

**Stretching the Safety Net:  
The Rising Uninsured at Washington's Community Health Centers**

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This report is a product of  
The Community Health Network of Washington

The Community Health Network of Washington (CHNW) is a statewide network of community health centers that exists to ensure that all Washingtonians have access to primary care, regardless of geographic location, nationality, insurance status, or income level. CHNW addresses the health care needs of Washington on two important levels.

First, as safety net providers, the community health centers that comprise CHNW guarantee access to high-quality, affordable health care for all those who need it, including the uninsured.

Second, CHNW is the parent of the Community Health Plan of Washington, a nonprofit managed care plan that serves over 200,000 Medicaid, Basic Health, SCHIP and PEBB enrollees. Community Health Plan of Washington's delivery system is comprised of over 250 community health center and affiliate provider offices, 1500 primary care physicians, 8000 specialists and over 90 hospitals.

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## Executive Summary

Washington's community and migrant health centers are the first layer of our state's health care safety net, providing cost-effective primary care services and a medical home to patients regardless of their ability to pay. This commitment means that the health centers are the principal resource for those who lose their health insurance or cannot access or afford health care - *the primary care safety net*. In 2003, the state's health centers served 507,000 patients during the course of nearly two million visits, in 33 counties. Of these patients, more than a third were uninsured, representing over \$50 million in uncompensated care. The rest were insured through Medicaid, SCHIP, Medicare, the Basic Health Plan (BH), the Public Employees Benefit Board (PEBB) or private insurance.

In 2004, this safety net is in trouble. The number of uninsured people in Washington has been steadily increasing over the past few years, driven by job loss, rising costs for private health insurance, and program changes implemented as part of major budget cuts during the 2003 and 2004 legislative sessions. These changes created thousands more uninsured children and adults in our state. Budget proposals for 2005 would further cut Basic Health, dramatically reduce state funding for uninsured care, and implement premiums for Medicaid children.

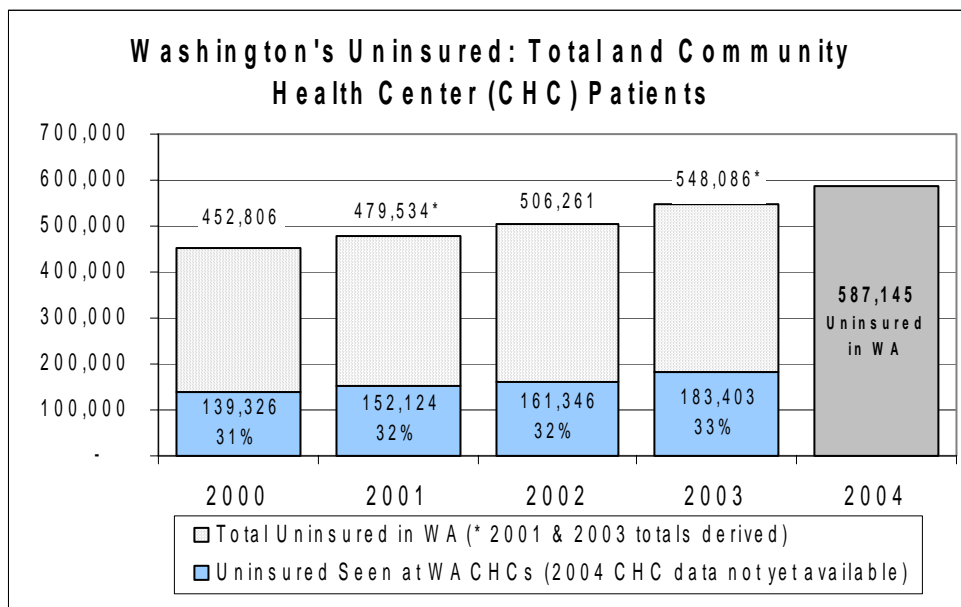
The budget cuts produce a double whammy for safety net health centers - draining crucial funding for insured visits and turning insured patients into uninsured ones who can only afford to pay for a fraction of the care they need. Federal and state revenues to help offset the cost of caring for the uninsured have not kept pace with the problem. This report presents the findings of research conducted by the Community Health Network of Washington (CHNW) to learn more about how state policy and budget changes are impacting health centers and their patients.

### Growing Pressure on the Community Health Center System

CHNW analyzed the effect of both existing and anticipated policy and budget changes on community health centers by: 1) tracking uninsured patient trends both statewide and at community health centers; and 2) interviewing representative clinic staff, administrators, and patients at risk of losing their coverage.

Researchers found that the dramatic rise in uninsured people in the state is directly impacting community health centers, threatening the continued viability of this critical component of the safety net.

- The number of uninsured patients at the health centers is increasing steadily every year (see figure below). In 2003, there were *over 20,000 more uninsured patients* seeking care at the health centers than in 2002. One third of Washington's uninsured population now receives care at community health centers.



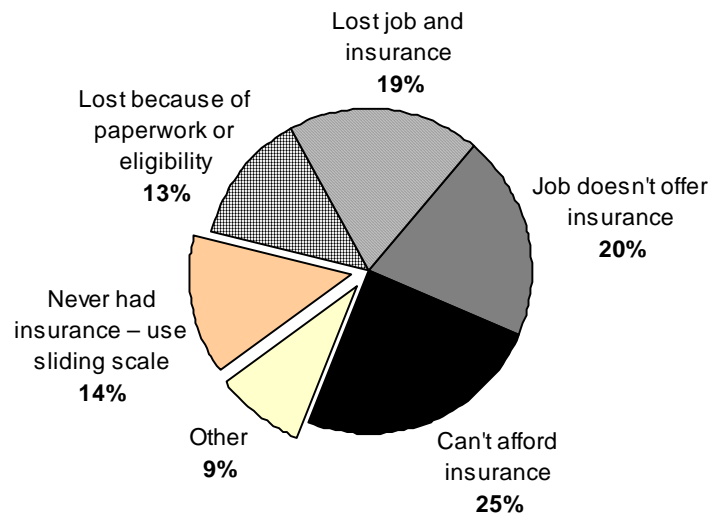
- While revenue from thousands of insured patients has stopped flowing to the health centers, the patients have not stopped coming. Uninsured patients pay for the care that they receive on a sliding scale, but their contribution covers only a small portion of the cost, or about 18 cents on the dollar.
- Health center staff agree that cost-sharing in Basic Health (BH) and children’s Medicaid (including higher premiums, copays, deductibles, and coinsurance) will continue leading to greater loss of health coverage than anticipated by the Legislature. Patient interviews support this prediction.

### Uninsured and Caught by the Safety Net

CHNW also focused specifically on *uninsured patients* seeking care at the community and migrant health centers. Findings from a random, representative survey demonstrate that among the thousands of uninsured people accessing care at health centers across the state:

- Most patients are uninsured through circumstances beyond their control (see figure below).

### Reasons Why Health Center Patients Are Uninsured



- Over half (57%) of the uninsured using the health centers are working, but many are working at jobs that do not offer insurance to their employees.
- Basic Health is effectively not an option for most of the uninsured people that use health centers. At the time of the survey, only 10% of BH applications were successful, in part because nearly half of the applicants were placed on the waiting list. The program has remained near or at capacity for years.
- The majority (73%) of uninsured people say that they will avoid needed care due to cost.
- Ninety-six percent of all uninsured patients would apply for insurance if there were an affordable option available.

### The Future of Washington’s Health Care Safety Net

Together these findings detail a dangerous and growing dilemma for the primary care safety net and the people who depend on it. Patients who are currently insured through public programs may not be able to hold on to this insurance in the face of significant program changes. With shrinking revenues, the health centers cannot continue to absorb the cost of serving those who have lost their health insurance. Ultimately, if we cripple the safety net at the same time that we eliminate health coverage for thousands of people, we can expect that they will turn up in emergency rooms, adding to acute access problems and resulting in higher health care costs for everyone.

## Introduction

Washington's community and migrant health centers are the first layer of our state's health care safety net, providing cost-effective primary care services and a medical home to patients regardless of their ability to pay. This commitment means that the health centers are the principal resource for those who lose their health insurance or cannot access or afford health care - *the primary care safety net*. In 2003, the state's health centers served 507,000 patients during the course of nearly two million visits, in 33 counties. Of these patients, more than a third were uninsured, representing over \$50 million in uncompensated care.<sup>1</sup> The rest were insured through Medicaid, SCHIP, Medicare, Basic Health Plan, the Public Employees Benefit Board (PEBB) or private insurance.

In 2004, this safety net is in trouble. The number of uninsured people in Washington has been steadily increasing over the past few years, driven by job loss, rising costs for private health insurance, and program changes implemented as part of major budget cuts during the 2003 and 2004 legislative sessions.<sup>2</sup> These changes created thousands more uninsured children and adults in our state.<sup>3</sup> The budget cuts produce a double whammy for safety net health centers - draining crucial funding for insured visits and turning insured patients into uninsured ones who can only afford to pay for a fraction of the care they need.<sup>4</sup>

To learn more about how these policy and budget changes are impacting health centers and their patients, the Community Health Network of Washington (CHNW) implemented a dual research strategy.

### **Growing Pressure on the Community Health Center System**

This section presents a quantitative and qualitative analysis of how recent state policy changes will affect health centers and their patients. CHNW analyzed the effect of both existing and anticipated policy and budget changes on community health centers by: 1) analyzing data on uninsured patient trends statewide and at health centers; and 2) interviewing representative clinic staff, administrators, and patients at risk of losing their coverage. Researchers found that the dramatic rise in uninsured patients is threatening the continued viability of this critical component of the safety net, and that budget changes may sustain or accelerate the trend seen over the past several years.

### **Uninsured and Caught By the Safety Net**

CHNW also focused specifically on uninsured patients seeking care at the health centers. This section presents findings from a random, representative survey that demonstrates that most uninsured patients are: uninsured through no fault of their own, wish they could have affordable insurance, and will avoid needed care due to cost.

Together these findings detail a dangerous and growing dilemma for the primary care safety net and the people who depend on it. Patients who are currently insured through public programs may not be able to hold on to this insurance in the face of significant program changes. With shrinking revenues, the health centers cannot continue to absorb the cost of serving those who have lost their health insurance. Ultimately, if we cripple the safety net at the same time that we eliminate health coverage for thousands of people, we can expect that they will turn up in emergency rooms, adding to acute access problems and resulting in higher health care costs for everyone.<sup>5</sup>

## I. Growing Pressure on the Community Health Center System

As the first tier of the health care safety net, community and migrant health centers are directly affected by policy and budgetary changes to public insurance programs such as Medicaid and Basic Health. In the past several years, both of these programs have undergone significant changes that increase out-of-pocket costs and/or administrative requirements for their low-income enrollees. These changes have been implemented at the same time that the number of uninsured across Washington State is rising.

CHNW conducted qualitative and quantitative analyses to learn more about how these combined actions would impact health centers and their patients:

CHNW analyzed uninsured patient trends at the 19 Federally Qualified Health Centers that are members of the Washington Association of Community and Migrant Health Centers. Together these health centers served over 500,000 patients in 2003;<sup>6</sup> and

Researchers conducted a series of interviews and focus groups with staff, administrators, and patients at four representative health centers in order to understand how changes to public programs affect patient behavior and center operations. The centers are Community Health Association of Spokane, Peninsula Community Health Services, Puget Sound Neighborhood Health Services and Yakima Valley Farm Workers Clinic. These health centers see over 35,000 patients per month in both rural and urban communities, and they represent the diversity across community health centers in the state.

This section places the findings from this research within the context of rising numbers of uninsured, and recent legislative policy changes; and discusses how these changes have contributed to the rise in uninsured patients at health centers.

### The Number of Uninsured People in Washington is Growing

In 2004, 587,000 Washingtonians were uninsured, an increase of more than 80,000 people since 2002.<sup>7</sup> Policy changes enacted during the 2002, 2003, and 2004 legislative sessions cut over \$800 million from public health insurance programs and have led to major reductions in the number of people covered under these programs.

- In October 2002, Washington's Legislature eliminated Medicaid coverage for approximately 29,000 undocumented people. Ninety percent of those affected were children. While this group was given the option of enrolling in Basic Health and paying monthly premiums, over half had not successfully made the transition over a year later, most likely because of the cost. By December 2003, the number of successful transitions had peaked at 44% (12,705) and had begun to steadily decline. By January 2005, only 6,200 members of this transition group remained insured by Basic Health. This means that over 22,000 people from this group likely remain uninsured.<sup>8</sup>
- A January 2003 freeze on Basic Health enrollment caused 30,000 people to lose their coverage that year. These cuts were made despite a voter initiative (I-773), passed by a 2 to 1 margin the previous year, which raised \$150 million annually through tobacco taxes to *expand* Basic Health. It is unlikely that many of those who dropped off found other coverage, as there are few affordable options for low-income people whose income qualifies them to apply to Basic Health.<sup>9</sup> The program is again on the chopping block in 2005. In his 2005-07 biennial budget, Governor Locke has proposed cutting the program by another 17,200 slots unless the state can raise new revenue.
- In 2002 and 2003, the state increased administrative barriers for children in Medicaid and SCHIP programs, resulting in a drop of approximately 50,000 children from these programs. The changes, which make it more difficult for children to enroll and stay in these programs, included: reapplication every six rather than twelve months; income documentation at the time of application certification; and a signature requirement on applications instead of phone or online applications. The state also repealed continuous eligibility, which had previously allowed children to remain covered by insurance until their next eligibility determination.<sup>10</sup>

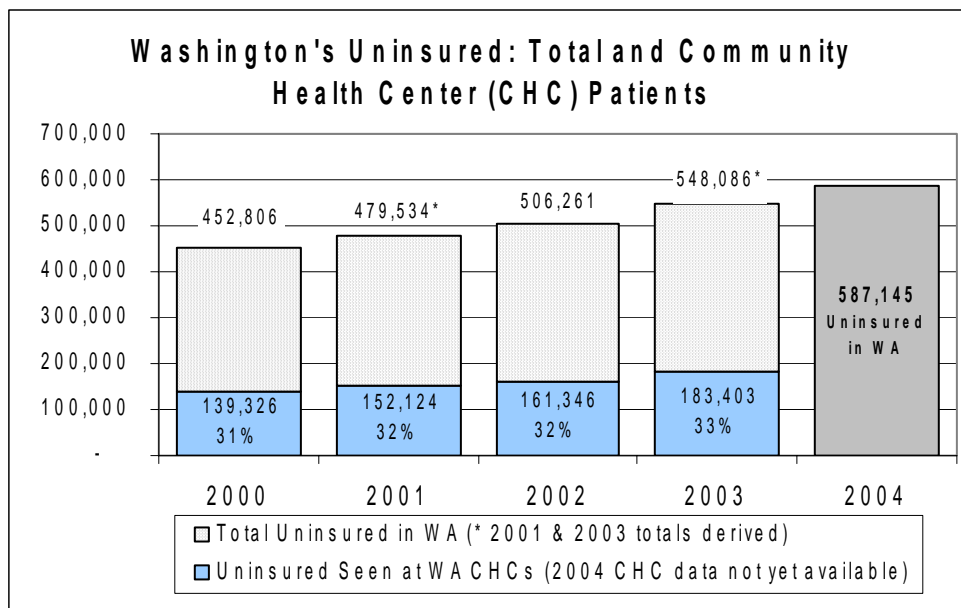
- Premiums for children’s Medicaid coverage were adopted by the Legislature, but initially delayed by the Governor. These premiums are currently scheduled to begin in July 2005. While the Legislature moderated its earlier decision to charge premiums to *all* children living above poverty, an estimated 75,000 children living above 150% of poverty will still be subject to \$10-\$15 monthly premiums for their coverage.<sup>11</sup>

For the low-income uninsured who lose their coverage there are virtually no other affordable health insurance options, leaving them to fall back on our state’s health care safety net.

### The Number of Uninsured at Health Centers is also Growing

In 2003, over a third of the patients that received care at community health centers were uninsured. The number of uninsured continues to grow each year, increasing by over 20,000 patients between 2002 and 2003 alone. Cumulatively, this represents a 32 percent increase in uninsured patients since 2000. Previously, health centers responded to increased need by opening new sites, hiring more providers and staying open more hours, but budget cuts will make it impossible to continue providing this level of access, let alone meet the needs of an even larger uninsured population.

The rise in uninsured community health center patients is tied to the continuing rise in Washington’s uninsured population. As the chart below demonstrates, about a third of the uninsured receive care at Washington’s Community Health Centers.<sup>12</sup> Recently released data show that over the last two years the number of uninsured people in the state rose 16 percent, leaving one in every 10 Washington residents without health insurance. Based on current trends and anecdotal CHC evidence, this rise is being reflected at the community health centers as they stretch to care for the continually increasing numbers of uninsured in Washington.



Although the increase in uninsured people has hit both rural and urban health centers, prior experience indicates that rural areas of Washington will be hit harder. In 2000, the rate of uninsured people in Eastern Washington rural counties was about twice the rate in the Western urban counties.<sup>13</sup> Specialty care is even more difficult for uninsured patients to access in rural areas, further compounding the impact of increases in the number of uninsured in rural Washington.

## Community Health Centers are Struggling to Meet Growing Uninsured Demand

In addition to providing well-child visits, immunizations, screenings, and a full range of primary care services that keep insured patients healthy and out of the emergency room, the state's community and migrant health centers provide the same services to uninsured patients. As the number of uninsured people has increased, and as the amount of uncompensated care provided by private practitioners and non-safety net organizations has eroded, an increasing number of people have been seeking this care at the health centers.<sup>14</sup>

As the 2003 and 2004 budget cuts continue to impact residents, and more people lose their insurance coverage, the health centers will bear an even larger burden. In the first year of the Basic Health freeze, almost 18,000 health center patients lost their Basic Health coverage.<sup>15</sup> While revenue from these insured patients has stopped flowing to the health centers, the patients have not stopped coming.

Health centers are losing critical funds from insured patients that help them offset uncompensated care costs at the same time that these costs are rising. While uninsured patients pay for the care that they receive on a sliding scale, their contribution covers only a small portion of the cost, or about 18 cents on the dollar (see Figure 3).<sup>16</sup>

Since there are fewer insured patients to help offset these costs, the funds must come from savings on operating expenses or staff. Such changes affect patients, centers, and the community at large. One health center CEO walked through the financial scenario her organization is facing:

*What's the breaking point? The payer mix has to be there. When the scales tip so far, when your cost is over \$100 for a person and you are getting \$15, and only 40% of people actually pay that, it's not long before you have to shut your doors because the costs are too high.*

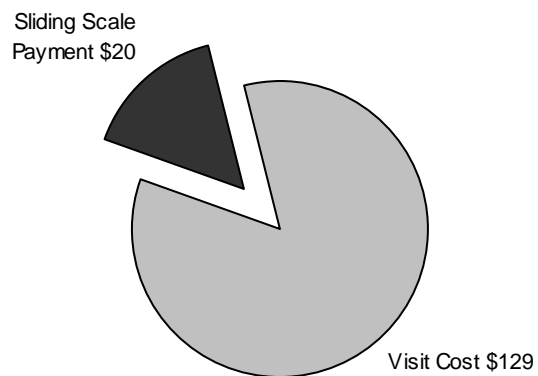
Another CFO explained the impact of the budget cuts on the larger community:

*If you consider the 5,000 people [our center has] lost off Basic Health since January 2003, the amount that is going into the community - whether it is to our staffs' salaries, or specialists' offices, hospitals, or physical therapy offices - easily adds up to a couple of million dollars not going into our local economy one way or another. We have not yet laid off any staff because right now we are supporting the present with money we would have invested in our company's future, which means we will not see expansion or more services.*

## Upcoming Changes Will Further Endanger Patients

Changes still lay ahead for the community health centers. Interviews with Basic Health enrollees and parents of Medicaid children at health centers around the state suggest that as new costs and the full

**Fig 3: Average Uncompensated Care Cost for Uninsured Services at Community Health Centers**



impact of the new recertification policies hit, there will be confusion and even more significant loss of health coverage. One clinic manager explained:

*These are people that sometimes don't have their \$10 copay when they come in the door. ...They are going to get sent to collections for that part that they can't pay when they get specialty care and then their credit will be ruined. It's all just pushing them down, holding them down. ...Unfortunately what happens is that some patients won't pursue [care] because they find out how much it will cost.*

Perhaps one of the least understood ramifications of living without insurance is the difference in access to specialty care. Although the centers have been stretching their resources to provide primary care access to more uninsured people, they cannot solve the specialty care crisis in the state. Staff and administrators say that there are few specialty providers left in local communities who are willing to take uninsured patients.

Staff report that finding a specialist to see an uninsured patient requires "hustling" and "begging," and is often an impossible task. Staff from Spokane report sending patients across the state to Harborview Medical Center in Seattle for specialty care. In cases where the patient does not have the time or resources to travel, they may be sent to the nearest emergency room.<sup>17</sup> One referral specialist explained:

*If the doctor's on call they have to see them. They don't have to see them at the hospital, but they have to see them [at the emergency room]. If you have a child with a broken foot or whatever, we have to do that to get an orthopedic doctor to see them.*

With the recent budget cuts, hospitals find themselves similarly unable to absorb the overwhelming demand for basic specialty care. Patients will be left with no options for care.

#### **Expected Impacts of Basic Health Plan Cuts and Cost-Sharing**

In January 2004, changes in cost sharing for Basic Health went into effect that have been difficult for enrollees to manage. Staff and patients said that they expected these changes to cause more people to fall off the program. Once again, with no other affordable health insurance options, these changes will contribute to the rising numbers of uninsured in Washington.

- **Cost sharing:** Along with increased premiums and copays for Basic Health, 2004 also brought significant new patient cost sharing, including \$150 deductibles and 20% coinsurance with a \$1500 out of pocket maximum.<sup>18</sup> To put these changes in perspective, the health insurance available to Washington's legislators and state employees, who generally have higher income, includes lower copayments and is not subject to coinsurance.<sup>19</sup>

Basic Health enrollees around the state told us that 2004 program changes would hit them hard. Premium and copays will be difficult, but in most cases feasible to pay. They stated that the new Basic Health coinsurance and deductibles, however, will not only be confusing, but untenable for most members who get sick. Knowing this, some patients considered dropping coverage immediately to save up money in case they get sick. Many will have to make extremely difficult choices about paying for health care, which may jeopardize their long-term health and self-sufficiency.<sup>20</sup>

- **Waiting list increases:** When Basic Health enrollment was frozen in January 2003, it triggered a build up in the program's waiting list (at almost 40,000 in January 2004).<sup>21</sup> Thousands of patients waited to get on the program for over one year.<sup>22</sup> The capping of the program has serious health and financial consequences for those who have avoided care while waiting for coverage.

### Expected Impacts of Children's Medicaid Premiums & Eligibility Verification

Although they were initially delayed, July 2005 will bring the implementation of premiums for many families with children on Medicaid in addition to the more onerous eligibility verification requirements already in place. Health center staff and patients raised serious concerns about the ability of parents of Medicaid children to meet these increased financial and logistical requirements, a problem that will add to the number of uninsured children in Washington.

- **Increased eligibility barriers:** New administrative rules for Medicaid have already caused nearly 50,000 children to lose coverage.<sup>23</sup> Both health center staff and patients report that most children fail recertification not because their parents' income suddenly jumps too much to remain ineligible, but because they do not receive the paperwork, cannot fill it out correctly, or because of administrative errors. Now that the process must be repeated every six months instead of annually, these problems will become more frequent. These first hand accounts are supported by findings from a recent University of Washington study that shows a high return rate for those disenrolled from Medicaid for the general category, "failed at recertification", few of whom were actually ineligible when dropped.<sup>24</sup>
- **Premiums:** The \$10-15 monthly premiums imposed on Medicaid children living above 150% of poverty (or \$1959/month for a family of three) are expected to cause thousands of children to lose their health insurance because their parents cannot afford the cost.<sup>25</sup> While these costs may seem small to middle-income earners, low-income families are extremely worried about how they will come up with the money to keep their kids covered while also paying for basic necessities like rent and food.

Health centers expect to see increasing numbers of former Medicaid and Basic Health enrollees seeking care as uninsured patients. Not only do uninsured patients place a strain upon the safety net, they also are more likely to avoid care and suffer financial hardships because they lack insurance. The following section takes up the question of uninsured health center patients in detail, focusing on the reasons they are uninsured, their health, and their options for health care coverage.

## II. Uninsured and Caught by the Safety Net

The number of uninsured patients continues to rise across the entire state of Washington and within the community health centers that serve as the primary care component of the safety net. National research has consistently shown that lack of insurance directly affects physical and financial health.

- Uninsured people must exhaust themselves financially trying to pay for health bills. Almost half of all personal bankruptcies are due to medical costs.<sup>26</sup>
- Anticipating high medical bills, many of the uninsured are not able to follow recommended treatment. Over one third of uninsured adults say they did not fill a drug prescription in the past year and another one third went without a recommended medical test or treatment due to cost.<sup>27</sup>
- Uninsured people also delay care until they are seriously ill with health problems that could have been avoided. As a result, many treatable illnesses, such as pneumonia or diabetes, are not discovered until they are advanced and more costly or dangerous to treat.<sup>28</sup>
- Because the uninsured are less likely than the insured to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems. When they are hospitalized, they are more likely to receive fewer services and to die in the hospital than are insured patients.<sup>29</sup>
- Uninsured children are 70 percent more likely than insured children to have foregone medical care for common conditions such as ear infections, and 30 percent less likely to receive medical attention when they are injured. One third of uninsured children have not seen a doctor in the past year.<sup>30</sup>
- Children who lack health insurance have poorer attendance and poorer grades than insured children.<sup>31</sup>

The following section focuses on the reasons that Washington State community health center patients are uninsured, and answers important questions about their health, health care avoidance, and attitudes towards health insurance. The findings present a troubling picture of working people who are uninsured due to circumstances beyond their control, often avoiding care they need, and wishing there was an affordable insurance option available to them. Although the community and migrant health centers are available to patients regardless of their ability to pay, they cannot completely fill the gaps left by our state's incomplete patchwork of health coverage options.

### Methodology

In January 2004, CHNW, in conjunction with four community and migrant health centers in Washington State, conducted a representative, random phone survey of 383 uninsured patients who visited the four centers between June and November 2003, the most recent six-month data period available at the time of the survey. The survey calls were made in January 2004. Due to the sample size and random, representative design, the patients surveyed are representative of thousands of uninsured patients seen at community health centers statewide, with a +/- 5% margin of error.<sup>32</sup>

The four health centers chosen for this study see over 35,000 patients per month in both rural and urban communities, and they represent the diversity across community health centers in our state. The four participating centers are:

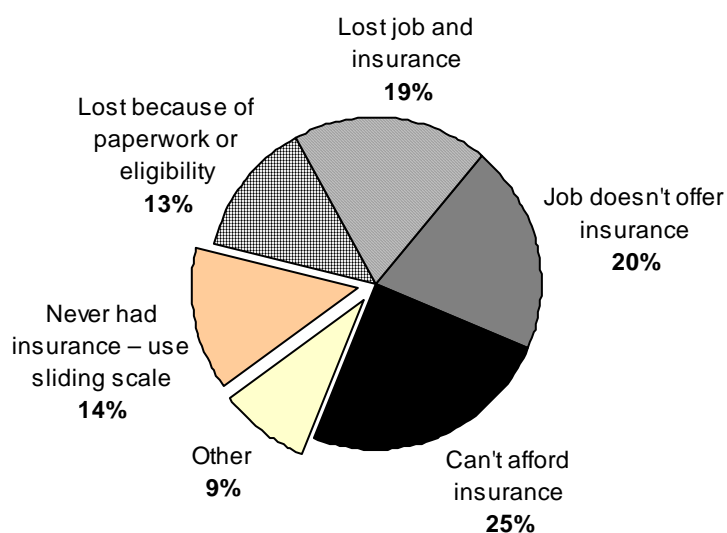
- Community Health Association of Spokane (Spokane)
- Puget Sound Neighborhood Health Centers (Greater Seattle)
- Peninsula Community Health Centers (Bremerton to Grays Harbor)
- Yakima Valley Farm Workers Clinic (Greater Yakima and Spokane)

## Uninsured Patient Study Findings:

- Most health center patients are uninsured due to circumstances beyond their control.

In response to the question, “Why were/are you uninsured?” at least 70% of patients explained that they had not chosen to be uninsured, but rather were uninsured due to various circumstances beyond their control. Nineteen percent of these uninsured patients had lost their insurance when they lost their job. Another 20% were working at jobs that didn’t offer insurance, and were therefore in a similar position to the 25% who stated that they simply could not afford the insurance that was available in the private market. Finally, 13% of uninsured patients lost their insurance because of paperwork or eligibility issues (see Fig 4).

**Fig 4: Reasons Why Health Center Patients Are Uninsured**

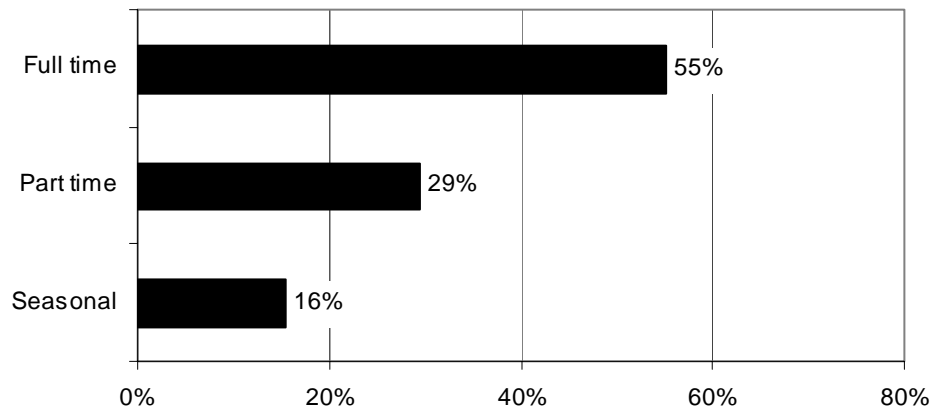


Only 14% of uninsured patients had made a choice to go without insurance. People in this group said that they had never had insurance or preferred to visit the clinics on a sliding scale or cash basis. The remaining 9% of patients gave a variety of “other” reasons for being uninsured, including having lost insurance coverage under another family member’s plan due to divorce or age requirements.

- Over half of the uninsured using the health centers are working, but many are working at jobs that do not offer insurance.

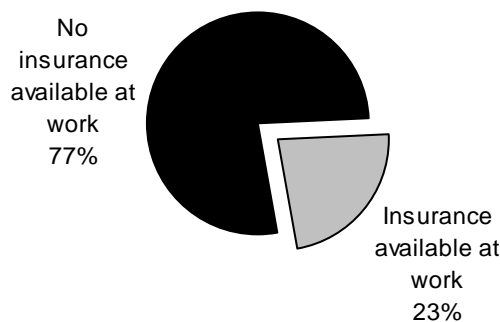
Although uninsured people are often depicted as unemployed, this study found that over half (57%) of the uninsured patients at health centers were working. In fact, over half of these workers were employed full-time at their jobs or at their own businesses.<sup>33</sup> Nearly one third of the uninsured workers were employed part-time, and 16% were working seasonal jobs (see Fig 5).

**Fig 5: Employment Status of Uninsured Workers Seen at Health Centers**



Even though they are working, over three fourths of all uninsured workers are uninsured because they are not offered coverage on the job (see Fig 6). The lack of employer-based insurance is not limited to those working part-time or seasonally, but is also a significant issue for full-time workers.

**Fig 6: Availability of Insurance at the Workplace for Uninsured Workers Seen at Health Centers**



A closer look at uninsured full-time workers shows that 70% of them did not have access to health insurance at their jobs. Without this job benefit most lower-income workers are unable to afford insurance.

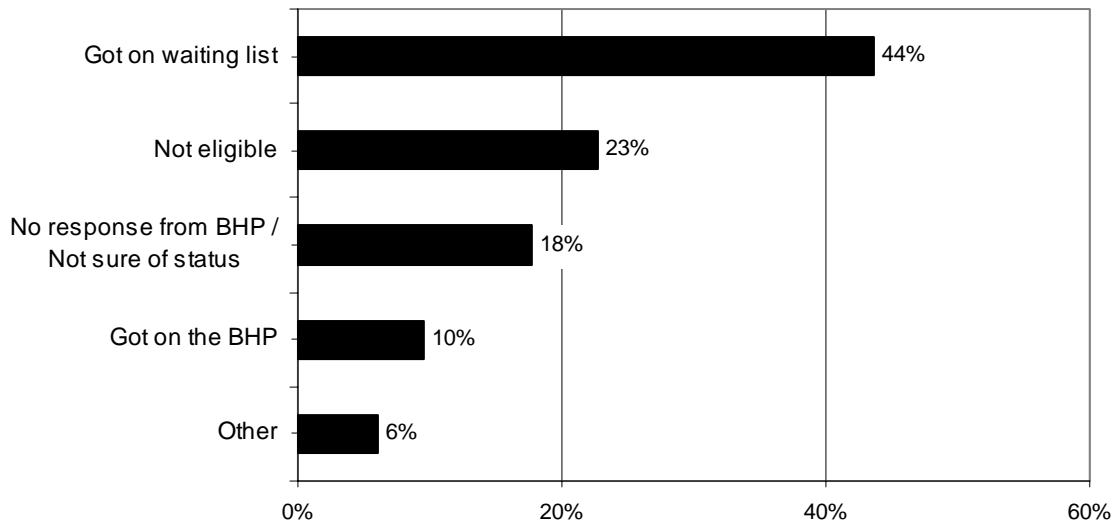
Many of the remaining 30% of uninsured full time workers noted that although there was a health insurance option at their job, they could not afford the monthly cost and therefore went without insurance.

- **Basic Health is effectively not an option for most of the uninsured people that use health centers. Only 10% of Basic Health applications were successful, in part because nearly half of the applicants resided on the waiting list.**

In Washington, there are very few affordable insurance options available to uninsured patients who visit community centers. Basic Health is a health insurance program available to those living below 200% of the federal poverty level, with enrollees and the state sharing in the cost of monthly premiums. But the program’s enrollment was frozen in January 2003 and eventually capped at 100,000 slots, triggering a build up in the program’s wait list that reached over 40,000 applications by January 2004.<sup>34</sup> For many, Basic Health represents the only potentially affordable insurance option.

Over half of the uninsured patients surveyed (57%) stated that they had applied for Basic Health. The overwhelming majority of these applications, however, did not lead to insurance coverage. Only 10% of the applications resulted in acceptance in the program (see Fig 7).

**Fig 7: Result of Basic Health Plan Application for Health Center Patients**

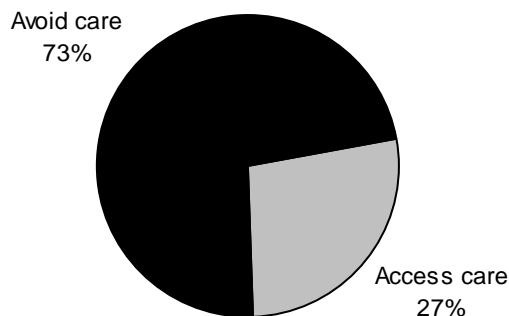


Over 40% of the applicants were put on the waiting list. Another 18% had not been contacted about their applications or did not know their status. The final 23% of applicants stated that they were ineligible for Basic Health coverage for a variety of reasons, often related to income. Since most employees surveyed did not have access to insurance through their jobs, even if they were working full-time, this meant they were left without affordable insurance options.

■ **Uninsured people avoid care and will get sicker.**

Although all of the patients surveyed had recently visited the clinics as uninsured patients, studies demonstrate that insurance is the most important predictor of service use and access to care.<sup>35</sup> In order to determine how insurance status was affecting decisions about seeking health care, uninsured patients were asked if they would “Avoid or delay getting care since they did not have insurance.”

**Fig 8: Percent of Uninsured Health Center Patients Avoiding Health Care**



Nearly three fourths of the uninsured people surveyed said they would avoid or have already avoided getting health care because they do not have insurance to pay for it (see Fig 8). Although this statistic may not be surprising given the rising cost of health care, it does indicate serious problems for patients and the health care safety net in Washington State.

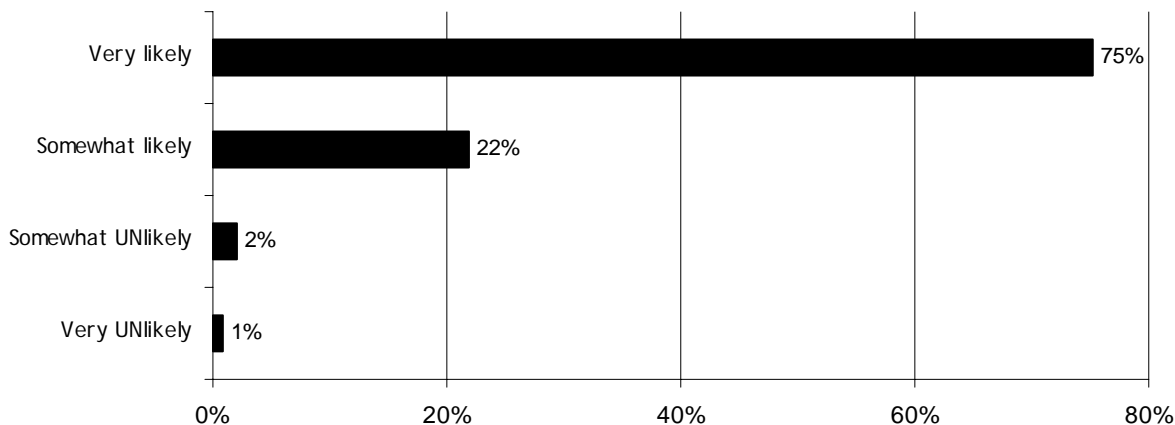
Multiple nationwide studies clearly demonstrate that when people avoid or delay care, preventable health problems turn into serious conditions that are more costly and more serious to treat.<sup>36</sup> The health

centers are designed to provide preventive and primary care. When uninsured patients require specialty care for health problems that have become acute, health center providers have difficulty finding doctors to see them. In many cases, the only option for finding their patients help is to send them to already overcrowded emergency rooms.

■ **Nearly all uninsured patients would apply for insurance if they could afford it.**

Finally, uninsured patients were asked how likely they would be to apply for health insurance if it was affordable to them (see Fig 9). Nearly all of the uninsured (96%) said that they were likely to apply for an *affordable* insurance plan if it was offered to them. Many of the people surveyed expressed eagerness to apply for some kind of coverage, and were disappointed to find out that their clinic could not offer them an option at this time.

**Fig 9: Likelihood of Applying for Affordable Insurance if Available**



When uninsured patients were asked what monthly premium they would consider affordable, they came up with rates similar to Basic Health premium rates (see Table 1).<sup>37</sup>

**Table 1: Monthly Premiums Uninsured Health Center Patients Consider Affordable**

Affordable Premium	Percent Responses
Less than \$10	28%
\$10 - \$20	40%
\$20 - \$30	17%
\$30 - \$40	7%
Over \$40	7%

### Uninsured and without affordable health insurance options

Uninsured patients are faced with difficult choices. The majority of uninsured health center patients are uninsured through no fault of their own. Almost all of them would apply for affordable health insurance if it were available, but only 10% of those who applied to Basic Health were offered coverage. Although health centers are there to provide care to all regardless of their ability to pay, uninsured patients are still likely to avoid care, making them more apt to end up in hospital emergency rooms with health concerns that were avoidable.

Interviews with health center staff, administrators, and patients all suggest that the rising number of uninsured people will persist or grow in 2005, due in large part to policy changes intended to save state dollars. Future studies will look more closely at patients who lost their coverage during 2004 to determine the impact of budget changes made in 2003 and 2004, and to determine how to best provide insurance to the thousands of uninsured Washington State residents who are in danger of falling through the health care safety net.

## Conclusion

The safety net in Washington State is in trouble. The backbone of this safety net, the community health centers, are virtually the only place that most uninsured children and families can go for primary care when they lose their health coverage. The majority of patients visiting health centers around the state are uninsured through circumstances beyond their control. The stagnant economy, combined with skyrocketing health care costs, have left them with no options for coverage. They seek care at community health centers where they pay out-of-pocket for their visits, but their contribution covers only a small portion of the cost and they have little or no access to specialty care.

Just over three-fourths (76%) of the patients who came into the health centers as uninsured patients in the last half of 2003 were still uninsured in January 2004 when the survey was conducted, demonstrating the persistence of this problem. In 2005, the health centers expect continuing increases in the number of uninsured patients and visits due to both past and potential future budgetary decisions, including Basic Health cost-sharing, premiums for Medicaid children, and administrative eligibility hurdles, all of which will continue to cause thousands of children and adults to lose their coverage. The ultimate impact of a growing number of uninsured patients with nowhere to turn is a sicker, more costly population that relies heavily on the already overwhelmed safety net system made up of our state's community health centers and hospital emergency rooms.

If uninsured health center caseloads keep rising at unsustainable rates, and in the absence of revenues to help cover the cost of care, the centers will have to make difficult decisions about the services they can provide. If we let the safety net crumble, thousands of people across the state will lose access to critical health services. Already in debt, they will be left with few options outside of avoiding care or using the emergency room. The costs for these more expensive options do not disappear, but are instead passed on to the privately insured and taxpayers. In fact, it is likely that not insuring people in the short run will cost Washington State much more in the long run.

## Endnotes

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<sup>1</sup> Data on the community health center patients is compiled annually for the 19 Federally Qualified Health Centers (FQHC) that are members of the Washington Association of Community and Migrant Health Centers (WACMHC).

<sup>2</sup> Data on rising numbers on uninsured in the state is available through the Washington Population Survey on line at <http://www.ofm.wa.gov/sps/index.htm>. In addition to current uninsured levels, several policy changes adopted by the legislature have compounded the problem. These changes are discussed in Section 1 of this report. For information on Washington's unemployment rate see: Bureau of Labor Statistics, "Unemployment Rate for States, Monthly Adjusted Seasonal Rankings, November 2003 (Preliminary)," January 2004, <<http://www.bls.gov/web/laumstrk.htm>>. For information on the rising cost of employer-sponsored health insurance and employee take up rates, see: Bureau of Labor Statistics, "Employee Benefits in Private Industry, 2003," News Release, September 17, 2003, <<http://www.bls.gov/news.release/pdf/ebs2.pdf>>.

<sup>3</sup> Upcoming changes include premiums for children's Medicaid coverage scheduled to start in July 2004. Children living between 150-250% of the federal poverty level will be charged \$10-\$15 a month for their coverage.

<sup>4</sup> The 2004 legislature did try to redress some of the impact of their previous policy changes on the health centers by allocating \$2.5 million to the Community Health Services (CHS) program whose mission is to promote access to and health care for the uninsured, underinsured, and tribes. However, these funds will be spread across over 30 CHS contracted clinics and will make up for only a small fraction of the cost of covering those who became uninsured due to 2003 policy changes.

<sup>5</sup> Indeed, between 2000 and 2002, hospital emergency room visits in Washington increased 12%. (Washington State Hospital Association Data, 2004). Emergency rooms are required to see patients regardless of their ability to pay. The cost of the uncompensated care they provide must be made up by charging higher rates to the privately insured, starting a cycle of cost increases and insurance loss. The legislature's 2003 decision to eliminate the Medically Indigent program, which reimbursed hospitals for a portion (30%) of the uncompensated care they provide, will exacerbate this cost shift. In 2004, the legislature restored \$10 million, a small portion of the original cuts, to urban hospitals to make up for their earlier decision.

New national figures show health care spending increased by 9.3% in 2002 over 2001, driven in large part by hospital spending. In 2002, U.S. health spending was about \$5,440 for every American. See K Levit, et al, "Health Spending Rebound Continues in 2002," *Health Affairs*, (Jan/Feb 2004): 147-159. By maintaining adequate access to primary care services, community health centers can relieve hospitals from having to provide this care in their emergency rooms. J Meyer, M Legnini and E Waldman, "The Health Care Safety Net in Four Communities: Current Policy Issues Affecting Safety Net Providers," Economic and Social Research Institute, August 1999.

<sup>6</sup> Within this report, data on uninsured community health center patients is taken from data set compiled annually for the 19 Federally Qualified Health Centers (FQHC) that are members of the Washington Association of Community and Migrant Health Centers (WACMHC).

<sup>7</sup> 2004 Washington Population Survey data on the insurance status of Washingtonians is available on line at <http://www.ofm.wa.gov/sps/index.htm>. 2002 data on the uninsured is available online, and in Washington State Office of Financial Management, "The Uninsured Population in Washington State: 2002 Washington State Population Survey Research Brief Number 16 (Revised)," August 2003.

<sup>8</sup> Children's Alliance, "Losing Ground: More Children Lose Health Coverage and Essential Services: Results of the Immigrant Health Insurance Transition to Basic Health," December 2003. Current immigrant transition figures updated in communication with Children's Alliance, January 2005.

<sup>9</sup> In order to qualify for the Basic Health, family income must be below 200% of the federal poverty level. At this income, patients report that most private market insurance plan premiums are unaffordable. A survey discussed in this report demonstrates that job-based health insurance is not available for many uninsured people.

<sup>10</sup> The drop off was calculated beginning October 2002, and has been significantly higher than originally predicted by the legislature. Children's Alliance, "Condition Critical: Washington's Curable Children's Health Crisis," December 2004, <http://www.childrensalliance.org/publications/reports.htm>.

<sup>11</sup> Documents provided to the authors by Medical Assistance Administration, March 2004.

<sup>12</sup> Total number of uninsured people found in the Washington Population Survey for 2000, 2002, 2004. This survey is only conducted every two years. For illustration purposes, the number of uninsured in non-survey years is calculated by adding the difference between the two survey years to the prior survey year. <http://www.ofm.wa.gov/sps/index.htm>.

<sup>13</sup> Health Policy Analysis Program, *The Pulse Report 2002*, University of Washington, November 2002, <[http://depts.washington.edu/hpap/vital\\_signs/pulse\\_indicators.html](http://depts.washington.edu/hpap/vital_signs/pulse_indicators.html)>.

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<sup>14</sup> *America's Health Care Safety Net: Intact but Endangered*, ME Lewin and S Altman, Editors, Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine, 2000; P Cunningham, et al, "Managed Care and Physicians Provisions of Charity Care, *JAMA*, 281(12): 1087-1092; J Mann, G Melnick, A Bamezai and J Zwanziger, "Uncompensated Care: Hospitals' Responses to Fiscal Pressures", *Health Affairs* (Spring 1995): 263-70; P Cunningham, "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001," Tracking Report No. 6, Center for Studying Health System Change, Washington D.C., December 2002, <<http://www.hschange.org/CONTENT/505/505.pdf>>.

<sup>15</sup> Community Health Plan of Washington, Enrollment Report, November 2003.

<sup>16</sup> Data on average visit cost was collected from community health centers by the Washington Association of Community and Migrant Health Centers. The average patient contribution per visit was calculated at \$20 based on interviews with four community health centers and data collected from a sample of centers by the Community Health Network of Washington.

<sup>17</sup> Staff and administrators at three of the four study sites reported major difficulty getting local specialists to see their patients, often regardless of their insurance status. Multiple studies have highlighted safety net providers' limited ability to provide behavioral, diagnostic and specialty services to their uninsured patients. See M Gusmano, G Fairbrother, and H Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* (Nov/Dec 2002): 188-194; S Felt-Lisk, M McHugh, and E Howell, "Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?" *Health Affairs* (Sep/Oct 2002): 277-283; and J Weissman, et al, "Limits to the Safety Net: Teaching Hospital Faculty Report On Their Patient's Access to Care," *Health Affairs* (Nov/Dec 2003): 156-166.

While safety net access is critically important, it is not an adequate substitute for health insurance. A recent study concluded that "the highest levels of access to care are found in communities with both strong insurance and strong CHC [Community Health Center] presence," and that "high insurance coverage generally trumps a strong CHC presence" in guaranteeing access to care. J Holahan and B Spillman, "Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance," Urban Institute, January 2002, <[http://www.urban.org/UploadedPDF/310414\\_anf\\_b42.pdf](http://www.urban.org/UploadedPDF/310414_anf_b42.pdf)>. See also P Cunningham and J Hadley, presentation at 2003 Academy Health Annual Research Meeting, Nashville, June 2003.

<sup>18</sup> Each member of a family is subject to the deductible and coinsurance with no cap on family costs. Ninety percent of Basic Health enrollees make less than \$1,908 per month for a family of three. See Basic Health Plan website for more detailed information on cost-sharing: <<http://www.hca.wa.gov/basichealth/index.shtml>>.

<sup>19</sup> Public employees receive their benefits through the Public Employees Benefit Board. See L Ku and M Broaddus, "Funding Health Coverage for Low-Income Children in Washington," Center on Budget Policy and Priorities, November 10, 2003.

<sup>20</sup> Cost-sharing causes low-income people to reduce both inappropriate and necessary care. For a review of the literature, see *Health Insurance Premiums and Cost-Sharing: Findings From the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, Pub. No. 4071, April 2003, <<http://www.kff.org/medicaid/4071-index.cfm>>. See also L Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget Policy and Priorities, May 7, 2003, <<http://www.cbpp.org/5-7-03health.pdf>>.

Research has also shown that when patients avoid care, they suffer from avoidable health problems and use emergency rooms at higher rates. For a review of this research see: American College of Physicians-American Society of Internal Medicine, "No Health Insurance? It's Enough to Make You Sick - Scientific Research Linking the Lack of Health Coverage to Poor Health", November 1999, <<http://www.acponline.org/uninsured/lack-contents.htm>>; Kaiser Commission on Medicaid and the Uninsured, "Uninsured in America: A Chartbook, Second Edition," Pub. No 1407, March 2000, <<http://www.kff.org/uninsured/1407-index.cfm>>.

<sup>21</sup> Waiting list data from Washington State Health Care Authority, January 2004. This figure is the number of applications. The number of individuals waiting for coverage may be much higher since an application may be for multiple family members.

<sup>22</sup> Data from Health Care Authority, January 2004.

<sup>23</sup> Children's Alliance, "Condition Critical: Washington's Curable Children's Health Crisis," December 2004, <http://www.childrensalliance.org/publications/reports.htm>.

<sup>24</sup> Health Policy Analysis Program, "The Costs of Enrollment Instability in Washington State's Medicaid Program," Working Paper, University of Washington, March 5, 2004, <[http://depts.washington.edu/hpap/Publications/medicaid\\_cycling.html](http://depts.washington.edu/hpap/Publications/medicaid_cycling.html)>.

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<sup>25</sup> Medical Assistance Administration (MAA) estimates that 4,000 children will drop off the Medicaid rolls because of the imposition of premiums. Documents provided by MAA, March 2004. There are several reasons to believe that this estimate is optimistically low: 1) the state greatly underestimated the drop off due to the imposition of administrative barriers; 2) to ensure that they meet their budget, MAA will necessarily err on the low side; and 3) experiences in other states suggest significantly higher drop off rates. Contact authors for more details.

<sup>26</sup> A Crenshaw, "Study Cites Medical Bills for Many Bankruptcies," *Washington Post*, April 25, 2000: E1.

<sup>27</sup> Kaiser Commission on Medicaid and the Uninsured, "Access to Care for the Uninsured: An Update", Pub. Code. 4142, September 2003, <<http://www.kff.org/uninsured/4142.cfm>>.

<sup>28</sup> Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care," Pub. Code 1420-04, February 2003, <<http://www.kff.org/uninsured/142004-index.cfm>>.

<sup>29</sup> J Hadley, "Sicker and Poorer - The Consequences of Being Uninsured," *MCRR*, 2003, 60(2): 3-76.

<sup>30</sup> See endnote 28.

<sup>31</sup> See Children's Health Assessment Project, "Health Status Assessment Project-First Year Results," *DataInsights Report No. 10*, November 2002, <<http://www.mrmib.ca.gov/MRMIB/HFP/PedsQLYr2CHHS.pdf>>; P Damiano, J Willard, E Momany, "Hawk I: Impact on access and health status," First Evaluation Report, University of Iowa Public Policy Center, March 2001, <<http://ppc.uiowa.edu/hawk-i/impact.html>>.

<sup>32</sup> The sample size was chosen to present results with a 5% margin of error, at a 95% confidence level. Percentages presented in the findings section are based on the total number of people who answered each question. The number of respondents to each question may vary as some survey participants chose not to answer each question. Contact the authors for further methodology.

<sup>33</sup> Remaining statistics and figures in this section are calculated based on the 57% who stated that they were employed, referred to as workers.

<sup>34</sup> Washington State Health Care Authority, January 2004. See Basic Health Plan website for more detailed information on Basic Health: <<http://www.hca.wa.gov/basichealth/index.shtml>>.

<sup>35</sup> J Holahan and B Spillman, "Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance," Number B-42 in Series, "New Federalism: National Survey of America's Families," Urban Institute, January 2002.

<sup>36</sup> See endnote 20.

<sup>37</sup> Basic Health premiums vary depending on income. Analysis has not yet been conducted to determine how income affects what premium was listed as affordable. In addition to premiums, Basic Health members must also pay office copayments, deductibles and 20% coinsurance (capped at \$1500 per person). See Basic Health Plan website for more detailed information on cost sharing and the Basic Health: <<http://www.hca.wa.gov/basichealth/index.shtml>>.