

Washington Health Security Trust Fund Preliminary Fiscal and Economic Findings March 2, 2007

Frank Fox, PhD, Douglas A. Conrad, PhD, Ann Derleth, PhD

Introduction and Key Findings

This preliminary fiscal and economic analysis of the Washington Health Security Trust ("WHST") includes the following:

- Problem statement
- Key issues
- Project definition
- Key findings
- Program revenues
- Other revenues
- Program cost
- Dynamic economic implications of WHST
- Tables 1-4
- Appendix A--bibliography

Problem Statement

To determine the expected cost of a defined set of health care services for all residents of Washington State in the year 2009. To estimate 2009 expected revenues that would be potentially available from 3 sources: (1) a payroll tax on employers of Washington State employees; (2) a monthly tax on state residents who meet certain defined criteria, e.g., at least 18 years of age; and (3) other current state programs that could be "folded" into this Trust.

Key Issues

- The expected costs of providing a set of defined health care benefits to state residents in the year 2009 must be estimated.
- The populations that would be taxed must be defined, then quantified. Most notably, this includes (1) estimating the size of the current population who would

bear the tax; (2) determining groups who would be excluded from the tax, such as persons with adjusted gross incomes less than 150% of Federal Poverty Guidelines; and (3) projecting these figures forward in time to the year 2009.

- Defining, then estimating revenues from other state sources that could become part of the Trust. This task also includes taking current estimates and projecting them to 2009.
- Qualitatively evaluate the dynamic economic implications of the WHST program on peoples' consumption of health care and businesses' and state residents' responses to taxes.

Project Definition (Tasks)

1. Program Revenues (Taxes). Quantify the revenue streams generated from future year taxes on future year populations. There are 2 tax levies defined within the WHST proposed legislation:

"Health Security Assessment:" Gross Wage and Salary Tax

- a. A payroll tax of 9% per quarter on gross payrolls paid to Washington State employees, where:
 - i. Employers' current quarterly gross wages and salaries paid to Washington residents exceed \$125,000 per quarter;
 - ii. Federal employees are excluded;
 - iii. Persons covered by Taft-Hartley are excluded; and
 - iv. Native Americans are excluded.
 - v. Estimated tax revenue would be based on current (2006) actual wage and salary figures for covered workers inflated forward to the year 2009 using a forecast of the Consumer Price Index—All Services (Urban).
- b. A payroll tax of 0.9% per quarter on gross payrolls paid to Washington State employees, where:
 - i. Employers' current quarterly gross wages and salaries paid to Washington residents are less than or equal to \$125,000 per quarter;
 - ii. Federal employees are excluded;
 - iii. Persons covered by Taft-Hartley are excluded; and
 - iv. Native Americans are excluded.
 - v. Estimated tax revenue would be based on current (2006) actual wage and salary figures for covered workers inflated forward to the year 2009 using a forecast of the Consumer Price Index—All Services (Urban).

"Health Security Premium:" Personal Tax on Washington State Residents

- c. A monthly fee assessed on selected Washington residents, where:
 - i. Persons 18-64 years old and persons 65 and older (assumed Medicare beneficiaries) would be included if their adjusted gross

income ("AGI"), as defined by the IRS, exceeds 150% of the Federal Poverty Guidelines ("FPG").

1. Persons 18-64 who meet this income criterion would pay \$75 per month in 2009
 2. Persons 65 and older who meet this criterion would pay \$50 per month in 2009
 - ii. Exclusions:
 1. Federal employees and retirees and their families
 2. Families of persons covered by the Taft Hartley trust
 3. Native Americans
 - iii. Taxes would begin in 2009
 - iv. The Consumer Price Index-All Items (urban) would be used to inflate current estimates of AGI and the FPG to "2009 dollars."
 - v. The CPI-All Items would be used to annually inflate the monthly premiums after 2009.
2. Other Revenues. Quantify future revenue streams generated from other state programs that would become part of WHST. To include revenues from:
- a. State Health Services Account
 - b. Health Care Authority
 - c. Tobacco Settlement funds
 - d. Community Health Center Funding
3. Program Cost. Estimate the expected cost of providing a defined set of health care benefits to all Washington residents except the excluded groups, as noted above.
4. Dynamic Implications. Qualitatively discuss the dynamic aspects of the WHST program. This includes two issues: (1) The price and income effects on consumption of health services when its relative price falls; and (2) residents' and employers' responses to proposed WHST taxes. What would short and longer run responses from employers include—would the tax be shifted to employees? To consumers? What would residents' responses be when at the margin, the relative price of leisure falls, i.e., income is taxed? What happens when income falls?

Key Findings

- This analysis presents researched, and in the authors' opinions, reasonable estimates. However, it must be explicitly recognized there is uncertainty regarding both projected revenues and program costs.
- Projected revenue from 9% and 0.9% payroll taxes applied to selected state resident employees' gross wages would be \$9.52 billion (2009 dollars).
- Projected revenue from a personal tax of \$75 per month on eligible persons 18-64 and \$50 per month on eligible persons 65 and older would be \$3.34 billion (2009 dollars).

- Projected revenues from other state programs identified by WHST proposed legislation would be \$773.8 million without DSHS Medical Assistance Payments, and \$4.8 billion with them (2009 dollars).
- Program cost could range from \$19.3 billion to \$26.3 billion (2009 dollars). It is the authors' opinion the most defensible figure is the lower estimate. However, an actuarial study is the only precise method to estimate program costs, testing a well-defined benefits package (as in the WHST proposal). The incremental cost of the program in 2009 is projected to equal \$800 million to \$1 billion.
- Dynamic responses to the program in terms of increased demand for health care and the economic impact of WHST taxes are expected to be modest—both from employers and state residents. This area, however, has only been qualitatively assessed---it should have further research and empirical analysis.

1. Program Revenues

Health Security Assessment (Business Payroll Tax)

- Table 1 presents the estimated revenue generated from the Health Security Assessment, if applied in the year 2009 at a 9% rate to gross payrolls currently above \$125,000/quarter, and 0.9% to gross payrolls currently less than or equal to \$125,000/quarter. It utilizes Washington Department of Employment Security unpublished statistics on gross payrolls for the year 2006 for employers of Washington resident employees.
- Gross payroll statistics were compiled for two groups of Washington State employers: (1) those with non-Federal state resident employees where quarterly payroll figures exceeded \$125,000 per quarter; and (2) those with non-Federal state resident employees where quarterly payroll was \$125,000 or less per quarter (Table 1).
- The Consumer Price Index-All Items (Urban) ("CPI-U") was used to project each of these two 2006 payrolls figures into 2009 dollars. The CPI forecast was taken from www.seattle.gov/financedepartment/cpi/forecast.htm This CPI projection is specific to the Seattle metropolitan area, and prepared by Conway Pederson Economics, Inc. It is very similar to the CPI-U for the U.S.
- Taft Hartley trust covered workers are an excluded group from the gross payroll tax, just as Federal workers. There was no available source for this wage data. The estimating approach included the following steps: number of workers was inferred from a total covered family figure by dividing number of persons by 2.49, to yield employees; average annual wage data (Washington Department of Employment Security, 2006) was multiplied by number of workers, yielding estimated gross payroll (2006); This 2006 gross payroll figure estimate was inflated forward using the CPI-U, and the 2009 projection was subtracted from the gross payroll forecast for those employers who had 2006 quarterly gross payrolls greater than \$125,000.
- Native Americans are also an excluded group, just as Taft Hartley trust covered

workers and Federal workers. As with Taft Hartley trust covered workers, there was no available source for this wage data. The estimating approach included the same analytical process described above for Taft Hartley trust covered workers. The 2009 projection was subtracted from the gross payroll forecast for those employers who had 2006 quarterly gross payrolls greater than \$125,000.

- The final steps were to apply a 9% tax on the higher payroll projection (2009 dollars) (for employee groups where 2006 quarterly payroll was greater than \$125,000), and a 0.9% tax on the smaller payroll projection (2009 dollars) (all other non-excluded employee groups), then sum the two forecast revenue figures.
- ***Table 1 indicates the projected revenue from a 9% and a 0.9% payroll tax applied to defined state resident employees' gross wages and salaries (net of Federal employees, Taft Hartley trust covered workers and Native American workers) is \$9.52 billion (2009) (See Table 1).***

Health Security Premium (Population-Based Tax)

- Table 2 presents a series of calculations used to develop the projected number of Washington residents who would be pay a health security premium.
- Analysis began with total state population estimates and projections, by age cohort, as provided by Washington Office of Financial Management (November 2006). Persons less than 18 years old were excluded from these estimates and projections.
- To adjust the population figures for income, statistics from the US Health and Human Services, Federal Poverty Guidelines would be applied to the resident population income figures, from the US Census. However, actual adjusted gross income statistics are not available per person, by age cohort group, as needed. But the number of state residents between the age of 18-64 and 65 and older whose adjusted gross income exceeded 150% of FPG have been estimated by HHS. These HHS percentages were held constant over time, i.e., if 86.2% of Washington residents 18-64 had AGI >150% of FPG in 2005, the analysis assumes this percentage remains constant over the forecast period. This avoids the obvious problem of lack of actual statistics of AGI, by person, by age, which is not compiled, and it also avoids the problem of attempting to differentially project growth in AGI and FPG, then comparing them in 2009.
- Washington Employment Security Department statistics (2006, unpublished) were used to estimate the number of federal employees, as of 2005. An OFM household size figure of 2.49 (2006) for Washington residents was used to extrapolate from the number of Federal employees to employees plus family members. The ratio of federal workers plus their families to all Washington residents was calculated for the year 2005. This ratio was then used to project the size of Federal "families," given aggregate projected state population. The ratio was held constant at its 2005 value. Similarly, OFM data for all state residents was then used to establish ratios of age cohorts, so the estimated Federal "family" population figure could be subdivided into age cohorts 18-64 and 65 and older. These estimates were subtracted from the resident-eligible population, detailed above (See Table 2).
- Taft Hartley trust covered families were excluded from the WHST Health Security

Premium population. Estimates of the number of covered families were obtained from a published study. The best available published figure was for 2002. As with Federal workers, the ratio of workers plus their families to all Washington residents was calculated for the year 2002. This ratio was held constant over time, and used to project the size of Taft Hartley trust covered families, given aggregate projected state population. OFM data for all state residents was then used to establish ratios of age cohorts, so the “covered family” figure could be subdivided into age cohorts 18-64 and 65 and older. These estimates were subtracted from the resident-eligible population (See Table 2).

- Native Americans, as defined by 25 U.S.C. 1603, were excluded from the WHST Health Security Premium population. A year 2000 estimate of Washington State Native Americans was obtained from National Center for Health Statistics, This figure was extrapolated forward using an annual growth rate of 1.2%, the average annual growth of all state residents, (OFM, 2006). Age cohort ratios were also obtained from NCHS, and were applied to the estimated and projected Native American population figures (Table 2). The estimated population for Native Americans 18-64 and 65 and older was subtracted from projected Washington residents eligible for the WHST Health Security Premium.
- The final step was multiplying the projected number of eligible residents, by age cohort group, by WHST monthly taxes.
- ***Table 2 indicates the estimated 2009 revenue from a proposed WHST tax of \$75 per month on eligible persons 18-64 and \$50 per month on eligible persons 65 and older would generate \$3.34 billion (2009 dollars)***

2. Other Revenues

- Table 3 presents forecast revenues the proposed WHST legislation indicates would be transferred from selected other state health programs to the WHST. Estimates in Table 3 have been taken from the Governor’s 2007-2009 Biennium Proposed Budget¹.
- The Governor’s Proposed 2007-2009 Budget lists funds for the Health Care Authority. Funds designated for the Uniform Dental Plan, which is not within the initial defined WHST benefits plan were excluded from Table 3 estimates. The Health Care Authority amount includes several funds mentioned in the WHST legislation as separate items, including Administration, Community Health Centers, Health Services Account, Basic Health Plan, Public Employee Benefits Plan. These funds and their 2007-9 budgeted amounts are given in the notes to the table.
- Funds budgeted for transfer to the Health Services Account, State, were included in Table 3, including those listed in the 2007-2009 Budget as “Health Services

¹ <http://www.ofm.wa.gov/budget07>

Accounts” in the budgets for the Department of Social and Health Services and the Department of Health.

- Funds from the Tobacco Settlement Fund, also designated in WHST proposed legislation are included in the Health Services Account budget—they are in Table 3. Similarly, revenues from various state taxes such as the liquor sales tax, liquor liter tax, beer tax, tobacco products tax, and cigarette tax are also already included in the Health Services Account, thus, they were included in Table 3.
- The 2007-2009 biennium Budget figures were divided by 2 to estimate the annual budget for 2009, then subtotaled to obtain the total funds transferred from Health Services Programs, excluding amounts currently part of the Medicaid program.
- Funds budgeted in the Department of Social and Health Services for Medical Assistance Payments are listed, and administrative costs and dental, vision and hearing costs are subtracted, again to be consistent with funds included in the estimates of WHST program costs. The result is divided by 2 to obtain an amount for 2009. Inclusion of these funds will require a waiver as discussed in Section 3 of the WHST proposal.
- Table 3 has not excluded certain tax funds that would be repealed as part of WHST legislation.²
- ***Table 3 indicates that estimated current state health program revenues to be transferred to the WHST in 2009 would total \$773,828,500. If the Medical Assistance Payments from the Department of Social and Health Services were added, “Other Revenues” would total \$4.8 billion.***
- ***Summing the amounts in Tables 1, 2 and 3 gives a total projected WHST program revenues of \$13.6 billion (2009) without Medical Assistance Payments and \$17.8 billion if Medical Assistance Payments were included.***

3. Program Cost

This section of the report presents preliminary estimates of the expected healthcare costs of delivering a defined set of benefits reflecting the proposed statutory language of the WHST proposal. The purpose of these estimates is to produce a set of intended “conservative” benchmark estimates as a starting point for more detailed simulation of WHST program costs and dynamic response modeling as the proposed legislation evolves. The estimates are conservative in the sense that assumptions regarding cost drivers have been chosen as objectively as possible, using the available historical data and leaning toward “high-side” estimates of cost in instances where judgments were

² See Section 38 of “A Legislative Proposal to Cover Health Care for All Washington Residents: Washington Health Security Trust—Statutory Language For the Proposal,” Unpublished, 2006.

required for estimation³. Three distinct program cost estimating methodologies to assess the sensitivity of each estimate to alternative approaches are presented below.

- ***Analysis indicates the WHST Program cost could range from \$19.3 billion to \$26.3 billion (2009 dollars). (See Table 4).***

Method 1

- Method 1 uses data from the Medical Expenditures Panel Survey (“MEPS”) of the Agency for Health Care Research and Quality (AHRQ). MEPS began in 1996 and is a large sample, nationally representative survey of families and individuals, their medical providers (doctors, hospitals, pharmacies, etc.), and employers across the United States. MEPS collects data on health services utilization – frequency, cost, and how they are reimbursed, as well as data on the cost, scope, and breadth of health insurance purchased by and offered to U.S. workers. For states of sufficient sample size (29 of the 50 states), including Washington, MEPS can be used to produce sample estimates of the proportion of the state’s population with medical expenses in a year and of the mean medical expense per year for those with medical expenses, coupled with standard errors for each estimate.
- It should be noted that MEPS is a sample survey, thus, has a statistical distribution. This simply means there is a confidence interval associated with MEPS “point” estimates in personal health care expenditures.
- The Method 1 calculation starts with the 2003 MEPS estimate of mean medical expense per capita in Washington State (multiplying the probability of medical expense > 0 by the mean medical expense, given non-zero expense). The proportion of medical expense not covered by the WHST (i.e., dental and nursing home services) were then removed, and the mean expense per capita was inflated from 2003 dollars to 2009 dollars (the forecast year). The most recent annual estimates and projections of the personal health care expenditure (“PHE”) deflator (a broad-based measure for inflation in the health care items included in personal health expenditure) through 2011 were used to inflate the 2003 cost figures. The mean expense per capita was then multiplied by the Washington Population Survey (January 2007) estimated population for Washington State in 2009⁴.
- ***Estimated cost is \$9.3 billion (2009 dollars). See Table 4.***

³ For example, even though the WHST proposal’s suggested statutory language defers the question of inclusion of a long term care benefit to a subsequent financial feasibility study, this report includes home health benefits as a component of the medical care expenses possibly to be covered by the proposed program. Nursing home costs *per se* are excluded, however, in the calculations.

⁴ The projected 2009 population is adjusted downward to reflect three Washington State population sub-groups initially excluded from coverage in the WHST proposal: (1) Federal employees of the state of Washington and the covered persons in their families, (2) Taft-Hartley Trust covered persons, and (3) Native Americans.

Method 2

- Method 2 uses provider-based estimates of personal health expenditures from the Centers for Medicare and Medicaid Services (CMS) to produce a second type of initial estimate of covered medical expenses per Washington State resident. Since providers practicing in Washington do deliver services to residents from other states and areas (for example, the University of Washington School of Medicine and other referral centers in Washington State serve residents of the entire Northwest (explicitly, the states of Wyoming, Alaska, Montana, and Idaho, or WWAMI), it is quite likely that assigning provider location-based health expenditures to Washington residents will result in overestimates of mean medical expense for Washington State residents.
- The ratio of Washington resident-based estimates of mean medical expenses per capita from MEPS (2003) to the provider-based estimates of the same year was computed, and then multiplied by the 2004 resident-based estimate of personal health expenditures from CMS to obtain an “adjusted” 2004 value for mean medical expense per capita. That value was then inflated to 2009 dollars by compounding for 5 years by the PHE deflator.
- ***Estimated cost is \$24.0 billion (2009 dollars.)***

Method 3

- Finally, Method 3 simply inflated Frank Fox's⁵ 2000 per capita estimate of program costs, after adjusting for the population proportion of the three excluded subgroups, to 2009 dollars and 2009 forecast population, using the same PHE deflator as in Methods 1 and 2 and population forecasts as used above for to project the WHST Health Security Premium.
- ***Estimated cost is \$26.3 billion (2009 dollars.)***

4. Dynamic Implications---The Incremental Healthcare Costs and Other Economic Implications of WHST Programs

- The three methods are used not only to estimate 2009 total population healthcare costs of the WHST proposal, but also to generate comparative estimates of the incremental costs of the WHST program. The estimates described above in section 3 (and in Table 4) for each method represent “status quo” estimates, in the sense that they project 2009 healthcare costs in Washington State for the population and services potentially covered by WHST, but assuming the program were not actually implemented (i.e., without the WHST). In contrast, the second set of estimates for each method (1A, 2A, and 3A) reflect projected costs in the event the program is implemented (i.e., with the WHST). (See Table 4). The difference between 1 and 1A,

⁵ “Review of Universal Health Coverage Proposal for Washington Residents Key Findings and Recommendations, Preliminary Report, January 2000,” Frank Fox, PhD.

2 and 2A, and 3 and 3A thus represents the estimated incremental health care cost attributable to the WHST, respectively, using each of the three methods. The incremental program health care cost is primarily driven by the increased demand for health services when previously uninsured persons receive expanded financial access to health care services—this is a reflection of both a price or substitution effect and an income effect.

- The key assumption is that healthcare expenditures for the 9.3% of the Washington State population currently uninsured increase by 46% after enactment of the WHST. This point estimate, which should be subjected to further sensitivity testing, is based on data from the RAND Health Insurance Experiment (Newhouse 1993), comparing the level of medical expenses for persons with virtually free care (the most generous form of WHST, i.e., without significant enrollee cost-sharing) and those paying almost completely on their own (95% coinsurance in the RAND HIE).
- The estimates of total program healthcare costs (in 2009 dollars) range from roughly \$19.25 billion to \$26.34 billion using the three methods. However, the range in incremental costs is much narrower – given that the major impact of the WHST on demand will be concentrated on the currently uninsured population in Washington State. (This assumes that WHST copays and deductibles on currently insured residents would be structured and of the same magnitude as presently).
- The incremental costs of the program vary from approximately \$800 million in Method 1/1A to roughly \$1 billion under Methods 2/2A and 3/3A. Interestingly, in a recent paper examining options considered for universal health insurance coverage in Massachusetts, Blumberg, Holahan, Weil et al. (2006) concluded, “These results show that universal coverage could be achieved in Massachusetts for \$700 million to \$900 million per year.” (p. 117)
- The incremental and total costs of achieving universal health insurance coverage in Washington State each would be reduced dollar-for-dollar by taking into account the dollars in uncompensated care already spent in Washington State and cost-shifted to health care providers and private health plans. The most recent estimate of uncompensated care (Washington State Office of the Insurance Commissioner 2006) estimated those costs as \$553 million in 2004, based on an uninsured population of roughly 784,000 persons at that time. Thus, a substantial portion of the estimated incremental costs of the WHST would be offset by eliminating uncompensated care – even after accounting for the decline in the number of uninsured persons between 2004 and 2006⁶.
- Administrative Costs. Quantitative estimates of administrative costs associated with the WHST have not been prepared, pending determination of the actual management structure for the WHST program. In that respect, the estimates of program cost might best be considered as forecasts of “pure premium” of the covered benefits. This is the actuarial term for healthcare claims costs; and the figure omits the “retention” component of insurance premiums, which is comprised of claims processing costs, marketing and sales cost, risk margin, and contribution to surplus (or “profit”).

⁶ To wit, if uncompensated care costs (to a first approximation) are proportional to the number of uninsured, a reduction from 784,000 to 593,000 uninsured would lower total uncompensated care costs to \$418 million – still almost half of the incremental costs of the WHST program.

However, previous work (Himmelstein, Woolhandler, and Wolfe 2004; Woolhandler, Campbell and Himmelstein 2003) implies that unified financing of universal health insurance coverage for all can be expected to lower not only the administrative costs of health insurance, but also the opportunity costs borne by providers in dealing with multiple health plans and diverse health plan guidelines for payment and utilization management.

- Revenue and Financing Dynamics. Another important aspect of the WHST proposal is its financing structure. This report presents estimates of the revenue raised through assessments on individuals and on employer payrolls, as well as a variety of other sources. The preliminary estimates in this report are “static”, in that they are calculated by multiplying the assessment rates per dollar by the revenue base – related to personal income level or employer payroll, respectively. However, in reality individuals, families, and firms (representing their owners or equity-holders) do change their behavior when income or payroll is assessed or “taxed” (Entin 2004). However, unanticipated, one-time taxes or assessments will not likely affect behavior, nor will lump sum taxes that do not vary with the level of economic activity (e.g., hours worked, income earned, payroll level).
- In the case of the WHST, there are two proposed payroll taxes: 9% on quarterly employer payrolls above \$125,000, and 0.9% on quarterly payrolls less than or equal to \$125,000. In the case of the 9% payroll tax, a 1996 survey by Foster Higgins and William M. Mercer found that firms with over 500 employees contributed approximately 13.8% of payroll toward health insurance for their employees. A comparable and more current figure for Washington State is not available for the present study. However, for larger employers, the net effect on economic performance from either paying insurance premiums or paying a 9% payroll tax for their contribution toward health insurance for employees and their family members is likely to be positive. That is, by substituting the WHST payroll tax for current employer contributions toward health insurance, at least for larger employers, the incentive to expand employment is increased, on balance, simply because the relative cost of labor has fallen. For smaller employers currently offering either no or only a modest contribution toward employee health insurance, the WHST payroll tax, even at 0.9% of payrolls, will create at least some incentive to reduce payroll through a combination of a decreased number of employees or reduced levels of compensation per employee. To the extent that the payroll tax is not fully shifted “backward” to employees in the form of reduced wages and/or some substitution of capital for labor, employers will also tend to shift “forward” the imposition of the tax in terms of higher prices to consumers. The net economic effect of WHST payroll taxes and their incidence—who bears them-- is uncertain, but all of the above will tend to occur. Net impact will depend on market conditions, the size of the employer, and short run and long run sensitivities to changes in relative prices of labor and for good and services.
- The best available estimates of probable employer and employee response to these marginal tax incentives are derived from the economic literature on labor supply and firms’ demand for labor. Classic papers by McCurdy (1981), Gruber and Poterba (1995), and a survey by Fuchs, Krueger, and Poterba (1998) provide a reasonably tight range of estimates of the proportionate change in employers’ demand for labor and employees’ supply of their labor for a given change in net compensation to labor.

- The best estimates of these “elasticities” of labor demand and supply suggest that employees would see their wages reduced by roughly \$0.75 to \$0.80 for every dollar of net payroll tax imposed on the employer⁷. “Net” tax is emphasized because for those larger employers whose current contributions toward health insurance are greater than the 9% WHST payroll tax that would replace those contributions, the same logic suggests that wages will be increased and employment increased in response to the implied net subsidy to employment. Since larger employers account for the bulk of payroll in the state, it seems unlikely that wage offsets or reductions in employment would be substantial.
- On the consumer demand-side, employers (producers of goods and services) will shift at least some of the net tax to consumers. Just as above, to the extent the WHST tax replaces higher cost insurance premiums, then consumers would receive some benefit from the subsidy passed forward. The magnitude of this impact is unknown, and requires more quantitative analysis.
- In terms of the WHST assessment on adult individuals, there will also be economic responses. The WHST tax is designed as a fixed monthly Health Security Premium, based only on whether one’s income is at or above 150% of the Federal poverty level of adjusted gross income (AGI). This design suggests any behavioral response by individuals to this quasi-tax is likely to be modest. In theory, with the imposition of a tax, there will tend to be a “price or substitution” effect and an “income” effect, but in this case, the “margin” of economic activity potentially affected by the monthly premium is the notch at 150% of AGI. The empirical questions are:
 1. The extent to which adults would adjust their work decisions and other income-generating activity (e.g., investments) to fall below the notch—work less, in order to avoid a premium ranging from \$50 to \$75 dollars per month (the “substitution” effect), or to say the same thing another way, if attaining a certain level of income gets more expensive, people will tend to substitute away from it—consume more leisure; and

⁷ The general formula for change in wage due to changed health insurance contributions is derived in Gruber and Poterba (1995): $dW/dC = -\{E^d - \alpha E^s\}/\{E^d - E^s\}$. The terms are defined as follows: W is the employee’s wage, C is the cost of insurance to the employer, E^d and E^s are the elasticity of the employer demand for labor and the employee supply of labor, respectively, and α measures value to the employee of an additional dollar of health insurance spending. As Gruber points out, this expression differs from the standard expression for the incidence of a tax on labor by the term αE^s in the numerator, which reflects the increase in labor supply due to employee valuation of more expensive health insurance. Therefore, if employees value a dollar in increased health insurance spending as equal to the cost to the employer (i.e., if $\alpha = 1$), then the full amount of increased employer cost of health insurance will be shifted to employees as reduced wages, and there will be no effects on employment.

The estimate is based on a classic paper in the labor economics literature: MaCurdy, T.E. 1981. An empirical model of labor supply in a life-cycle setting. *Journal of Political Economy* 89 (6): 1059–1085. The calculation is: $dW/dC = -\{E^d - \alpha E^s\}/\{E^d - E^s\} = -\{.50 - (1.5)(.15)\}/\{.50 - .15\} = -0.79$. We assume $\alpha = 1.5$ to reflect the empirical observation by Gruber (1998) that “job lock” exists in employer-sponsored health insurance, thus implying that at the margin employees value a dollar of health insurance contribution by their employer more than a dollar in wages.

2. The extent to which persons change their work efforts when, after the WHST tax, their effective income has fallen (the “income” effect). This would suggest the person would consume less of everything, including leisure. Put differently, they may work harder to maintain their income (pre-WHST tax) level.
- These effects on income-generating activity and the “cost” of leisure also are likely to be modest in comparison to the reduction in work effort and associated economic activity that would occur if -- instead of a fixed monthly premium “notched” at 150% of AGI--the WHST individual contribution were structured as a proportional or progressive income tax, where the individual doesn’t experience a “notch, but instead, a constantly growing tax contribution. As it stands, the population-based Health Security Premium is a contribution toward social insurance against the financial consequences of ill health and one that is expected to have minimal behavioral offsets to expected premium revenues. This is an area for further empirical research.

Table 1
Washington Health Security Trust Analysis
Projected Number of State Residents Eligible for Health Security Premium,

**and Forecast 2009 Tax Revenues
March 2007**

<i>Washington Population, By Age Cohort</i>	2005	2006	2007	2008	2009
0-17	1,531,411	1,549,045	1,569,819	1,587,781	1,604,478
18-64	4,014,488	4,099,900	4,187,749	4,271,131	4,349,077
65+	710,501	726,655	745,977	771,764	797,886
Total	6,256,400	6,375,600	6,503,545	6,630,676	6,751,441

<i>WHST Population Subset</i>					
18-64	4,014,488	4,099,900	4,187,749	4,271,131	4,349,077
65+	710,501	726,655	745,977	771,764	797,886
Total	4,724,989	4,826,555	4,933,726	5,042,895	5,146,963

<i>WHST Population Subset Whose Adjusted Gross Income is Above 150% Federal Poverty Guidelines</i>					
% of all Residents 18-64 years whose AGI > 150% FPG	86.20%				
% of all Residents 65 and older whose AGI > 150% FPG	80.40%				
18-64	3,460,489	3,534,114	3,609,840	3,681,715	3,748,904
65+	571,243	584,231	599,766	620,498	641,500
Total	4,031,731	4,118,344	4,209,605	4,302,213	4,390,405

Sub-Group Exclusions

<i>Federal Employees and Their Families</i>					
Federal employees & Families as % of WA population, 2005	2.77%				
18-64 as % of total (based on 2009 WA Total)	64.42%				
65 and older as % of total (based on 2009 WA Total)	11.82%				
Total	173,167	176,466	180,008	183,526	186,869
18-64	111,549	113,674	115,956	118,222	120,375
65+	20,465	20,855	21,273	21,689	22,084
Total	132,014	134,529	137,229	139,911	142,460

Used 2.49 family size figure to estimate number of persons from number of federal employees.

Table 1 Continued

Taft Hartley Covered Employees and Families					
Taft Hartley-covered employees & Families as % of WA population, 2002	2.06%				
18-64 as % of total (based on 2009 WA Total)	64.42%				
65 and older as % of total (based on 2009 WA Total)	11.82%				
Total	128,613	131,064	133,694	136,307	138,790
18-64	82,849	84,427	86,122	87,805	89,404
65+	15,200	15,489	15,800	16,109	16,402
Total	98,048	99,917	101,922	103,914	105,807

Native Americans					
% of Native Americans within the 18-64 Cohort (NCHS)	0.629				
% of Native Americans within the 65 and older Cohort (NCHS)	0.054				
Total Number of Washington State Native Americans	118,848	120,266	121,701	123,153	124,622
18-64	74,756	75,648	76,550	77,463	78,387
65+	6,418	6,494	6,572	6,650	6,730
Total	81,174	82,142	83,122	84,114	85,117

WHST Population Subset Net of Excluded Populations	2005	2006	2007	2008	2009
18-64	3,191,335	3,260,365	3,331,212	3,398,224	3,460,737
65+	529,161	541,392	556,120	576,050	596,284
Total	3,720,496	3,801,757	3,887,333	3,974,274	4,057,022

WHST Population (Net of Excluded Populations) Tax Revenue	2009 (Estimated)
18-64 (\$75/per person/month)	\$ 3,114,663,458
65+ (\$50/person/month)	\$ 357,770,598
Total	\$ 3,472,434,056

Table 2
Washington Health Security Trust Analysis
Projected Revenue From Gross Payroll Taxes Applied to Selected

**Employees of Washington Residents, 2009
March 2007**

	2006	2007	2008	2009
Gross Payrolls Statistics, 2006 Actuals, Less Federal Government employees (Firms with payrolls > \$125,000/Qtr.)				
First Quarter	\$ 24,477,676,820	\$ 25,132,431,084	\$ 25,828,162,613	\$ 26,534,857,677
Second Quarter	\$ 24,079,234,051	\$ 24,723,330,354	\$ 25,407,736,904	\$ 26,102,928,525
Third Quarter	\$ 25,987,984,256	\$ 26,683,137,788	\$ 27,421,796,941	\$ 28,172,096,094
Fourth Quarter	\$ 25,926,024,702	\$ 26,619,520,875	\$ 27,356,418,946	\$ 28,104,929,264
Total Year	100,470,921,835	103,158,422,108	106,014,117,412	108,914,813,570

Gross Payrolls Statistics, 2006 Actuals, Less Federal Government employees (Firms with payrolls < \$125,000/Qtr.)				
First Quarter	\$ 3,127,531,541	\$ 3,230,268,466	\$ 3,319,690,759	\$ 3,410,522,194
Second Quarter	\$ 3,264,912,571	\$ 3,372,162,354	\$ 3,465,512,642	\$ 3,560,333,970
Third Quarter	\$ 3,327,773,417	\$ 3,437,088,128	\$ 3,532,235,731	\$ 3,628,882,697
Fourth Quarter	\$ 3,152,141,134	\$ 3,255,686,464	\$ 3,345,812,394	\$ 3,437,358,554
Total Year	12,872,358,663	13,295,205,413	13,663,251,527	14,037,097,416

Gross wages and salaries are inflated based on the forecast of the CPI-All Items, prepared for the Seattle metropolitan area.

Source: Washington Employment Security Division, special data base compilation from unpublished files, February 2007.

Sub-Group Exclusions

Taft Hartley Covered Employees	2006	2007	2008	2009
Total Year	\$ 2,097,041,028	\$ 2,153,134,855	\$ 2,212,739,268	\$ 2,273,282,944

Native Americans	2006	2007	2008	2009
Total Year	\$ 2,015,527,718	\$ 2,066,703,128	\$ 2,119,324,520	\$ 2,171,744,326

Estimated Gross Payrolls on WSHT-Covered Workers (Payrolls > \$125,000/Qtr.) Minus Excluded Groups' Payrolls	2009 (Estimated)	Estimated Gross Payrolls on WSHT-Covered Workers (Payrolls < \$125,000/Qtr.)	2009 (Estimated)
	\$ 104,469,786,300		\$ 14,037,097,416

Estimated Revenues from 9% Tax Applied to Covered Workers Payrolls (Payrolls > \$125,000/Qtr.) Minus Excluded Groups Payrolls	2009 (Estimated)	Estimated Revenues from 10% Tax Applied to Covered Worker Payrolls	2009 (Estimated)
	\$ 9,402,280,767		\$ 126,333,877

Total Estimated Revenue From Payroll Tax, 2009

\$ 9,528,614,644

**Table 3
Washington Health Security Trust Analysis**

Other Projected Revenue Sources, 2009 March 2007

Other Revenues

Current Health Programs Transferred to WHST	Biennium Budget			2009 Annual
	2003-2005 Actual	2005-2007 Estimated	2007-2009 Proposed	
Health Care Authority (Sec 19)*	\$ 547,794,944	\$ 645,775,921	\$ 789,599,000	
less Uniform Dental	\$ 9,311,490	\$ 9,895,921	\$ 9,486,000	
Subtotal*	\$ 538,483,454	\$ 635,880,000	\$ 780,113,000	\$ 390,056,500
Health Services Account-State (Sec 33)				
In Dept of Social & Health Services (DSHS)	\$ 689,352,000	\$ 683,080,000	\$ 695,538,000	\$ 347,769,000
In Dept of Health	\$ 34,162,193	\$ 41,942,000	\$ 72,006,000	\$ 36,003,000
Subtotal	\$ 1,261,997,647	\$ 1,360,902,000	\$ 1,547,657,000	\$ 773,828,500
DSHS, Medical Assistance Payments	\$ 7,338,628,000	\$ 7,709,386,000	\$ 8,451,890,000	
less Administrative Costs			\$ 194,496,000	
less Optional Dental, Vision, Hearing			\$ 279,585,000	
Subtotal			\$ 7,977,809,000	\$ 3,988,904,500
Total, Including Medical Assistance				\$ 4,762,733,000

Notes

* Activities in Health Care Authority include:

Health Services Account	\$ 407,137,368	\$ 468,290,000	\$ 583,200,000
Community Health Services (Sec 32)	\$ 22,727,273	\$26,727,273	\$ 24,210,000
Insurance-Adults - 100-200%Poverty			\$ 270,917,000
Insurance-Adults < 100% Poverty			\$ 320,061,000
Insurance-Children -100-200%Poverty			\$ 16,429,000
Insurance-Children <100% Poverty			\$ 20,794,000
Public Employee Benefits (Sec 25)			\$ 32,036,000
Uniform Medical			\$ 35,684,000
Administrative			\$ 24,202,000

HCA also includes (2007-9 in thousands) Prescr Drug 9,146; HlthCare Planning 15,308; Ins Safety net 2,557; Small bus Hlth Ins 5,000; other statewide adj 3,769

Tobacco Settlement Funds (Sec 31) are incorporated into Health Services Account (\$91,322,000)

This analysis assumes the health services amounts above include the following tax revenues.

Tax (Section of WHST legislation)	Amount to Health Services Acct - Estimated			Estimated Annual
[estimated proportion of revenue that is designated for health services if less than 100%]	2003-2005	2005-207	2007-2009	2009
Liquor Sales Tax RCW 82.08.150 [0.18]	\$ 23,376,240	\$ 26,441,100	\$ 29,068,920	\$ 14,534,460
Additional taxes on spirits (Sec 30) [0.168]	\$ 22,999,032	\$ 35,119,560	\$ 37,109,184	\$ 18,554,592
Beer Tax \$4.78/bbl (Sec 27) [0.592]	\$ 35,969,328	\$ 36,505,680	\$ 37,550,560	\$ 18,775,280
Cigarette tax RCW 82.24 (Sec 28)[0.402 & adj 1773]	\$ 262,507,168	\$ 348,124,243	\$ 337,730,172	\$ 168,865,086
Tobacco tax 3.4% RCW 82.26 (Sec 29) [0.481]	\$ 15,534,376	\$ 24,086,075	\$ 26,151,970	\$ 13,075,985
Total	\$ 360,386,144	\$ 372,210,318	\$ 467,610,806	\$ 233,805,403

Estimates are based on total biennium revenue and proportion of tax allotted to health services

Revenues from taxes (2) dedicated to health spending that are repealed (Sec 38) are not estimated or deducted

Table 4

Washington Health Security Trust Analysis Projected Cost of Program Coverage, 2009 March 2007

Preliminary Forecast of 2009 WA State Personal Health Care Expenditures <i>without</i> WHST										
Method 1:		Take 2003 MEPS average WA PHE per capita, remove estimated percentage of personal health expenditures not covered in WHST (dental&NH) , project forward to 2009 PHE/capita at PHE annual deflator, then multiply by 2009 WA State population								
	equals	\$19,427,153,527	then adjust for covered population net of Federal employees, Native Americans, and Taft-Hartley Trust beneficiaries					equals	\$18,467,846,891	
		Note: The MEPS per capita figure is based on a sample. And thus is subject to sampling error. Combining the standard errors for the % with medical expense and mean medical expense for those with expenses > 0 (which are 1.7% and \$341, respectively in the MEPS 2003 figures) yields a 95% confidence interval around the expected mean expense per capita of +/- approximately 24%.								
Method 2:		Take CMS WA State (Provider-based) 2004 estimates of PHE/capita (remove dental&NH), multiply by estimated fraction of WA state providers' care to WA residents, project to 2009 (5 years) at annual PHE deflator, then multiply by WA State 2009 population (net of excluded population subgroups).								
		Note: The assumed share of PHE (excluding dental) to out-of-state residents is calculated by inflating (@ PHE deflator) the 2003 WA State medical expense per capita (resident-based) to 2004 \$ and computing its ratio to the corresponding 2004 per capita PHE provider-based figure.								
	equals	\$23,019,820,095	Note: This "provider denominator-based number" is based on the "universe" of data for WA State from the HHS Office of the Actuary and thus is not subject (directly) to the same sampling error that is reflected in the MEPS per capita figure.							
Method 3:		Take Frank Fox's PMPY(per member per year) estimates for 2000, adjust for the population proportion of the 3 excluded subgroups, inflate by the PHE deflator to 2009\$, and then multiply the 2009\$ per capita estimate by the projected WA state population for 2009.								
	equals	\$25,269,733,600								
Preliminary Forecast of 2007 WA State Personal Health Care Expenditures <i>with</i> WHST										
Method 1A (will apply Method 1 assumptions, adjusted for behavioral effects on health care demand)										
	equals	\$19,250,612,955	Estimated Incremental Healthcare Cost of WHST over 2009 Projected "Status Quo":					equals	\$782,766,064	Method 1/1A
Method 2A (will apply Method 2 assumptions, adjusted for behavioral effects on demand)										
	equals	\$23,995,523,114	Estimated Incremental Healthcare Cost of WHST over 2009 Projected "Status Quo":					equals	\$975,703,020	Method 2/2A
Method 3A (will apply Method 3 assumptions, adjusted for behavioral effects on demand)										
	equals	\$26,340,799,980	Estimated Incremental Healthcare Cost of WHST over 2009 Projected "Status Quo":					equals	\$1,071,066,380	Method 3/3A

Appendix A

Bibliography

(* denotes data used in the report. Websites accessed over period 2/14/1007-2/28/1007)

REVENUE

Consumer Price Index-All Items (Urban (“CPI-U”))

*Conway forecasts for Seattle www.seattle.gov/financedepartment/cpi/forecast.htm

<http://www.bls.gov/news.release/pdf/cpi.pdf>

CPI Urban, all services, seasonally adjusted yrs 2000 – 2006. (2006 % change was 2.5%)

Population

For WA State Office of Financial Management pop projections by age 2000-2030 based on Nov, 2006 projections

* <http://www.ofm.wa.gov/pop/stfc/stfc2006/stfc2006.xls>

Fed Poverty Guidelines

Used HHS guidelines for Medicare, Medicaid — the first link has tabs that take you to several tables, including one with 135% and 150% of poverty level by age groups

*http://pubdb3.census.gov/macro/032006/pov/new46_000.htm

http://pubdb3.census.gov/macro/032006/pov/new46_100125_01.htm

<http://aspe.hhs.gov/poverty/faq.shtml>

<http://www.ed.gov/about/offices/list/ope/trio/incomelevels.html>

<http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>

If needed, households and persons per household:

<http://www.census.gov/popest/housing/>

Excluded Populations

Taft Hartley: See report “Summary of the Health Insurance Sectors in Washington and Avenues of Reforms”, Heubner, Jeff, MD, UW and Charles H Thulin, Ekman, Bohrer & Thulen, P.S., page 6. 124,200 people covered in 2002. Expenditures \$291,000,000 in 2002.

*http://www.insurance.wa.gov/special/coverwashington/answers/avenues_for_reform.pdf
<http://www.afscme.org/publications/9727.cfm> (Taft Hartley Trusts)

<http://www.ofm.wa.gov/economy/healthins/2005/ehidb2005.pdf> See page 30-31 for employer health insurance expenditures: \$1721/ worker, \$4014/enrollee in 2002: estimated for 2005 \$2307/worker, \$5381/enrollee.

Native Americans: State health planning report bases numbers on 2000 census, NHIS and BHRFS surveys – pages 17-23 give tables. HIS “active users (HIS services in prior

3 years)" 2001 – 54,312.

<http://www.aihc-wa.org/AIHCDP/aihcdp.htm#aihcdp>

Federal employees – (See table; used numbers from ESD Wage and Salary data below)

Employer Tax on Wages

Employment security data analyst site – <http://www.workforceexplorer.com>

The figures below have been put in the table for wages >\$125,000/quarter and <\$125,000/quarter. Special run obtained from David Wallace 360-438-4818.

dbwallace@esd.wa.gov

<http://www.workforceexplorer.com/cgi/dataanalysis/?PAGEID=4&SUBID=146>

(Click on Annual Average Wage and Employment

*source of #'s for 2005 average annual wage) (total wages/total employees)

\$40,705

<http://www.workforceexplorer.com/aspdotnet/search/adSearch.aspx?quickSearch=definitions> from here could get to additional annual employer benefits surveys for average annual wages:

*\$ 39,024 for 2004;

For health insurance uptake rates, etc, go to <http://www.workforceexplorer.com> and click on Employee Benefits survey.

Size of firm data Q1-2006 in categories like Frank Fox's 2000 analysis, see:

http://www.workforceexplorer.com/admin/uploadedPublications/7201_061SIZE.xls

National average wage data:

http://stats.bls.gov/oes/current/oes_nat.htm#b00-0000

Existing revenues to be shifted to this program

Tables for 2007-2009 budget include 2003-2005 actual, 2005-2007 estimated and 2007-2009 proposed amounts by agency and activity.

<http://www.ofm.wa.gov/budget07>

Click on Agency Details for each agency.

*<http://www.ofm.wa.gov/budget07/detail/default.asp>

Department of Social and Health Services

*<http://www.ofm.wa.gov/budget07/detail/NL300.pdf>

Health Care Authority

*<http://www.ofm.wa.gov/budget07/detail/NL107.pdf>

Department of Health

*<http://www.ofm.wa.gov/budget07/detail/NL303.pdf>

Agency Recommendation Summaries show difference from 2005-2007 estimated and proposed 2007-2009 budgets. <http://www.ofm.wa.gov/budget07/recsum/default.asp>

Click on agency as above for each.

Revenues by fund type for 2005 -

<http://www.ofm.wa.gov/budget05/summary/table01.htm>

Revenue detail (157 pages) is <http://www.ofm.wa.gov/budget07/summary/table10.pdf>

Tax revenues, such as liquor tax, etc are shown in Department of Revenue reports:
http://dor.wa.gov/content/statistics/2005/Tax_Reference_2005/default.aspx?track=TaxesMain and click on the tax of interest, for example :
http://dor.wa.gov/docs/reports/2005/Tax_Reference_2005/09liquor_sales.pdf

Tobacco Settlement funds In Health Care Authority funds:
from Kaiser Family Foundation site for WA state

*<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Washington&category=Health+Costs+%26+Budgets&subcategory=Tobacco+Settlement+Funds&topic=Distribution+of+Current+Appropriation>
On health services, 2005: \$91,332,000 % of annual funds: 63.4 of total
These do not appear to be in jeopardy from Health Tech fund – it uses bonus that starts in 2007

LEAP (Legislative Evaluation and Accountability Program Committee: Expenditure history – Operating 1995-2005, estimated 2005-2007, proposed 2007-2009 by activity <http://leap.leg.wa.gov/leap/Oversight/histotot.pdf> has DSHS and HCA

For actual spending 2003-2005 –HCA, DSHS, Dept of Health
http://leap.leg.wa.gov/leap/oversight/index_finalm.asp

Kaiser Family Foundation WA state facts cited above lists total state health spending in 2003 at \$7,759,000,000 but doesn't give accounts. <http://www.statehealthfacts.org>

Estimated Program Cost and Economic Analysis

Blumberg LJ, Holahan J, Weil A, et al. Toward universal coverage in Massachusetts. *Inquiry* 43 (2): 102-121, 2006 (Summer).

Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey Household Component, 2003. Accessed at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/state_expend/2003/table1.htm

Centers for Medicare and Medicaid Services. Chapter 7: State Data in *Data Compendium: 2006 Edition*. CMS: Baltimore, MD, 2006. Accessed at http://www.cms.hhs.gov/DataCompendium/18_2006_Data_Compendium.asp (February 20, 2007).

Centers for Medicare and Medicaid Services. Washington [(State; emphasis added)] Personal Health Care Expenditures (PHCE), All Payers 1980 – 2004.

- Includes totals by type of care (hospital, physician services, other professional services, dental services, home health care, prescription drugs, other non-durable medical products, nursing home care, and other personal health care
- Data are gathered according to state of provider location, and therefore are not

valid estimators of expenditures per capita

Entin SJ. Tax incidence, tax burden, and tax shifting: Who really pays the tax? *Center for Data Analysis Report*, #04-12. Heritage Foundation: Washington, DC, 2004 (November 5). Accessed at <http://www.heritage.org/Research/Taxes/cda04-12.cfm> (February 21, 2007).

Fuchs VR, Krueger AB, and Poterba JB. Economists' views about parameters, values, and policies: Survey results in labor and public economics. *Journal of Economic Literature* 36: 1998 (November).

Gruber, J and Poterba J. Tax subsidies to employer-provided health insurance. *Working Paper No. 5147* National Bureau of Economic Research: Cambridge, MA, 1995 (June).

Himmelstein DU, Woolhandler S, and Wolfe SM. Administrative waste in the US health care system in 2003: The cost to the nation, the states, and the District of Columbia, with state-specific estimates of total savings. *International Journal of Health Services* 34 (1): 79-86, 2004.

MaCurdy, TE. An empirical model of labor supply in a life-cycle setting. *Journal of Political Economy* 89 (6): 1059–1085, 1981.

Newhouse, JP and the Insurance Experiment Group. *Free for All: Lessons from the RAND Health Insurance Experiment*. Harvard University Press: Cambridge, MA, 1993.

- Table 3.2 (Annual Use of Medical Services per Capita, by Plan, p. 41)

Percent of persons with an expense, mean expense per person with an expense, and distribution of expenses, by source of payment, United States, 2003 (29 states are shown separately, *including Washington*; emphasis added). *Medical Expenditure Panel Survey (MEPS)*. Accessed at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/state_expend/2003/table1.htm (February 18, 2007).

Poisaal JA, Truffer C, Smith S, et al. Health spending projections through 2016: modest changes obscure Part D's impact. *Health Affairs* 26 (2): w242-w253 (published online 21 February 2007; 10.1377/hlthaff.26.2w242).

Washington State Office of Financial Management. *Medical Insurance Data Tabulations*. Olympia, WA, 2006.

Accessed at <http://www.ofm.wa.gov/sps/2006/medins.asp> (February 22, 2007)

Categories tabulated include:

- Total Number of Persons Currently Insured
- “ “ Currently Uninsured
- “ “ Received Employer/Union Sponsored Health Insurance
- “ “ Received Medicare
- “ “ Received Medicaid or Other DSHS Medical Assistance
- “ “ Received Military Health Plan
- “ “ Received Basic Health Plan
- “ “ Received Coverage from outside Household
- “ “ Received Other Health Coverage

Washington State Office of the Insurance Commissioner. The uninsured and the cost of uncompensated care in Washington State: a data report by region and county. August 2006. Accessed at:

[http://www.insurance.wa.gov/special/coverwashington/WashMap\(August2006\).pdf](http://www.insurance.wa.gov/special/coverwashington/WashMap(August2006).pdf)

(February 24, 2007)

Woolhandler S, Campbell T, and Himmelstein DU. Costs of health care administration in the US and Canada. *New England Journal of Medicine* 349 (8): 768-775, 2003 (August).

Other

Health Care data including link to Kaiser Family Foundation site (URL listed below)

– Health insurance data and WA State Population Survey

Has “health economics” links to data such as state fiscal condition and Medicaid, WA State Public Employee Benefits Board, CMS, Federal Medical Assistance Percentages (HHS revenue streams?)

<http://www.ofm.wa.gov/healthcare>

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/prov-highlights2004.pdf> state health expenditures all payers, % GSP, GSP

Kaiser Family Foundation state health facts

<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>

Other Sources or references

Medical Insurance Data Tabulations: <http://www.ofm.wa.gov/sps/2006/medins.asp>

This page has links to pick up number of persons in 2006, 2004, etc, with the different types of insurance, including Medicare, Medicaid, employer based, etc

Medical Expenditure Panel Survey (MEPS) Insurance Component info- by state:

http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2

State Planning Grant report on data for assessing Health Insurance Access (Katz) (reviews different sources of data and coverage) Recommends WA State Population Survey as main source with Current Population Survey (US government) after 2002 for comparison with other states, Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey (EHIS) for employer information.

<http://www.ofm.wa.gov/healthcare/spg/research/10assessment.pdf>