

It's Not Too Late: I-773 Revenues Can Increase Access to Care for Washingtonians

Jeff Huebner, MD, Erin Burchfield, MPA, and Bob Crittenden, MD, MPH

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Executive Summary

In the fall of 2001, Washington voters approved Initiative 773 (I-773), raising the cigarette tax to fund an expansion of the Basic Health Plan (BHP). At that time, approximately 130,000 Washingtonians had health insurance through the BHP. The passage of I-773 meant that a dedicated funding source could be used to expand the program to cover 175,000 people annually.

While enough new tax revenue has been collected each year to dramatically expand the BHP, I-773 was never enacted as voters intended. Instead, amidst budget pressures, the Legislature chose to *cut* enrollment by 30,000 slots and re-direct I-773 funds. Washington missed the opportunity to expand affordable health care to tens of thousands of people each year—and our state is feeling the effects both in terms of the rising number of uninsured and the cost-shifting that ensued.

State policymakers clearly cannot go back in time and reverse these effects. However, as we approach a new legislative session, the continued collection of I-773 revenue can still provide an opportunity for Washington. Analysis of the most recent BHP cost data and I-773 revenue data demonstrates that redirecting existing, sustainable I-773 funding would provide affordable health care to tens of thousands of Washingtonians.

Text of Initiative 773

The Health Care Authority may enroll up to fifty thousand (50,000) additional persons in the Basic Health Plan during the biennium beginning July 1, 2003, above the base level of one hundred twenty-five thousand (125,000) enrollees.

- 1) Restoration of this sustainable funding source to its intended use **could insure nearly 67,000 more people in Washington each year.**
 - In 2005 the tax raised over \$118 million dollars that had been intended to fund a BHP expansion.
 - At 2005 BHP costs, this revenue would directly fund the state's share of nearly 67,000 new BHP slots.
- 2) Expanding the BHP with existing I-773 revenue could **reduce the number of uninsured in Washington by 11%.**
- 3) Such an expansion would **cut nearly in half the number of Washingtonians that have become uninsured since 2000, creating the first decrease in uninsured people this decade.**

As Washington moves forward, policymakers must consider how to confront key issues—like the growing number of uninsured—within the context of a continually tight state budget. The BHP is recognized nationwide as an affordable, innovative health coverage model for low-income, previously uninsured populations otherwise lacking access to health care. The BHP remains a cost-effective partnership between the state and individuals, both of which contribute to the cost of care. This shared-cost model has allowed the BHP to substantially control costs. In fact, **during this decade BHP costs have consistently been constrained more effectively than costs in the private insurance market, growing at an average of 4% each year while private insurance grew at an average of 11% annually.**

Unfortunately, too few people can access the BHP today. Although the Legislature has recently begun making efforts to restore BHP slots, the 6,500 slots funded in the 2006 budget do not adequately address the growing need for affordable health care. It is time to expand the BHP to cover the increased number of Washingtonians that the I-773 initiative and its supplied revenues allow.

I. A Brief History of the Basic Health Plan (BHP)

When enacted in 1987, the BHP was the first program of its kind in the nation. Legislators recognized the need to provide access to a no-frills health insurance program for uninsured low-income people, the majority of which are employed.¹ After successfully passing out of its pilot stage, BHP grew to offer insurance to people in all corners of the state. It gradually increased in size to cover over 130,000 people at its peak from 1997-2001.²

Eligibility

Currently, the BHP provides subsidized health care benefits to 100,000 Washington residents with incomes at or below 200% of the Federal Poverty Level, which is currently at \$3,333 per month before taxes for a family of four.³ Individuals or families that qualify pay a portion of the monthly premium on a sliding scale basis depending on family income.

Benefit Structure

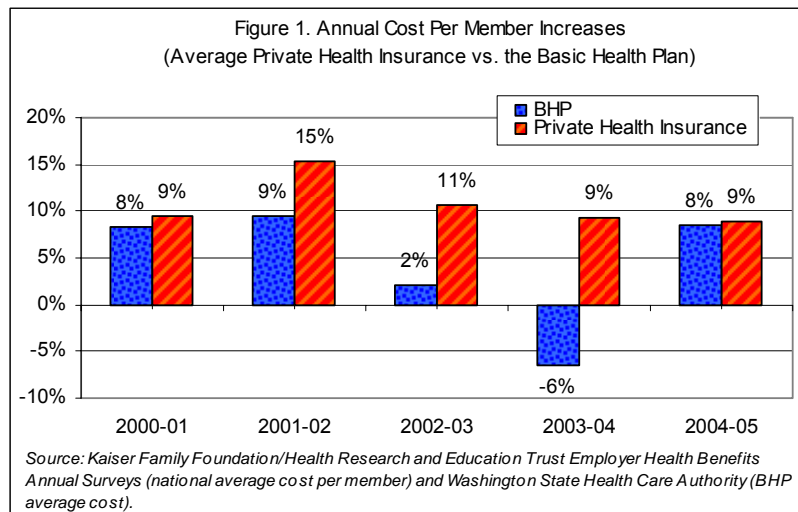
The BHP is a no-frills plan. While it provides access to necessary preventive and acute medical care, it offers fewer benefits and requires greater cost-sharing than many employer plans. Outpatient, hospital, emergency, pharmacy, and mental health benefits are included, but the BHP requires enrollees to share responsibility for their health care and contribute to the cost by paying co-payments, premiums, and deductibles.⁴ In fact, the Legislature increased the level of patient cost-sharing measures in 2004.⁵ The only exception is preventive care visits, which continue to be covered without co-pays in order to facilitate cost-effective primary care and life-saving screening exams.

Cost Containment

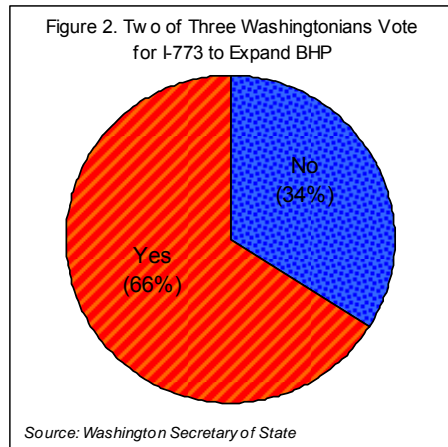
The BHP is a lifeline for many low-wage Washingtonians who otherwise could not afford health insurance. Even with year to year changes in benefits, cost sharing, member demographics, and underlying medical trends, the BHP has consistently constrained its costs more effectively than the private insurance market. From 2000 to 2005, annual per member costs for private health insurance grew at an average of 11% each year, while BHP per member costs grew at an average of only 4% each year.⁶

As Figure 1 demonstrates, while average per member costs for private health insurance grew at 9% to 15% each year, increases in the annual per member costs for the BHP were consistently lower. Several factors have contributed to this cost constraint, including benefit design changes imposed by the

Legislature which resulted in the 6% per member BHP cost decrease in 2003 – 2004.⁷ Although such cost shifting provisions are not as dramatically visible within the aggregate national data, health insurance surveys from 2004 report that cost sharing in the private market increased between 2003 and 2004 and that most workers had to make out of pocket payments for services.⁸



Highlighted nationally as an innovative state-based model for increasing health care access, the Basic Health Plan was included during national *Cover the Uninsured Week* events in Washington, D.C. in May 2006.⁹ The BHP continues to meet its goal of increasing access to preventive, primary, and hospital care for people that would otherwise go uninsured.



II. A Missed Opportunity: Initiative 773

Voters Overwhelmingly Support a Basic Health Plan Expansion

Over the last several years, continuously rising health care costs have led to increasing numbers of uninsured Washingtonians. Since 2000, over 150,000 more people have become uninsured in Washington, resulting in over 605,000 state residents without coverage today.¹⁰

In 2001, health care providers, low-income advocates, and the tobacco prevention community teamed up to find a sustainable funding source to meet the growing need for affordable health coverage. Initiative 773 (I-773) proposed a 60-cent per pack tax on tobacco products that would fund

both tobacco control efforts and an expansion of the BHP by up to 50,000 new slots over subsequent years. I-773 directed the state to:

- Maintain the existing base of 125,000 BHP slots;
- Increase the BHP by 20,000 additional slots above that base during the 2001-03 biennium; and
- Add 50,000 more slots above that base during the 2003-05 biennium for a total of 175,000 slots.

I-773 was overwhelmingly approved by two-thirds of Washington voters in the November 2001 elections, a voter response unmatched in any subsequent election (see Figure 2).¹¹

Voters Undermined: Money Re-directed from the Basic Health Plan

Unfortunately, none of the provisions of I-773 were ever implemented as intended by the voters and Washington missed the opportunity to expand affordable health care to thousands of working families. Over the course of the next two years, the Legislature delayed and then eliminated the provisions calling for both minimum enrollment base and enrollment expansion provisions.

- 1) The 2002 Legislature, worried about projected state deficits for the upcoming biennium, chose to delay implementation of the Initiative's expansion provision, instead of increasing the BHP by 20,000 slots.
- 2) In 2003, the Legislature and Governor Locke passed SB 6057 which eliminated the expansion provisions altogether. As shown in the I-773 excerpt (right), this law changed the intent of I-773 by:

Text of I-773: Original and Legislative Changes (indicated by strike-through text)

...The remainder of funds deposited into the health services account shall be appropriated solely for Washington Basic Health Plan enrollment. Funds appropriated pursuant to this ~~must supplement, and not supplant~~, the level of state funding needed to support enrollment of a ~~minimum of one hundred twenty-five thousand persons (125,000)~~ for the fiscal year beginning July 1, 2002, and every fiscal year thereafter.¹

The health care authority may enroll up to ~~twenty thousand additional persons in the basic health plan during the biennium beginning July 1, 2001, above the base level of one hundred twenty-five thousand enrollees.~~ The health care authority may enroll up to ~~fifty thousand additional persons in the basic health plan during the biennium beginning July 1, 2003, above the base level of one hundred twenty-five thousand enrollees.~~ For each biennium beginning on and after July 1, 2005, the health care authority may enroll up to ~~at least one hundred seventy-five thousand enrollees.~~

- Eliminating the provision for non-supplementation of current BHP funding for a base of 125,000 slots; and
- Striking the provision for a BHP expansion so that the new I-773 revenues were not used to expand the program.¹²

3) State policymakers chose not only to eliminate expansion, but also to cut the program. Beginning in Fiscal Year 2004, enrollment in the BHP was capped at 100,000 slots, a cut of nearly 30,000. This cap has remained in place despite continued demand for additional slots and continued collection of tobacco tax revenues. Since 2004, the program has primarily operated either with a significant waiting list or a lag time of several months between application and coverage.

What if we had implemented I-773 as voters intended?

Since January 1, 2002, the state has been collecting tax revenues from the increased cigarette tax mandated by I-773. As much as \$123.6 million has been generated annually from the dedicated

| Fiscal Year | Available I-773 revenues for BHP expansion ¹³ | Annual State cost per BHP member ¹⁴ | Additional BHP slots that could have been funded by I-773 revenue ¹⁵ | Additional BHP slots allowed by I-773 |
|-------------|--|--|---|---------------------------------------|
| 2002 | \$97.8 million | \$1,753 | 55,819 | 20,000 |
| 2003 | \$119.8 million | \$1,889 | 63,440 | 20,000 |
| 2004 | \$123.6 million | \$1,803 | 68,579 | 50,000 |
| 2005 | \$118.4 million | \$1,768 ¹⁶ | 66,988 | 50,000 |

I-773 revenue stream for a BHP expansion, but these revenues have been spent in other areas (see Table 1).

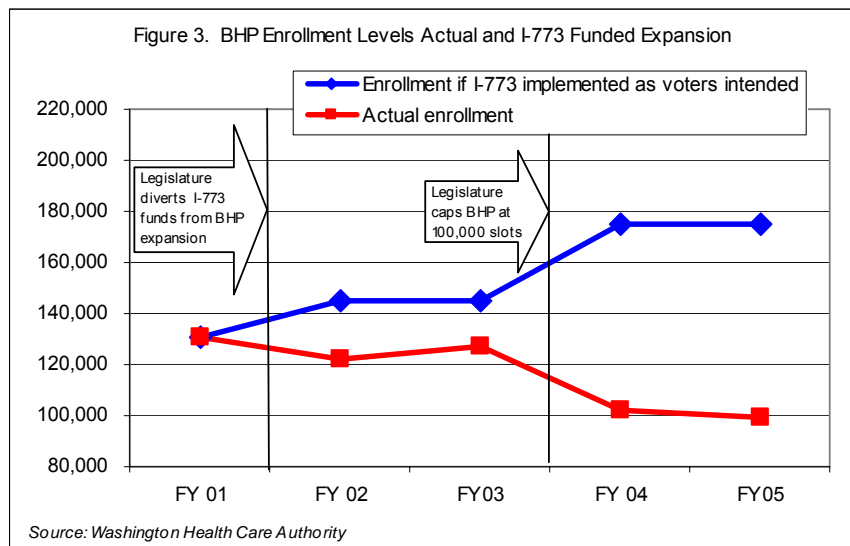
The table to the left illustrates BHP expansion if I-773 had been implemented as intended, including:

1) the annual tobacco tax revenues that would have been dedicated to the BHP expansion on a fiscal year basis; and 2) the potential number of additional slots that could have funded BHP expansion each year.

As shown in Table 1, I-773's dedicated funding source has furnished more than enough annual revenue to exceed the phased-in BHP increases allowed by the Initiative.

- In the 2001-03 biennium (FY 2002 and 2003), I-773 allowed an expansion of 20,000 slots. During this period, the tobacco tax would have provided close to three times the funds necessary to finance the expansion.
- In the 2003-05 biennium (FY 2004 and 2005), I-773 allowed an expansion of 50,000 slots. During this period, the tobacco tax would have generated enough funding to pay for that designated expansion plus over 15,000 additional slots.

If I-773-generated funding had been used for the BHP



as intended by voters, the program would have maintained its original baseline goal of 125,000 enrollees and funded the additional 50,000 slots annually, reaching the designated total of 175,000. Figure 3 shows the comparison between actual BHP enrollment over time, and BHP enrollment if I-773 revenue had been implemented as voters intended.

III. Expanding the BHP is Politically Feasible

Financing remains one of the main obstacles to coverage for our state's over 605,000 uninsured. As Washington moves forward, policymakers must consider how to confront such key health care issues within the context of a continually tight state budget. It is still possible to make up for the missed opportunity of I-773 by re-examining the use of this existing, dedicated revenue source. In 2007 policy makers can take immediate steps to increase the availability of affordable health care by utilizing I-773 revenue as it was originally intended.

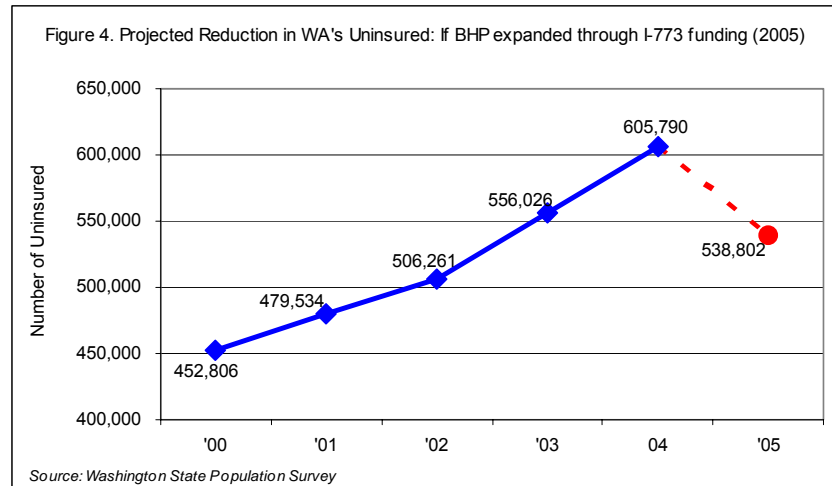
Even with the rising costs of health care, existing I-773 tax revenue could pay the state's share of tens of thousands of needed BHP slots each year. As data on BHP cost and I-773 revenue have remained relatively stable over time, examining the most recent data available (FY 2005)

makes it possible to project how I-773 revenue could impact Washington's uninsured in future years (see Figure 4).¹⁷ This 2005 example demonstrates three key impacts:

- 1) Restoration of this sustainable funding source to its intended use could **insure nearly 67,000 more people in Washington each year.**
 - In FY 2005, the tax raised over \$118 million that was originally intended to fund a BHP expansion.
 - At FY 2005 BHP costs, this revenue would directly fund the state's share of nearly 67,000 new BHP slots.
- 2) Expanding the BHP with existing I-773 revenue could **reduce the number of uninsured in Washington by 11%.**
 - If 2005 I-773 revenue had been utilized to fund a BHP expansion of nearly 67,000 slots, the number of uninsured in Washington would have dropped to 538,802.¹⁸
- 3) Such an expansion would **cut nearly in half the number of Washingtonians that became uninsured this decade.**
 - Since 2000, the number of uninsured Washington residents has risen by over 150,000.
 - Utilizing I-773 funds for the BHP would ensure that nearly 67,000, or 44%, of these Washington residents could have health coverage each year in a funded Basic Health program.¹⁹

The Need for a Basic Health Expansion

There is an unmet need for health coverage in this state—over 605,000 Washingtonians are uninsured.²⁰ Numerous studies show that insurance helps assure regular access to a doctor, ability to buy medications, and receive appropriate screening, diagnosis and treatment of disease.²¹



Insurance coverage and access to a medical home also reduce emergency room visits.²² A national study by the National Association of Community Health Centers estimated that in 2006, \$355 million will be wasted in Washington emergency rooms for non-emergency care.²³ This wasted expenditure could have been saved if residents had instead received their non-emergency care through a medical home, such as a community health center.

Research also demonstrates that the uninsured and underinsured avoid or delay needed medical care because they cannot afford the cost. By the time they seek care their illnesses have often grown acute, necessitating expensive trips to the emergency room and specialty care. This leads to unpaid medical bills, resulting in more bankruptcies.²⁴

A recent national report highlighted the significant disparities in medical care received by the uninsured compared to those with insurance. Washington State had one of the ten worst scores for the number of uninsured residents who said they could not see a doctor because of cost (48%) and for the number of uninsured women who could not receive a mammogram (59%).²⁵

Uncompensated care hurts individuals and the community

Uncompensated care costs do not only affect uninsured individuals, they also directly affect health care providers, employers, and insured members of the community.

Community clinics and hospitals have been suffering from an increasing burden of uncompensated or charity care that threatens the viability of facilities that all of us depend on as part of the health care safety net. In 2005 alone, Washington State health care providers had to absorb over \$726 million in health care costs for the uninsured.²⁶ This hits safety net providers hard. For example, Harborview Medical Center, the only Level One trauma center in the region, suffered under the weight of \$98,000,000 in charity care in 2005 - an amount that has more than doubled in just three years.²⁷

"This . . . gives a warning to our state and national leaders by showing that our neighbors, friends and relatives without health coverage live sicker, and will likely die younger, than those who have insurance."

— Risa Lavizzo-Mourey MD, MBA
President and CEO
Robert Wood Johnson Foundation

Recent research also demonstrates that these uncompensated care costs show up as increased premiums for the insured. In 2005, the average family health insurance premium in Washington included \$1,206 just to cover system costs for providing uncompensated care.²⁸

IV. Conclusion: Recent Progress Made, But Much More to be Done

The Basic Health Plan was a visionary program for the nation at the time of enactment, and it remains so today. Legislators and the public recognized that working Washingtonians needed a program that preserved access to affordable health care when employers did not provide it. The BHP has increased access to affordable health care, preventing the number of uninsured Washingtonians from rising even higher during the past two decades. This proven partnership between the state and low-income residents ensures that Basic Health enrollees contribute to the cost of their care, and that health care costs for the state and the system are controlled. Research shows that the entire community benefits when their neighbors have health care coverage and community clinics and hospitals are able to remain open and viable.

During the 2006 session, the Legislature made progress by deciding to reverse some of the previous BHP cuts and restore funding for 6,500 slots. Washingtonians also continue to support the notion of expanding the BHP to provide access to health care for those in our communities who otherwise would not have it. In a 2005 Working for Health Coalition poll, nearly 9 in 10 voters (86%) said it was

important for the State of Washington to provide affordable basic health insurance for residents who cannot afford it.²⁹

Now more than ever, access to health care is in crisis for many Washingtonians. Over 605,000 of our neighbors are uninsured, many of whom would be eligible for affordable coverage under BHP if slots were available. When I-773 was approved, about 275,000 Washingtonians were eligible for BHP but unable to access it because of under-funding. That number has since jumped to 375,000.³⁰

The Legislature began to expand this valuable program in 2006. Now is the time to make up for the missed opportunity that I-773 offered to Washington by expanding the Basic Health Plan, an affordable health care program with a proven track record. With the revenues provided by I-773, the state has sufficient funding to substantially increase access to cost-effective health care for Washingtonians and reverse the trend of increasing uninsured. Let's not miss the opportunity again.

- ¹ A recently released JLARC report on the BHP demonstrates that the program still serves a majority of members from working families: 61% of BHP members are employed. <http://www1.leg.wa.gov/JLARC/Audit+and+Study+Reports/2006/>.
- ² A History of the Basic Health Program. Washington State Health Care Authority. Accessed at <http://www.basicealth.hca.wa.gov/history.shtml>, 29 March 2006.
- ³ The 2006 HHS Poverty Guidelines. Accessed at <http://aspe.hhs.gov/poverty/06poverty.shtml>, 24 May 2006.
- ⁴ 2006 Benefits and Services. Washington State Health Care Authority Basic Health Plan. Accessed at <http://www.basicealth.hca.wa.gov/benefits.shtml>, 30 April 2006.
- ⁵ Changes in the BHP benefit structure are due to legislative requirements, which are described by the Health Care Authority, Basic Health Annual Report (2002-03) as follows: "There were no copay increases or benefit changes for 2003. However, to meet the higher costs of health care coverage with less funding, the legislature directed the HCA to (1) lower Basic Health's enrollment level to 100,000 members (from 115,031 in July 2003), and (2) reduce the actuarial value of Basic Health's benefits package by 18%, starting in 2004. This meant that fewer members would be covered by Basic Health, and those who were enrolled would pay more for their coverage."
- ⁶ Private insurance: The average annual per member cost is defined as the national annual premium cost for "all plans" individual health insurance coverage, and the 2000-2005 data is from: Kaiser Family Foundation/Health Research and Education Trust Employer Health Benefits Annual Surveys. (<http://www.kff.org/insurance/ehbs-archives.cfm>) BHP: Average annual BHP cost is defined as the average state cost per member plus the average individual per member cost for a year's coverage in the BHP and was received from the Washington State Health Care Authority, the agency which administers the BHP, on May 12, 2006.
- ⁷ See endnote 5 for details on reducing the actuarial value of Basic Health's benefits package.
- ⁸ Although a similarly visible decrease in costs is not apparent in the aggregate national average data, the national 2004 health insurance survey reports that cost sharing increased in 2004 including increases in coinsurance and deductibles. Kaiser Family Foundation/Health Research and Education Trust Employer Health Benefits Annual Survey, 2004. Accessed at <http://www.kff.org/insurance/7148/index.cfm>
- ⁹ Capitol Hill Briefing Webcast, Cover the Uninsured Week 2006. Accessed at <http://covertheuninsured.org/webcast>, 24 May 2006.
- ¹⁰ The uninsured population in Washington State. 2004 Washington State Population Survey. Accessed at <http://www.ofm.wa.gov/researchbriefs/brief031.pdf>, 18 May 2006.
- ¹¹ The measure was submitted to the voters at the November 6, 2001 general election and approved by the following vote: For – 948,529 Against – 486,912. http://www.secstate.wa.gov/elections/initiatives/statistics_initiatives.aspx. Since that time, no other initiative has exceeded this percentage of yes votes. I-901, with a 63% approval vote, comes closest.
- ¹² SB 6057 struck out the supplantation and expansion provisions for net I-773 generated revenue, but did not alter the provision that the funds would flow into the Health Services Account. As a result, net I-773 funds have been deposited in the Health Services Account and used to fund the variety of programs paid for by that fund, such as the existing costs for the Basic Health Plan – which was not the original intent of I-773.
- ¹³ I-773 generates funds to be used for specifically designated purposes. This column includes the net funds remaining after the 1) Tobacco Prevention, Water Quality, and Violence Reduction funding allotments are satisfied and 2) a 6.9% BHP administration ratio is subtracted from the remaining funds (as determined by the Health Care Authority for 2005 and applied retroactively as an administration ratio proxy). I-773 revenue figures received from the Department of Revenue, April 2006. BHP administration ratio received from the Washington Health Care Authority, August 2006.
- ¹⁴ Washington Health Care Authority, May 2006.
- ¹⁵ Working for Health Coalition calculation, May 2006.
- ¹⁶ Decreases in the state cost per BH member are due to legislative requirements, which are described by the Health Care Authority, Basic Health Annual Report (2002-03) as follows: "There were no copay increases or benefit changes for 2003. However, to meet the higher costs of health care coverage with less funding, the Legislature directed the HCA to (1) lower Basic Health's enrollment level to 100,000 members (from 115,031 in July 2003), and (2) reduce the actuarial value of Basic Health's benefits package by 18%, starting in 2004. This meant that fewer members would be covered by Basic Health, and those who were enrolled would pay more for their coverage."
- ¹⁷ Data on Washington's uninsured is available through the Washington Population Survey for 2000, 2002, and 2004. For the purposes of the graph, intervening years are an estimate of uninsured increase comprising half of the two year increase.
- ¹⁸ The most recent data available for Washington's uninsured (Washington Population Survey) from 2004 shows that 605,790 people were uninsured in CY 2004. Although new Washington Population Survey data will not be released until Winter 2006, recently released national Census data shows that the number of uninsured in Washington grew slightly from 2004 to 2005. (<http://www.chn.org/pdf/2006/2005UninsuredCensusDataByState.pdf>) Given this uninsured data trend, holding the number of uninsured steady at 605,790 is a conservative proxy for the number of Washington's uninsured in 2005. The number of people that could have been insured through the BHP for FY 2005 (66,988) can then be subtracted from this uninsured proxy. Although this calculation crosses FY and CY data, it is an appropriate measurement for the effect of I773 funded BHP spaces on the uninsured in WA, because 1) it is necessitated by the lack of CY data on I773 revenue, and 2) it is conservative given the conservative 2005 uninsured estimate utilized in the calculation.
- ¹⁹ The most recent data available for Washington's uninsured (Washington Population Survey) from 2004 shows that 152,984 people became uninsured since 2000. In 2005, 66,988 new BHP slots would have been funded by net I-773 revenue, reducing the number of uninsured in WA by 44%.
- ²⁰ The uninsured population in Washington State. 2004 Washington State Population Survey. Accessed at <http://www.ofm.wa.gov/researchbriefs/brief031.pdf>, 18 May 2006.
- ²¹ Care without Coverage: Too Little, Too Late. Institute of Medicine. May 2002. Accessed at <http://www.iom.edu/Object.File/Master/4/160/0.pdf>, 25 May 2006.
- ²² Davidoff A et al. Effects of the SCHIP on Children with Chronic Health Conditions. The Urban Institute. 8 June 2004. Accessed at <http://www.academyhealth.org/2004/davidoff.pdf>.
- ²³ Recent NACHC research utilizes Kaiser Family Foundation, Medical Expenditure Panel Survey (MEPS) and Uniform Data System (UDS) data to calculate: 1) the cost of non-emergency ER visit in Washington, and then 2) subtract the cost of care at a community

health center for the same number of visits. The result is a calculation of \$355 million in extra spending for non-emergency care received at an emergency room above the cost of care at a community health center. National Association of Community Health Centers (NACHC), "2006 Access to Community Health Databook: Washington". <http://nachc.org/research/wa.asp> .

²⁴ Risky Business: Working People Losing Health Coverage. Working for Health Coalition. June 2004.

²⁵ The Coverage Gap: A State-by-State Report on Access to Care. Cover the Uninsured Week 2006. Accessed at <http://covertheuninsured.org/media/research/CoverageGap0406.pdf>, 24 May 2006.

²⁶ A Families USA report demonstrated that there was \$726,102,000 in total health care costs for the uninsured that were not paid by the uninsured or by government programs. Paying a Premium: The Added Cost of Care for the Uninsured. Families USA, June 2005. http://familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.

²⁷ Harborview Medical Center Charity Care Trends. Presented at Seattle City Club Cover the Uninsured Week event, May 4, 2006.

²⁸ Paying a Premium: The Added Cost of Care for the Uninsured in Washington. Families USA, June 2005.

²⁹ Working for Health Coalition Poll. January 2005.

³⁰ Analysis of Washington State Population Survey data for uninsured residents under 200% FPL, the general income guideline for BHP eligibility. Data available at: <http://www.ofm.wa.gov/sps/default.asp> .