WASHINGTON STATE HEALTH SERVICES RESEARCH PROJECT

Public-funded Health Coverage in Washington: 2017

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Introduction

Health coverage funded by government is a major source of coverage for Washington's population. In 2017, more than 50 percent of Washingtonians had health coverage that was funded, in whole or in part, by government in one way or another. In this brief, we describe and provide estimates of public-funded health coverage in Washington state using data from the 2017 American Community Survey.

What Is Public-funded Health Coverage?

Public-funded health coverage refers to health coverage or insurance that relies on public funds, in whole or in part, from federal, state or local government.[1] There are generally two broad categories of public-funded coverage. One is health coverage programs designed to aid persons with low income, the elderly or those who have certain long-term health condition or disability. The best known examples from this category are Medicare and Medicaid.

Medicare is a coverage program for the elderly population (age 65 and above), or those below age 65 who are eligible for Social Security, have Lou Gehrig's disease or have permanent kidney failure requiring regular dialysis or kidney transplant. The federal government funds Medicare. Medicare enrollees share coverage cost by paying premiums, deductibles and copays.

Medicaid (also known as *Apple Health* in Washington) is a coverage program for persons with no or low income. It is funded by both the federal government and the state government. Prior to 2014, the funding for Medicaid in Washington was roughly evenly split between the federal government and the state government. Under the Medicaid expansion of the Patient Protection and Affordable Care Act (ACA) that started in 2014, the federal government provided 100 percent of the funding for expansion-eligible individuals during 2014-16. For the next three years, the federal share for the expansion- population decreased to 95 percent in 2017, 94 percent in 2018 and 93 percent in 2019. Starting in 2020, the federal funding level will be set at 90 percent. Meanwhile, coverage for persons eligible for "traditional" Medicaid continued to be funded in the way it was prior to 2014.

Subsidized coverage obtained through Washington Healthplanfinder (Subsidized Exchange) is another federal program under the ACA. The subsidized Exchange provides premium tax credits to eligible individuals who purchase market coverage through the federal or state-based marketplaces. This program helps eligible individuals with a family income above the threshold for Medicaid but at or below 400 percent of the federal poverty level. Individuals enrolled in this program receive federal subsidies on a sliding scale with diminishing subsidies as the level of family income increases. Beside premiums, subsidized Exchange members are also responsible for deductibles and copays in sharing the coverage cost.

The other broad category of public-funded health coverage includes coverage provided through public service or public employment. This category consists of three sources: the military, Veterans Affairs and civilian government employment. Although funded with public dollars, this category of coverage has usually been treated by analysts as private health coverage and reported as such to contrast with coverage through public medical assistance programs. For this brief, however, we grouped this category in public-funded coverage.

[1] Note the distinction between coverage funding and coverage administration as public-funded coverage is mostly administered by private entities such as insurance companies or health management organizations (HMOs).

Coverage by the military, also known as Tricare/CHAMPUS, is a service-based coverage for enlisted personnel of the armed forces and their immediate family members. The federal government funds this coverage. There is no cost-sharing for active duty members and their families. Others receiving Tricare/CHAMPUS (e.g., military retirees and their families) share the cost through copay and, depending the specific plan, premiums.

Coverage by the Veterans Affairs is funded by the federal government for veterans of the armed forces. A veteran is a person who served in active duty. While VA coverage is generally free to veterans, cost-sharing through copay is required for care provided for illness not related to military service or if a veteran's income is above a certain threshold or his/her income information is not available.

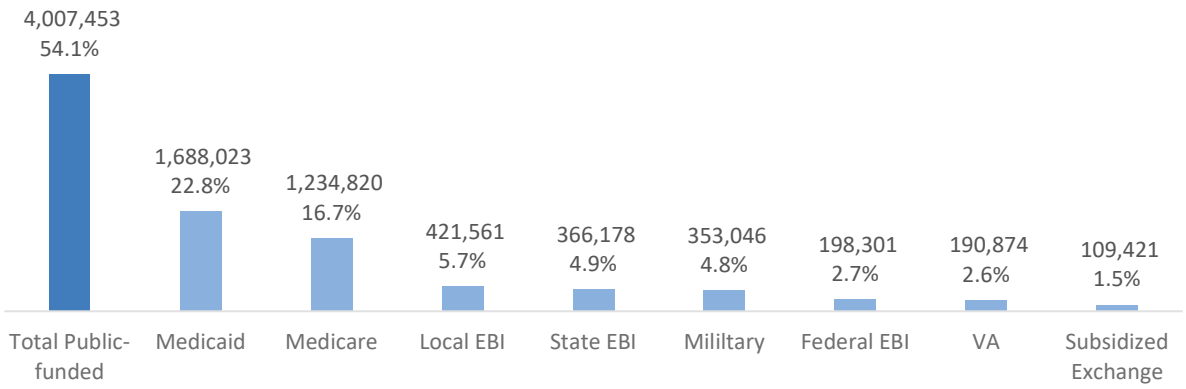
Employment-based health insurance for government employees is for civilian government employees and, in most cases, their immediate family members. Included in this source are three levels of government: *federal*, *state* and *local* (county or city). We refer to this coverage as government employment-based insurance (EBI). Government EBI in general requires cost-sharing by employees such as premiums, deductibles and copays, although the amounts shared by employees can vary considerably across governments, insurance type (e.g. HMO, fee-for-service, managed care) and number of family members covered by EBI.

The Appendix at the end of this brief contains a table with additional information about the public-funded coverage sources and another two tables for data reported in this brief.

Population in Public-funded Coverage

In 2017, there were 54.1 percent or four million of Washington's population having public-funded coverage (Figure 1). Among the public-funded coverage sources, Medicaid served the largest share of the state's population, at 22.8 percent. Medicare had the second largest share, at 16.7 percent. Local EBI made up the third largest share at 5.7 percent. It was followed by state EBI (4.9 percent), military (4.8 percent), federal EBI (2.7 percent), VA (2.6 percent) and subsidized Exchange (1.5 percent). These categories from Figure 1 are not mutually exclusive, meaning that a person could be counted in more than one of these public coverage sources. Thus, the sum of these eight public-funded coverage sources is greater than the number reported for "Total Public-funded" (4,007,453 or 54.1 percent) in Figure 1. Furthermore, a person could have private coverage (through employment or marketplace) in addition to public-funded coverage.

Figure 1. Number and Percentage of Population in Public-funded Coverage
Washington, 2017
(categories **not** mutually exclusive)



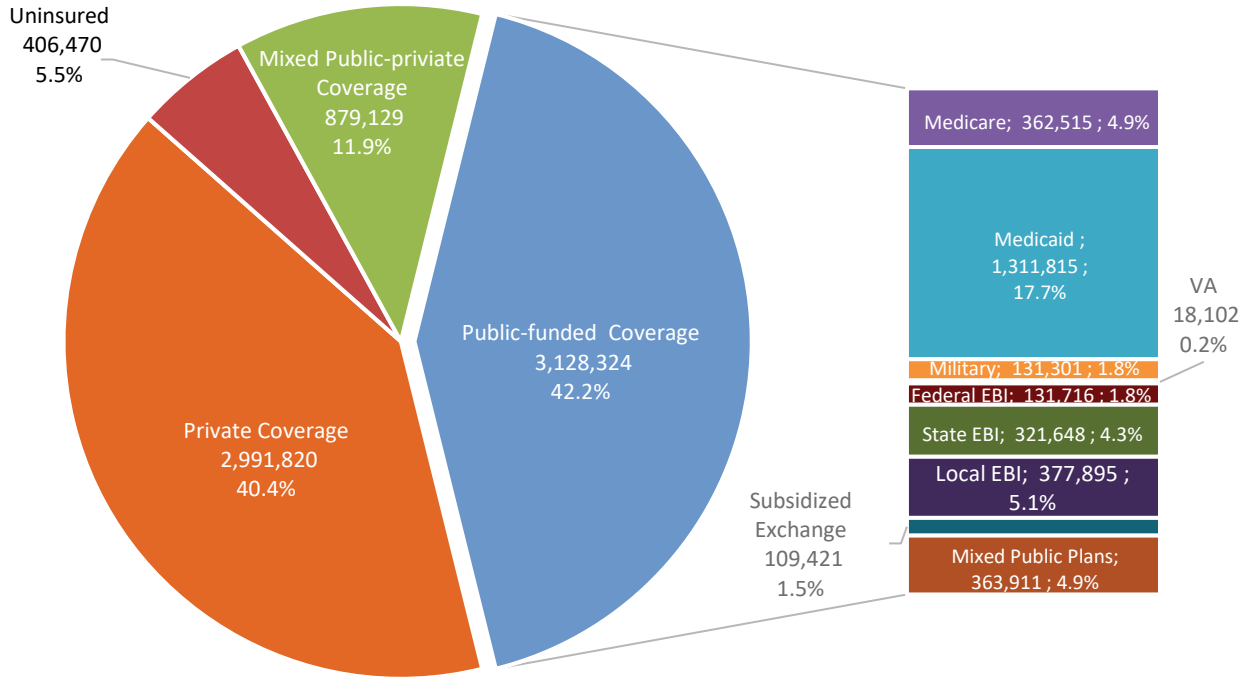
Public-funded Health Coverage as the Sole Source Covers the Largest Share of the Population in Washington

Figure 2 presents the distribution of the state's entire population in 2017 in mutually exclusive categories of health coverage. Each category is either a sole source of coverage[2] or a mix of multiple public coverage sources (e.g., dual coverage of Medicare and Medicaid) or a mix of public-private coverage sources (e.g., Medicaid and private EBI). In addition, the category of uninsured (no coverage) is included.

The pie-chart in Figure 2 shows that the vast majority of Washington's population, 94.5 percent, had health coverage in 2017. Public-funded coverage as the only source had the largest share of the total population, at 42.2 percent, followed by 40.4 percent with private-funded coverage only, and 11.9 percent with mixed public-private coverage. The remaining 5.5 percent, approximately 400,000, were uninsured.

The bar of the pie in Figure 2 shows the nine sources composing the public-funded only coverage. Medicaid was the largest source of the nine, covering 17.7 percent of the state's total population. That is, 17.7 percent or 1.3 million Washington residents had Medicaid as their only health coverage in 2017. Local EBI had a distant second largest share with 5.1 percent. Medicare and mixed-public plans tied for the third largest share of 4.9 percent each. Next in order was the state EBI accounting for 4.3 percent. The remaining four sources each covered less than two percent: military and federal EBI each at 1.8 percent, subsidized Exchange at 1.5 percent and VA at 0.2 percent.

Figure 2. Population Distribution by Health Coverage, Number and Percentage
Washington, 2017
(categories mutually exclusive)



[2] For example, the category "Medicare" here includes persons with Medicare coverage only (with no supplemental coverage from private insurance companies nor dual coverage with Medicaid).

Data Source and Notes

Data source. The original data source for this research brief is the US Census Bureau's 2017 American Community Survey 1-year Public Use Microdata Sample file for Washington. The Health Care Research Center at the Office of Financial Management adjusted the ACS sample weights to correct the undercount of Medicaid enrollment reported in ACS beginning in 2014.[3] This adjustment may have resulted in minor changes in estimates besides counts of Medicaid enrollment. Estimates reported in this brief are based on the adjusted ACS data.

Estimates for public-funded coverage. Estimates for Medicare, Medicaid, military and VA were computed using existing data fields in the ACS. Estimates for federal, state and local government's employment-based insurance (EBI) as well as subsidized Exchange were calculated using the imputed coverage status. Methods for the imputation are described below.

Imputation of federal, state, and local government EBI. The imputation of federal, state and local EBI utilized the ACS information for employment-based insurance. Prior to the imputation, health insurance units were assigned to the ACS records. A health insurance unit is one that includes parent(s) and their unmarried children under age 26, or a married couple, or an unmarried person without any children under age 26. A household may consist of more than one health insurance unit. The next step was to check a person's employment status and type. If a person had EBI coverage and was employed by a federal, state or local government and the job was at least half-time, that person's health insurance unit was designated as a federal, state or local government EBI, respectively. In cases where a unit was associated with more than one type of government EBI (e.g., one unit member with federal EBI and another with local EBI), a hierarchical assignment was used in the order of federal, state and local EBI. If a unit was determined to be a government EBI unit, any members in that unit that the ACS data showed to have EBI, regardless of their actual employment status, were assigned the unit's government (federal, state or local) EBI status.

Imputation of subsidized Exchange. The imputation of subsidized Exchange utilized the ACS information for "insurance purchased directly from an insurance company." Of the existing health insurance categories in the ACS, this is the only likely category to contain coverage through the Exchange. To impute subsidized Exchange in the ACS, the 2017 national Medical Expenditure Panel Survey (MEPS) was used in a logistic regression model to predict Exchange participation. The MEPS has Exchange as one of its health coverage categories. The logistic regression was performed on MEPS records known to have Exchange coverage or other coverage the respondents purchased directly from insurance companies. The model parameter estimates from the MEPS logistic regression were then applied to the ACS records with insurance purchased directly from an insurance company to predict the probability of an ACS respondent receiving Exchange subsidy. Records with high probability were assigned the subsidized Exchange coverage status. Washington's subsidized Exchange enrollment number for June 2017[4] was used as the control total for this imputation.

Estimates of private-funded coverage. The estimates for private-funded coverage were residuals from the original employment-based insurance and directly-purchased insurance categories in ACS after the government employment-based insurance and subsidized Exchange were assigned and removed from these two coverage categories.

Limitations. The accuracy of the estimates in this brief may be affected by a number of factors related to the data source and the methods used in deriving the estimates. The usual errors associated with population-based survey such as survey sampling errors and survey response errors apply to the American Community Survey used for our estimates. Our imputation of government EBI status may also have introduced errors. For instance, in a health insurance unit, one spouse has public employment and the other has private employment and both are reported to have EBI. The couple in reality may have enrolled in the private EBI or in their own EBI, instead of the federal, state or local EBI designated by our imputation.

[3] For a description of the rationale and methodology for the adjustment, see https://ofm.wa.gov/sites/default/files/public/legacy/healthcare/healthcoverage/pdf/undercount_medicaid.pdf.
[4] https://www.wahbexchange.org/wp-content/uploads/2017/12/HBE_EN_171204_September_Enrollment_Report.pdf.

Appendix

Table 1. Public-funded Health Coverage: Funding Sources and Eligibility

Public-funded Coverage	Funding Source	Eligibility Criteria
1. Medicare	Federal	**A.** age 65 or older: citizen or permanent legal resident in the US for at least five years, 40 plus Social Security credits (applicant or spouse) or government retiree (applicant or spouse) who has paid Medicare payroll taxes while working. **B.** age 64 or younger: receiving Social Security benefits for at least 24 months, or receiving a disability pension from the Railroad Retirement Board, or having Lou Gehrig's disease or having permanent kidney failure requiring regular dialysis or a kidney transplant (https://www.aarp.org/health/medicare-insurance/info-04-2011/medicare-eligibility.html).
2. Medicaid (Apple Health)	Federal and State	**A.** individual adults (age 18-64): monthly household income at or below $1,436, $1,945, $2,453 and $2,961 for single-person, 2-person, 3-person and 4-person household, respectively; US citizen or meeting Medicaid immigration requirements; and not receiving Medicare. **B.** parents/caretakers: monthly household income at or below $511, $658, $820 and $972 for single-person, 2-person, 3-person and 4-person household, respectively; and having dependent children under the age of 18 living in home. **c.** Children (below age 19): free for household income at or below 210% of federal poverty level, monthly premium for household income between 211% and 312% of the federal poverty level. **D.** Aged, blind, or disabled: age 65 and older, blind, or disabled who meet the month household SSI income and resource limits – Household Size / Income Limit / Resource Limit 1 / $771 / $2,000 2 / $1,157 / $3,000 **E.** Pregnant women: pregnant and monthly household income at time of application at or below $2,720, $3,431 and $4,141 for 2-person, 3-person and 4-person household, respectively (unborn child is counted as one person) (https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf).
3. Military	Federal	Tri-care: military members and their families (https://www.military.com/benefits/tricare/tricare-eligibility.html).
4. VA	Federal	Members who served in the active military, naval, or air service and didn't receive a dishonorable discharge (https://www.va.gov/opa/publications/benefits_book/Chapter_1_Health_Care_Benefits.asp).
5. Federal Government EBI	Federal	Employment-based insurance
6. State Government EBI	State	Employment-based insurance
7. Local Government EBI	Local	Employment-based insurance
8. Subsidized Exchange	Federal	The federal subsidy is provided to eligible individuals in the form of tax credit. To get this credit, individuals must: obtain individual market coverage through Washington Healthplanfinder (the state's Health Insurance Marketplace), meet certain requirements and file a tax return. Household income cannot exceed 400% of the federal poverty level. Individuals must not be eligible for coverage through a government program, like Medicaid, Medicare, CHIP or TRICARE, and must not be able to get affordable coverage through an eligible employment-based plan. They also must pay the portion of the premium not covered by the federal premium tax credits. (https://www.irs.gov/affordable-care-act/individuals-and-families/eligibility-for-the-premium-tax-credit).

Table 2. Public-funded Health Coverage (categories not mutually exclusive), 2017

Public-funded Coverage	Population	Percent
Medicaid	1,688,023	22.8
Medicare	1,234,820	16.7
Local EBI	421,561	5.7
State EBI	366,178	4.9
Military	353,046	4.8
Federal EBI	198,301	2.7
VA	190,874	2.6
Subsidized Exchange	109,421	1.5
Total Public-funded	4,007,453	54.1

Note: The sum of the population in individual public-funded coverage types is greater than "Total Public-funded" due to non-mutual exclusion of these coverage types.
(Source: OFM Health Care Research analysis of the 2017 American Community Survey 1-Year PUMS.)

Table 3. Health Coverage Distribution, Total Population, 2017

Health Coverage	Population	Percent
Uninsured	406,470	5.5
Private	2,991,820	40.4
Mixed Public-Private Plans	879,129	11.9
Public-funded	3,128,324	42.2
Medicare	362,515	4.9
Medicaid	1,311,815	17.7
Military	131,301	1.8
VA	18,102	0.2
Federal EBI	131,716	1.8
State EBI	321,648	4.3
Local EBI	377,895	5.1
Subsidized Exchange	109,421	1.5
Mixed Public Plans	363,911	4.9
Total Population	7,405,743	100

(Source: OFM Health Care Research analysis of the 2017 American Community Survey 1-Year PUMS.)