduced choice of providers in Basic Health as compared to Medical Assistance. Outreach workers also noted that some families had to change primary care doctors or offices to find one in the local Basic Health provider network.<sup>96</sup> A recent assessment by the Department of Health (DoH) for Yakima County provides an example of how choice varies among programs. In Yakima, a county with a large immigrant and low-income population, Federally Qualified Health Centers saw 66 percent of Medicaid managed care patients (Healthy Options) and 59 percent of Basic Health patients, but only about one-third (35 percent) of Medicaid fee-for-service patients. Therefore, in Yakima, it appears that fee-for-service enrollment provided more access to private providers.

Changes in insurance generally cause some disruption, but the extent of disruption depends on both local and individual factors. In some areas, providers are more willing than in others to accept both Medical Assistance fee-for-service and Basic Health enrollees. Thus, access to providers under Basic Health was also related to geographic location.

***Preexisting Condition Restrictions.*** The Basic Health program requires some new enrollees to wait before receiving coverage for preexisting conditions. Insurance companies that offer coverage through Basic Health may impose up to a nine-month benefit-waiting period for preexisting conditions. Past months of coverage count as credit toward a health plan's benefit waiting period in some instances. A person gets credit against the nine-month benefit-waiting period if they were enrolled in a similar plan within three months of the date they applied or made a "reservation" for Basic Health. ("Reservation" includes the postcards and questionnaires that immigrants were sent by DSHS and asked to mail back as an expression of interest in Basic Health.)

If an enrollee's previous continuous coverage (i.e., Medical Assistance) was in effect within three months of either the date Basic Health received a reservation (or application) or the date Basic Health coverage began, an enrollee receives one month's credit for each month of continuous coverage. If there was a break in coverage longer than three months from the date someone applied for Basic Health, the nine-month waiting period applies.<sup>97</sup> However, Basic Health enrollees can always receive prenatal care and prescription drugs without a waiting period. A plan can also choose to cover care during a waiting period on a case-by-case basis; for example, if it would be cost-effective to do so. Basic Health offers a maximum of three months' credit for time on the waiting list. Given the enrollment delays experienced by some immigrants, it is likely that some families ran into preexisting waiting-period problems, although we have not measured the magnitude of this problem.

## **Impact on Safety Net Programs and Institutions**

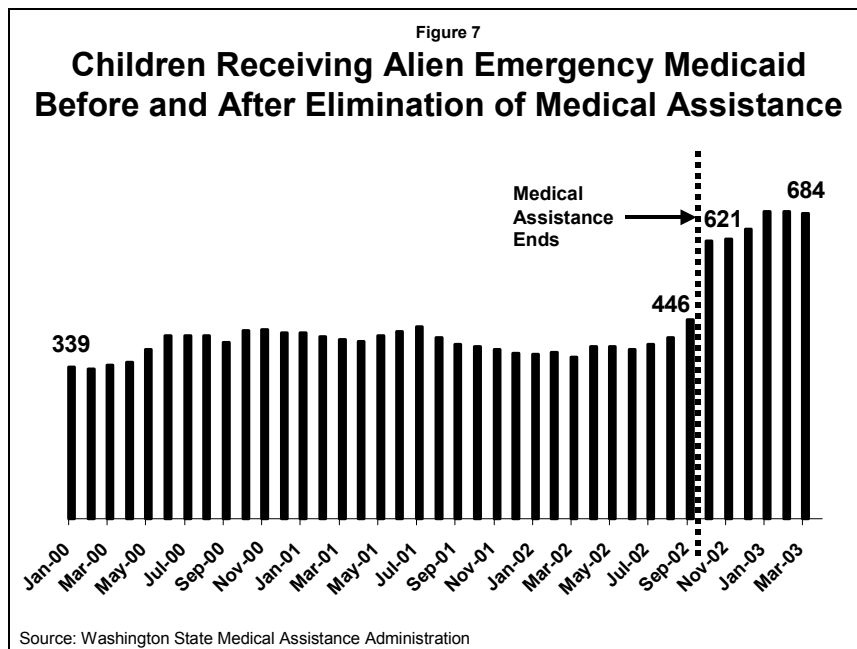
***Increased Use of Alien Emergency Medicaid.*** Various organizations involved in the transition engaged in a number of ad hoc methods to fill some of the gaps in care in Basic Health. One effect of the shift of these populations from Medical Assistance to Basic Health was an increase in the use of Alien Emergency Medicaid (AEM). AEM is the one federal program available to

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<sup>96</sup> Interviews with outreach workers.

<sup>97</sup> Pre-existing condition limitations are likely to apply to immigrants who have applied for Basic Health without having previously received Medical Assistance or other coverage, for example, those who arrived here since October 2002.

individuals who have an emergency medical condition but who are not eligible for Medicaid because of their nonqualifying immigrant status.<sup>98</sup> As Figure 7 shows, use of AEM, although still relatively infrequent in absolute terms, increased substantially in the first few months of the transition. This increase is both the result of use by those who made the transition, and those who did not.



Background interviews with outreach workers conducted at the beginning of this project indicated that a number of the workers were able to successfully help transition population clients use AEM to cover some of their needs.<sup>99</sup> One large pediatric hospital tracked 198 chronically ill immigrant patients, most of whom were formerly covered by Medical Assistance. The hospital was able to obtain assistance for 60 of these patients through AEM.<sup>100</sup>

However, the ability of AEM or similar programs to fill the gap is limited. The assistance is time-limited and is provided to pay for acute care needs associated with emergent conditions. AEM is not often approved for people with chronic conditions, unless those conditions result in an emergency situation. Regulations sharply circumscribe the types of conditions covered.<sup>101</sup> Providers we interviewed for this project noted only minimal success in using this avenue to fill specific gaps in Basic Health coverage, particularly for chronic care issues.<sup>102</sup> Administrators of health plans noted that they had had limited success in getting the Medical Assistance

<sup>98</sup> To qualify for AEM, an individual must be a child under age 19; an adult living with related dependent children; pregnant; age 65 or over; or disabled and unable to work for at least one year. DSHS “Eligibility A-Z Manual,” [http://www1.dshs.wa.gov/esa/EAZMANUAL/Sections/EA\\_AlienMedical.htm](http://www1.dshs.wa.gov/esa/EAZMANUAL/Sections/EA_AlienMedical.htm), WAC 388-438-0110.

<sup>99</sup> Interviews with outreach workers.

<sup>100</sup> Interviews with providers and health plans.

<sup>101</sup> As interpreted in the Washington State Administrative Code (WAC 388-500-0005), emergency medical condition “...means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: Placing the patient’s health in serious jeopardy; Serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

<sup>102</sup> Interviews with providers and health plans.

Administration to cover some of these cases through AEM, in part, because of the agency's interpretation of federal restrictions on the scope of program.<sup>103</sup>

**Appeals to Health Plans.** Patients unable to pay for care or qualify for AEM can appeal to their Basic Health plan in an effort to get that plan to pay for a non-covered service, but this can be difficult. Plans may at times use a cost-benefit analysis to evaluate the request with the goal of saving plan dollars the criteria for making a decision. According to one plan administrator, "We can't make exceptions to covered benefits; we can't change the way we cover from one kid to the next based on severity. A health plan can do a cost-benefit analysis. It is not fun to have to sit down to see if we can save money by covering a life-sustaining benefit. The worst case scenario is that someone would die. We cannot add benefits on a case-by-case basis, otherwise it will all end up in the newspapers."<sup>104</sup>

**Cost-Shifting to Providers and Charities.** As children began appearing in health care facilities with health care needs no longer covered, local health care professionals expended substantial effort to locate alternative means of financing needed services. Many providers also saw a substantial increase in demand for charity care or an increase in emergency room usage. In response to limitations on coverage, various providers and public health workers tapped into available charities on an ad hoc basis. One public health worker noted that the agency would attempt to get assistance for families from local charity agencies, such as the Lion's Club, or identify hospitals willing to arrange charity specialty care for a particular illness or treatment. Another public health agency was able to use some one-time funds to pay for needed care for some families.<sup>105</sup> One pediatric hospital estimated that it spent about \$100,000 per month on non-covered services used by immigrants who had become uninsured or who had inadequate coverage.<sup>106</sup> A clinic-based outreach worker noted that "...use of emergency services is on the rise. Our clinic still provides services to those without Basic Health, so they are still getting care but it's straining our resources."<sup>107</sup> A multi-clinic pediatric oral health organization estimated that it had about 600 patients from the transition population receive care at its clinics, which accounted for about 8 percent of all their patients. This network received one-time state money allocated to cover dental services and will continue to see children after the funding ends as part of its charity care.<sup>108</sup> Many immigrant patients were seen through a school outreach program, an effort not reimbursed by the state.

**Use of Children with Special Health Care Needs Funds.** Funds to pay for non-covered Basic Health services, previously covered by Medical Assistance, were dispensed by the State Department of Health from the federally-funded Children With Special Health Care Needs (CSHCN) program. Public Health Nurses affiliated with this program also spent considerable work time attempting to arrange care or financing for these children. Hours spent by Public Health nurses or public health staff in attempting to arrange care for these children ranged from 1 hour to 30 hours over the period from January to July of 2003. Because the CSHCN program funds are limited and often expended treating other segments of the children with special health care needs population, nurses or county staff arranged special grants from sources including the Make a Wish Foundation, the Shriners, a Lions' Club, and a Wal-Mart foundation.<sup>109</sup>

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<sup>103</sup> Ibid.

<sup>104</sup> Ibid.

<sup>105</sup> Interviews with public health officials.

<sup>106</sup> Interviews with providers and health plans.

<sup>107</sup> Interviews with outreach workers.

<sup>108</sup> Interviews with providers and health plans.

<sup>109</sup> Information provided by Washington State Public Health Nurses.



## V. CONCLUSION AND IMPLICATIONS

The 2002 budget bill that eliminated programs for immigrants intended that they be shifted from Medical Assistance to Basic Health. The object was not to reduce enrollment or the cost of care given to this population.<sup>110</sup> Rather, the intent was to shift funding from one state budget account to another in order to draw down new revenues that would have otherwise been used to expand Basic Health, as required by a recently-passed citizen initiative. However, this apparently simple policy change resulted in half of the people in these immigrant groups disenrolling from coverage and the others experiencing reductions in coverage. Not only did individuals experience problems when the initial transition took place, but their retention rate for Basic Health coverage also has been low.

### Summary of Findings

***Only about half of the original Medical Assistance population made the transition to Basic Health.*** Although some of those who lost their public coverage may have found private coverage, it is highly likely that most of the children and parents who did not make the transition became uninsured. For immigrants who did enroll in Basic Health, disenrollment rates were several times higher than they were in the Medical Assistance programs.

***Complicated enrollment processes and documentation requirements created enrollment barriers for the transition population.*** Requiring families to complete Basic Health enrollment procedures rather than automatically transferring them between programs resulted in a substantial number of individuals losing insurance. Various complexities of the enrollment process, including agency loss of contact with enrollees, lost paperwork, documentation requirements, and language and literacy difficulties were enrollment barriers. Also, reenrollment procedures contributed to a high attrition rate for those who were initially able to enroll.

***Premiums served as an enrollment barrier and may contribute to retention problems for this population.*** This finding accords with numerous academic studies and with common sense. As costs go up, enrollment goes down, especially for very low-income families who must trade off a number of basic goods within family budgets in order to make ends meet.

***Limited coverage within Basic Health leads to access problems, particularly for children with special health care needs.*** Limiting the scope of covered treatment for chronic diseases produced negative consequences for families and resulted in cost-shifting to providers and other organizations. Those with chronic diseases, such as cerebral palsy victims needing therapy, or children with digestive disorders needing feeding tubes, were particularly at risk given coverage limitations in Basic Health.

***Other safety net programs and organizations attempted to fill the gaps created by the transition, which shifted costs to other parts of the health care system.*** The breadth of the networks within the health care delivery system, such as hospitals, community clinics, and associated community organizations and public health agencies, reduced the negative consequences of the transition by assisting in enrollment and helping to locate care or coverage for the uninsured and those needing non-covered services. However, these efforts appeared to tax existing systems. The problem of insufficient resources to fill gaps will intensify as health care costs continue to increase and public programs further restrict enrollment.

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<sup>110</sup> Because the Medical Assistance programs for immigrant programs were fee-for-service and since this population tended to be light users of care, the per capita cost for enrollees of these programs was similar.

## Implications

These findings may help inform other states that are considering program changes. Following are some early lessons:

***Enrollment processes have a significant impact on enrollment and retention.***

Washington's experience with terminating individuals from one program and requiring them to actively enroll in another led to significant losses in coverage. To minimize such coverage disruption, use of automatic, seamless transfers is important.

***Premiums, benefit limits, and cost sharing requirements can create barriers to coverage and care for low-income populations.***

Basic Health was originally designed for a population with slightly higher incomes than the Medical Assistance groups. It includes premiums and cost sharing not found in Medicaid or Medical Assistance, and its benefits are more limited than Medicaid/Medical Assistance, as well as most employer-sponsored plans. These aspects of Basic Health served as impediments to coverage and care for the transition immigrant population, which is comparable to Medicaid-eligible populations. This underscores the importance of the comprehensive benefit package and cost sharing limits in the Medicaid program for the population it services.

***Reductions in the scope of coverage do not necessarily create overall system savings because costs are shifted to providers and other organizations.***

In Washington, moving immigrants from the more comprehensive Medical Assistance coverage to Basic Health placed a substantial burden on local public health agencies, the community organizations involved in enrollment outreach, and health care providers. Substantial amounts of money and resources have been expended to assist people in enrolling and to provide services not covered within the Basic Health program, increasing costs in other parts of the state's health care safety net.

## Conclusion

When Washington eliminated its Medical Assistance coverage for immigrant families, just over half of enrollees transitioned to the state's more limited Basic Health program. Those that did enroll had difficulty retaining the coverage. It is likely that many of those who have not enrolled in or maintained Basic Health have become uninsured. Problems navigating the Basic Health enrollment process and difficulty paying premiums created barriers to enrollment. Among those families that enrolled in Basic Health, it appears some may be experiencing problems accessing necessary care due to benefit limits and copayment requirements. Other safety net programs and organizations have helped to fill some of the gaps in coverage created by the transition from Medical Assistance to Basic Health, but, as a result, they are facing increased costs and strains upon their resources.

This experience in Washington State has implications for states considering reductions in their Medicaid programs. Basic Health was originally designed for a population with slightly higher incomes than Medicaid-eligible groups, and it appears that many aspects of the program created difficulties for the lower-income immigrant transition population, which is comparable to other Medicaid-eligible groups. Programs that have income documentation requirements, premiums, limited benefits, and cost-sharing may be problematic for Medicaid and other very low-income populations. The comprehensive benefit package and cost sharing limits in Medicaid were important for this population. Finally, the findings also reveal that savings in the Medicaid budget can result in increased costs in other parts of the health care safety net, reducing overall savings.

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