

Health Impact Review

Proposed Cuts to Health Care and Human Services Programs

March 31, 2009

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I. Executive Summary

The State Board of Health, in collaboration with the Governor’s Interagency Council on Health Disparities, was asked to assess the potential impacts that proposed cuts to health and human services may have on health disparities. This report summarizes the evidence and finds that indeed, the proposed cuts would adversely affect the health of Washingtonians. Further, these cuts would not impact us all equally, but rather would disproportionately impact those who are already disadvantaged, including low-income families and children, communities of color, and women. Therefore, as the health of individuals directly affected by these cuts decreases, Washington would likely see an increase in health disparities by income, race/ethnicity, and gender. While the cuts would not impact all Washingtonians equally, they would likely affect us all as other areas of the state budget and local communities stretch to absorb the medical and societal impact.

Elimination of the GA-U Program: The Governor’s proposed budget would eliminate the General Assistance-Unemployable (GA-U) program, including both medical coverage and financial assistance grants to individuals. **The program’s elimination would result in increased health disparities by income and race/ethnicity.**

- ✓ More than 16,000 people with serious and complex behavioral and physical health problems would be left without health coverage and without the ability to pay for basic needs, such as housing and food.
- ✓ People without health coverage have less access to care, are less likely to receive regular care, receive poorer quality care, and have poorer health outcomes.
- ✓ Homelessness, poor neighborhood quality, inadequate nutrition, and food insecurity contribute to preventable illness and premature death.
- ✓ GA-U program recipients are some of our state’s most disadvantaged. They are extremely low-income and are more likely to be people of color, particularly African Americans and Native Americans.

Reduction of Funding for Basic Health Plan: The Governor's proposed budget would reduce funding for Basic Health Plan by 42%, likely resulting in decreased enrollment though attrition and increased consumer contributions, such as increased premiums, deductibles, and copayments. This decreased enrollment would in turn result in increased uninsurance among Washingtonians. **Reductions in Basic Health Plan Funding would likely result in increased health disparities by income, race/ethnicity, and gender.**

- ✓ There are approximately 76,000 people currently enrolled in the Basic Health Plan. Decreasing enrollment through attrition would result in thousands of Basic Health Plan-eligible individuals waiting to enroll and most likely, remaining uninsured during the interim. People without insurance have poorer health outcomes.
- ✓ Increases in premiums, deductibles, and copayments results in decreased use of preventive services, decreased use of essential medications, and decreased enrollment, all of which have negative consequences on health.
- ✓ Basic Health Plan enrollees are by definition low-income. While enrollment data by race/ethnicity is not available, there is some evidence that Basic Health Plan enrollees are more likely to be people of color, particularly Hispanic/Latino and African American.

Suspension of Funding for the Apple Health for Kids program: The Governor's proposed budget would suspend funding to provide subsidized health care coverage to children in families with incomes between 250 and 300% of the Federal Poverty Level (FPL). While the Governor has since directed the Department of Health and Human Services to proceed with expanding the program's coverage to 300% FPL, this review assessed the impacts of the proposed suspension. Suspension of program funding for children in families up to 300% FPL will result in a potential reduction in health disparities not being realized.

- ✓ An estimated 78,000 Washington children are uninsured. The suspension of coverage to 300% FPL could result in an estimated 8,600 children remaining uninsured by 2011.
- ✓ Uninsured children are particularly vulnerable, as the negative impacts on health can result in increased school absenteeism and reduced academic performance.
- ✓ There is some evidence that children of color would most likely be disproportionately represented in the Apple Health for Kids program at the 250-300% FPL.

Elimination of the Universal Vaccine Program: The Governor's budget proposes to eliminate the Universal Vaccine program with a phased-in implementation schedule. State funding would be discontinued for HPV vaccine starting July 1, 2009 and for all other vaccines by July 1, 2010. **The elimination of the Universal Vaccine program could potentially result in health disparities for low-income children and children of color.**

- ✓ Underinsured children would have to obtain vaccines through federally-qualified health centers, even if they do not use those centers for their medical home. This fragmentation of care may lead to lower immunization rates and other decreased health outcomes.
- ✓ VFC-eligible children may need to obtain vaccines through community health centers if their medical home provider opts out of the system due to increased administrative burdens and cost, again resulting in discontinuity in care and adverse health outcomes.

II. Introduction

The State Board of Health, in collaboration with the Governor's Interagency Council on Health Disparities, completed this health impact review in response to three separate but essentially identical requests received from Representative Dawn Morrell, Representative Sharon Tomiko Santos and Senator Rosa Franklin on March 20, 2009. The Board was asked to review proposed cuts in Governor Gregoire's budget related to health care and human services safety net programs. More specifically, this review assesses potential impacts on health disparities related to the following proposed cuts:

- Elimination of the General Assistance-Unemployable program, including both medical coverage and financial assistance grants.
- Reduction of funding for the Basic Health Plan by 42%.
- Suspension of funding to provide subsidized health care coverage for children in families with incomes between 250 and 300% of the federal poverty level through the Apple Health for Kids program.
- Elimination of the Universal Vaccine program. State funding would be discontinued for HPV vaccine starting July 1, 2009 and for all remaining vaccine starting July 1, 2010.

The term health disparities describes the disproportionate burden of disease, disability, death, and other adverse health conditions that exist among specific populations or groups. Health disparities based on race, income, gender, education, and sexual orientation are well documented (US Department of Health and Human Services 2000). Many factors interact to produce the health disparities experienced by people of color; biological/genetic factors do not fully explain these disparities in health.

A health impact review is a review of a legislative or budgetary proposal that analyzes the extent to which the proposal is likely to have a positive or negative impact on health disparities.

The purpose of this review is to assess whether proposed cuts to health care and social service programs would either increase or decrease health disparities in Washington State. While health disparities by race/ethnicity were the focus of this review, health disparities for low-income individuals, health disparities by gender, and health disparities for underinsured children were also considered throughout various sections of this report.

III. Methods

To conduct the review, Board staff relied on discussions with state agency staff and other stakeholders with related program expertise and a limited literature review. Internet search engines and searches of database, such as PubMed, were used to conduct the literature review.

A conceptual model was developed for each of the four program areas to focus the research for this review, see Figures 1-4. The left side of each model describes the policy and subsequent direct results. The models then indicate how the direct results may or may not lead to impacts on

health and health disparities. The model uses dashed arrows to indicate where research was conducted to identify whether evidence exists to support the model.

IV. Elimination of the General Assistance-Unemployable (GA-U) Program

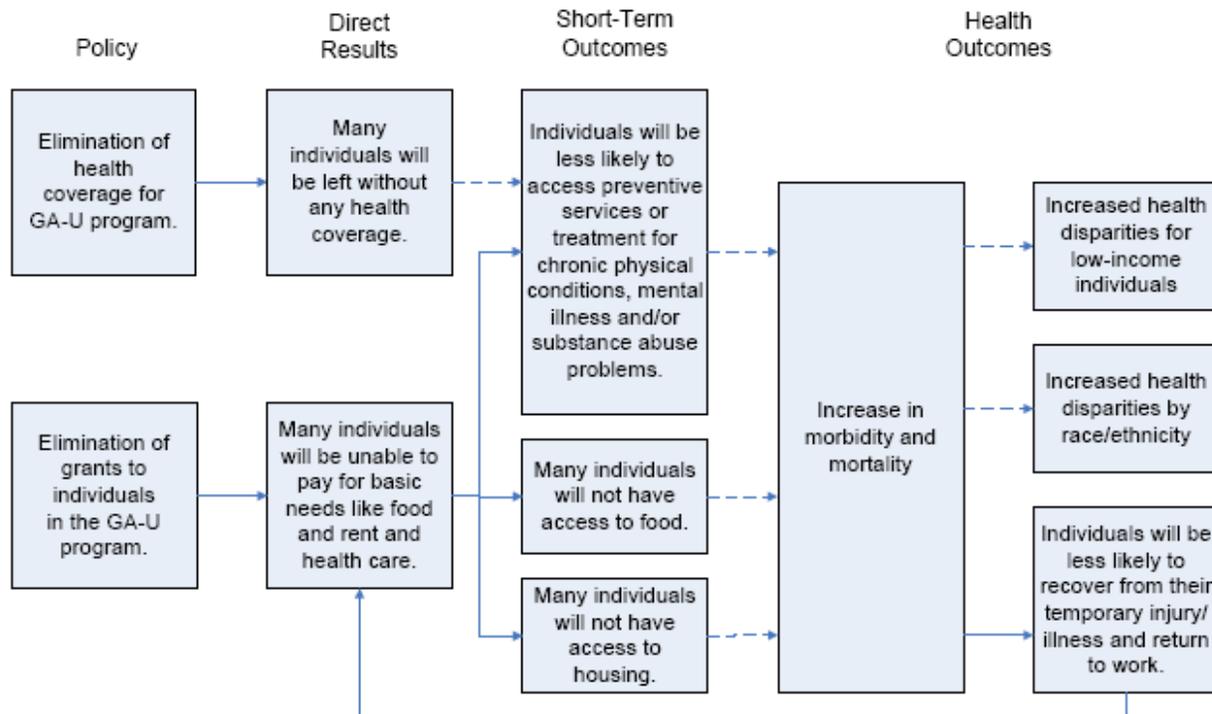
GA-U Program Overview

The GA-U program provides financial assistance and medical benefits to childless adults who are unable to work for at least 90 days due to a short term physical disability or mental illness.

The program provides a stipend of \$339 per month to help clients pay for basic needs, such as housing and food. In King and Pierce counties, GA-U clients receive health care through clinics contracted through the Community Health Plan of Washington under a managed care arrangement. GA-U clients in all other counties receive health care through the use of fee-for-service coverage from the Department of Social and Health Services. Currently, the GA-U program provides only limited mental health care services for patients enrolled in the Community Health Plan of Washington managed care pilot. Chemical dependency treatment is available for all clients through the Division of Alcohol and Substance Abuse treatment expansion funded in 2005.

GA-U clients often transition to the General Assistance-Expedited Medicaid (GA-X) program, which supports clients with pending applications for Supplemental Security Income (SSI). Some clients will be in the GA-U program for only a short time while others may be in the program for much longer. Other General Assistance programs include Aged (GA-A), Blind (GA-B), Disabled (GA-D), Institutionalized (GA-I), and Regular (GA-R). In 2008, GA-U clients accounted for 51.5% of all General Assistance cases (DSHS 2008). During 2008, the average monthly GA-U enrollment was 16,088 individuals. Client demographic data from June 2008 showed that almost 60% of clients were male and clients had a median age of 44 years.

Figure 1: Conceptual model describing how the elimination of the GA-U program could result in health disparities



Potential Impacts of Eliminating GA-U Medical Coverage on Health

The elimination of medical coverage for the GA-U program would leave more than 16,000 people with serious and complex health problems without health coverage.

There is ample evidence which demonstrates that people without health coverage have greater problems accessing health care because of cost, are less likely to have a regular doctor or a medical home, and are less likely to report that they receive the health care they need when they need it (Collins 2007, Ayanian 2000). Indeed, according to the Institute of Medicine (2003), the single greatest determinant for accessing health care is health insurance coverage.

Moreover, those without health coverage are more likely to receive poor quality care, have worse health outcomes, and have shorter life expectancies than patients with health insurance coverage (IOM 2003, Collins 2007, Ayanian 2000). In terms of quality of care, one study found that uninsured patients were less likely than insured patients to receive clinically indicated preventive services for cancer screening, cardiovascular risk reduction, and diabetes management than insured patients (Ayanian 2000). The authors of that study concluded that the provision of insurance would improve access to care and result in improved clinical benefits to uninsured adults, particularly to those with major health problems.

Comprehensive reviews of the literature have found that worse health outcomes, including premature death, were found for uninsured patients with asthma, cancer, diabetes, cardiovascular disease, kidney disease, and mental illness when compared to outcomes for insured patients

(IOM 2003; Hoffman 2008). One of the reviews also found that uninsured patients were more likely to have overall declines in health function, preventable hospitalizations, and severe disease at the time of diagnosis (Hoffman 2008). Further, one study which attempted to quantify the costs of uninsurance on individuals and society found that the greatest costs were attributable to the poorer health and shorter life expectancies of people without health coverage (Miller 2004).

Participants in the GA-U program, by definition, have a serious behavioral health and/or physical health condition. A review of GA-U clients found that 71% had at least one chronic physical condition, 66% had a mental illness, and 38% had a substance abuse problem, with 26% having all three (Mancuso 2009a). GA-U clients have an average of 2.6 chronic physical conditions. Common behavioral health conditions include depression, anxiety, and bipolar disorder (Mancuso 2009a, Ribas 2009). Common physical conditions include musculoskeletal disorders, cardiovascular disease, gastrointestinal disease, central nervous system disorders, respiratory disease, and diabetes (Mancuso 2009a).

Due to the complex and serious health problems that GA-U clients have, the above review of the literature suggests that providing health coverage, including coverage for mental health and substance abuse treatment, is likely to improve access to care and improve health outcomes. Indeed, recent GA-U program evaluation data suggests that program improvements to increase access to a medical home and to mental health and substance abuse treatment services resulted in improved health outcomes, improvements in public safety, and medical cost savings (Wickizer 2009a, Wickizer 2009b, Mancuso 2009b, Schultz 2009). Conversely, the elimination of health coverage for these individuals is likely to lead to increased illness and death.

Potential Impacts of Eliminating GA-U Grants to Individuals on Health

The GA-U grant program currently provides \$339 per month to individuals with less than \$1,000 in assets who are temporarily unemployable. The elimination of the GA-U grants will likely leave more than 16,000 people unable to pay for basic needs, such as food and housing.

Both homelessness and the quality of neighborhoods and housing have impacts on health. Homeless people have far greater mortality and disease severity than the general population and even very-low income people. Factors that directly contribute to poor health among the homeless include overcrowded living conditions in shelters, exposure to extreme cold and weather, the stress of day-to-day survival, and increased rates of crime victimization and assault (Gelberg 2006). Too, neighborhood and housing quality effects health through environmental exposure to toxins and other physical hazards, through influences on health behaviors, and through psychosocial factors, such as social support or perceptions of safety and security (Stafford 2006).

According to the Washington State Department of Health in the *Health of Washington State, 2007*, both inadequate nutrition and food insecurity contribute substantially to preventable illness and premature death (Department of Health 2007). Food insecurity is defined as not having enough food for all household members due to inadequate resources. Individuals who are food insecure tend to eat smaller portions, skip meals, or eat less nutritious foods. Food insecurity can result in adverse health outcomes such as malnutrition, poor overall health status, increased risk of chronic disease, inability to properly manage chronic diseases like diabetes, and mental health problems such as depression. Individuals with low incomes are more likely to be food insecure,

as are individuals who have experienced stresses, such as job loss, or loss of Basic Food program benefits (Department of Health 2007). In addition, inadequate nutrition may result in health consequences, as evidence suggests that fruit and vegetable intake might prevent certain cancers and reduce the risk of cardiovascular disease and other health conditions (Department of Health 2007, Robertson 2006).

Potential Impacts of Eliminating the GA-U Program on Health Disparities

The above section demonstrates that the elimination of the GA-U program will result in reduced health for the population accessing GA-U services. This reduced health will occur directly via the elimination of medical coverage (including coverage for mental health/substance abuse treatment), resulting in decreased access to care for physical and behavioral health concerns among a population that by definition has high needs in these areas. Reduced health will also occur indirectly via the elimination of individual grants, resulting in increased insecurity in meeting basic needs such as housing and food.

Health Disparities for Low-Income Individuals

In Washington State, 29% of the total population is classified as low-income (i.e., at less than 200% federal poverty level (FPL)), with 13% being at or below 100% FPL. This equates to 837,790 people at 100% FPL and more than 1.8 million at 200% FPL (statehealthfacts.org).

By definition, GA-U clients have extremely low incomes. In order to qualify for the program, individuals must not have assets exceeding \$1,000. Because this population has such low-incomes, the elimination of the GA-U program will have the effect of increasing health disparities for those at the lowest income levels. However, because the total population served by the GA-U program is relatively small (approximately 16,000 people compared to 837,790 at 100% FPL), the overall impact on health disparities will also be relatively small. Some would argue, however, that health disparities suffered by the most disadvantaged in our society, such as GA-U clients, are the most inequitable (Braveman 2006).

Health Disparities by Race/Ethnicity

It appears as though African Americans and Native Americans are over-represented among GA-U clients. While African Americans make up only 3.4% of the total Washington population, they make up 11.3% of the GA-U population (see Table 1). Similarly, while Native Americans represent 1.4% of the total state population, they represent 4.2% of the population enrolled in GA-U. Because the elimination of the GA-U program will have a negative impact on the health of GA-U clients, it appears as though its elimination will have the effect of increasing health disparities for African Americans and Native Americans.

African American and Native American populations in Washington State already experience disparities in the conditions most common among GA-U enrollees, including chronic physical and behavioral health conditions, such as cardiovascular disease and diabetes. It appears as though elimination of the GA-U program will exacerbate these disparities that already exist in Washington State among African American and Native American populations. Because the

number of African Americans and Native Americans enrolled in the GA-U program is relatively small, however, the overall impact on health disparities among these groups will also be small.

Table 1: Distribution of GA-U Participants and Washington Total Population by Race/Ethnicity

Race/Ethnicity	% in GA-U Program	% in Washington
White	66.7%	76.2%
Hispanic	6.1%	9.3%
African American	11.3%	3.4%
Asian or Pacific Islander	3.2%	6.9%
Native American	4.2%	1.4%
Two or More Races	N/A	2.8%
Unknown	8.4%	N/A

Sources: (1) Department of Social and Health Services 2008 (2) Office of Financial Management 2008

V. Reduction of Funding for the Basic Health Plan

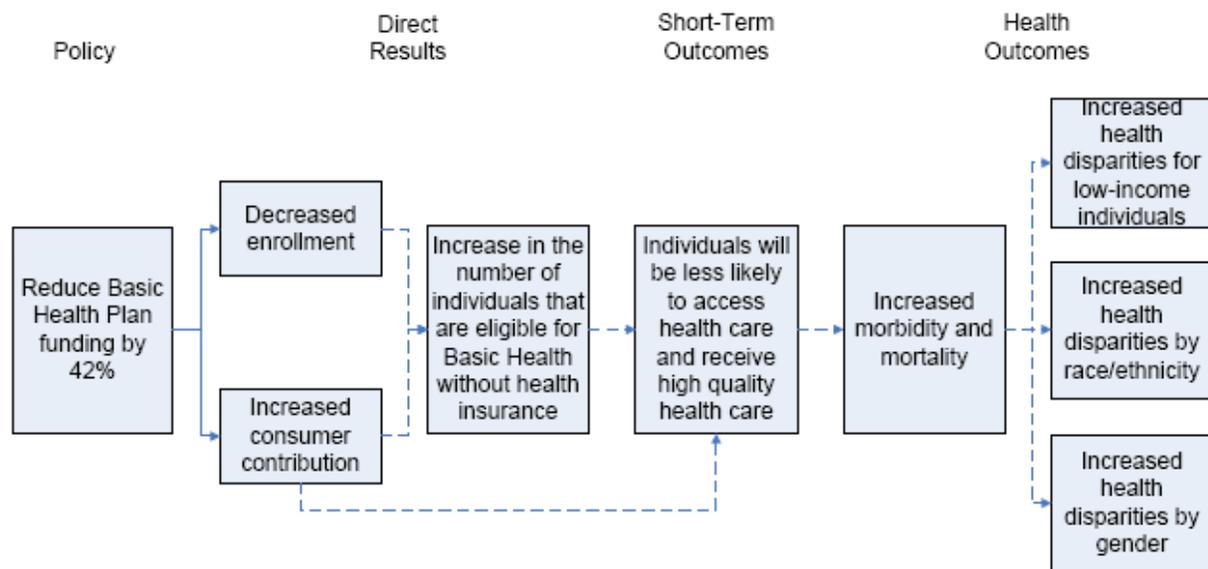
Basic Health Plan Overview

Established in 1987, Washington's Basic Health plan is a state-sponsored program providing low-cost health care coverage to Washington State residents through managed care contracts through private health plans. The plan serves low-income individuals and families who are not eligible for federal health coverage, such as Medicaid, yet are unable to access coverage through their employers or afford private insurance. Eligibility criteria include a gross family income at or below 200% FPL.

The Health Care Authority currently contracts with five private health plans to provide health care coverage under the Basic Health Plan. All health plans that participate in the Basic Health Plan offer the same base benefits, but monthly premiums, providers, and some details of coverage vary, such as whether the plan offers any additional preventive services. The Health Care Authority pays negotiated premiums directly to the health plans participating in the Basic Health Plan, with enrollees reimbursing the Health Care Authority for a portion of the premium. The amount that enrollees pay is determined on a sliding scale based on their age, family size, gross family income, county of residence, and the particular health plan that they choose.

Governor Gregoire's proposed budget is calling for a 42.7% reduction in funding for the Basic Health Plan. Health Care Authority staff indicate that the agency is considering a number of budget scenarios, with the greatest likelihood involving enrollment attrition and cost sharing (personal communication on March 24, 2009).

Figure 2: Conceptual model describing how reductions in the Basic Health Plan funding could result in health disparities



Potential Impacts of Decreased Basic Health Plan Enrollment on Health

Decreasing enrollment through attrition will likely increase the total number of uninsured in Washington. This will increase the number of Washington residents eligible for the Basic Health Plan waiting to enroll. In 2006, fifty-five percent of enrollees were uninsured prior to entering the Basic Health Plan, suggesting that a significant number of these individuals will remain uninsured (Joint Legislative Audit and Review Committee 2006).

Because of Washington’s broad Medicaid eligibility for low-income children, the majority of Basic Health Plan enrollees are adults. There is substantial evidence in the scientific literature which demonstrates that adults without health insurance coverage experience on average poorer health outcomes than those with coverage. More specifically, uninsured adults have more problems accessing care, are less likely to receive regular medical care, receive poorer quality care, and are more likely to have worse health outcomes and premature death. As noted in the above section on the potential impacts of eliminating GA-U, those without health coverage are more likely to have worse health outcomes and shorter life expectancies than those with health insurance coverage (IOM 2003, Collins 2007, Ayanian 2000). Poorer health outcomes have been found for uninsured patients with chronic conditions such as asthma, cancer, diabetes, cardiovascular disease, kidney disease, and mental illness when compared to outcomes for insured patients (IOM 2003; Hoffman 2008). Therefore, Basic Health Plan-eligible individuals who remain uninsured may experience declines in their health while they wait to enroll.

In 2008, there were 726,000 uninsured people in Washington State (Gardner 2008a). Currently there are 76,001 individuals enrolled in the Basic Health Plan (personal communication on March 24, 2009). While staff from the Health Care Authority was unable to estimate how many Basic Health Plan slots may be lost through attrition, they did indicate that their charge is to

cover as many eligible individuals as possible within the appropriated funding. If 10% of the Basic Health Plan slots were lost through attrition, 7,600 Basic Health Plan-eligible individuals would be likely left uninsured. The number of uninsured could go up to 15,200 or to 22,800 if 20% or 30% of the slots are lost through attrition, respectively.

Potential Impacts of Increased Consumer Contributions on Health

Two streams of consumer contributions are typically used as cost-containment strategies within the health insurance industry: premiums and cost sharing.

Several studies document the negative impact of increased premiums on people participating in public health insurance programs. For example in a two-state study, Kenny (2007) found that nominal \$10-\$20 increases in premiums reduced enrollment in state children's health insurance programs by 18% and 5% in Kentucky and Arizona, respectively. Moreover, their research found that elevated premiums resulted in increased enrollment in those states' non-premium-paying categories of their children's health insurance programs. This finding suggested a spillover effect causing recipients to switch from one public insurance program to another. The authors conclude that "imposing nominal premiums may reduce state spending, but projected savings appear to be small relative to total state SCHIP spending and resulting increases in enrollment in other public programs."

A case study of the Oregon Health Plan, a program similar to Washington's Basic Health Plan, found that increases in both premiums and cost sharing significantly curtailed new enrollment, as well as increased disenrollment among current Oregon Health Plan members (Wright 2005). Higher premiums and cost sharing were found to be particularly influential among the most economically vulnerable members who left the plan. Among those leaving the plan, the unemployed, and those with extremely low incomes were far more likely to have done so for reasons related to increased premiums and cost-sharing than their counterparts. While the study did not quantify the impact of each consumer contribution strategy, authors state that both had an effect.

Prior research of Washington's Basic Health Plan demonstrated that plan enrollment decisions were highly sensitive to fluctuations in premium costs. As premiums increased, enrollment dropped and vice versa (Watts 2002, Long 2002). Staff from the Health Care Authority is judiciously reviewing premium changes with this in mind (personal communication March 2009).

Methods for containing costs using cost sharing include raising deductibles, copayments, and out-of-pocket maximums. A recent comprehensive review of the literature, which looked at the impacts of increases in cost sharing on health care utilization, found that overall, the current research was inconclusive (Remler 2009). However, a few notable exceptions were mentioned, including a decrease in the use of preventive services and a reduced use of essential medications among the chronically ill with increased cost sharing. Clearly, both scenarios could negatively impact health outcomes.

These exceptions were reflected in a low-income public insurance population as well. In a study of the Oregon Health Plan, Wallace (2008) reported decreases in pharmacy, ambulatory and

emergency department utilization, and increases in inpatient and hospital outpatient use following the introduction of copayments. The authors' overall observation, however, was that cost sharing shifted treatment patterns but did not provide expected savings.

In 2004, Basic Health Plan enrollees in Group Health Cooperative experienced a 100% increase in out-of-pocket costs over a two year period. A study that examined the effects of increased cost sharing found that enrollees had somewhat fewer visits after cost sharing increases without affecting total costs, disenrollment, or select quality of care indicators (Von Korff 2008).

While there is conflicting evidence in the research literature, there is some evidence to support that increasing consumer contributions can lead to decreases in enrollment and decreased use of health care services. To the extent that disenrollment and decreased use of health care services do occur, increases in cost sharing can result in decreased health outcomes for Basic Health Plan enrollees.

Potential Impacts of Decreasing Enrollment on Health Disparities

The above section demonstrates that proposed cuts in the Basic Health Plan will result in increased uninsurance among the population accessing the Basic Health Plan, primarily adults. This increase in uninsurance will likely result in decreased health status among those who remain uninsured via reduced access to acute, preventive, and chronic care.

Health Disparities for Low-Income Individuals

Basic Health Plan enrollees have incomes below 200% FPL, with 54% having incomes at or below 100% FP (Joint Legislative Audit and Review Committee 2006). Therefore, the potential health impacts that result from enrollment attrition and increased consumer contributions will be experienced by low-income families. To the extent that these impacts result in decreases in health, an increase in health disparities for low-income individuals will occur.

Health Disparities by Race/Ethnicity

The Health Care Authority does not require mandatory reporting of race/ethnicity by enrollees, and as a result, approximately 70% opt not to report (personal communication on March 24, 2009). Therefore, data on the distribution of Basic Health Plan enrollees by race/ethnicity is not available. Nonetheless, there is some data and information that suggests that Basic Health Plan enrollees are more likely to be people of color.

A majority of Basic Health Plan enrollees (60%) choose the Community Health Plan of Washington to provide their health care coverage (Joint Legislative Audit and Review Committee 2006). While only 7% of patients seen in the community health center network have public insurance through the Basic Health Plan (the majority are enrolled in Medicaid or are uninsured), the distribution of community health center patients by race/ethnicity can provide some information about the possible racial/ethnic distribution of Basic Health Plan enrollees. People of color, particularly those that are Hispanic/Latino are disproportionately represented among community health center patients (Community Health Network of Washington 2007). While Hispanics make up only 9.3% of the total state population, they represent 36% of

community health center patients. Similarly, African Americans represent only 3.4% of the state's population, but 6% of those served in community health centers.

In addition, income eligibility requirements for the Basic Health Plan assure that all Basic Health Plan enrollees are classified as low-income (at or below 200% FPL) and low-income populations are more likely to be populations of color. In Washington State, an estimated 33% of Hispanic, 24% of African Americans, and 22% of American Indian and Alaska Native adults lived in households with annual incomes less than \$20,000, compared to 14% of Asian and Pacific Islander and 12% of White adults (Grinstein-Weiss 2005). Similarly, Hispanics, American Indians and Alaska Natives, and African Americans in Washington State are more likely to live in poverty (i.e., have household incomes below the FPL) than Asians and Pacific Islanders and Whites (Grinstein-Weiss 2005). National literature indicates that the disparities in wealth (a variable that measures the accumulation of past savings) between African American households and White households is greater than the disparity in income (Washington State Department of Health 2007). Therefore, to the extent that the reductions in the Basic Health Plan can result in increased health disparities for low-income individuals, a similar increase in health disparities by race/ethnicity is possible.

Health Disparities by Gender

The proposed budget reduction to the Basic Health Plan may also result in increased health disparities by gender. Sixty percent of Basic Health Plan adult enrollees are female. (Joint Legislative Audit and Review Committee 2006). Therefore, the potential health impacts that result from enrollment attrition and increased consumer contributions will be experienced disproportionately by women. Moreover, there is evidence that women are more likely to report cost-related problems accessing health care services, due in part to lower average incomes compared with men and to women's greater need for and use of health care services (Patchais 2007). Thus, increases in consumer contributions will likely result in worse health outcomes for women enrollees in the Basic Health Plan than for men, leading to increases in health disparities by gender.

VI. Apple Health for Kids Funding Suspension

Apple Health for Kids Program Overview

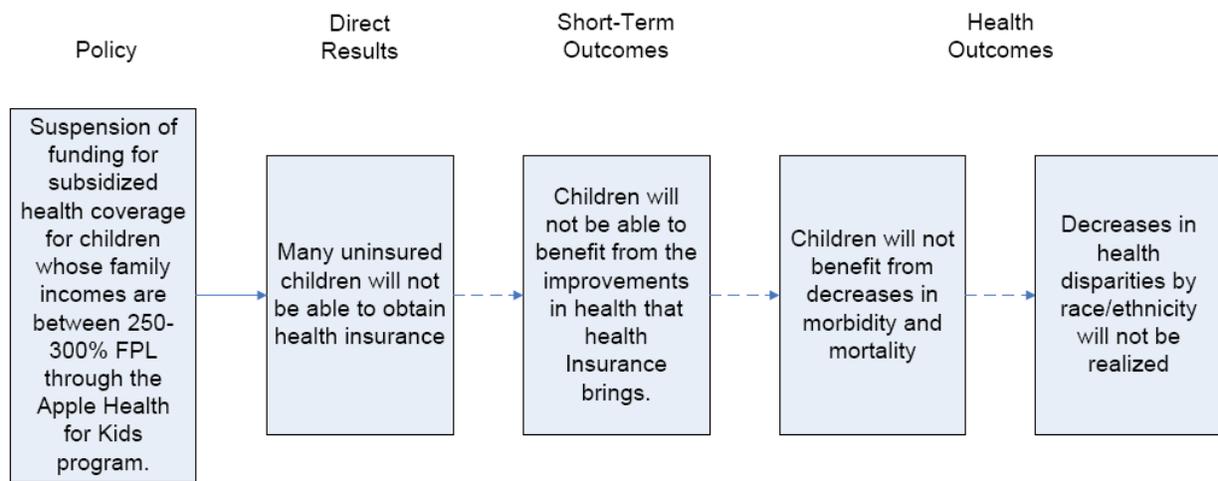
In March 2007, the Washington State Legislature passed and Governor Gregoire signed into law the Child Health Care Act, which provides comprehensive health insurance coverage options for all children in Washington. All funding sources for children's health insurance programs were combined under a single program called Apple Health for Kids, and outreach and enrollment efforts were greatly enhanced. Coverage is free for children in families below 200% FPL. Low-cost, state-subsidized coverage is available to children in families up to 300% FPL.

Governor Gregoire's proposed budget calls for the suspension of funding to provide subsidized health coverage to children in families with incomes between 250-300% FPL. On February 4, 2009, President Obama signed the Children's Health Insurance Program (CHIP) Reauthorization Act and rescinded a restriction on CHIP eligibility to children in families with incomes less than 250% FPL. Following that critical change, Governor Gregoire directed the Department of Social

and Health Services (DSHS) to proceed with expanding Apple Health for Kids coverage to 300% FPL.

In an effort to be responsive to the Board’s health impact review request, this section of the review will continue to assess the potential impacts on health disparities that would result if funding to provide coverage to children in families between 250-300% FPL was again suspended.

Figure 3: Conceptual model describing how a suspension in funding for Apple Health for Kids could result in health disparities



Potential Impacts of an Apple Health for Kids Funding Suspension on Health

As demonstrated earlier in this review, uninsured individuals have worse health outcomes, including premature death – see above section on the potential impacts of eliminating GA-U medical coverage on health for a brief review of this literature.

Children are particularly vulnerable, since a lack of regular medical care and its subsequent impact on health can result in increased school absenteeism and reduced academic performance. Just as health impacts education, education, in turn, is a key social determinant of health; therefore, it is critical for all children to have the opportunity to learn and succeed in school.

In 2008, an estimated 78,000 Washington children were uninsured (Gardner 2008a). Efforts to provide health insurance coverage for these children are critical to ensure their health and academic achievement. Staff from DSHS estimate that with the expansion of Apple Health for Kids to 300% FPL, the program would be able to enroll an additional 2,000 children by June 2009, an additional 3,100 children by June 2010, and an additional 3,500 children by June 2011 (personal communication on March 25, 2009). Since January 1, 2009, 817 children, or 9.5% of the estimated potential enrollment, in this income level have already been enrolled (personal communication on March 26, 2009). This appears to indicate that the program expansion is filling a gap in services and helping to cover children who otherwise may remain without health insurance.

Potential Impacts of an Apple Health for Kids Funding Suspension on Health Disparities

If funding to provide coverage to children in families between 250-300% FPL is suspended, the thousands of children that DSHS estimated would enroll in the program, would no longer have that option. It is likely that many of those children are currently not insured and would remain uninsured. Thus, the health improvements that would result from expanding health insurance coverage to these children would not be realized.

Health Disparities by Race/Ethnicity

In August 2008, 13,058 children were enrolled in the State Children's Health Insurance Program (SCHIP), the subprogram of Apple Health for Kids for children in families with incomes between 200-250% FPL. While this number is relatively small, representing less than 1% of all Washington children, it appears as though children of color were disproportionately enrolled. White children make up 68% of the total child population in the state, but only 52% of the SCHIP enrollment (Department of Social and Health Services 2008).

Data from the Office of Financial Management provides additional evidence that people of color are disproportionately enrolled in public insurance programs. The proportions from each racial/ethnic group that are enrolled in public insurance are 35% for Hispanics, 33% for American Indians/Alaska Natives, 24% for African Americans, 16% for White and 13% each for Asians and Pacific Islanders (Gardner 2008b). African Americans, American Indians/Alaska Natives, and Hispanics were significantly more likely to be enrolled in public insurance than Whites, with Hispanics being two and half times more likely to be publicly insured.

Furthermore, the proportions of each racial/ethnic group that are uninsured are 21% for Hispanics, 23% for American Indians/Alaska Natives, 14% for Pacific Islanders, 12% for Whites, 10% for African Americans and 9% for Asians (Gardner 2008b). Hispanics and American Indian/Alaska Natives were significantly more likely than Whites to be uninsured.

Data on the racial/ethnic distribution of the 817 children that have already enrolled in Apple Health for Kids at the 250-300% FPL were not available at the time of this review. Further, staff from DSHS indicated that the racial/ethnic distribution of the 8,600 children they estimated would enroll in the program from the 250-300% FPL by June 2011 was also not available.

However, because people of color are more likely to be enrolled in public health insurance (Hispanics, American Indians/Alaska Natives, and African Americans) and are more likely to be currently uninsured (Hispanics and American Indian/Alaska Natives), we can safely assume that children of color will be disproportionately represented in the Apple Health for Kids program at the 250-300% FPL. Therefore, the program expansion could have the effect of reducing health disparities for children in these racial/ethnic groups. Conversely, if the program were to be suspended, this potential reduction in health disparities will not be realized.

VII. Elimination of the Universal Vaccine Program

Universal Vaccine Program Overview

Since 1990, Washington State has maintained a Universal Vaccine program, providing vaccines to all Washington children free of charge, regardless of income or health insurance status. The federal Vaccines for Children (VFC) entitlement program began in 1994. Through Washington's Universal Vaccine program, whatever vaccines are provided to VFC-eligible children are also provided to non-VFC eligible children. No child can be denied state-supplied vaccine because of their inability to pay an administration or office visit fee and no child can be charged for state-supplied vaccine.

The Governor's budget proposes to eliminate the Universal Vaccine program with a phased-in implementation schedule. State funding would be discontinued for HPV vaccine starting July 1, 2009 and for all other vaccines by July 1, 2010. With the elimination of the Universal Vaccine program, the federal VFC program will continue, covering the cost of vaccine for an estimated 55% of Washington children. VFC-eligible children include uninsured children, Native American and Alaska Native children, children who are enrolled in Medicaid or are Medicaid-eligible, and underinsured children who receive their vaccines from a federally qualified health center or rural health center (Centers for Disease Control 2009). Although there is no formal income eligibility requirement for federal VFC, the vast majority of children who benefit from the program are low-income.

The VFC program does not cover children in Washington state-sponsored health insurance programs (outside of Medicaid), including the State Child Health Insurance Program, Children's Health Program (for children ineligible for federal programs due to citizenship status), and the Basic Health Plan. Further, the VFC program does not cover children who are privately insured or insured through the state employee health insurance plan. These children are currently eligible for free immunizations through the Universal Vaccine program.

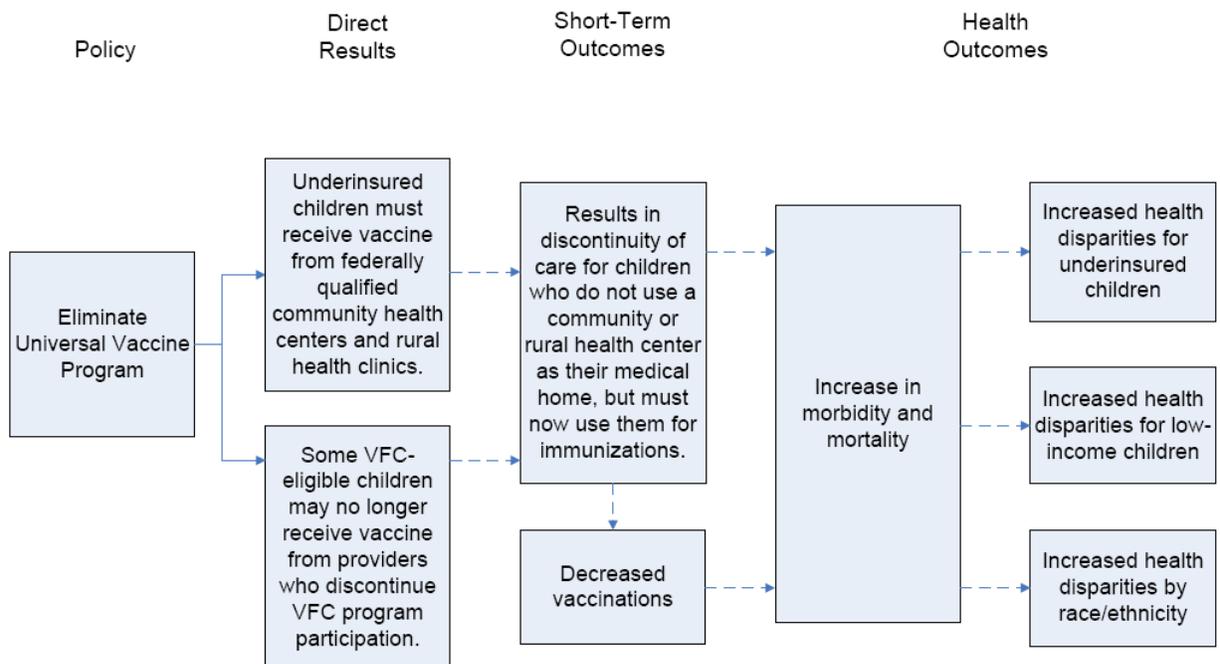
Despite a Universal Vaccine program, Washington lags behind many states in childhood immunization. Washington's ranking varies by report and year, yet all indicate that childhood immunization is an area where the state can improve. For instance, according to the United Health Foundation's 2008 *America's Health Rankings*, Washington ranked 48th nationally for childhood immunization,¹ with a rate of 73.9%, down from 78.6% in 2007. The national average was 80.1% in 2008. The Healthy People 2010 goal is to have 90% of children fully vaccinated (U.S. Department Health and Human Services 2009).

Higher rates of childhood vaccination in a community or population protect not only the individual children who receive the vaccine but the community within which that child lives. Public health experts estimate that herd immunity, defined as the ability to stop the spread of

¹ Ranking based on 5 vaccine series. The federal government standard to measure performance is the 6 vaccine series known as 4:3:1:3:3:1, which includes diphtheria/tetanus/pertussis (DTaP), polio, measles/mumps/rubella (MMR), Haemophilus influenza B (Hib), Hepatitis B, Varicella (chickenpox) vaccines for 19-35 month olds.

disease based on a proportion of subjects with immunity in a given population, becomes operational when a community or population experiences approximately 75%-85% coverage for a given vaccine. To the extent that Washington's Universal Vaccine program supports herd immunity, that program is protecting the health of entire communities.

Figure 4: Conceptual model describing how the elimination of the Universal Vaccine program could result in health disparities



Potential Impacts of Eliminating the Universal Vaccine Program on Health

Immunizations protect children from infectious diseases such as polio, measles, diphtheria, mumps, pertussis (whooping cough), rubella (German measles), tetanus, Haemophilus influenzae type b (a cause of spinal meningitis in children), varicella (chicken pox), and hepatitis B. The risk of illness when unvaccinated is not limited to the individual child, but can spread to others. From 1989-91, a measles epidemic resulted in more than 55,000 cases, 11,000 hospitalizations, and more than 120 deaths. Over half of the deaths were among children under 5 years of age (U.S. Department of Health and Human Services 2000). The Centers for Disease Control and Prevention listed vaccines as one of the top ten public health achievements of the 20th century (Centers for Disease Control 1999). More recently, childhood immunization has been ranked at the top of clinical preventive services in terms of health impact and cost-effectiveness (Maciosek 2006).

Universal purchase is one strategy states use to maximize childhood immunizations. Research is mixed, however, on this strategy's effectiveness. For example, a study of North Carolina's universal program reported increased immunization rates following implementation, with changes varying according to insurance status (Freed 1999). Most impacted were children who were on Medicare, children who experienced periods of being uninsured, and privately insured

children with no well-child coverage. Other studies found no impact on immunization rates with universal purchase (Kauf 1998, Olshen 2007).

Moreover, a case study of programs found that the states with the highest immunization rates did not all use universal vaccine purchase (Harrington 2007). Other factors beyond state vaccine financing policy may contribute to success including provider incentives and education, adequate Medicaid reimbursement, public health campaigns, and immunization registries. The case study concluded that "...high immunization rates are not associated with one particular program, one specific practice, or one financial arrangement – rather, successful immunization programs employ various approaches simultaneously to increase immunization rates."

Potential Impacts of Eliminating the Universal Vaccine Program on Health Disparities

Health Disparities for Underinsured Children

If the universal vaccine program is discontinued, underinsured children (i.e., those with health insurance that either provides partial vaccine coverage or no coverage at all) would be required to receive VFC-financed immunizations from a federally qualified health center or rural health center. National data indicates that an estimated 14% of children were underinsured for vaccines in 2000 (Lee 2007). For those children previously receiving vaccines from a private provider as a part of their comprehensive care, switching to a community or rural health center for vaccines only may disrupt care.

Continuity of care provided through a medical home has been shown to enhance immunization rates (Smith 2005, Irigoyen 2004). One study found that among VFC-eligible children, children who had a medical home were significantly more likely to be up-to-date on their immunizations, compared with children who did not have a medical home, 72.3% compared to 63.5%, respectively (Smith 2005). The authors conclude that removing barriers to the adoption and consistent use of a medical home may result in increased vaccination coverage (Smith 2005). Moreover, continuity of care has also been shown to support other preventive and medical services (Starfield 2004, Swingle 2008). Care may be further disrupted if health department immunization programs and community health centers experience difficulty absorbing the influx of underinsured children, due to their own budget constraints and capacity limitations. Finally, community and rural health centers are not available in some areas, creating barriers for underinsured children living in those areas (Lee 2007). Therefore, the elimination of the Universal Vaccine program could result in increased health disparities for underinsured children through the potential disruption in care for these children.

It should be noted that the Department of Health is working with the Centers for Disease Control and Prevention on modifying VFC policies in an effort to delegate the community health centers' authority to provide vaccines to underinsured and uninsured populations to additional health care providers.

Health Disparities for Low-Income Children

Elimination of the Universal Vaccine program could similarly affect VFC-eligible recipients who are established with private health care providers if these providers choose to discontinue VFC program participation. Currently, the Universal Vaccine program enables providers to obtain their total childhood vaccine supply through state purchase. Elimination of the Universal Vaccine program would require the provider to manage separate vaccine stocks—a state purchase stock for VFC-eligible recipients and a private purchase stock for non-VFC eligible children. Some providers might opt out of the public payer venue, leaving a smaller pool of private providers participating in the VFC program. Department of Health staff in the immunization program indicated that health care providers, specifically the Washington Chapter of the American Academy of Pediatrics and the Washington Academy of Family Practitioners, have expressed concerns over the administrative burden and costs associated with redesigning information technology and billing systems to accommodate billing for vaccines to various insurers. These provider groups have suggested that some practices may choose to no longer provide immunization services to all groups of children (personal communication on March 23, 2009). In this case, some VFC-eligible children would need to receive their vaccines elsewhere, and like the underinsured, experience disruption in continuity of care.

If VFC-eligible children are disproportionately more likely to be low-income, then the elimination of the Universal Vaccine program could result in health disparities for low-income children due to disruptions in continuity of care, as described above. VFC-eligible children include Medicaid eligible children, uninsured children, Native American/Alaska Native children, and underinsured children receiving VFC vaccine from a community or rural health clinic. While little is known about the income distribution of underinsured children, there is evidence that children who are Medicaid-eligible, uninsured, and Native American/Alaska Native are disproportionately more likely to be low-income. Medicaid-eligible children are by definition low-income, since family income must be at or below 200% of the FPL. Uninsured children are disproportionately low-income as well, with 71% of Washington's uninsured population living at or below the FPL in 2008. (Gardner 2008). And finally, 22% of American Indian and Alaska Native adults in Washington lived in households with annual incomes less than \$20,000, compared to 12% of White adults (Grinstein-Weiss 2005). Therefore, it is possible that the elimination of the Universal Vaccine program may result in increased health disparities for low-income children through the potential disruption in continuity of care.

It is unclear how the elimination of the Universal Vaccine program will affect children enrolled in state sponsored health care programs. While the State Children's Health Insurance program, the Children's Health program, and the Basic Health Plan currently provide immunization benefits, it is not known whether the state will continue to finance such benefits in the absence of Universal Vaccine.

Health Disparities by Race/Ethnicity

As described above, health disparities for low-income children may increase due to the potential for disruptions in continuity of care faced by VFC-eligible children. Previous sections of this health impact review have demonstrated that low-income children, Medicaid-eligible children, and uninsured children are more likely to be children of color. Therefore, to the extent that the

elimination of Universal Vaccine program can result in increased health disparities for low-income children, a similar increase in health disparities by race/ethnicity is possible.

VIII. Policy Considerations

Certain Investments in GA-U could improve outcomes and save costs

A recent analysis of the GA-U program by the Washington Budget & Policy Center suggests that three investments in the GA-U program could result in improved outcomes for enrollees, result in societal benefits and save costs (Schultz 2009). First, the report documents evidence that providing a medical home for GA-U recipients, such as clients in King and Pierce counties receive through the GA-U pilot program, will result in increased access to care and reductions in pharmaceutical and emergency room spending. Second, there is evidence that expanding coverage for mental health and substance abuse treatment can result in long-term cost savings, reduced criminal activity, and improved employment outcomes. Lastly, ensuring that GA-U recipients who are eligible for federal SSI or Veterans Administration benefits are identified and referred can result in cost savings.

State-sponsored health insurance programs will need to explore how to finance vaccines

Assuming that the Universal Vaccine program is eliminated, the Department of Social and Health Services and the Health Care Authority will need to explore options for financing vaccines for children enrolled in the State Children's Health Insurance Program (SCHIP), the Children's Health Program, and the Basic Health Plan. Currently, these children are considered insured, and therefore, not eligible for VFC vaccine.

Currently, Washington's SCHIP program is considered a "separate-SCHIP program." In order to provide VFC vaccine to these children, the state would either have to become designated as a "Medicaid-expansion SCHIP" program or it would have to define these children as "state vaccine eligible" and purchase vaccine at the federal contract price for these children.

Enhanced funding for community health centers will not completely make up for poorer health resulting from reduced health insurance coverage rates

The Governor's budget proposes to add \$40 million to support community health centers and \$10 million has just been awarded through the American Recovery and Reinvestment Act to help community health centers meet increased demands. Community health centers serve as the state's primary health care safety net, serving patients regardless of insurance status or ability to pay. Moreover, community health centers provide care that is tailored to the needs of underserved communities. While providing greater support for community health centers in a time of expected decreases in health coverage among low-income Washingtonians, such as those who are no longer able to receive health care through the GA-U program or through the Basic Health Plan, is likely to provide some level of continued access to care, greater health status gains could be made by maintaining and increasing health coverage rates.

Community health centers fill an important gap in health care for the uninsured; however, there is evidence that insurance coverage is a key determinant of accessing quality health care, even within community health centers (Shi 2008). More specifically, one study that compared the experiences of Medicaid patients and uninsured patients treated in community health centers found that those with Medicaid were more likely to report visits with a primary care provider and specialists and were more likely to report having preventive health screenings, such as a Papanicolaou test, breast examination, and mammogram, than uninsured patients. Further Medicaid patients were more likely to have had counseling for smoking and alcohol use than uninsured patients. The authors concluded that community health centers (CHCs) “should not be thought of as a single solution for the problem of ensuring healthcare services for the uninsured, since uninsured patients of CHCs in this study appear not to experience the same level of primary care as those covered by Medicaid. As a result, the elimination of disparities in primary care, and ultimately health, will not be achieved without attention to the availability of insurance coverage and the broader array of and interactions among risk factors experienced by vulnerable populations.”

Community health centers may struggle to meet increasing demand

While determining whether the proposed \$40 million for community health centers is sufficient is beyond the scope of this review, there are several issues regarding capacity in community health centers that should be highlighted. Many community health centers are already at capacity and the additional funding may not be enough to support the infrastructure that is needed to care for the rising number of uninsured. The number of uninsured in Washington is growing, not just from those who may lose coverage through the GA-U program or the Basic Health Plan, but also those individuals who are losing employer-sponsored coverage as a result of job loss. Moreover, this review points out that more children may use community health centers for immunizations if the Universal Vaccine program is eliminated. As demand for care in community health centers continues to rise, existing patients will also likely feel the effects through longer wait times and reduced services.

IX. Conclusion

Proposed cuts to health and human services in the Governor’s budget would adversely affect the health of Washingtonians if implemented. The cuts would lead to poorer health outcomes by increasing the number of uninsured, by limiting access to health care, by disrupting continuity of care, by decreasing access to high-quality health care, and by eliminating essential financial assistance for some of Washington’s most disadvantaged. These cuts would not impact us all equally. There would be disproportionate impacts on those who are already vulnerable, including low-income families and children, communities of color, and women. As the health of individuals directly affected by these cuts decreases, this would lead to increased health disparities for the affected communities. Cuts to even small-enrollment programs like GA-U become exacerbated because of the cumulative impacts on the same populations. While the cuts would not impact all Washingtonians equally, they would likely affect us all. Though broader impacts are beyond the scope of this review, we can safely assume that other areas of the state budget and local communities would need to find ways to absorb the medical and societal impact. Hospitals and community health centers, already burdened by an increase in uninsured

patients would receive an even greater influx. Homeless shelters, food banks, and other community assistance organizations may struggle to provide additional services when they are already overloaded due to the economic recession. Further, the public's safety could be at risk and the jail system further overloaded if the large percentage of GA-U clients with mental health and substance abuse problems do not get the treatment that they need—treatment that has been shown to effectively improve health outcomes, reduce arrests, and save costs.

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