WISCONSIN STATE PLANNING GRANT

FINAL REPORT TO THE SECRETARY

OCTOBER 26, 2001

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Executive Summary

Wisconsin continues to enjoy one of the lowest rates of uninsurance in the nation. Based on estimates from the 2000 Wisconsin Family Health Survey (FHS), there were 209,000 state residents who were uninsured for a continuous period of 12 months or more. This was just 4% of the State's household residents. A point-in-time measure of the insured and uninsured from the FHS shows that just 6% (310,000) of Wisconsin household residents were uninsured at a given point in time during 2000. About 4.8 million residents (94%) had some type of private or public health insurance coverage.

Wisconsin has made and continues to make significant investments in public programs that expand access to heath insurance coverage for its citizens. Since July 1999 alone, Wisconsin has implemented or authorized new public programs that expand eligibility for either comprehensive or single service coverage to over 275,000 people in the State. These programs include:

- BadgerCare, Wisconsin's State Children's Health Insurance Program (SCHIP) that provides comprehensive benefits to 89,000 family members, including 61,000 adults (parents) and 28,000 children with family income below 200% of the federal poverty level (FPL).
- Medicaid coverage to uninsured women diagnosed with breast or cervical cancer. This program expansion authorizes comprehensive health benefits for women who are screened for breast or cervical cancer through an existing federal breast and cervical cancer-screening program. It is expected to cover several hundred women.
- SeniorCare, Wisconsin's newly authorized program projected to provide prescription drug coverage for over 160,000 seniors with income below 240% FPL, beginning in September, 2001. Seniors with income above 240% of the federal poverty level can use prescription drug expenses to "spend-down" to become eligible.

In addition, the State anticipates federal approval by year's end of a pending Section 1115 Medicaid waiver to implement an eligibility expansion for family planning services. The waiver would expand coverage to an estimated 40,000 women between the ages of 15 and 44 whose income is at or below 185% FPL.

Summary of Grant Activities

Wisconsin is clearly committed to maintaining its low rate of uninsured. Through publicly-funded health care programs alone, the State invests nearly $4.0 billion annually in health care benefits for its most vulnerable and low-income citizens. In September 2001, Wisconsin's combined Medicaid and BadgerCare enrollment reached 534,500, its highest level ever.

Wisconsin further demonstrates this commitment with its high level of employer-based, private health insurance coverage. Based on the 2000 Wisconsin FHS an estimated 80% (4.1 million) of Wisconsin residents who do not have Medicare are covered by an employer group insurance plan (74%) or other privately-purchased coverage (6%). Because of its high rate of employer-based, private coverage and the fact that a majority of Wisconsin's uninsured live in households connected to full-time employment, Wisconsin elected to invest a significant portion of its State Planning Grant (SPG) funds in research on employer-based health insurance, including:

- Adding a new question set to the FHS to obtain additional information from Wisconsin households regarding the relationship between employment and health insurance coverage;
- The conduct of focus groups and interviews with small employers and low-wage employees to better understand their perspectives on health insurance coverage;
- Purchasing a larger sample size and conducting detailed analysis of Medical Expenditure Panel Survey (MEPS) data for Wisconsin; and
- Receiving technical assistance and assessment services from national experts with regard to Wisconsin's two existing programs that rely on public-private partnerships in their approach to increasing access to health insurance coverage.

These research activities have provided new insights regarding the characteristics of employer-based coverage in Wisconsin. When offered insurance by their employer, the vast majority (78%) of Wisconsin employees will take that coverage. Among the remaining employed adults not insured by their own employer, many are insured by a spouse's employer, public coverage, or privately-purchased insurance. Employees of large employers (those with more than 50 employees) are more likely than employees of small employers (those with 50 or fewer employees) to have insurance through their own employer. This is likely due to differences in offer rates, eligibility rates and decline rates between the two employer groups.

Employees of small employers are less likely to be offered coverage and are less likely to be eligible for offered coverage than their large employer counterparts. Nearly 79% of employees who work for large employers are eligible for the insurance offered by their employer, but only 51% of employees who work for small businesses are eligible. Employees of small employers are also more likely to decline offered coverage. On average, 15% of employees of small employers decline coverage as compared to 9% large business employees. This may be due, in part, to differences in contribution rates and premium costs between small and large employers. While small employers and large employers contribute the same amount, on average, toward single coverage for their employees, small employers contribute less on average than large employers for family coverage. This lower employer contribution toward family coverage coupled with higher overall premium costs would result in higher out-of-pocket costs for employees of small employers.

Preliminary data from the 2001 Wisconsin FHS suggests that low-income employees are also much less likely to be offered insurance by their employers. Low-income FHS respondents were twice as likely (34% compared to 17%) to report that their employer did not offer health care coverage to them. Decline rates were also higher for low-income employees, 28% of low-income employees reported declining the coverage as compared to 22% of all employees. Similar to employees of small business, low-income employees may be declining coverage at higher rates because they are faced with higher out-of-pocket costs than employees, in general. In fact, 1998 MEPS data illustrates a correlation between wages and health benefit levels among Wisconsin employers. The data indicate that employees in establishments that pay relatively lower wages have to contribute significantly more toward their coverage than employees in establishments that pay higher wages.

Wisconsin's very low rate of uninsurance challenges researchers to identify the specific characteristics of the largest (numerically or proportionally) subsets of uninsured persons among the small share of uninsured residents statewide. Wisconsin used the FHS to do exactly that in order to target certain groups for research projects under its SPG program. Among the 209,000 Wisconsin residents who were uninsured for the 12 months prior to the survey, the numerically largest groups are as follows:

- Individuals with income below 200% FPL (117,000 individuals);
- White, non-Hispanic residents (157,000 individuals);
- Uninsured adults without dependent children (108,000 individuals, 50,000 of whom are below 200% FPL); and
- Uninsured individuals connected to employment (187,000 individuals).

Certain groups in Wisconsin are disproportionately more likely to be uninsured, including:

- Young adults ages 18-24 (9% uninsured);
- Individuals with income below 200% FPL (9% uninsured);
- Adults who were employed part-time (10% uninsured);
- Adults who were not employed (8% uninsured);
- Members of some minority race and ethnicity groups (7% to 12% uninsured); and
- Farm residents (10% uninsured)

To obtain information about certain of the above groups, Wisconsin conducted the following population-based research activities:

- Focus groups with Hmong, Latino and African American residents
- Surveys and focus groups with young adults
- Surveys of farm families
- Analysis of the relationship between health insurance and health care utilization
- Redesign of the Family Health Survey to better meet the State's information needs so as to inform policy decisions on current and emerging issues
- An analysis of health care costs and utilization by Milwaukee County's general assistance medical program participants

Through these population-based research projects, it has become evident that the remaining uninsured groups in Wisconsin each have unique circumstances creating a variety of barriers to accessing health insurance coverage. The development of effective solutions or approaches for specific groups of uninsured will require partnerships between state and local governments as well as private entities involved in the business of providing health care and insurance coverage.

Policy Options

Wisconsin SPG projects were designed and implemented prior to the Administration's introduction of the state budget bill and simultaneous to the Legislature's budget debates. As a result, the timing of the grant period was not conducive to initiating legislative policy discussions based on research evidence and projects initiated through the SPG program. However, although

Wisconsin has not enacted a program to expand coverage as a direct result of the State Planning Grant, as previously noted, it has recently made significant gains in expanding access to coverage through new programs that have been authorized or implemented by the State over the course of the last two years.

Certainly, the SPG research allowed the State to developed a more comprehensive understanding of the remaining uninsured that will serve the State extremely well in the years to come as policy discussions on expanding access to health insurance continue to emerge.

Recommendations for Federal Action

SPG funds were used successfully by Wisconsin to identify the state's remaining uninsured population and to identify remaining barriers to accessing coverage for this population. The State would like to makes the following recommendations with regard to how the Federal government could further support states' efforts to collect data and develop effective strategies for expanding access to the remaining uninsured:

- Wisconsin recommends that the Federal government consider continuing financial support for States to administer data collection efforts that help States better understand health insurance coverage issues in their respective states. The value of having current, state-specific data that adequately informs policy decisions and debates cannot be overstated.
- Wisconsin recommends that the Federal government invest in research on new health care cost containment strategies. Efforts aimed at improving access to health care coverage need to be partnered with efforts to address rising health care costs. As a State and a Nation, we need to get to the root causes that create the greatest barriers to accessing coverage. We cannot have increased access unless health care costs are contained.
- In the context of current Federal and State budget challenges, it is recommended that the Federal government focus on assembling the information obtained through the various SPG programs to develop viable strategies for improving access to health care coverage when adequate resources again become available. It would not, seemingly, be in the States' best interest to make federal funding available for programs that increase access to health insurance coverage and to pressure states to find the matching funds at a time when simply sustaining funds for existing programs will be difficult.

Wisconsin State Planning Grant
Final Report to the Secretary

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

Using data from the Wisconsin Family Health Survey (FHS), State Planning Grant project staff were able to identify the population groups with the greatest risk of being uninsured. Various projects to better understand the availability of insurance coverage for these populations were undertaken as part of the State Planning Grant. This section provides: (a) data on the characteristics of the uninsured in Wisconsin; (b) qualitative research findings from focus groups and surveys targeted to these populations; and (c) a summary of the network of safety net programs serving the uninsured. Finally, a short discussion and some data on the problem of underinsurance in Wisconsin is provided.

Characteristics of the Uninsured

For calendar year 2000, there were an estimated 209,000 Wisconsin residents who were uninsured for a continuous period of 12 months or more. This was 4% of all State household residents. Another 380,000 were uninsured for one to eleven months, and also were insured for some time during the previous year (7% of State residents).

All of the data reported on the characteristics of the uninsured are estimates from recent Wisconsin Family Health Surveys. This random sample telephone survey is an ongoing project in the Wisconsin Department of Health and Family Services, providing estimates of health insurance coverage, health status, health problems, and health care utilization to program managers and policymakers within the Department and across the State. Additional information about the FHS design and methodology is in Appendix III.

Table 1 displays characteristics of the 209,000 Wisconsin residents who had no health insurance for a continuous 12-month period. Data were collected through telephone interviews during May through December 2000, so the 12-month period of being uninsured can be any consecutive 12 months starting in May 1999 and ending in December 2000.

Table 1. Characteristics of People Uninsured for 12 Months, Wisconsin, 2000

	Number Uninsured	Percent Uninsured
Total	209,000	4%
Household Income Reported in 1999		
Less than $25,000	102,000	10
$25,000 – 49,999	59,000	4
$50,000 – 74,999	13,000	1
$75,000 or more	7,000	1
Not ascertained	27,000	4
Age Group		
Younger than 18 years	30,000	2
18-24 years	43,000	9
25-34 years	42,000	6
35-44 years	32,000	4
45-64 years	57,000	5
65 years and older	4,000	1
Gender		
Male	118,000	5
Female	91,000	3
Family Composition		
Lives in household that includes at least one child	100,000	4
Lives in household with no children present	108,000	5
Health Status (self-reported)		
Excellent	48,000	3
Very good	68,000	4
Good	57,000	6
Fair or Poor	34,000	6
Employment Status (Ages 18-64)		
Employed full time	85,000	4
Employed part time	39,000	10
Not employed	48,000	8
Race/Ethnicity		
White Non-Hispanic	157,000	3
Black Non-Hispanic	17,000	7
American Indian Non-Hispanic	8,000	11
Hispanic	16,000	12

	Number Uninsured	Percent Uninsured
Geographic Location		
Milwaukee County	44,000	5
All other metropolitan counties	79,000	3
Nonmetropolitan counties	86,000	4
Farm Resident	35,000	10
Poverty Status		
Below 200% poverty level	117,000	9
At or above 200% poverty level	72,000	2
Not ascertained	20,000	10

Source: 2000 Family Health Survey, Wisconsin Department of Health and Family Services

Note: The column titled "Percent Uninsured" displays the percentage uninsured in the group identified in the left-hand column. For example, 10% of all people with household incomes less than $25,000 were uninsured, while 4% of people with household incomes between $25,000 and $49,999 were uninsured. Both the number and percent uninsured are estimates, based on sample survey data.

The Wisconsin Family Health Survey asks a series of questions about current health insurance coverage, followed by one question about coverage over the past year: *Thinking about all kinds of private and government health insurance, including Medicare, Medical Assistance, BadgerCare, employer provided coverage, and insurance that you pay for, were you covered for all 12 months since [date one year ago], or covered for part of that time, or not covered at all by health insurance since [date one year ago]?* All persons who were not covered at all are defined as those uninsured for 12 months, and are described in this table. This measure is roughly comparable to the Current Population Survey measure of persons uninsured for an entire calendar year.

Race and ethnicity are measured by two questions; results are combined for this table. The questions are: *Are you Hispanic or Latino? Which one or more of the following is your race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, or White?* Race/ethnicity estimates are presented only for groups with a sample size of 100 or greater. Employment status is reported for the time of the survey interview. Poverty status is based on reported household income for 1999 relative to federal poverty guidelines for size of family unit and annual income.

The Wisconsin FHS also provides information on the availability of employer-sponsored insurance. Table 2 provides data on the number and percentage of employed adults ages 18-64 who are offered insurance through their employer and among those the number and percentage who "take up" the offered coverage.

Table 2. Offer and Take-Up of Employer-Sponsored Insurance Among Employed Adults Ages 18-64, Wisconsin 2001

	Number of Employed Adults	Percent
Total employed adults	2,349,000	100%
Insurance not offered	394,000	17
Insurance offered	1,919,000	82
Taken	1,488,000	64
Declined	431,000	18
Not ascertained	36,000	1

Source: 2001 Family Health Survey, interviews conducted January-June 2001, Wisconsin Department of Health and Family Services

Calculations using the data shown in Table 2 yield a take-up rate of about 78% among employees who were offered insurance coverage by their employers. It is worth noting that substantial proportions of employed adults not insured by their own employer are insured by a spouse's employer, by public coverage, or by privately-purchased insurance.

The Family Health Survey also collects information about health insurance coverage at the time of the survey interview, for a point-in-time measure of the insured and uninsured. Statewide, an estimated 310,000 Wisconsin household residents were uninsured at a given point in time during 2000; this was 6% of all residents. About 4.8 million residents (94%) had some type of private or public health insurance coverage. This included 3.8 million residents (74%) who were covered by an employer group insurance plan, and another 318,000 (6%) who had privately-purchased coverage.

As illustrated in Table 3, a significant percentage of Wisconsin residents also receive all or a portion of their health care services through Wisconsin's two major, publicly funded program's - Wisconsin Medicaid and BadgerCare. Together, these programs provide coverage to over 10% of the State's population.

Table 3
Medicaid and BadgerCare Enrollment
September 2001

Category	Description	Eligible Individuals
AFDC	AFDC- related Medicaid	145,700
BadgerCare	BadgerCare Eligibles	88,912
Healthy Start	Pregnant women, children under 6 and OBRA '90 children	117,570
Presumptive Eligibility	Pregnant women presumed to be eligible by qualified providers	334
Family Coverage-Subtotal		**352,516**
SSI	Receiving or deemed to be receiving an SSI payment	99,379
SSI-Related	Meet SSI income and asset requirements, not receiving SSI	18,754
Institutionalized	Residing in nursing home or other long term care institution	27,683
Waiver	Eligible under a community waiver program	11,514
Elderly & Disabled – Subtotal		**157,330**
TB-related	Has tuberculosis and is eligible for TB-related services	112
Medicare Beneficiaries	Medicaid pays only for Medicare premiums, copayments, etc.	4,984
Foster Care	Children in foster care placements	10,300
Subsidized Adoption	Medicaid coverage is part of the adoption contract	9,168
Miscellaneous	Miscellaneous	85
Other Coverage Subtotal		**24,649**
TOTAL		**534,495**

Source: Medicaid Management Information System, September Eligibility Reports.

Key Population Groups of Wisconsin's Uninsured

Several groups stand out in importance relative to development of policy and programs for the uninsured. Among the 209,000 Wisconsin residents who were uninsured for the 12 months prior to the survey, the numerically largest groups are as follows:

- Individuals with income below 200% FPL (117,000 individuals);
- White, non-Hispanic residents (157,000 individuals);
- Uninsured adults without dependent children (108,000 individuals-50,000 of whom are below 200% FPL); and
- Uninsured individuals connected to full time employment (187,000 total individuals-124,000 employed adults and 63,000 who live in a household with an employed adult).

Certain groups in Wisconsin are disproportionately more likely to be uninsured; that is, their uninsured rate is higher than the statewide population rate of 4% who were uninsured for 12 months. Those more likely to be uninsured include:

- Young adults ages 18-24 (9% uninsured);
- Individuals with income below 200% FPL (9% uninsured);
- Adults who were employed part-time (10% uninsured);
- Adults who were not employed (8% uninsured);
- Members of some minority race and ethnicity groups (7% to 12% uninsured); and
- Farm residents (10% uninsured)

Qualitative Research Findings

Under the State Planning Grant, Wisconsin conducted several focus groups, interviews and short surveys with the population identified as having rates of uninsurance higher than the statewide population, including:

- Focus with minority racial and ethnic groups and 18-24 year olds;
- Focus groups and interviews with low-income employees and small business employers; and
- Short surveys with 18 to 24 year-olds and farm families.

(More detailed information about these data sources is provided in Appendix III.)

These qualitative projects provided insight into questions such as: How much are low-income employees willing to contribute towards health care coverage? Why don't individuals enroll in public programs for which they are eligible? What are the barriers to coverage for the State's minority racial and ethnic groups? Why do 18-24 year olds have such high rates of uninsurance? How do the uninsured access health care services?

Low-Income Employees and Affordable Coverage

One would expect that the amount uninsured individuals would be able to contribute towards health insurance would depend on factors such as their age, income, health condition, family status, and work status. In focus groups conducted with low- to modest-wage employees, these employees raised the issue of affordability in terms of what they, as well as their small employer, could reasonably contribute towards their health insurance premium. Most employees stated that the reason why their small employer does not offer coverage is because the employer is unable to afford it. Employees are acutely aware of the extent to which health insurance premiums have risen, and that this ongoing increase makes it very difficult for their employer to offer any coverage options to employees. Given this awareness, employees generally expect to contribute to their health insurance premium, although the amount that they were willing to pay for coverage differed by their part- or full-time work status, as well as age, income, health status and family status.

Full-time employees indicated they could afford to contribute $40 to $75 per month towards their health insurance premium for single coverage. The range was wider in terms of what they indicated they could pay for family coverage at $100 to $150 per month. The amount that part-time employees said they could afford to pay was proportionally lower, ranging between $30 to $40 per month for single coverage and $75 to $100 for family coverage. The upper and lower limits of these ranges were influenced by the employee's wage level and whether s/he had a spouse or partner contributing to household expenses.

Focus groups with small employers provided similar results. The employers participating in the focus groups generally thought that their low-wage employees would be able to contribute $40 to $100 per month towards health care coverage. A few employers thought their employees, particularly their older employees, could contribute more, with some saying between $100 and $200 per month. The employers were in general agreement that their younger employees, particularly those that did not value coverage, would be willing to pay very little, approximately $10 to $20 per month.

In other focus groups conducted with 18 to 24 year-olds residing in Dane County, the participant's willingness to pay for health insurance varied substantially. The variation was influenced largely by the type of employment held by participants and their views about their future job possibilities. Participants who currently worked in fast food restaurants for example, and who did not see opportunities for advancement or for alternative career choices, indicated a much lower willingness to pay.

Participants were asked to describe the type of health insurance coverage they would like to have and how much they would be willing to pay to get that coverage. Participants were not asked to distinguish between single and family coverage, although most participants were single. Across all three focus groups with this population, about half of the participants were willing to pay between $0 and $100 per month for health insurance, and the remaining half indicated they were willing to pay between $100 and $175 per month. The average across all three groups was $85 per month. Over half of the participants indicated they would like dental coverage, about one-fourth indicated they would like vision coverage and several also indicated they would like coverage for prescription drugs.

The amounts expressed by the 18 to 24 year-old participants are higher than those expressed by low-wage employees. One reason for this may be that the 18 to 24 year-old were recruited based on their previous emergency room or urgent care usage. Indeed, many of these participants had accrued large health care bills. Two of the groups were specifically asked about their medical debt. About half indicated that they had debt of $4,000 or more, with an average across the two groups of $5,000.

Low-Income Employee's Experience with Employer-Sponsored Coverage

When asked in focus groups about their previous experience with employer-sponsored coverage for which they were eligible, employees related very different experiences with employer contribution levels, provider choice and access. The employees indicated that while some of their previous employers paid most of the monthly premium, just as many contributed less than 50% towards the monthly premium.

Employees were more likely to take up coverage if their employer paid a majority of the premium cost. While some employees indicated that they were willing to pay for over half their premium if they or their family members needed coverage, employees with children were generally more inclined to take up coverage in this situation.. Most indicated that they would decline coverage where the employer paid less than 50% because it was too expensive relative to their immediate health needs.

Uninsured employees also reported being less willing to take up employer-sponsored coverage if their choice of health plans or provider panels was limited. In some cases small firms provide coverage through a single plan which, in some parts of the State, translates to access to only a handful of doctors. Employees preferred to stay with providers who were familiar with their medical history and family history and would like the flexibility to choose a plan that includes physicians they know.

Working parents in particular wanted to stay with pediatricians that they and their child like and trust. Some employees went as far to say that they would be willing pay more for an expanded choice of physicians. In this context, a few employees also pointed out the importance of employers also offering their employees access to dental and vision coverage.

Employee's Preference for Employer-Sponsored Insurance

A majority of uninsured low-wage employees reported during focus groups that they would prefer to receive coverage through their employers rather than through a public program or on their own. In fact, many employees believe health benefits are an integral part of their total compensation and that their employer bears a significant responsibility in providing health benefit options.

Nearly all the full-time employees reported health insurance coverage a leading factor in selecting and staying with their employer. They viewed employers' decision to offer coverage as a symbol of whether the employer respects and values its employees. In turn, many said their decision to stay with their employer for a year or more hinges on if the employer eventually decides to offer coverage. Several indicated that their co-employees had left their current employer specifically because he or she did not offer health coverage.

One of the frequently cited advantages of employer-sponsored coverage is the expert intermediary role that employers and brokers assume when employees have questions or problems with their coverage. Employees identified this role as one of the real benefits of employer-sponsored coverage and placed a high priority on having a liaison with the knowledge and the time to intervene on their behalf with the insurance carrier.

> I had a problem where I went to the emergency room, and it was not a life-threatening problem but I twisted my ankle. Four weeks later I get this bill and they said they're not going to pay anything I didn't get pre-approval for. And then I called my agent from work and he said fax me the bill and the next day he called and said it was taken care of.
> - Full-time employee, Milwaukee, WI

In most cases, their direct phone interactions with insurance carriers had been negative. Employees emphasized the need for resources and expertise through their employer to help them navigate what they perceive as a complicated and changing health care system. In general, obtaining health coverage through an employer was also perceived as being lower cost relative to other private sources, and in some cases, even public coverage.

Low-Income Employees Views on Individual Tax Credit Proposal

Focus group participants who were asked to consider the merits of the Bush Administration proposal that would provide an individual tax credit for the purchase of health insurance.

Most participants in focus groups were vocal about their skepticism and dislike of the individual tax credit. They indicated that the proposed $1,000 for single coverage and $2,000[1] for family coverage credit amount was not nearly enough to cover the cost of coverage in the individual market. One employee indicated that he thought the tax credit proposal would likely end up costing more to administer than it would actually provide in medical services.

Employees also discerned that under this proposal, they would have to navigate provider networks and administrative issues on their own. As we previously discussed, employees want an intermediary. They were also clear about needing to receive the tax credit monthly in order to meet a budget, rather than once a year. Several other participants voiced serious concerns about the potential for fraud where people would use the credit for purposes other than health insurance. They were concerned about how the credit would be adequately monitored and feared their tax dollars may be fraudulently used by others.

Overall, the employees indicated that they were not likely to utilize the individual tax credit because they found the overall concept confusing and added that unless the amount significantly defrayed the premium cost that it would not really address the needs of uninsured employees. As one full-time employee said, "I think in the end, it sounds wonderful on paper, but are people really going to do it? If the rubber hits the road and they either can't get coverage or the cost is too high, people will decide to gamble."

For these reasons, many participants found the concept of employment-based coverage through a purchasing pool to be comparatively more appealing. From their point of view, a purchasing pool had a number of advantages:

- They expected lower costs for them through group purchasing;
- The pool would provide an expert entity intervene on their behalf if they have questions or problems;
- Purchasing pools offer some choice of plan rather than being limited to what their employer selects.

A few Milwaukee employees were uncomfortable with receiving any type of subsidy, even if it were coordinated through their employer because it was perceived to be a government program. These employees had previous negative experiences with receiving public benefits and were reluctant to re-enter the "public" system. However, while some employees were uncomfortable with receiving a subsidy, most reported that they would accept the subsidy rather than remain uninsured.

Barriers to Access -Views of Minority Ethnic and Racial Groups

Focus groups conducted in Dane County with Latino, Hmong and African American individuals provided additional and important insights into the barriers that prevent the purchase of health insurance among certain minority ethnic and racial groups.

Uninsured Latino Participants

Language is a significant barrier to obtaining health insurance for the Latino participants. Participants identified a lack of information about health insurance and indicated that little information is provided in Spanish, and when it is provided it is very difficult to understand.

In general, participants reported some confusion about how the health insurance system works in the United States. For example, some participants were not sure whether employers were required to offer health insurance and what they were required to provide. Others indicated that it was difficult to understand the benefits under different insurance policies. Still others experienced difficulty understanding billing systems.

Despite these barriers, participants expressed a desire to learn about health insurance. Most participants felt that interpreters provided a valuable service. In addition, some suggested the need for workshops where health insurance representatives could come and talk about insurance options. Others suggested that a telephone hotline staffed with Spanish-speaking individuals who could answer questions about health care and health insurance would be useful.

In addition to language barriers and a lack of information, some participants indicated that their immigration status prohibited them from obtaining health insurance. Participants expressed fear of being fired from their jobs and concern that if they signed up for health insurance, they would be reported as undocumented.

All participants indicated they would be willing to pay for health insurance. In general, participants did not expect health care or insurance to be free. As one participant said when discussing the cost of care, "Not free because we are all aware that things cost money and the doctors need to have their income in order to survive." However, many expressed the opinion that there was little value in having insurance that does not cover all or most of the costs of care. For example, one woman indicated that her husband's insurance covered only $30 of a $210 bill for x-rays. She felt that it was not worth having to pay a premium each month if she still would have to pay for a large portion of the cost of her care.

A few participants had been offered insurance through an employer but turned down the insurance because the coverage appeared to be minimal relative to their premium costs. In referring to her husband's employer-sponsored insurance, one woman summed up her feelings, "He was going to have a deduction [from salary] of $60, and then I have to pay $20 for each appointment and on top of that extra expenses. Then what's the benefit of having insurance?"

Uninsured African American Participants

The six African American participants in the focus group did not indicate that either race or culture was a barrier to accessing health care or health insurance. Instead they identified cost as the primary barrier to obtaining health insurance. All participants indicated that they wanted insurance for themselves and their children. As one African American woman stated, "You would have a safety net. It's peace of mind." However, participants indicated that insurance was either not available or too expensive.

Lacking access to employer-sponsored insurance, some participants sought insurance through the individual market, these attempts generally were unsuccessful. For example, one participant said that initial price quotes were low, but when it came time to purchase the insurance, premiums were much higher than the initial quotes.

African American participants did not seem to feel that a special phone line or additional workshops were needed because they did not have difficulty knowing where to seek health insurance. All felt that people in general were aware of health insurance, but simply could not afford it.

Insured Latino Participants

The Latino participants who had health insurance felt that it is very important to have health insurance in the United States. Like the uninsured participants, insured Latino residents value the security of health insurance. One insured participant expressed that her health is a high priority – "… for me, my health is first" - something not expressed by uninsured participants. Although difficult to assess, it appears that Latino residents who have insurance may have been in situations where they received more information from their employers and elsewhere compared to residents who are uninsured. One person explained, "When you apply for a job, and if you are accepted, they explain all your benefits, and also medical insurance." The insured participants did not express concerns about immigration status, but it is not known if any of the participants were undocumented residents.

Similar to the uninsured Latino participants, some insured participants expressed confusion about the health insurance system in the United States. For example, one person wondered if it was a requirement that all people have health insurance. Insurance coverage also did not guarantee access for this group as insured participants indicated some level of difficulty in accessing health services and using their insurance. Language also appears to be a barrier for this group in terms of understanding what is covered under their insurance policies, how to use the policy and where to go for services covered under the policy. Lack of information can have a high cost. For example, one person went to a clinic that was out of the plan network and ended up paying out-of-pocket for services that otherwise would have been covered under their insurance plan.

Similar to uninsured focus group participants, insured participants used interpreters, which helped to alleviate some confusion. They suggested that a phone line for Spanish-speaking individuals could help provide information about health insurance. The group generated other ideas about community-based support, such as workshops to provide general information about health insurance coverage.

Insured Hmong Participants

Like all of the other focus group participants, both insured and uninsured, the five Hmong focus group participants like the security that insurance affords them. Most participants learned about health insurance through their job or from the State for coverage under the Medicaid and BadgerCare programs.

Unlike participants in other groups, some Hmong participants indicated that they would not want to work for an employer that did not offer insurance, even if the employer paid a higher wage. This was made clear as they were the only participants that indicated that they prefer to pay for insurance through payroll deduction. Without it, they stated that they would likely spend the money on something other than health insurance coverage.

Cultural and language barriers impact Hmong participants. These participants were the only focus group participants to express concerns about discrimination. When discussing promptness of care in the emergency room, one woman stated, “I feel that maybe, like myself, I feel I am different people so they don’t acknowledge and work with me.” Participants expressed some confusion about having a regular doctor, indicated they had difficulty making appointments, and appeared to wait until they were very sick to go to the doctor.

Hmong participants generally agreed that the biggest problem they faced was the language barrier. They indicated that even documents translated into Hmong were of little use, especially for their parents. According to the Office of Refugee Services in Wisconsin, the Hmong culture traditionally placed a heavy emphasis on oral communication as opposed to written language. Thus, language barriers are often compounded by low literacy levels. Although the Office of Refugee Services indicates that this appears to be changing for the Hmong community, focus group participants still expressed concerns for older generations.

As a result, Hmong participants have experienced difficulties in completing insurance forms and understanding billing procedures. Further, as with Latino residents, language issues have resulted in misunderstandings about covered services. Focus group participants expressed confusion about why health insurance does not cover all services and medicine, and why there are co-payments and deductibles. Hmong participants expressed the need for more interpreters and other services to help alleviate these problems.

Access to Health Care for the Uninsured

Questions about where uninsured individuals receive their health care services were answered in many of the focus groups. Some uninsured participants indicated that they received care from local clinics. For example, about one-third of 18 to 24 year-old focus group participants indicated that they have primary physicians they see at area clinics. They reported having long-standing relationships with these physicians and in some cases had set up payment plans to pay for their regular care in the absence of insurance coverage.

Many uninsured focus group participants indicated that the care they seek and receive is not for primary or preventive services. For example, most participants in the 18 to 24 year-old focus groups indicated they did not seek care for routine medical services.
Reasons provided for not seeking such care included:

- Did not need care unless really sick
- Using home remedies
- Cannot afford it
- Already have accumulated large health care bills
- No insurance
- Bad experiences with physicians.

Some participants did not indicate a reason or simply said that they “just don’t” seek such care.

Having insurance does appear to make a difference as to whether a person receives preventive care services. Participants in a focus group with insured Latino residents of Dane County reported having a doctor and receiving annual check-ups, mammograms and other preventive care services. By comparison, when asked, none of the participants in the focus groups with uninsured Latino residents indicated they receive these services regularly, if at all.

Emergency Room Utilization

Local providers have raised concerns about high emergency room utilization among the uninsured. Qualitative research from focus groups with uninsured Latino and African American residents of Dane County and with uninsured 18 to 24 year-olds in the county provide some insights into the use of hospitals for care.

The uninsured Latino and African American focus group participants indicated that they use the emergency room even more than local clinics to access care. None of the Latino residents had been denied medical care because they were uninsured, but most believed that lack of insurance

was the biggest barrier preventing them from seeking care through a doctor or clinic. Most participants expressed a preference for care provided by a doctor or in a clinic instead of going to the emergency room as many of them indicated they do now.

Compared to the uninsured Latino participants, African American focus group participants were even more likely to seek medical treatment from the emergency room. While the Latino focus group participants indicated a preference for going to community clinics to obtain care, the African American participants indicated that the emergency room was preferential because of its "promptness, efficiency, and quick service." Attempts to seek care in a clinic setting were frustrating due to difficulties in scheduling appointments.

Finally, the uninsured 18 to 24 year-old focus group participants also indicated that they seek treatment in the emergency room. When participants need routine, non-urgent health care, most use emergency rooms or urgent care clinics at hospitals. The primary reasons for using hospitals include: being uninsured; being billed later for services; it is less expensive than using clinics; free prescription drugs (although this policy has changed); better care available than from clinics; shorter waits and they cannot be denied service.

Some participants, though, expressed disadvantages to using hospital emergency rooms, some in direct contrast to the above-mentioned advantages. These include: long waits; its more expensive than clinics; patients see a different doctor each time; lower quality doctors; less attention; more "hassle"; and unnecessary testing.

About one-third of the 18 to 24 year-old participants visited hospital emergency rooms in true emergency situations such as car accidents, severe pain, emergency surgery or asthma attacks. Others visited the emergency room for non-life threatening situations such as dehydration, respiratory infections, strep throat, and migraine headaches. One participant used the hospital emergency room as her prenatal caregiver during her pregnancy.

Many participants indicated that they did not plan to pay their emergency room bills. Participants in two of the three focus groups with 18 to 24 year-olds were specifically asked how much medical debt they have. About half of the participants in these groups indicated they have debt of $4,000 or more. The average among the two groups was approximately $5,000.

Family Health Center Participants

In order to better understand the needs of uninsured young adults and farm residents, two short surveys were targeted to 18-24 year olds and farm families that participate in the Family Health Center of Marshfield Clinic (FHC). A detailed description of the FHC is provided under "Safety Net for the Uninsured and Underinsured".

A short survey was sent to the 179 members of the FHC who are 18 to 24 years of age. While the FHC functions like a health insurance program (e.g. participants pay a sliding fee premium in exchange for health care services), the FHC is a federally funded community health center and not a health insurance policy. The services covered under FHC are limited and do not include inpatient hospitalization.

The part-time employment status of many respondents was also a barrier to accessing group coverage through their employer. About 40% of the young adult respondents indicated that they were unable to get insurance through their job because they are a part-time employee, they are a temporary employee, or for some other reason. . In addition, the cost of obtaining health insurance was identified as a barrier for the young adults responding to the survey. About 67% of the respondents indicated that they could not afford other insurance coverage.

About half of the respondents to the survey indicated they would like to have insurance coverage in addition to their FHC membership due to the limitations in services under FHC. Respondents generally indicated they would like more comprehensive services. Of those who responded that they would like to have health insurance coverage, 48% indicated that they would like to have coverage for hospitalization, about 32% indicated they would like to have dental coverage, and about 19% indicated they would like to have added coverage in general. A few respondents indicated that they would like to have coverage that extended beyond the Marshfield area, particularly while enrolled in school. In general, those that did not express interest in additional coverage reported that they liked the services they received from the FHC and that the FHC covered all of their current needs

A second short survey conducted under the State Planning Grant was sent to the 68 farm families who were participating in the FHC at that time. Results, in combination with a separate survey conducted by the Barron County Health Department, indicate that farmers often pay high premiums for health insurance coverage that has high deductibles and does not cover primary care services such as annual check-ups. Therefore, the FHC provides important services for these farm families.

Safety Net for the Uninsured and Underinsured

In addition to having high rates of private coverage through employer-sponsored insurance and public coverage through the Medicaid and BadgerCare (S-CHIP) programs, Wisconsin has a broad network of safety net programs and providers, which provide care individuals without access to insurance.

In addition to State-subsidized programs, the State's uninsured and underinsured may receive care from hospitals with outstanding Hill-Burton obligations and/or with missions that include the provision of charity care. The State also has a network of clinics providing care on a sliding fee scale, including Community and Migrant Health Centers, Healthcare for the Homeless programs, Tribal Health Centers, and an FQHC look-alike clinic. Finally, there are some privately administered and funded programs that help low-income uninsured and underinsured persons receive the health care they need; for example, the Family Health Center of Marshfield Clinic.

Local health departments in Wisconsin are a primary contact and conduit of information and referrals for many of these services. Compared to other states, Wisconsin's local health departments have typically been less oriented to direct service provision, although they are an

important provider of HealthCheck (EPSDT) services, family planning services and targeted screening services.

The following is a summary of the programs that comprise Wisconsin's safety net system.

Relief Block Grant program

Through the Relief Block Grant program, the State provides funding to counties that serve dependent adults. To qualify for State dollars, a county must provide health care assistance to dependent persons and may also provide non-medical assistance to dependent persons. Counties develop dependency criteria and may define the scope of health care services that will be provided by the Relief Block Grant program, but may not use RBG dollars to provide AODA or mental health services. Counties may provide services directly or through contractual arrangements with providers.

Since 1996, participation in the program is optional for counties, which may use State dollars for their programs, fund general relief programs solely with local funds, or have no general relief program. Currently, the State's appropriation to all counties in the State, except Milwaukee County, is $800,000 per year. Since 1996, approximately 40 counties (not including Milwaukee) have claimed State funding and have provided services to an average of 2,200 medical recipients and 1,470 non-medical recipients each year.

General Assistance Medical Program (GAMP)

GAMP is Milwaukee County's Relief Block Grant program. Like Wisconsin's other 71 counties, Milwaukee County defines dependency and the scope of services provided under its program, with similar restrictions on funding of AODA services and mental health services. Unlike other counties, Milwaukee County may fund only medical services. In CY 2000, total funding for the program was $36 million. GAMP is funded with State dollars, federal Medicaid funds, and Milwaukee County tax levy.

GAMP contracts with providers in the community to provide benefits for clients. The network includes all of the hospitals in the community, 15 independent, community-based clinics, with 27 separate service sites across the county, 240 specialty care providers and 25 pharmacies.

To be eligible for GAMP, an individual must reside in Milwaukee County; must not be eligible for any other public or private coverage; and must meet the program's income guidelines, which for CY 2000 was $882 gross monthly income for one person. In addition, individuals may apply for GAMP only when they are in need of health care services. Once determined eligible for GAMP, eligibility is retained for six months. In calendar year 2000, GAMP served more than 20,000 individuals, and since 1996, the program has served an average of 19,000 persons annually. The majority of those served reside in the City of Milwaukee.

Research under the State Planning Grant included an analysis of the health care costs and utilization of participants in GAMP. Inpatient hospital and specialty services constitute the majority of the GAMP budget, although the program has successfully used primary care services

provided in community based clinics and selective utilization management techniques to control and reduce inpatient and outpatient hospital costs in recent years. Program staff have also worked to educate participants about, and improve access to, preventive services to further manage program costs. Like the health care marketplace generally, GAMP has been experiencing significant increases in pharmacy costs.

Tribal Relief Block Grant Program

Wisconsin's 11 tribes administer this program for dependent American Indian and Alaska Natives living on tribal land. The tribes develop dependency criteria and determine the scope of health care services to be provided. Tribes are prohibited from funding mental health services with Tribal Relief Block Grant dollars but may fund AODA services. The Tribal Relief Block Grant is funded with $800,000 of tribal gaming revenues.

Public Health Programs

Wisconsin has a number of programs that provide health care screening and services for persons categorically eligible with specific health care needs. These programs are generally funded with a combination of federal and State dollars. These programs include:

- Maternal and Child Health and Family Planning programs- provides reproductive health care services, including traditional family planning services
- Women and Infant Children – provides food and nutritional services
- Sexually Transmitted Disease (STD) prevention and services
- HIV/AIDS program - provides access to insurance continuation funding, the AIDS Drug Reimbursement Program, HIV testing, case management and early intervention primary care services
- Wisconsin Well Women Program - provides screening and referral for heart disease, osteoporosis, mental health, domestic violence, and breast and cervical cancers. In addition, the State has recently added Medicaid eligibility for uninsured women diagnosed with breast or cervical cancer through this screening program.

Health Insurance Risk Sharing Program (HIRSP)

The Wisconsin Health Insurance Risk Sharing Program (HIRSP) offers health insurance to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market.

Generally to be eligible, a person must be under 65 (persons on HIRSP who reach age 65 may continue coverage under HIRSP) and must meet one of the following four eligibility criteria:

1. Be eligible for Medicare because of disability;
2. Have tested positive for HIV;
3. Within nine months prior to applying for coverage, have received notice of rejection or termination of coverage, substantial reduction of coverage, a premium increase of 50% or more, or a quoted premium of 50% above that for a person with standard risk;

4. Be an “eligible individual” and submit a valid certificate of “creditable coverage” from his or her previous insurer.

The HIRSP program currently serves approximately 12,000 Wisconsin residents.

WisconCare

Established in 1985, the WisconCare program funds and arranges health care for under- and unemployed persons through a network of medical providers. Basic health services, including routine physician visits, outpatient diagnostic and laboratory, inpatient maternity care and prescription medications are available to persons who are poor or near poor, but do not qualify for Medicare or Medicaid. Eligibility is based on the following criteria:

1. Clients are not eligible for health care coverage through another program and have no other health care insurance coverage with outpatient and/or maternity benefits;
2. Clients have a gross family income at or below 150% of the federal poverty level (FPL); and
3. Clients are unemployed or working fewer than 25 hours per week and available for full-time work.

WisconCare is supported through a combination of State revenues and donated professional services by providers. Physicians and other health care providers receive payment only for the non-labor technical costs of the services they render.

WisconCare currently serves approximately 400 people in 17 of Wisconsin’s 72 counties.

Chronic Renal Disease

Established in 1974, the Chronic Renal Disease (CRD) program pays Wisconsin health care providers for the treatment of chronic renal disease for certified CRD Program recipients after all other sources of payment have been exhausted. To be eligible for the program, a person must be:

1. Diagnosed as having chronic renal disease defined as “that stage of renal impairment which is irreversible and requires a regular course of dialysis or kidney transplantation to maintain life;”
2. A permanent Wisconsin resident; and
3. Paying Medicare Part B premiums if eligible for Medicare.

The CRD Program currently serves approximately 6,100 people.

Rural Health Clinics, Federally Qualified Health Centers & Community Health Clinics

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are federally designated programs to improve and provide access to health services among the underserved population. As such, RHCs and FQHCs must be situated in medically underserved areas of the

State. Both RHCs and FQHCs are eligible for cost-based reimbursement for furnishing Medicaid services. FQHCs are obligated under federal law to provide care on a sliding fee basis.

Community and Migrant Health Centers (CHC) and Health Care for the Homeless Programs are automatically eligible for FQHC status by virtue of receiving federal grants under the Public Health Service Act. In addition, Indian Tribal clinics and urban Indian clinics receiving funds under Title V of the Indian Health Care Improvement Act are categorically eligible for FQHC status. In Wisconsin, there are 12 Community and Migrant Health Centers, two Health Care for the Homeless Programs, one FQHC Look-alike, 11 Tribal Health Facilities, and one urban Indian clinic. There are 62 Rural Health Clinics serving Wisconsin residents. CHCs also receive State grant funding allocated in proportion to the volume of health services provided by each clinic.

All federally-funded Migrant and Community Health Centers provide comprehensive primary health care for adults, children and families. In 2000, Wisconsin's Community and Migrant Health Centers and Health Care for the Homeless Programs provided medical services to 89,000 patients, dental services to 15,600 patients, and other health related services to 14,000 patients. Patients served by these clinics are among the most needy in the community, with 50% having incomes at or below the FPL and another 19% having incomes between 101% and 200% FPL.

Family Health Center of Marshfield Clinic, Inc.

The Family Health Center of Marshfield Clinic, Inc. (FHC) sliding fee program provides primary care services for persons in an eleven county service area with family income under 200% of FPL. Once a person is in the FHC program, they may remain in the program as long as they meet the income eligibility criteria. The program conducts annual eligibility recertifications and requires members to notify the program of changes in income, which could affect their eligibility or premium payment.

The program receives funding from a number of sources: federal grants, Marshfield Clinic in-kind contributions, State community health center grant funds, and member premiums. Funding is limited for any one year, so the program typically has a waiting list for membership. Average monthly enrollment in the program during CY 2000 was 2,796 members. As of October, 2001, the program had 2,887 members. Currently, 1,778 individuals are on a waiting list to receive services through the program. Approximately 27% of those served by the program have income under 100% FPL; while the remainder (63%) have incomes between 100 – 200 % FPL.

SeniorCare

The 2001-2003 Wisconsin biennial budget authorized the design and operation of SeniorCare, a subsidized prescription drug program for Wisconsin seniors with incomes at or below 240% of FPL. Seniors with income above 240% may use their prescription drug expenses to "spend-down" to become eligible.

SeniorCare is designed to help those with limited prescription drug coverage. Seniors with other health insurance that covers prescription drugs may be eligible for the program, but SeniorCare will only cover eligible costs not covered under the other insurance plan. The State estimates

that approximately 260,000 seniors will be eligible for the program based on income limits and age and that approximately 160,000 will participate.

The plan requires a $20 annual enrollment fee and cost-sharing of a $500 deductible, co-payments of $5 for generic drugs and $15 for brand-name prescriptions. Deductibles are waived for seniors with incomes at or below 160% FPL.

Uncompensated Care

Uncompensated care is the term used to define the sum of charity care and bad debt for services provided by hospitals. Charity care is that care for which a hospital does not charge because it has determined that the patient cannot afford to pay; while bad debt is that payment which is expected but that the hospital has not collected. Charity care and bad debt may be difficult to differentiate from each other because reporting and accounting systems vary across hospitals. Furthermore, at least one study has suggested that many claims that are written off as bad debt are incurred by patients with incomes under the federal poverty level, such that they could reasonably be expected to qualify for charity care or public insurance.[2]

One hundred and twenty nine of Wisconsin's hospitals provided a total of $301 million in uncompensated care, either as charity care ($116.8 million) or as bad debt ($184.2 million), in fiscal year 1999, up from $257 million in fiscal year 1998.[3] Measured as a percent of total hospital charges, uncompensated care accounted for 3% of total charges in fiscal year 1999. Uncompensated care averages 6% of total hospital revenue when measured as a percentage of total gross non-government revenue.

The Underinsured

Wisconsin SPG Research did not specifically examine underinsurance nor has the State attempted to develop a single definition of what it means to be uninsured. However, several SPG projects have provided some level of information on this topic.

The Family Health Survey provides information about underinsurance by asking respondents the following three questions:

- *Does this health insurance plan pay for all, some, or none of the costs of general check-ups and other preventive services, when you are not sick?*
- *For health care at a doctor's office or health care clinic when you are sick or injured, does you health insurance cover all, some, or none of the expenses?*
- *For overnight hospital stays, does this health insurance cover all, some, or none of the expenses?*

Among individuals with employer group health insurance coverage, 4% said none of the costs of preventive care were covered; only 1% said none of their acute care expenses were covered, and less than .5% said none of their hospital care was covered. Roughly half said that some of their care was covered, for each of these three questions.

In addition to data from the Family Health Survey, a study conducted by the Barron County Health Department indicates that farmers often pay high premiums for insurance coverage with high deductibles that does not cover primary care services such as annual check-ups. In particular, the Barron County study compared farmers who had health insurance through employment off the farm with farmers who had purchased insurance on their own. Among the 189 Barron County dairy farmers that did have insurance for themselves or their families, approximately 30% had health insurance through a job off the farm. The remaining 70% of the insured survey respondents purchased their own insurance. Both price and coverage differences were reported between the policies available to these two groups.

Health insurance premiums and deductibles were considerably higher for Barron County dairy farm families who purchased their own coverage as compared to those who obtained coverage through off-farm employment. Over 42% of the dairy farmers reported annual deductibles in excess of $1,000, while only 4% with access to employer-sponsored coverage off the farm reported annual deductibles over $1,000. In addition, while over 70% of the dairy farmers with access to off-farm employer-sponsored coverage reported monthly premiums between $50 and $200, 82% of those that purchase their own coverage reported monthly premiums in excess of $200.

The insured Barron County dairy farmers also reported coverage differences depending on the source of their coverage. Farmers who obtained their coverage through non-farm employment were more likely to report coverage of primary care services, such as annual physicals and immunizations. Primary care services were less likely to be reported as covered under the self-purchased policies. For example, only 21% of the farmers with self-purchased insurance reported coverage of immunizations, compared to 81% of those with non-farm employer-sponsored insurance.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

State Planning Grant (SPG) activities provided detailed information on the characteristics of Wisconsin employers that offer health care coverage to their employees and those who do not. Employers were compared based on their size, industry sector and employee wage levels. The ability to access health coverage through an employer was also studied from the point of view of the employees. Employees were compared based on their income, geographic location in the State and full-time status. Small employer focus groups and employer interviews conducted under the Wisconsin SPG project explored the likelihood of employers who do not offer coverage being influenced by the development of purchasing alliances, individual or employer subsidies/tax incentives or an economic downturn. These qualitative research findings are also reported in this section.

Employer and Employee Characteristics

Using State Planning Grant funds, a set of new questions were added to the 2001 FHS and the sample size was doubled for interviews conducted between January and June 2001. With the questions added to the 2001 FHS, the data can be analyzed to tie characteristics of a job to the

likelihood that the employee would be covered through group insurance. The new survey questions focused on job characteristics (tenure, hours per week), employer characteristics (type of employer, small business status), employer offer of insurance, employee acceptance or refusal of insurance, and dependent coverage under employer insurance.

The following information on employer characteristics was compiled from the new FHS dataset and 1998 Medical Expenditure Panel Survey (MEPS) data for Wisconsin. MEPS, the largest annual employer survey, is conducted by the U.S. Agency for Healthcare Research and Quality (AHRQ). More detailed information on these data sources is included in Appendix III.

Employer Size

For the purposes of State Planning Grant activities, small employers were defined as businesses that employ 50 or fewer employees. Large employers were defined as businesses with more than 50 employees. In Wisconsin, large employers are more likely to offer health care coverage to their employees than small employers and employees of large employers are more likely to be eligible for offered coverage. The following table provides more detailed information on health care coverage in Wisconsin by employer size.

Table 4. Establishments That Offer Health Insurance and Their Employees.

	Total	Small Employers	Large Employers
Establishments in Wisconsin	130,100	102,800	27,300
Number That Offer Health Insurance	73,700 (57%)	46,800 (46%)	26,900 (98%)
Employees in Wisconsin	2,393,400	805,200	1,588,200
In Establishments That Offer Health Insurance	2,161,200 (90%)	585,400 (73%)	1,575,600 (99%)
Eligible for Employer-Offered Insurance	1,659,800 (69%)	409,800 (51%)	1,249,400 (79%)
Declined Employer Offer	267,200 (11%)	122,100 (15%)	144,900 (9%)
Accepted Employer Insurance	1,392,600 (58%)	287,700 (36%)	1,104,500 (70%)

Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component, 1998.

Approximately 1.7 million employees are eligible for the insurance offered by their employer.

Employees who work for small employers are less likely to be offered coverage. Nearly 79% of employees who work for large employers are eligible for the insurance offered by their employer, but only 51% of employees who work for small businesses are eligible. In addition to those who were not eligible, a significant number of employees within establishments that offered insurance declined the coverage offered. In total, nearly 1.4 million of the 2.4 million employees in the State were covered by health insurance through their own employer in 1998.

As compared to employees of small employers, employees of large employers are more likely to have insurance through their own employer.

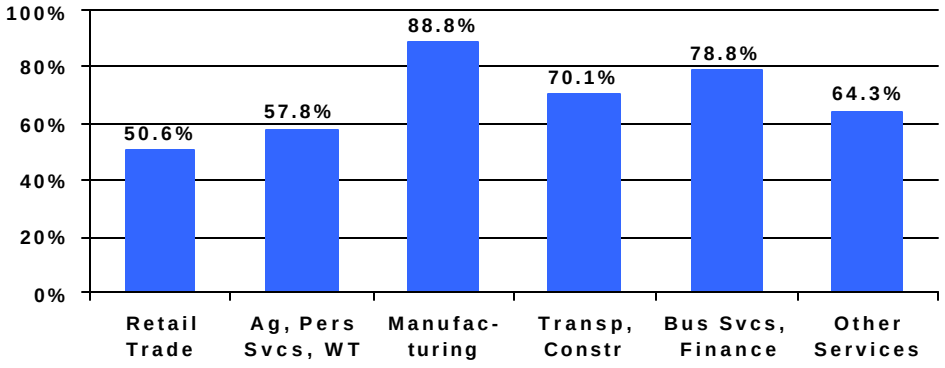
Employees who decline or are not offered coverage by their own employer are not necessarily uninsured. They may be covered by health insurance through a spouse or other family member. Alternatively, they may be covered by a public program, such as Medicaid or BadgerCare.

Industry Sector

Employer health care coverage offer rates also vary by industry sector. According to 1998 MEPS data, Manufacturing establishments and Business Service and Finance establishments were the most likely to offer their employees health care coverage. The following chart summarizes offer rates by industry.[4]

Table 5

Percent of Workers Offered Health Coverage at Work, by Industry
Wisconsin, 1998



Source: Institute for Health Policy Solutions analysis of Data from the 1998 MEPS Survey of Private-Sector Business Establishments, the U.S. Agency for Healthcare Research and Quality

Employee Income Brackets

Preliminary data from the 2001 Wisconsin Family Health Survey (FHS) suggests that low-income employees are much less likely to be offered insurance by their employers.[5] The survey defines "low-income employees" as individuals with household income less than twice the federal poverty level. Twice as many low-income FHS respondents reported that their employer did not offer health care coverage to them (34% of low-income employees compared to 17% of all employees).

When coverage was offered, approximately 72% of the low-income employees reported accepting the coverage. While 28% of the low-income employees reported declining the coverage. Among all employees, approximately 22% declined coverage when offered. Therefore, low-income employees are more likely to decline coverage than employees in general.

While an employee's wage is not necessarily a predictor of their family income, employee wage levels also correlate with the employer offer rates. For Wisconsin establishments, the MEPS survey has also found that high wage employees are more likely to be offered coverage than low-wage employees. The data shows that approximately 93% of employees earning more than $20 per hour were offered coverage by their employer, while only 51% of employees earning less than $7.50 per hour were offered coverage.

Percentage of Part-Time and Seasonal Employees

Very few part-time employees in Wisconsin have health care coverage through their own employer. According to 1998 MEPS data, only about 8% of part-time employees in the State had coverage through their employer. This compares to just over 69% of full-time employees covered by their employer. Low rates of coverage for part-time employees can be attributed to two factors: first, a greater proportion of part-time employees are employed by establishments that do not offer coverage (28% compared to 5.6% of full-time employees), and second, part-time employees are less likely to be eligible for employer-sponsored coverage. Establishments reported that over 53% of part-time employees compared to 14% of full-time employees were not eligible for offered coverage.

Data from the first six months of the Wisconsin 2001 FHS illustrates a similar relationship. For the purposes of the survey, an individual was considered to be working full-time, if they worked more than 30 hours per week for a single employer. While 90% of full-time employees reported being offered coverage by their employer, only 35% of part-time employees reported being offered coverage. In addition, just 13% of part-time employees reported being the policyholder of their health care coverage, while 71% of full-time employees reported being the policyholder. The majority of part-time employees (61%) reported being covered under someone else's group health insurance policy.

Geographic Location

Information on offer rates by geographic location of the employer is not available. However, the Wisconsin FHS provides data on employer offer rates by the residential location of Wisconsin employees. According to this data, the employer offer rate for employees residing in Wisconsin metropolitan counties[6] is 84%. For employees residing in non-metropolitan counties, the employer offer rate was 81%.

Cost of Policies

Among employers offering coverage, the cost of health coverage and the employer's contribution to those costs was examined across employer groups.

The most recent information available on the health care premium costs to Wisconsin employers offering coverage comes from the 1998 Medical Expenditure Panel Survey. The unit of analysis in the survey is the responding establishment's most comprehensive plan with the lowest out of pocket premium costs to the employee. Given the recent trend in rising health care costs, however the MEPS data may significantly understate the current costs faced by Wisconsin employers.

According to the survey, overall premiums faced by small employers (50 or fewer employees) were slightly higher than those for large employers. The average small employer paid $2,375 for single coverage and $5,726 for family coverage annually in 1998. This compares to $2,121 for single coverage and $5,474 for family coverage for the average large employer. The 1998 national average for all employers was $2,080 for single coverage and $5,273 for family coverage. Therefore, it appears that Wisconsin employers were paying more on average for coverage than their national counterparts.

Level of Contribution

On average, Wisconsin employers paid 81% of the cost for the most comprehensive, lowest-cost single coverage policy they offered their employees. Employer contributions were 74% on average for the cost of family coverage. The percent of the costs contributed by the employer did not vary significantly by employer size for single coverage, but smaller employers contributed less toward family coverage.

There does, however, appear to be a correlation between wages and health benefit levels among Wisconsin employers. The 1998 MEPS data indicate that the employer contribution toward coverage varied by the wages of the establishment's employees. High-wage employers (those with over 50% of their employees earning more than $15.00 per hour) contributed more on average toward the cost of coverage than did modest-wage (those with 50% of employees earn between $6.50 and $15.00 per hour) or low-wage (those with over 50% earning less than $6.50 per hour) employers for both single and family coverage. Consequently, employees of high-wage establishments pay less for their coverage. In fact, according to the MEPS data, employees working in low-wage establishments were asked to contribute more than twice as much for coverage as employees working in high-wage establishments.

For all establishments in Wisconsin, the average monthly contribution by the employee for family coverage was $117.08 per month or $1,405 annually. However, there was wide variation among employers, with 5% of eligible employees facing a required contribution of more than $304.66 per month ($3,656 annually) for the most comprehensive lowest cost family plan offered by their employer. The average monthly employee contribution for single coverage was $32.66, or $392 per year. As with family coverage, there was wide variation among employee contributions for single coverage, with 5% of eligible employees in small establishments facing a required contribution of more than $150 per month ($1,800 annually).

Some Wisconsin employers paid the entire cost of health insurance premiums for their employees. As compared to family coverage, businesses were nearly twice as likely to cover the

full costs of single coverage. For all establishments, 27% of eligible employees were not required to pay anything toward their single coverage, but only 14% were not required to pay anything toward family coverage. Surprisingly, smaller establishments had a higher percentage of eligible employees who did not have to pay anything toward their health insurance coverage. Just over 40% of eligible small business employees did not have to contribute toward their single coverage and 30% did not have to contribute toward their family coverage.

Table 6

Percent of Employees Eligible for Employer Coverage Who Are Not Required to Contribute to Enroll in That Coverage, by Coverage Tier and by Firm Size, United States and Wisconsin, 1998

United States	All Firms	Small Firms (<=50 Ees)	Larger Firms (>50 Ees)
Employee-Only Coverage	33.1%	55.7%	25.9%
Full Family Coverage	16.8%	31.8%	12.4%
Wisconsin			
Employee-Only Coverage	27.1%	40.3%	22.7%
Full Family Coverage	13.8%	30.5%	8.3%

Source: Special Tabulations from the MEPS-IC Employer Survey for 1998 prepared by the U.S. Agency for Healthcare Research and Quality.

However, small firms that offer coverage and do require employees to contribute in order to enroll tend to require employees to contribute more than larger firms do, particularly for family coverage. In the following two tables, the "mean" contribution levels include eligible employees who are not required to contribute at all (i.e., their contribution level is $0), while the percentile distributions are based on employees who must contribute some non-zero amount in order to enroll.

Table 7

Range of Monthly Employee Contributions for Employee-Only Coverage under Lowest-Cost Plan Available to Eligible Employees through Their Employer, by Firm Size, United States and Wisconsin, 1998

United States	Mean	25th Percentile	Median	75th Percentile
All Firms	$30	$21	$36	$57
Small Firms (<=50 Ees)	$28	$30	$50	$82
Larger Firms (>50 Ees)	$31	$20	$34	$53
Wisconsin				
All Firms	$33	$23	$34	$58
Small Firms (<=50 Ees)	$35	$24	$50	$85
Larger Firms (>50 Ees)	$32	$23	$33	$52

Source: Special Tabulations from the MEPS-IC Employer Survey for 1998 prepared by the U.S. Agency for Healthcare Research and Quality.

Table 8

Range of Monthly Employee Contributions for Full-Family Coverage under Lowest-Cost Plan Available to Eligible Employees through Their Employer, by Firm Size, United States and Wisconsin, 1998

United States	Mean	25th Percentile	Median	75th Percentile
All Firms	$129	$74	$128	$204
Small Firms (<=50 Ees)	$150	$121	$205	$295
Larger Firms (>50 Ees)	$123	$67	$115	$182
Wisconsin				
All Firms	$117	$65	$120	$172
Small Firms (<=50 Ees)	$134	$101	$167	$257
Larger Firms (>50 Ees)	$111	$59	$104	$170

Source: Special Tabulations from the MEPS-IC Employer Survey for 1998 prepared by the U.S. Agency for Healthcare Research and Quality.

From this data, it appears that small firms, especially the smallest firms, are "bi-modal" with respect to their contributions for health benefits. Some small firms are very generous, paying the full cost even of family coverage. Others are less generous, presumably paying just enough to get their employees to take employee-only coverage so that participation is sufficient to maintain a group plan, but not contributing very much at all toward coverage of dependents.

High-wage employers also had a large percentage of employees who had access to no-cost coverage, as did employees in the manufacturing and construction industry categories. Of all employees who did not have to contribute toward their health insurance, over 40% were in the manufacturing and construction industry categories.

In addition to understanding the general characteristics of employers that do and do not offer health care coverage to their employees, SPG activities identified factors that influence small employer's decisions about whether or not to offer coverage. Information collected through small employer focus groups and interviews focus on why small employers do and do not offer health care coverage and what policy options might increase the likelihood that they would offer coverage to their employees.

Small Employer Views on Offering Coverage

The most recent Kaiser/HRET Survey of Employer-Sponsored Health Benefits (2001) reports that: "Cost is the most important factor cited by small employers for not offering health insurance." The survey found that "64% of all small firms (3-199 employees) who do not offer coverage cite high premiums as a very important reason for not doing so. Other factors cited as important by many employers [include] the observation that employees may be covered elsewhere (56% say it's very important); the company can attract good employees without offering health insurance (30% say very important); and the fact that the administrative hassle is too great (22% say very important)."[7]

Based on focus groups and interviews with Wisconsin employers, it appears that similar factors influence whether an employer offers health insurance coverage or not. Among the non-offering employers that participated in focus groups, the prevailing reason they cited for not offering coverage was the high cost of health insurance. It is important to note, though, cost was a relative term for these employers. Many indicated that they had not recently inquired into the cost of group coverage but instead most based their understanding of the cost of coverage on what they were paying for their own policy. The amounts employers were paying varied widely due to the level of coverage they had, their age, and their health status. For instance, one employer indicated that she was paying $1,057 a month for an individual policy with a $1,400 deductible. Her coverage was probably so expensive because she was over 40, had been a former smoker, and had high blood pressure.

A factor related to the overall cost of the coverage was the ability of either the employer or the customer to absorb such costs. Employers with larger profit margins or greater ability to pass on their costs to their customers would be more likely to offer coverage.

> Contributing $300 [$50 per employee for six employees per month] will quite literally come out of my pocket and plain and simple, why should it…because I can't raise the price of my [products].
>
> -Non-offering Retail Store, Friendship, WI

The second most frequently cited reason why employers did not offer health insurance was that their employees did not need coverage since they had it through some other source, typically a spouse. Employer responses varied regarding the number and type of employees who had coverage through other means. Some employers, particularly those with less than 10 employees and/or with low employee turnover, indicated that at least all their full-time, and many of their part-time employees, had coverage elsewhere. Other employers, particularly those with more than ten employees or with a fair amount of turnover among their lower-wage employees, cited that their more important or senior employees had coverage elsewhere while their younger or more junior employees were uninsured.

Some employers indicated that if an employer can attract an adequate supply of qualified labor and keep those employees, the employer does not have great incentive to offer coverage. Non-offering employers also mentioned that they sought employees who already had coverage from other sources so they would not have to deal with the issue of offering coverage.

> I mean almost have to put yourself in a position where you find those people where you know I hate to say it, but you put yourself in a position where all things being equal who would you rather hire, some you know 25 year old girl who needs health insurance or some 25 or 30 year old girl or woman who's husband has got the insurance plan that you know you don't have to worry about it. And it's not going to be an issue.
>
> -Non-offering Service Firm, Milwaukee, WI

Conversely, if an employer cannot attract qualified employees or is having difficulty retaining employees that are critical to his or her business, the employer will most likely decide to offer coverage. Lastly, some employers indicated that they did not offer coverage because they did not want to take on the responsibility of offering or the hassle of administering coverage. In particular, some employers did not think offering coverage was worth the hassle since their employees would not value the benefit.

> Employees forget that health insurance is a benefit…they don't look at the contribution made by an employer as a wage.
>
> -Non-offering Research Firm, Milwaukee, WI

Many employers thought that even if coverage were available at no cost to their younger employees, many of them would probably not go to the effort to obtain it. The employers were generally pessimistic regarding the value their younger employees placed upon health insurance. They thought these employees believe they are "invincible" and only appreciate health insurance if they become ill or seriously hurt. The employers generally agreed that younger employees typically only begin to value health insurance when they get older (around 30 years of age or so), have children, and/or begin to accumulate some assets that they want to protect from a

catastrophic event. This attitude was amplified by one of the younger employers who participated in a focus group and who was uninsured.

> Yeah, I fall under that category that I don't necessarily believe in a lot of types of insurance. I think they make you jump through hoops, they only want to find the healthy people. As soon as you're sick they're either booting you out of there or raising your rates. They just want to keep making their money. They don't really care whether you get help or not. That's why you're filling out tons of paperwork and you're doing this and you're doing that. It's not they're like oh, we care, we want you to be, but then if something happens you're like, oh that's not covered under your policy even though you thought it was. I mean I think it's the same with any insurance home, auto, you know as soon as you get in a car accident your rates go up… I mean it's probably me being younger and that just leaves a bad taste in my mouth, and I do understand the importance of it because my mother she had cancer and my sister had cancer and my sister had no health insurance. She found government programs that got her through that, so I do understand the importance, but yet part of me is also like I'm beyond that. I rarely get sick. I've never had any major, I've never broken anything so I wouldn't say invincible but you know you're kind of like until something happens.
>
> -Non-offering Food Establishment, Milwaukee, WI

There were a number of reasons cited by employers <u>for offering coverage</u>. Some employers considered it to be their responsibility to offer coverage - it is the right thing to do. Other employers thought that by offering coverage they could reduce the number of part-time positions they had and could create a more reliable, dependable work force. Other employers may offer coverage (even when it means paying lower wages) because they believe it helps their employees remain healthier, thereby having a positive effect on employee productivity and reducing employee absenteeism.

> Mostly the reason is, you feel that everybody needs it. I'd rather say to people it's health insurance if it cost me a $1 an hour, off of a $1 an hour less to work and I think it's important. I mean you see people getting sick, not when they are 18 and 19 and 20, but when they are 35 and 45, you know that they're all gone. I mean they'll never be able to pay their hospital bills, they don't have insurance, I think it's just a quality of life thing that as employers we should take a little bit of responsibility for it if we possibly could.
>
> -Non-offering Employer, Camp Douglas, WI

Several non-offering employers also commented that they would like to be able to offer coverage so they could expand their business. These employers reported being in a Catch-22 situation: they could not expand their business without bringing on a qualified individual or individuals who would demand health insurance, and they could not afford to offer health insurance unless they expanded their business.

Some employers indicated that they were willing to offer coverage and had offered coverage in the past but were not offering coverage now for a variety of different reasons such as the following:

- Employees did not want coverage, particularly if they had to contribute towards it.

- The employer could not afford to contribute the full amount and the employee could not afford the amount they had to contribute.
- Employers in seasonal industries like construction could not offer coverage because their employees would not make their premium payments during the off-months. These employers had contemplated pre-funding their health plan by deducting an additional amount each month from their employees' paychecks to apply towards coverage during the off-season, but the employees could not afford or would not agree to the additional payroll deductions.
- Most of their uninsured employees worked part-time, and therefore would be ineligible for coverage or would not be able to afford to contribute towards their premium.
- Some of their uninsured employees were "uninsurable" thereby causing the premiums quoted to the group to be significantly more expensive than either the employees or the employer could afford.

Throughout the interviews and focus groups, employers emphasized their concerns about providing health insurance to employees in several reiterations of four common themes.

- Cost of providing health insurance
- Mistrust of insurance programs
- Skepticism about value of health insurance to employees
- Burden of ongoing administrative workload

Small Employer Views on Various Policy Options

Small employer focus groups and employer interviews explored the likelihood of employers who do not offer coverage being influenced by the development of purchasing alliances, individual or employer subsidies or additional tax incentives. These particular options were explored primarily because there has been a fair amount of widespread interest in these approaches at the national or State level.

Individual Tax Credit

Through our interview and focus group work, we asked employers to provide their thoughts about an individual tax credit. Employers indicated a fair degree of skepticism regarding individuals, particularly lower wage or income ones[8], being influenced by the existence of a tax credit to purchase health insurance coverage.[9] When the employers asked how they though their lower-wage and/or lower-income uninsured employees would react to the existence of an individual tax credit, most doubted the credit would result in these employees obtaining health coverage for various reasons. In addition, a few employers expressed concern that their lower-wage or income employees would not qualify for the full credit because they do not pay enough in taxes to be eligible.[10]

Employees Would Misuse the Credit

Typically, when it was explained that the tax credit would be a monthly subsidy paid directly to their employees, almost all employers immediately expressed concern that the credit would be subject to fraud and abuse. Most employers thought it was naïve to assume that their lower wage and/or income employees would use the tax credit they received in the form of a subsidy towards health insurance. Although some of the employers thought that their employees would have good intentions and would attempt to use the tax credit appropriately, there was general agreement among the employers that their lower-wage or income employees are under a lot of financial pressure and would ultimately use the subsidy for some other purpose (having the car fixed or buying school supplies for their children).

Even when it was explained that the tax credit could be structured to avoid misuse of the subsidy dollars by sending the funds directly to the insurance carrier, some of the employers thought that their employees would engage in fraud or that a black market for the tax credits would be created. In addition, the employers feared that even if the tax credit could be structured so no fraud or misuse of funds could occur, their employees' coverage would lapse if they were required to make a premium payment. Some employers feared that their employees would fail to make their premium payment because they would forget to do so or would have too many other more immediate uses for that money.

> I don't think it's a matter of like, as it is a matter of human nature, the low income employee all of a sudden gets a little extra money in their hand, they're going to need something else a little more important than insurance.
>
> -Non-offering Employer in Camp Douglas, WI

Employers Concerned that Tax Credit Amounts Would not Be Enough

The employers also expressed concerns that the amount of the tax credit discussed—$1,000 for single coverage and $2,000 for family coverage—would most likely not be enough to entice their uninsured employees to get coverage. The age of the uninsured employees among the interviewed employers varied—for some employers, most of their uninsured employees were around 30 years old or younger, while others had employees who were in their 40's or 50's. Since many of the employers were older (average age around late 30's or early 40's) and had individual policies, they were intimately aware of the cost of individual coverage. Thus, they thought that the amount of the tax credits discussed could require a significant contribution on the part of their older uninsured employees and possibly some contribution on the part of their low-wage or income employees.[11] In either case, they thought this would result in their employees not using the tax credit to obtain coverage.

Some Employers Concerned that Individuals Would Not Purchase Good Policies.

The employers were more mixed regarding the ability of their lower-wage or income employees to select a good insurance policy and a good insurance company for their source of coverage. These employers were generally not questioning the intelligence of their lower-income or wage employees, but rather were indicating that they thought buying health insurance involved a

learning curve and that the most important lessons would be learned when the coverage was needed most. Some felt that understanding the various policy options would be beyond the ability of a lay person.

> Well yeah. It's a whole jungle out there. It depends on who you're going to believe and who you're going to trust because it's not, you know when you open this what you're going to get in that can. And you know if you open a Dr. Pepper what it's going to taste like. You don't know when you get these policies; there's fine print in them, the easiest way I've gotten rid of all the bad coverage ones, I say send me a copy of the policy. I want the boilerplate. I'm going to give it to my lawyer, and he's going to look at it. Nine times out of ten I will never get a policy sent to me because they know that that policy is bogus and if I turn it over to somebody who is trained, a lawyer to read a contract, and that's what it is, it's a legal contract they will say Mark here's their loophole here and here and here and this is how they're going to screw you basically…And they know it. I mean I want a copy of the policy before I sign it. I do not want the, but it's taken me and when I was younger I did sign a few bad policies. And the color brochures looked really good. But that's all I saw was the color brochures. It shouldn't be that complicated.
>
> -Non-offering Florist, Milwaukee, WI

Other employers were not as concerned about their lower-wage or income employees buying coverage. These employers were often times purchasing individual policies for themselves and thought that the individual market was for the most part not that intimidating or difficult.

Some Employers Preferred the Tax Credit Be Given to Them on Behalf of Their Employees

Many of the employers who expressed an interest in offering coverage to their employees if it were affordable tended to prefer that individual tax credits be given directly to employers. They suggested that many of the concerns they had about the individual tax credit could be resolved by making the payment directly to the employer. Most thought that a direct payment to the employer would ensure that the subsidy would be used for its intended purpose and more importantly, any necessary employee contributions easily could be handled through payroll deductions and thus premium payments would be made on time. These employers also indicated that they were relatively comfortable selecting among health insurance options and thought they could select better coverage than what their employees might do on their own.

A few of the employers did not like the idea of an individual tax credit because they thought it would not help them attract or retain employees. These employers wanted to offer coverage because, given their tight labor market, they thought it would help them attract and retain employees. They were concerned that if an individual tax credit were available, their employees would have less incentive to stay with them.

> We are all kind of saying…there is just…a huge labor shortage, we need things that are going to make people want to stay with us and if they have individual insurance and get a tax credit that completely bypasses the employer that doesn't help us keep them…
>
> -Non-offering employer, Pewaukee, WI

Employer Tax Credit

Employers participating in focus groups who did not offer coverage to their employees were asked to comment on the possibility of an employer tax credit. In general, those employers that had previously indicated an interest in offering coverage also expressed interest in an employer tax credit. The range of employer responses varied from lukewarm to very enthusiastic, with some employers hesitant about the concept while others viewing the tax credit as a real opportunity to allow them to offer coverage to their employees.

> I'm seeing this as the way the government is actually helping small business for once. And they're giving us a way that we can attract and keep qualified individuals that can go to bigger corporations.
>
> -Non-offering Travel Agency, Milwaukee, WI

Employers Interested in Employer Tax Credit

Almost all employers interested in offering coverage said if an employer tax credit were available, that they would offer coverage if the credit made it economically feasible to do so.

> I think it depends upon how bad you need an employee and if it's [health insurance] a factor in that. It would be nice to have a program out there available…that would be, it depends on the bottom line. You've got to work at your bottom line and your stockholders. You've got to answer to them and that's my wife and my two girls. And you know it's a tough group. It's a very tough group. They demand a return on their investment. So it just, if it's two thousand or three thousand dollars and you're getting a thirty five dollar credit that's three fifty, three seventy, I mean that's a big spread in there. And the employee's not going to, they'll come with some but you still get right back and they have less money to spend and they're going to want a pay raise and that's going to cost you. And then you've got to make up the difference in there so really it depends on how big the spread's going to be. If it's smaller, yes, but if it's going to be substantial and things are very tight right now.
>
> -Non-offering Florist, Milwaukee, WI

Unfortunately, though, there was not general agreement upon what would make offering coverage economically feasible.[12] Some employers indicated that the tax credit could constitute about a third of the cost of the premium, while others thought it would have to constitute about 75 or 80% of the premium. Part of these differences in opinion depended on how much the employers thought their employees could contribute towards coverage, which in part depended on the wage or income of the employee.

Employers Not Interested in Tax Credit

On the other hand, those employers that had not expressed a great interest in offering coverage were not overly interested in the prospect of an employer tax credit. Some of the employers were concerned about the administrative workload or hassle that might be associated with a tax credit.

> I don't know an easy, but I can't imagine an easy answer for that because the employers are not going to want to accept the responsibilities of keeping all these records [associated with a tax credit]. Because when you're a small business, you're just spinning your wheels sometimes just trying to keep yourself from not going under.
>
> -Non-offering Bakery, Milwaukee, WI

> Okay earning under ten dollars or let's just say a full time employee because we're saying that it should cover everybody at this point. What if, in December then you have instead of five full time employees, you have twelve full time employees and then in January you lose two and now you have ten full time employees. I mean how would that all work out? It just seems kind of mind boggling to me to try to cover someone the way the job market is where you have people who are fooling around, especially in small business… You'd spend a full day figuring out the paperwork and all unless it was a real, real easy common system to understand and to administer you know.
>
> -Non-offering Employer, Milwaukee, WI

Other employers were not overly interested in an employer tax credit because they thought it would only result in greater government intrusion into their lives and potentially greater government intrusion into the provision of health coverage to working Americans. A few of these employers were concerned that an employer tax credit might be the beginning of a slippery slope towards "socialized medicine."

> And you know you talk about government wanting to get more into our lives and offering health insurance and offering plans whatever and offer anything that makes things easier, but the government's never made anything easier and they're not doing it now, and I don't believe that anything that they can do at this stage of the game is going help them. It's going to move us more towards the socialistic situation that I think every intelligent person in this room would probably dread. So I don't know, it's a mess. It really is.
>
> -Non-offering Video Production Firm, Milwaukee, WI

One big concern for many employers was whether and how a tax credit would keep pace with increases in insurance premiums. The employers knew that for many firms, health insurance premiums have increased annually around 20% or more per year. They were concerned that if the tax credit did not keep pace with premium inflation, the credit would be eroded over a period of several years to the point where the employer and the employees would be bearing the full brunt of the cost.

> Once we start doing this that credit stays at thirty five and the premiums have gone up you know what from two hundred to nine hundred is what happened to you. What's the percentage on that? Unless there's a mechanism in there to make sure that the tax credit is going to keep going with it we're starting something that we cannot [maintain] and eventually we're going to have to pull the plug on and then you've really got a problem.
>
> -Non-offering Florist, Milwaukee, WI

Other employers were against the concept of an employer tax credit in general because they thought it was the wrong approach for government to take to solve the problem of the uninsured.

These employers were also concerned about the rising costs of health care and thought the government should focus on controlling rising health care costs rather than on increasing employer-based coverage for the uninsured. The employers disagreed as to what sector's costs needed to be controlled—insurance companies, providers, drug companies, etc.—but they thought that an employer tax credit would be a temporary fix that would not ultimately solve the problem.

Some employers expressed concern about the longevity of the tax credit and indicated that if the credit were only going to be in existence for a year or two, they would decline to use it. They believed that the worst thing they could do would be to make coverage available to their employees and then have to drop coverage once the credit phased out. Other employers, however, were not as concerned about the longevity credit and reasoned that as long as they explained the situation to their employees, it would be better to make coverage available for a year or two rather than not at all.

However, despite some of the employers strong beliefs that an employer tax credit might be a misguided attempt to solve the problem with health insurance in the U.S., some of these employers indicated that they were not so against the idea of an employer tax credit that if it were generous enough, they would not use it to offer coverage.

Employer Tax Credit Policy Considerations

If an employer tax credit were made available, a number of important policy dimensions would first need to be determined.

- Should the tax credit would be made available to all firms whether they offer coverage or not or only those firms that currently do not offer?
- Should all employees regardless of wage be eligible for the credit or just low-wage or income employees be eligible?
- Should any-sized firm be eligible for tax credits or only small firms—where most of the uninsured are employed

Employers that currently offer coverage were very strongly in favor of a tax credit being made available to all firms regardless of whether they currently offer coverage. These employers—many of whom were experiencing double-digit rate increases—felt strongly that since they were already making the effort to offer coverage to their employees, they should benefit from any available government support.

Opinions among firms currently not offering coverage were divided. Some non-offering firms thought it was only fair that all firms should be eligible for tax credits. These firms suggested that if the tax credit were only available to non-offering firms, those that offered would simply drop coverage for a year to become eligible. Others employers thought that since they were the ones who could not afford to offer coverage—those that were offering obviously could—any government tax credits should be made available only to them. Most of these employers did not consider this situation completely fair but reasoned that if the funding for the tax credits was limited it should be targeted at non-offering firms first.

The participating employers were also relatively divided regarding whether the tax credits should only be made available to lower-wage or income employees versus all employees. Although the number of observations are limited, it appears that these differences in opinion were related to the attitude each employer had about their lower-wage employees. Some employers thought it made sense to structure the credit in that manner since these employees are typically the ones who have the greatest difficulty affording coverage. Those employers whose workforce was primarily low-wage or who worked closely with and had a more personal relationship with their lower-wage employees were more inclined to think that the tax credits should be made available to only these employees. However, some of these employers questioned where the cut-off for eligibility should occur and suggested that moderate-wage or income employees should be eligible for some assistance as well.

On the other hand, employers whose workforce was not primarily low-wage or that had a high degree of turnover among these employees were more inclined to think that the tax credits should be available to all employees. Concerns were also raised about a tax credit limited to low-wage employees creating perverse incentives for employers to not increase wages for employees receiving the credit or to pay any more than the wage ceiling for credit eligibility.

> I guess that would concern me because what happens when an employee gets $10 and a quarter an hour; does that credit stop?…If that credit stops at that point I'm not giving him a raise.
>
> -Non-offering Machine Shop, Ashland, WI

Employers who thought that all their employees should be eligible for a tax credit also reasoned that it would be simpler to administer the tax credit if it applied to all employees. These employers also thought it was more equitable if all employees received the tax credit because higher-wage or income employees paid more in taxes than lower-wage employees and thus should get something in return. In addition, some employers expressed the concern that if their higher-wage employees were not eligible for the tax credit they would want something from the employer in return.

Finally, focus group participants were relatively split regarding whether low-wage or income employees should be eligible for a tax credit based on the size of their employer. Some employers thought that a low-wage employee earned a low-wage whether they worked at a small or large firm and thus should be eligible for a tax credit with either employer. Others, however, thought that larger firms had many advantages and benefits that smaller firms did not and thus employees who worked for large firms should not be eligible for tax credits.

Employers expressed different opinions regarding the role they would be willing to play if eligibility for a tax credit were based on an employee's income. Most employers agreed that if tax credits were to be targeted to lower-wage or income employees, it made sense to tie eligibility to employee income rather than wage, although this raised concerns for some employers who felt that their employees' income was none of their business. These employers did not want to have anything to do with trying to determine or verify their employees' eligibility.

Other employers were less concerned about violating their employees' privacy. They reasoned that if they explained that obtaining their employees' family incomes might result in their employees receiving health insurance, it would be okay to ask for such information. Employers already collect confidential information and they reasoned it would not be a significant issue to add family income information to these files. These employers also reasoned that if an employee absolutely refused to provide such information, than that employee would not be eligible for coverage.[13] Employers also suggested that information on family income could be collected without the employer being directly involved. For example, the employer could give their employees forms to be completed, sealed and returned by the employer to the government or other appropriate organization for review.

Purchasing Alliance

Most of the participating non-offering employers expressed interest in a purchasing alliance because they believed an alliance would overcome their frustrations with the market. Many of the employers indicated that they felt disadvantaged in the health insurance market compared to larger firms. These employers believed that larger firms receive lower premiums for equivalent coverage and that, if a purchasing alliance were established for small firms, insurance carriers would treat them as a large group and thus would give them lower premiums as well.

> I posed as a larger employer with 200 employees and received a quote from the insurance company that was $85 less per employee than the quote I received from the same company as a small employer.
>
> -Non-offering Service Firm, Combined Locks, WI

In addition, some employers were disenchanted with the rating structure in Wisconsin and thought it was unfair that some firms (or the firm's employees) had to pay much more in health insurance premiums because the firms had one or more employees with high-cost health conditions. Some of the employers thought this was the reason some non-offering firms did not offer. These firms thought that a purchasing alliance could overcome this frustration they have with the insurance market by spreading the cost of high-risk employees in certain employer groups across all employees participating in the pool.

> It would also be cushioned if [the cost of] your leukemia patient employee…it would be absorbed through the insurance through the group.
>
> -Non-offering Employer, Pewaukee, WI

However, not all non-offering employers were in favor of the idea of the pool spreading risk across participating employers. These employers understood that if the pool rated groups in that manner, the pool would suffer adverse selection as the better risk groups would leave the pool to get a better premium elsewhere. Others indicated a willingness to subsidize the costs of higher risk groups because they recognized that it would only take one sick or injured employee before they would become a high-risk group themselves.

Despite Interest, Employers Had Some Concerns about Purchasing Alliances

Despite their interest in purchasing pools, some of the non-offering employers had concerns about them. Several of them were skeptical that a purchasing cooperative could ever be formed in Wisconsin. These employers either had attempted to form association health plans and had little or no interest from carriers in Wisconsin or thought that small businesses could not join together effectively without some form of government intervention.

> I think a lot of people [would be interested in a pool], but we are basically on the tail end of the dog her, we are small businesses. We don't have any way to unite with each other to buy that group policy. We are too diverse and too far apart to even know that each other exist. We have no umbrella that we come underneath that we can communicate with each other and just set up something like that.
>
> -Non-offering Employer, Camp Douglas, WI

Other employers were concerned that they be able to exert control over the purchasing pool through some form of oversight role. These employers did not want to join the pool because they liked how it was structured and then find themselves in a situation where the structure had changed without their input.

> If changes had to be made would they come out and ask you 'Is this okay with you?' or do they, are they going to make changes on their own where you're like, 'Now we're stuck.' We're in this. And now they're making up these changes, we don't agree with them but we're stuck now.
>
> -Non-offering Employer, Steven's Point, WI

Other employers indicated that they would not join the purchasing pool unless they thought it was well managed and/or had good, reputable participating carriers.

Employers Agreeable to Tax Credits Only Being Made Available through Purchasing Alliance

Most of the employers thought it was acceptable to limit the availability of employer tax credits to purchasing alliances. They thought this would be acceptable if the purchasing pool offered reasonable coverage and contracted with credible health plans. In addition, they thought this would be acceptable if the purchasing pool did not incur large administrative costs and was somehow held accountable to its participating employers. The few employers who did not want the tax credit limited to the pool thought doing so would be discriminatory or would be government dictating where employers must purchase their health insurance.

A few employers also saw other advantages to limiting the tax credit to employers that participate in the purchasing alliance. They recognized that a purchasing alliance could potentially limit its vulnerability to adverse selection by limiting the availability of the tax credit to the alliance thereby creating a strong incentive for better risk groups to stay in the pool. Other employers thought that limiting the credit to the pool would enhance the pool’s credibility and thus increase its chances of attracting health plan and small employer participation.

> Well, there's an incentive for both [high risk and low risk firms] to stay there and to help keep the cost down rather than jumping ship and leaving that high-risk pool. Obviously, you have to weigh the cost benefits but I think there has to be a way to keep healthy groups in that pool.
>
> -Offering Employer, Wausau, WI

> I think you would almost have to give a tax credit just to get it going, just to give an incentive to join.
>
> -Offering Employer, Wausau, WI

Small Employer Response to Economic Downturn

The qualitative research with offering employers revealed several insights regarding how employers would react to an economic downturn or continued increases in premium costs. Not surprisingly, most employers indicated that they would attempt to control their costs by shifting more of the cost burden onto the employee either through offering benefit plans with higher deductibles and greater cost-sharing and/or increasing the share of premium the employee contributes. Other options were to substitute increases in wages for an increased employer contribution, increase the prices of their products or services, and/or compensate their employees for getting coverage through their spouse.

> Well, we are either going to delay some pay raises for several years, raise our labor rate, or we are still going to have to supply the insurance but that $1.00 an hour raise that maybe this guy is due for is going to be explained to him that you won't see this for a couple of years because your health insurance is costing us an extra $300.00 a month.
>
> -Offering Employer, Wausau, WI

Many participating employers indicated that they have been shifting the cost to their employees for the past several years with no great success. In addition, some employers were concerned that if they continued to shift more of the cost to their employees, those who were younger or had families might drop coverage because they could not afford or would not want to contribute that much.

> Especially with the younger workforce too because they have such high deductible and high co-pay, they're thinking, 'Why do I want to get insurance?'
>
> -Offering Employer, Milwaukee, WI

Given their inability to control their costs and with no foreseeable relief in sight, a number of employers indicated that they believe they are getting to the point where they may not be able to continue offering coverage. Some employers indicated they were giving Medical Spending Accounts (MSAs) greater consideration and one employer reported recently dropping coverage and instituting an MSA. Other employers were not clear regarding what eventual cost or combined rate increases would finally cause them to drop coverage, but indicated that they were coming to the reluctant conclusion that problems they have with the insurance market will not be solved without some form of government intervention.

…but again, I don't want the government to be involved but its gotten beyond something a company my size can handle.

-Offering Employer, Wausau, WI

SECTION 3. HEALTH CARE MARKETPLACE

A number of research projects related to the health care marketplace in Wisconsin. These projects included interviews with health plans, research on the existing regulatory environment, research on purchasing alliances in other states. A study of the relationship between health care coverage and health service utilization was also conducted to provide information on potential marketplace impacts of expanding coverage options. Lastly, a comparison of the Iowa Medicaid employer buy-in program and the BadgerCare Health Insurance Premium Payment (HIPP) program was conducted to generate new ideas for opportunities to partner public and private programs in the health care marketplace.

Wisconsin's Health Care Marketplace

In part, research into Wisconsin's health insurance marketplace was conducted to inform the development of the Private Employer Health Care Coverage Program (PEHCCP). Development of the PEHCCP, a statewide health insurance purchasing pool for small, private employers, was authorized by the Wisconsin Legislature in October 1999, before application for a State Planning Grant (SPG) was contemplated. As this policy option had already received approval of the Legislature, SPG funds were used to test the feasibility of this approach and to suggest ways to maximize its impact on the uninsured. Specifically, SPG research in this area focused on:

- Wisconsin's current regulatory environment.
- Health plan attitudes and practices in Wisconsin.
- Other States' experience with purchasing pools.
- Recommendations to enhance the likelihood of the PEHCCP's success.

Wisconsin's SPG proposal did not include projects designed to address questions on the adequacy of insurance products for certain groups, variations in benefit plans among various group plans or the prevalence of self-insured firms. According to recent correspondence with the Wisconsin Office of the Commissioner of Insurance (OCI), "By their very nature, questions regarding these topics ask for information that we, as a regulatory agency, do not gather nor would the insurance industry have this information readily available." OCI can provide the following information based on a survey conducted with the largest writers of group and individual health insurance in the State:

- 300 insurers write *group* accident and health insurance in Wisconsin. The 41 companies responding to the survey represent 76% of the group accident and health market and write over $4 billion in premium.
- 321 insurers write *individual* accident and health insurance in Wisconsin. The 41 companies responding to the survey represent 73.6% of the individual accident and health market and write over $635 million in premium

- The remainder of the survey data supplied to the SPG team demonstrated the percent distribution of insured and self-insured group and individual coverage among HMO, POS, preferred provider, and standard indemnity plans. No enrollment figures were provided. The survey only recorded self-insured coverage if one of the 41 responding insurers was acting as administrator of the self-insured plan; the data do not include plans administered by third party administrators (TPAs) or other entities.

Wisconsin's Regulatory Environment

Research into Wisconsin's regulatory environment and health plan practices focused on how the environment and practices could be addressed—operationally or on a policy level—to facilitate the start-up of the PEHCCP. Specific activities included:

- Review of statutes and administrative rules, particularly governing health insurance for small employers (defined as those with 2-50 employees).
- Consultation with the Office of the Commissioner of Insurance.
- Interviews with health plan executives regarding specific provisions of the PEHCCP statutes.
- A survey of health plans to gauge current practices with regard to rating, underwriting, and other administrative activities.

Key findings regarding Wisconsin's regulatory environment:

- Over 50 health insurers offer coverage in the small group market. This provides small businesses with a much broader range of health plan options than are available in many other states in the nation.
- The use of the following factors is *not* limited when setting premium rates for each small employer: age, sex, geographic location, family composition (number of dependents), and group size (number of employees). Collectively, these factors are often referred to as "case characteristics." Rates may also be varied without limitation to reflect differing benefit design characteristics, such as deductibles, copayments, etc.
- A "rate band" of 30% limits the use of the following factors: health status (as determined by medical underwriting), claims experience, and duration of coverage. Occupation will be included under the rate band effective September 1, 2001. The combined effect of these factors for groups with *identical* case characteristics and benefit design characteristics cannot be more than +/- 30% from a midpoint (arithmetic average) rate for such groups, resulting in a ratio of 1:1.86 from lowest to highest rate allowed.
- Wisconsin does not extend guaranteed issue protections beyond the federal requirements under HIPAA (the Health Insurance Portability and Accountability Act of 1996). Thus, only groups with between 2 and 50 employees are guaranteed coverage in Wisconsin.

To test health plan attitudes about these provisions, the SPG conducted telephone interviews with executives of 12 health plans, including both managed care and indemnity carriers, whose combined service areas provide coverage to Wisconsin residents across the State. A full copy of the report, however, is included as Appendix IV.

Other State's Experience With Purchasing Pools

Data collected about Wisconsin's market regulations, health plan attitudes, and other States' experience with purchasing pools have provided valuable guidance. This information was used to develop recommendations for revisions to the statute governing the pool.

Research into other States' experience with purchasing pools spanned the areas of public/private partnerships, incentives for employers to offer coverage, and regulation of the marketplace. Information about other States' expansions of public coverage was obtained separately, and is discussed at the end of this section.

Information about other States' experience with purchasing pools was obtained through:

- An extensive literature review.
- Interviews with purchasing pool staff in California, Colorado, Kansas, and Connecticut.
- Consultation with the Institute for Health Policy Solutions, an independent, non-partisan research organization with expertise in health insurance pooled purchasing.

Examples of findings:

- Employee choice of health plan, not price, is the purchasing pool's greatest advantage compared to the competition. However, as demonstrated by employer focus groups conducted under the SPG, Wisconsin small businesses may be unwilling to spend more to offer their employees a choice of plan.
- No State or private entity has successfully implemented a statewide purchasing pool with employee choice of health plan (as envisioned by PEHCCP supporters) in an environment with a rate band greater than 10%.
- In Kansas, all but one health plan declined to participate in an environment similar to Wisconsin's. With only one participating health plan, the Kansas pool still does not provide an operational model for Wisconsin.
- Timing can be important. Most successful purchasing pools first offered coverage in the early- to mid-1990's, when small group reform was high on many States' legislative agendas and there was a great deal of interest in the concept of pooling, not least because pools were an integral part of many federal health care proposals. Several States also benefited from the strong, vocal support of key leaders, though this support proved no guarantee for long-term success (as demonstrated in Texas).
- Funding and expertise are critical. California's HIPC (Health Insurance Plan of California) was started by a State agency with a loan of $5.5 million, spent during the first two years of development and operations and repaid over seven, as the pool collected a percent of premium from participating employers. The pool in

Connecticut was started by a private, statewide business association with a history of providing health insurance to its members, staff with experience in the industry, and well-established relationships in the insurance agent community.

Impact of Access on Utilization

Analysis of statewide survey data provided clear evidence of the effects of insurance on use of health care services. Not only was health insurance directly related to use of services, but the relationship held when controlling for the effects of other factors related to use of services. Having health insurance coverage for a full year increased the likelihood of seeing a doctor or other provider, having a routine check-up, visiting a dentist, and having a usual source of health care. These relationships continued even when controlling for the effects of age, gender, education, health status, physically limiting conditions, and presence of chronic conditions. People with no health insurance for a full year were one-fourth as likely as those covered for a full year to have visited a doctor or other health care provider; they were one-sixth as likely to have seen a dentist during the year. This analysis was based on Family Health Survey data collected in 1998-1999.

Based on these results, utilization would be expected to increase with universal coverage, as long as the coverage offered to the uninsured was comparable to existing benefits for the insured. The increase would be observed among those who were uninsured as well as among those with intermittent insurance coverage, although the latter group would be expected to have less overall increase in use of services. Utilization of physician visits and check-ups would be expected to increase the most among uninsured people who have chronic conditions, who are in fair or poor health, who are low income, and who have physical limitations.

Comparison of Buy-In Programs

Wisconsin enjoys high levels of employer-sponsored coverage. The SPG team looked to Iowa and other States for models designed to capitalize on the good will of the State's employer community.

Iowa's Medicaid program has been "buying in" to employer-sponsored coverage for nearly a decade. Anita Smith from the Iowa Department of Human Services, Division of Medicaid Services visited with the SPG team to describe her program and discuss ways in which Wisconsin's is similar and different. Three members of the SPG team also attended a conference of State CHIP staff to discuss "Effective Coverage Expansions for Uninsured Kids and Their Working Parents: Links to Job-Based Coverage."

Key findings:

- Every CHIP program is structured differently and the issues regarding buy-in are very complex.
- The availability and extent of Medicaid waivers greatly affect buy-in efforts.

- Iowa's HIPP program authorizes buy-in to cost-effective employer-sponsored coverage for *all* Medicaid recipients, not just CHIP eligibles. This difference changes the policy debate around crowd-out, outreach, and other important areas of concern in Wisconsin.

This information has not yet been used in policy circles, but will likely be valuable in further refinement of BadgerCare's HIPP program.

Wisconsin HIPP program was implemented as part of BadgerCare and became operational in October 1999. As of September 30,2001, the BadgerCare HIPP program had enrolled only 43 families. Another 129 families were found eligible for "buy in" to employer coverage, but were waiting for open enrollment periods.

The HIPP program has found that only about half of the BadgerCare population (families at or below 185% FPL) have access to employer sponsored family health insurance plans. Current program policies, limited access to employer sponsored family health plans and frequent job changes, make it difficult to enroll large numbers of low-income families into employer sponsored health coverage.

As part of the State Planning Grant, the Institute for Health Policy Solutions (IHPS) conducted an assessment of the BadgerCare HIPP program and made recommendations for increasing enrollment and improving program operations. IHPS recommendations included such policy changes as eliminating minimum employer premium contributions, establish BadgerCare HIPP eligibility as a qualifying event for immediate enrollment into employer health plans, include qualifying self-funded plans for HIPP, and enrolling families into qualifying employer plans even if the children are Medicaid eligible. IHPS estimates that implementing their recommended policy changes could increase the HIPP enrollment by as much as 40%.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

BadgerCare: A National Model to Provide Access to Low-Income Families

Wisconsin SPG projects were designed and implemented prior to the Administration's introduction of the State budget bill and simultaneous to the Legislature's budget debates. As a result, the timing of the grant period was not conducive to initiating legislative policy discussions based on research evidence and projects initiated through the SPG program.

Although the Wisconsin Legislature has not addressed a consensus policy to expand coverage nor has it enacted a program to expand coverage or access to health insurance as a direct result of the State Planning Grant, it is important to note that several programs, which expand access to coverage have been recently authorized or implemented by the State.

In general, previous expansions of health insurance coverage have developed in Wisconsin through a legislative approach that categorized a target population – a group of the uninsured residents with common characteristics thought to be unable or unlikely to secure health insurance

without assistance from the State. For example, BadgerCare's highly successful approach of covering both low-income children and their parents established important precedent both in terms of who is eligible for coverage as well as establishing a State-federal partnership to finance public program costs for a non-traditional population. BadgerCare currently covers approximately 89,000 family members including nearly 61,000 adults (parents) and 28,000 children in households with income at or below 200% of the federal poverty level.

Wisconsin's successful negotiation to secure SCHIP "enhanced match" federal funding for children and adults enrolled in BadgerCare has been vitally important to maintain the strong support the program enjoys in the Legislature. The fact that BadgerCare enjoys strong enrollment and wide acceptance among both public and private shareholders may lead to interest in other State-federal partnerships that address the uninsured - despite an underlying skepticism or reluctance to commit resources to new federal waiver efforts (and therefore commit to prescriptive policy/reimbursement rules).

Wisconsin has committed significant new State revenues to support funding increases in response to growing utilization in publicly administered health insurance programs. Specifically, the State authorized over $45 million in additional funding for BadgerCare. The Legislature and Governor strongly supported the additional funding needed to maintain the BadgerCare program without curtailing enrollment as is allowed under Wisconsin's Section 1115 waiver. In addition, a $430 million increase to the Medicaid budget was approved to reflect revised estimates of increased enrollment and provider costs for the current biennium.

Expanding access to publicly subsidized health insurance for uninsured low-income, working adults without children may be a logical incremental progression in the State, yet it remains a policy concept that is without consensus or commitment of funds at the State or federal level.

Recent Policies to Expand Access to Public Coverage

In the course of the State Planning Grant funding period, the State biennial budget was debated by the Wisconsin Legislature and signed into law by the Governor. The health-related policy and funding priorities that emerged during the budget debate included proposals to provide:

- Prescription drug coverage for the elderly (SeniorCare);
- Medicaid coverage to uninsured women diagnosed with breast or cervical cancer; and
- A tobacco control endowment trust fund to support community-based and statewide public health programs aimed at reducing tobacco use.

These initiatives benefited from strong support by interest groups that represent a specific category of coverage or population. Well organized, single-issue advocacy (e.g. activists for the elderly, tobacco control, women's health) has been effective in supporting these incremental expansions of coverage in Wisconsin.

Despite recent successes and general support of coverage initiatives, such as BadgerCare, State policymakers are struggling to identify State revenue to maintain programs that provide the majority of public coverage. In particular, the Wisconsin Medicaid and BadgerCare programs

are reporting record enrollment and higher than budgeted expenditures. Between July, 2001 and September, 2001, the number of people enrolled in Wisconsin's Medicaid program increased by almost 17,000 to 534,500 individuals, its highest enrollment level ever. Further, state costs to provide Medicaid recipient benefits is projected to exceed the annual percentage increase in health care costs nationwide.

Given the concurrent and significant downturn in forecasted and available State revenues, there is little likelihood to create, fund or expand programs beyond the previously stated priorities. Indeed, the Legislature and Governor strongly supported the creation of new prescription drug coverage, called SeniorCare, during the State budget negotiations to satisfy public demand for such a program. Seniors with income above 240% of the federal poverty level can use prescription drug expenses to "spend-down" to become eligible. Approximately 260,000 individuals are expected to be eligible for the program based on income and age, with expected enrollment of approximately 160,000 seniors.

In early 2001, Wisconsin was also among the first states to expand its Medicaid program to cover uninsured women diagnosed with breast or cervical cancer. The program expansion authorizes comprehensive health benefits for women who are screened for breast or cervical cancer through an existing federal breast and cervical cancer-screening program. In Wisconsin, it is expected that several hundred women will become eligible for Medicaid coverage because of this expansion. This expansion proposal was sustained with bipartisan support and the guarantee of federal matching funds to the State share of Medicaid benefit costs.

Later this year, the Department anticipates federal approval of a pending Section 1115 Medicaid waiver to implement an eligibility expansion for family planning services to women 15-44 years of age whose income is at or below 185% of the federal poverty level. It is estimated that approximately 40,000 women will be eligible for services under the family planning waiver. The Wisconsin family planning waiver program was explicitly designed to complement the BadgerCare and Healthy Start initiatives by serving populations ineligible for those programs. With the additional family planning services provided under the waiver, a comprehensive approach to women's health will be achieved by providing routine preventive family planning primary care to all low-income women of childbearing age in the State.

Again, while legislation was not introduced as a result of SPG activities, it should be noted the high level of access to insurance in the State provides important context to the legislative and policy environment. Recent State and national data shows that access to public and private health insurance coverage in Wisconsin remains remarkably high. Currently, the Medicaid and BadgerCare programs provide coverage to over 10% of the State's total population. Private employer health plans cover approximately 82% of the population. As a result of SPG research, the State has developed a more comprehensive understanding of the remaining uninsured – and convened preliminary policy discussions on the issue of expanding access to health insurance.

Policies to Expand Access to Coverage Through Private/Private Buy-In

New research funded by the SPG confirms that the remaining uninsured people in Wisconsin are most often working adults who do not have children. Uninsured employees are likely to be

employed by small businesses or to be self-employed and report a low income. Given these general parameters, the viability of existing public and private coverage, and the relatively small number who are uninsured in the aforementioned category– approximately 240,000 individuals according to the most recent Wisconsin Family Health Survey data - State-level options for expanding coverage would likely depend on State and federal cooperation and funding.

The Legislature has demonstrated interest in expanding private coverage by enacting legislation in March 2001, that in addition to approving new funding to support BadgerCare required the Department to make recommendations on how to increase participation (enrollment) in the BadgerCare HIPP employer buy-in program.

The Legislature's request for recommendations indicates some level of interest in supporting statutory changes to the HIPP program or to perhaps consider other employer coverage buy-in policies. A SPG research project supported the Department's formal recommendations to the Legislature which propose to:

- Simplify application and insurance verification procedures
- Eliminate the minimum employer premium contribution
- Establish BadgerCare eligibility as a "qualifying event" for immediate enrollment in an employer plan
- Increase employer awareness of the HIPP program.

State Policy and Funding in a Slow Economy

Like the rest of the nation, the growth of Wisconsin's economy slowed during the past 12 months restricting the ability of the Administration and Legislature to consider new health insurance programs beyond the consensus items mentioned above. Revenue reductions are severe enough that State agencies have been required to implement permanent 5% reductions in their operating budgets during each of the next two years. The Administration and Legislature are now considering additional administrative and benefit reductions in order to address a potentially significant budget deficit in the current fiscal year. The fiscal environment has also served to re-emphasize the importance of Wisconsin's strong private health coverage as well as the complexities of extending health coverage in a cost-effective manner to the relatively small remaining pockets of uninsured residents.

The State fiscal environment is seriously compromised by the federal Centers for Medicaid and Medicare Services (CMS) decision to disallow approximately $83 million in Wisconsin Medicaid expenditures. Barring a reversal of the CMS position, the State will face immense pressure to reduce funding that supports of the level of coverage achieved by the Medicaid and BadgerCare programs.

As mentioned, the Legislature and Administration acted to satisfy public demand for prescription drug coverage for elderly, targeted Medicaid expansions, and also to guarantee the on-going provision of tobacco control programming through the long term commitment of new revenues generated through the federal tobacco lawsuit settlement proceeds. At the same time the State's commitment to maintain a low rate of uninsured by providing comprehensive benefits through

BadgerCare was underscored by unanimous support of additional funding approved for the program.

Currently, there is not an active dialogue as to what approach, if any, should be pursued to increase access to health coverage to the remaining uninsured. Policy options to expand existing public insurance programs to other non-traditional populations, e.g. low-income, childless adults or self-employed employees, are currently not possible – and are likely to be debated only if federal funding is available and the expansion uses a program infrastructure that ensures participation by private insurers. If, however, proposed expansions relied solely on State tax revenues to support the cost of administration and benefits, the "state-only" or "government run" options would likely be viewed cautiously by consumers, policymakers, and private industry.

Since SPG research has only recently become available to policymakers, it is uncertain how new information about the uninsured population will be used to bolster or refute any single policy option. Clearly, new public or private expansion of health coverage will only be enacted as part of the larger State budget debate in two years and, as such, in the context of the overall economic condition of the State.

Absent federal initiatives to expand access to health insurance coverage, future State policies will most likely seek to strengthen partnerships with local government and community agencies to provide basic primary health care services and prevention programs.

SECTION 5. CONSENSUS BUILDING STRATEGY

Wisconsin undertook a number of activities to foster consensus around the activities conducted as part of the State Planning Grant.

The Wisconsin State Planning Grant Program (SPG) was authorized by former Gov. Tommy Thompson to develop and conduct a range of research and policy related activities. Under the auspices and designated authority of the Division of Health Care Financing in the Department of Health and Family Services, a SPG team was assembled and integrated to the existing decision-making structure of the Department and the Administration.

SPG staff were identified according to their expertise and responsibility for health programs and research within DHFS. Department staff further identified key representatives of other State and local agencies and private industry or advocacy groups to participate in a range of funded projects. Individuals and organizations identified as SPG partners were designated a State staff liaison or contract officer. Regular meetings and continuous communications between SPG team and our partners were conducted throughout the grant period.

The Governor's Office approved the SPG application and was routinely updated on SPG projects. Staff of key members of the Wisconsin Congressional delegation and State Legislature also received regular updates and communication from the SPG project staff. Ultimately, the SPG presented initial findings and supported a policy forum at a statewide conference held in Madison in September 2001. Approximately 250 attendees representing consumers, health

provider groups, the insurance industry, health advocates, academic researchers, elected State and local officials, employer associations and other State agencies participated in the conference.

SPG projects sought input on issues relating to the uninsured through the use of focus groups including several with uninsured, low-income employees, small business employers, and uninsured individuals from minority groups. Other groups disproportionately represented among the Wisconsin uninsured population, e.g. farmers and low-income young adults were surveyed to ascertain specific circumstances related to not having health insurance. SPG partnerships with local government (e.g. Dane and Milwaukee counties) and interested organizations (e.g. National Federation of Independent Businesses, Marshfield Clinic) were important venues for the collection and initial analysis of this information.

The SPG program convened a conference policy forum comprised of a diverse group of stakeholders including elected officials, business leaders, top State and local government officials, and researchers to discuss the current environment for expanding access to health insurance. The dominant concern raised by the panel was increasing health care costs. Cost increases were cited as a roadblock to further public program expansion and an immediate threat to the State's ability to sustain both public and private coverage at the current level.

In particular, cost pressures relating to private employer premiums were thought to be detrimental to new expansions. Several health sectors including pharmaceutical costs, hospital capital expenditures, and labor shortage issues were also described as limiting factors or areas of concern by policymakers and interest groups. Opportunities for coverage expansions were generally less focused on providing coverage to the uninsured than to strengthening coverage in the private sector. The need for new federal laws to allow expansion of inter-state multiple employer associations (MEAs) and to expand the use of medical savings accounts were priorities of small business leaders.

Wisconsin SPG projects and research were disseminated through various outlets including local print media, the release of information by SPG business partners, State agency press releases, direct mailing to interested parties and networking through SPG contractors. In addition, a web site that will contain issue briefs, public presentations, the final report and other miscellaneous information on the Wisconsin SPG activities is currently under development.

Although the SPG projects have only recently concluded, preliminary analysis of new State and federal data and research has been reported and utilized in important policy discussions on the uninsured. The national security crisis and the concurrent State and national economic downturn that has focused policymakers' attention on core State budget issues temper this progress.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Wisconsin's experience in administering its State Planning Grant has proven to be a most valuable one. One of the most critical activities conducted under the grant project was undertaking a redesign of Wisconsin's State-specific health survey – the Wisconsin Family Health Survey (FHS). Grant activities also allowed the State to gain valuable insights on working with community and employer groups. The following section comments on lessons learned from certain of the projects, describes the grant management structure that proved successful in Wisconsin and briefly comments on projects that were proposed in the original application that were not conducted.

Family Health Survey Re-Design

Wisconsin firmly believes that State-specific data are necessary to effectively inform discussions on issues of the uninsured engaged in by State legislators, policymakers, community advocates, and program managers. Although some State-level data collected at the national level is valuable in that it allows comparisons across states, decision-makers in Wisconsin have come to rely on State specific data collected and analyzed with State resources.

The Wisconsin Family Health Survey has been the State's primary means to obtaining State specific data on the number and characteristics of the uninsured in Wisconsin for several years. With the FHS, Wisconsin has had the ability to inform policy discussions with annual health insurance coverage data obtained through the FHS. In addition, the FHS allows documentation of changes from one year to the next which is key to identifying trends in Wisconsin's insurance coverage.

The State Planning Grant, however, provided the opportunity to examine the ways in which the Family Health Survey has been used, and to modify the survey to make it more useful to Department staff as well as other groups.

Five meetings were held with approximately 50 Department of Health and Family Services staff members, to discuss ways in which they have used the Family Health Survey, barriers they have found in trying to use it, and areas that they would like to see revised or improved. Additional conversations were held with various survey stakeholders outside the Department, including legislators, researchers, advocacy group leaders, and staff from other State agencies. Widespread interest in and support of the Family Health Survey was found, along with multiple suggestions for improving the utility of the survey results. Some of the suggestions will be implemented in the 2002 version of the survey, while others will be addressed in future years.

For example, beginning in 2002, a Spanish translation of the survey instrument along with an oversample of Hispanic residents will be implemented to strengthen the data available for analysis of this growing minority group. A sample large enough to provide county-level estimates, however, is beyond the scope of the survey's budget and mission, although the need for county-level data was frequently mentioned. A summary of all discussion group findings is available upon request.

Under the SPG, a survey contractor was hired to assist with technical aspects of the FHS survey redesign. The contractor reviewed the current survey instrument and provided specific suggestions for questions and topics that need to be revised. The contractor has also provided guidance in developing a format for transforming data collected during the telephone interview into a data set for analysis. The amount of time and effort needed to make this transition to useable data in the past had become a large burden for both Department and contractor staff. Much of this burden was due to the complex structure of the Family Health Survey interview, with one proxy respondent providing both household- and individual-level responses so that every household member would be represented in the final data set. Instead of simplifying the interview structure, and losing the rich detail afforded by this structure, the new data set format is expected to reduce staff burden in processing each data set.

The survey contractor also conducted an experiment with mailing advance letters to part of the sample, to determine whether the letter would increase the response rate. Given the somewhat small sample available for the experiment, no effect on response rate was found.

Several other states have conducted State health surveys, many of them focusing on health insurance coverage issues. Information about the topics covered and questions asked in a number of these surveys was compiled and reviewed in preparation for revisions to the Family Health Survey. In addition, background information about survey funding, management within State government, and overall survey design was collected to help frame the possible areas of change for the FHS.

The SPG program has provided Wisconsin the opportunity to make significant additional investments in the State's most critical data collection tool for health insurance coverage issues. The addition of a new question set on employment and insurance with the redesign activities will serve the State's data collection needs extremely well for many years to come.

Lastly, it is important to point out, though, that the Wisconsin State Planning Grant used a variety of methods (quantitative and qualitative) to produce new State-specific data about the uninsured, and specifically about the relationship between employment and insurance coverage. The combined methods yielded a much richer picture than could any single method.

Partnerships

As outlined in previous sections of the report, Wisconsin utilized a variety of data collection techniques and contracted with national, State and local organizations. The largest contracts were with national organizations that had specific expertise and prior experience in a related field. The data collection activities conducted under these contracts could not have otherwise occurred under the one year timeframe. the relative to the resources expended in conducting the work.

Community Partnerships. Wisconsin also entered into a number of agreements with organizations at the State or local level for the conduct of focus groups, surveys and data analysis. Although the funds associated with these activities were small, the person resources

expended by State staff in providing direction and oversight to the partner agencies was significant. Nonetheless, the data obtained from these community-based efforts was very valuable in providing qualitative information from groups of people with specific circumstances.

Building community partnerships was an effective strategy for improving data collection. Under the SPG grant program, the State was able to tap into local sources of information and further develop data collection efforts with community partners. It allowed the State to obtain valuable information and gain perspective on issues of the uninsured from a community or local viewpoint. These partnerships also served to allow local entities the resources to conduct research that may have been contemplated, but unaffordable.

The State learned about competing priorities and interests between various stakeholders within communities and became increasingly aware of how these influence expectations with regard to the State's role in addressing the issues of the uninsured. Each locality, whether it be a county, city, provider network or some other entity, faces its own unique challenges with regard to issues of the uninsured. Particular groups of uninsured face barriers to health insurance coverage for a variety of reasons that, perhaps, could be most effectively addressed at the local level or through pooling of resources and State-local partnerships.

Business Community Partnerships. Very early in the SPG planning process, it was evident that the business community would be key to the research conducted under the grant. Because of the high rate of employer-based insurance coverage in Wisconsin, a significant portion of the grant activities focused on obtaining data and other information that would provide a basis for developing policies that would build on and leverage private insurance. To this end, small business associations and small businesses themselves were directly involved in research conducted under the grant. They were asked general questions about their experiences and perspectives on health insurance issues and also reacted to specific models of increasing access to health insurance. Clearly, the employer community is experienced and well-informed on these issues. It is evident that the success of program models that are coordinated with private insurance would highly dependent on buy-in from the business community.

For example, in the development of the Health Insurance Premium Payment (HIPP) program under BadgerCare, the State worked closely with the business associations in developing policies and communications for the program. In addition, the State continues to seek feedback from the business community in efforts to improve and sustain the HIPP program. The business community has reacted favorably to this effort to form a public-private partnership for a common good.

Organizational or Operational Lessons

The Wisconsin SPG project was organized around a core team of individuals primarily from the Division of Health Care Financing in DHFS, but also including several members with expertise in health insurance from outside organizations. The core team met often and regularly and served as an efficient and effective vehicle for the planning, coordination, analysis, evaluation, information sharing and product development activities associated with grant management. This approach allowed the project director direct involvement and oversight of all activities directed

by team members in order to ensure a clear and coordinated course of action toward obtaining the goals of the SPG grant program.

For Wisconsin, this organizational approach seemed optimal for a variety of reasons. First, the fact that Wisconsin had recently implemented a major expansion of health insurance for low-income families, made working toward another expansion effort during the grant period unlikely. Garnering political and fiscal support for further expansion efforts at a time when BadgerCare was still in need of this same support would not become a reality. Further, with the State budget process coinciding with the grant period, a split Legislature and the fact that the research had yet to be completed, the development of an organizational structure designed to build consensus was not pursued. Rather, Wisconsin elected to conduct grant activities within the realm of State agency operations.

Proposed Projects Not Conducted

There were several smaller components of Wisconsin's original application that were not conducted as proposed. These activities and the reasons they were not conducted follow:

- Comparison of cost data for Milwaukee County's general assistance medical program (GAMP) and Wisconsin Medicaid/BadgerCare recipients. – In conducting data collection activities for GAMP participants, it became clear that a direct comparison of the cost of care associated with this group with that of Medicaid/BadgerCare would not be a valid comparison as the program purpose, rules and components for each are not the same. For example, under the GAMP program, individuals typically enter the program at the point when they are ill and seeking treatment. This factor alone could significantly influence cost differentials between the programs. Differences in data could not be attributed solely to differences in the populations served by these programs.

- Actuarial analysis of target population remaining uninsured for the purpose of establishing a baseline of information on typical benefit plans available to low-income employees. Early discussions revealed that it was unlikely that this effort would result in information relevant to future efforts in Wisconsin.

- Collection and analysis of data and information about uninsured and underinsured recipients from existing State, federal and local programs. This proposed activity continues to have merit. However, the complexities of establishing a common definition of "underinsured," combined with limited staff resources, prevented its completion during the grant period. The State may pursue this research in the future.

In terms of research that further inform questions related to employee perspectives on health insurance, it would be valuable to conduct additional focus groups with low-wage employees in Wisconsin. Due to time limitations and logistical difficulties, low-wage employee focus groups participants represented only two communities (Milwaukee and Appleton) in the State. As is often the case, it may be that Milwaukee and other more urban residents have different perspectives on issues compared to those who reside in other areas of the State. To enhance the

statewide policy relevance of the research conducted with low-wage employees, Wisconsin could pursue the conduct of additional focus groups with low-wage employees from other smaller urban and rural areas across the State. The State is considering this additional research as it reviews the availability of grant funds for the extension period.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Ongoing Support for Data Collection at the State Level

The State Planning Grant project has provided a solid base of new information on access to health insurance in Wisconsin. The activities conducted under the grant have served to build on and supplement data collection efforts administered and funded by the State on an on-going basis. Because of these efforts, Wisconsin now has a reliable set of data and other information that can better inform future policy debates on issues of the uninsured. However, even though Wisconsin has established the mechanism for regular collection of data, it may not have adequate resources that allow complete and timely analysis of the data once collected.

The value of having current, State-specific data that adequately informs policy decisions and debates cannot be overstated. Therefore, Wisconsin recommends that the Federal government consider continuing financial support for States for the administration of data collection efforts that help States better understand health insurance coverage issues in their respective State.

Wisconsin has demonstrated the significance of data collection efforts that can be accomplished with additional financial support from the Federal government. In less that a year, Wisconsin has:

- Developed and fielded a new questions set on employer sponsored health insurance within the existing Family Health Survey (FHS) and has completed preliminary analysis of the data
- Prepared and disseminated reports on current and new data
- Used existing data to conduct further analysis and reports on certain categories of Wisconsin's uninsured to respond to specific policy questions
- Redesigned and retooled the FHS

Under the SPG projects, the State was also able to provide FHS data specific to a particular county. County-level data is key to local efforts. With Wisconsin's low rate of uninsured, the ability to "drill down" to identify the characteristics of the uninsured at the county level becomes very important with regard to local policy considerations and State-local partnerships or collaboration. Ongoing support for such efforts could have a significant impact on the development of effective and successful approaches to addressing the issues of the uninsured.

Federal support with flexibility could also assist states in:

- Generating a large enough sample to study the uninsured--a minority of the population
- Supporting staff resources to analyze survey data. This would especially benefit states that have an ongoing survey yielding a significant volume of data, but that have relatively few resources for data analysis.
- Structuring and conducting targeted surveys of groups of interest, secondary analysis of survey data or other supplemental data collection activities.

The federal government's current research on health insurance coverage is very strong. The Medical Expenditure Panel Survey is excellent. The Agency for Healthcare Research and Quality has built good systems for dissemination of aggregate data and for making public use data available. The federal government should continue its current work but, perhaps, reevaluate what information is most useful and applicable and make slight changes in emphasis accordingly.

These recommendations could also apply to foundation support of health care services research.

Identify Target Populations and Strategies

The wealth of information shared by SPG grantee states will serve to help the Federal government identify key target populations of the uninsured. In addition, research findings will include new information that will help the Federal government and states formulate strategies for providing access to the uninsured.

However, the Nation and many States are currently facing unique circumstances and intense competition for existing resources. As stated previously in this report, Wisconsin, too, is experiencing a downturn in the economy and declining State revenues. Given that Federal and State governments alike are facing significant budget challenges, it is recommended that current efforts focus on assembling the information obtained through this grant program to develop viable strategies for reaching out to the uninsured that could be offered when adequate resources again become available. It would not, seemingly, be in the States' best interest to make federal funding available for programs that increase access to health insurance coverage and to pressure states to find the matching funds when simply sustaining funds for existing programs will be difficult.

Conduct Additional Research on Health Care Costs

Research, whether national or local, consistently shows that health insurance positively affects health status…and the health status of our citizens is critical to the overall well-being of our State and Nation. In Wisconsin, for example, the FHS shows that:

- 85% of persons who reported themselves as insured saw a doctor last year as opposed to 58% of those uninsured; and
- that more people who perceive their health status as only fair or poor were uninsured all year

Further, a recent national survey also found that uninsured children were 70% more likely to not have received medical care for common conditions.

In the end, however, efforts aimed at improving health care coverage cannot be discussed without addressing, rising health care costs. As a State and a Nation, we need to get to the root cause. We cannot have increased access unless health care costs are contained.

The private sector provides the vast majority of health insurance coverage both in Wisconsin and nationally. But the private sector is experiencing significant increases in premiums and rates. In Wisconsin, rates for health insurance for State employees will see a very significant increase in 2002:

- 14.6% for HMO plans on average
- 18.3% for more traditional indemnity plans

Likewise, the public sector is facing significant cost increases in the publicly funded health care programs. The Congressional Budget Office predicts that Medicaid will grow at an average annual rate of 8.6% through year 2011. Further, public spending on health care programs nationally is now about equal between Medicare and Medicaid. The current annual Medicaid budget in Wisconsin is $3.4 billion and, because it is extremely sensitive to economic conditions, it is now growing.

With our national economic conditions undergoing significant changes and stress, it become essential that initiatives to reach more uninsured persons need to be linked to effective prevention strategies. In Wisconsin, half of all deaths each year are directly related to only a few preventable causes. Advances in public health in the 21st century will come from:

- increasing access and utilization of preventive services to catch problems and risk factors early
- reducing the impact of disabling conditions
- life style changes by individuals

The underlying issue of increasing health care costs was a dominant theme among the stakeholder groups represented on the policy options discussion panel at Wisconsin's statewide conference on the uninsured. The business community, health plans, advocacy groups and government recognize that containing health care costs is integral to the success of existing and future expansion efforts.

With this, Wisconsin recommends that the Federal government further investigate health care cost trends and strategies for containing these costs, including the use of evidence-based medicine and the promotion of healthy lifestyles.

APPENDIX I

Baseline Information For Wisconsin

Total Population (2000)[14]	5,363,675
Number and Percentage Uninsured (2000):	209,000 (4%)
Median Age (2000)[15]	36.0
Percent of population living in poverty (2000)[16]	8.8 (avg. 1998-2000) 8.9 (avg. 1999-2000)

Non-Farm Industries in Wisconsin by Employment (2000)[17]

Services and Miscellaneous	765,920
Wholesale & Retail Trade	635,990
Manufacturing	616,610
Government	404,710
Finance, Insurance, and Real Estate	148,570
Transportation, Communications, and Public Utilities	133,460
Construction and Mining	128,950

Number and Percent of Employers Offering Coverage:

The following data was obtained from the 1998 MEPS-IC survey conducted by AHRQ.

Number of Establishments in Wisconsin, 1998:	130,100
Number that Offer Health Insurance, 1998:	73,700
Percent:	57%

For more detailed information, please see Section 2 of this report

Number and Percent of Self-Insured Firms: Not available

Payer Mix:

In the 2000 Wisconsin Family Health Survey, questions were asked about respondents' current health insurance status. This provides an estimate that is a "snapshot" of Wisconsin at one point in time. Based on the responses to questions about current health insurance status,

- 76% of Wisconsin residents have only private health insurance including employer-sponsored and privately purchased coverage. This group does not include individuals with Medicare or Medicaid coverage.

- 2% of Wisconsin residents have coverage under Medicare alone.
- 10% of Wisconsin residents have coverage from a combination of Medicare and private insurance (with 4% of these having employer-sponsored private coverage).
- 2% receive health insurance through a combination of sources.

In addition, based on enrollment data for Medicaid and BadgerCare, approximately 11% of the state's population had coverage covered under one of these programs in September 2001. It should be noted that Medicaid and BadgerCare wrap around other insurance coverage, so the percentage of residents with private health insurance coverage and the percentage covered under public programs are not mutually exclusive.

Provider Competition:

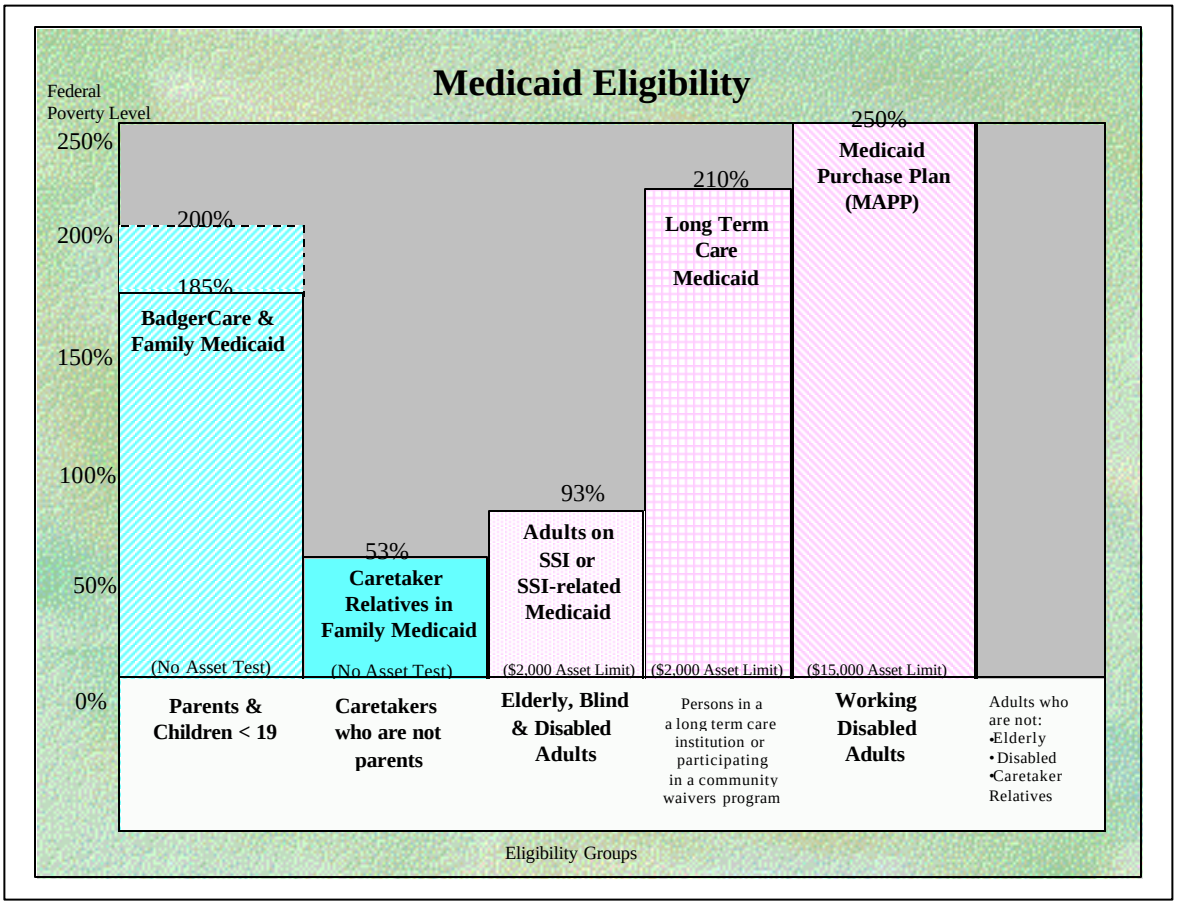
- SPG Activities did not assess provider competition in Wisconsin's marketplace.

Insurance Market Reforms:

- High Risk Pool – The Wisconsin Health Insurance Risk Sharing Program (HIRSP) offers health insurance to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market.
- Small Employer Purchasing Pool – Wisconsin's 1999-2001 budget act authorized the design and operation of Private Employer Health Care Coverage Program (PEHCCP), a risk pool for small employers to purchase group health insurance for their employees. The program is still in the design phase and is not yet operational.
- HIPAA Compliance – Wisconsin Act 27 of 1997 brought Wisconsin insurance laws into compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The changes included new restrictions in the group and individual markets, generally expected to assure better continuity of health insurance coverage.

  - Non-discriminatory practices – Employers that offer health insurance to offer the same health care plan to all of their employees.
  - Guaranteed Availability/Issue – Small market (groups consisting of 2 to 50 individuals) insurers must make all their small employer health plans available to all small employer groups that apply. Wisconsin law also has limited rate restrictions for small employer groups. Fully insured group plans are also subject to guaranteed renewability requirements. In these markets, insurance companies are required to renew group coverage each year as long as premiums are paid on time and there is not evidence of fraud.
  - Pre-existing Condition Exclusion Periods – A fully insured small employer plan (2 to 50 employees) can exclude coverage for preexisting conditions for up to 12 months. Preexisting conditions must meet a new definition and must have occurred within six months prior to an individual's date of enrollment. Self-insured plans can exclude coverage for preexisting conditions for up to 12 months. Again, preexisting conditions must meet a new definition and must have occurred within six months prior to the date of hire.

Eligibility for Existing Coverage Programs (Medicaid/SCHIP/others):



Use of Federal waivers:

Wisconsin has applied for and received several federal waivers to expand coverage and enhance services to Wisconsin residents. Recent requests include waivers for the BadgerCare program, the Family Care program, and Family Planning services. Wisconsin has also received several community-based waivers, as well as waivers for other targeted population groups.

Although this is not a comprehensive listing of all of Wisconsin's waiver requests, it provides an overview of the use of federal waivers in the state.

BadgerCare: Wisconsin's BadgerCare program is the state's highly successful SCHIP program that covers both low-income children and their parents. BadgerCare was implemented upon approval of a waiver of certain federal requirements under Section 1115 of the Medicaid statutes. BadgerCare currently covers approximately 89,000 family members including nearly 61,000 adults (parents) and 28,000 children in households with income at or below 200 percent of the federal poverty level.

Family Care: Wisconsin has received approval of four federal waivers under Section 1915 for Family Care, a long-term care program that provides services to elderly persons, physically disabled adults, and to a limited degree, adults with developmental disabilities. This program is currently available only in a limited number of counties in the state. The waivers authorize the state to: 1) use Medicaid funds to provide home and community based services instead of only institutional care for people whose care needs would qualify for Medicaid funding in a nursing home, and 2) make home and community based Medicaid waivers in pilot counties available only through the prepaid capitated Family Care benefit.

Family Planning: Later this year, the Department anticipates federal approval of a pending Section 1115 Medicaid waiver to implement an eligibility expansion for family planning services to women 15-44 years of age whose income is at or below 185 percent of the federal poverty level. It is estimated that approximately 40,000 women will be eligible for services under the family planning waiver.

Community-Based Waivers. Wisconsin has received approval of several Medicaid community-based waiver programs that offer medical and support services to certain groups of Medicaid-eligible recipients. These waiver include services to targeted groups of individuals, including:

- Elderly and physically disabled through the Community Options Waiver (COP-w) program and Community Integration II (CIP II) waiver;
- Developmentally disabled through the Community Integration IB (CIP IB) Community Integration IA (CIP IA), and Community Supported Living Arrangement (CSLA) waivers; and
- People with brain injuries through the Brain Injury Waiver (BIW)

SSI Waivers. In May 2001, Wisconsin implemented an SSI Waiver that allows participants to have the ability to increase and save their earnings, subsequently reducing their dependence on SSI cash benefits. As such, the SSI Waiver removes major barriers to employment for people who receive benefits under the Supplemental Security Income program. For example, absent the waiver, if a person currently has more than $2,000 in savings, he or she would be ineligible for the SSI benefit. Under the waiver, people who work will be allowed to save up to 50% of their earnings annually to purchase items such as a house or modifications to a car so they can get to and from work. An important feature of the waiver will eliminate the need for disability reviews for people with permanent disabilities so that individuals with permanent disabilities will not risk losing their eligibility for health care under Medicaid just because they are working. It is estimated that 1,200 to 1,800 Wisconsin citizens will take advantage of this waiver.

- Wisconsin is also seeking approval from the Social Security Administration for a similar waiver for the other major disability program Social Security Disability Insurance. SSDI is the federal program for people who have had a work history before they became disabled.

Other Waivers. Wisconsin waivers have targeted other population groups and services. For example, Wisconsin has submitted a waiver request for persons with AIDS.

APPENDIX II

Links To Research Findings And Methodologies

Wisconsin Family Health Survey:

http://www.dhfs.state.wi.us/stats/familyhealthsurvey.htm

The Wisconsin Family Health Survey methods are described and results are presented in the annual report, *Wisconsin Health Insurance Coverage, 2000*, available at this site.

Wisconsin State Planning Grant

This site is currently under development, but will contain all materials distributed at the State Planning Grant Conference, *Who Are the Uninsured in Wisconsin?,* including an overview of Wisconsin's SPG research projects, a set of briefing papers used to disseminate results from several Wisconsin State Planning Grant projects, and conference presentations. In addition, the final report to HRSA will be posted on the web site.

APPENDIX III

Data Sources

Wisconsin Family Health Survey

The Wisconsin Family Health Survey is a random sample telephone survey of Wisconsin households. The sampling frame consists of all Wisconsin households with a working telephone. The sample design includes five geographic strata and one oversample stratum which is expected to produce at least 20% black respondents. Data set weights adjust the final results to account for disproportionate sampling rates and response rates across the six strata.

The adult in each household who knows the most about the health of all household members is selected to answer all survey questions during the telephone interview. This person answers survey questions for him/herself as well as for all other household members. The final FHS sample for 2000 consisted of 2,664 household interviews, representing a total of 6,894 Wisconsin household residents. The overall response rate was 66%.

The Wisconsin Family Health Survey has been conducted on a continuous basis since 1989 by the Wisconsin Department of Health and Family Services (DHFS). Annual reports of survey results are available. For more complete information about survey design and methods, please see the most recent reports on the DHFS Web site (URL is in Appendix II).

The State Planning Grant did not have any direct effect on the design or conduct of the 2000 Wisconsin Family Health Survey. This survey was planned in late 1999, and represented a continuation of previous years' surveys.

SPG Focus Groups, Interviews and Surveys

Low-Wage Employees and Small-Business Employers

To better understand employees' perceptions of obtaining coverage through their employer relative to other sources of coverage, three focus groups with uninsured low-wage employees of small firms were held July 30 and 31 in Appleton and Milwaukee. A total of 24 employees participated. The participants were either full-time (15 participants) or part-time (9 participants) employees of small firms that do not currently offer health insurance coverage and who have family incomes between 100 and 200% of the federal poverty guideline. In addition, nine focus groups and 17 phone interviews were conducted with small-business employers. A total of 63 employers participated in the focus groups. Small business employers were defined as having between two and 50 employees, and having at least one employee earning less than $10 per hour. Separate focus groups were conducted with employers who did and did not offer health insurance.

Minority Racial and Ethnic Groups

Five focus groups were conducted in Dane County. Dane County's population is similar to the State population in terms of its diversity. Three focus groups were with Latino residents: two with persons who did not have health insurance and one with individuals who had health insurance. One focus group was conducted with African American residents who did not have health insurance. Lastly, one focus group was conducted with Hmong residents who had health insurance. Having insurance was defined as having third-party coverage (private or public) for primary health care services.

The recruitment process was not random. Most focus group participants knew their recruiter, because it was expected that participation would be higher if participants trusted the recruiter. All focus groups were conducted at locations accessible and familiar to participants. In addition, all focus groups were conducted in each population's native language, with moderators that were well known and trusted members of the respective communities In some cases moderators were interpreters and other staff employed by local health care providers.

In total there were 41 participants. Twenty-five people participated in the focus groups of Latino residents who were uninsured; five people participated in the groups of Latino residents who had health insurance; six people participated in the African American focus group; and five people participated in the Hmong focus group. Participants were not screened for gender, marital status or other demographic criteria apart from race or ethnicity.

18 to 24 Year-Olds

In June 2001, the Department of Health and Family Services in cooperation with the Family Health Center of Marshfield, Inc. (FHC) conducted a brief survey of 18 to 24 year-olds who use the FHC sliding scale program. Questions were asked about employment, student status, availability of insurance (other than Family Health Center membership), and barriers to obtaining health insurance. While the survey is not representative of 18 to 24 year-olds in the State, it provides additional information about an age group often considered vulnerable with respect to access to insurance. A 40% response rate was achieved, with 72 of the 179 mailed surveys being returned.

In addition, in September 2001, three focus groups were conducted in Dane County with 18 to 24 year-olds who had visited a hospital or urgent care center in the past year and who were uninsured. Participants were recruited by phone and mail, with most participants screened by phone. A total of 31 people participated in these focus groups.

Farmers and Their Families

In July 2001, a survey was conducted by the Department of Health and Family Services in cooperation with the Family Health Center of Marshfield, Inc. The survey was mailed to 68 farmers who participate in the FHC sliding scale program. The survey was returned by 34 farmers or 50% of the sample. Questions were asked about availability of insurance and preferences for insurance coverage.

In addition, although not funded by the State Planning Grant, in September 2000, the Barron County Health Department conducted a survey of dairy producers in Barron County. Surveys were mailed to 809 dairy farmers identified through the Farm Service Agency. The survey achieved a 28% response rate with 228 surveys returned. The respondents were not asked about farm size. The respondents were asked to report on their own insurance coverage and that of their families where applicable.

Employer Questions

The Wisconsin family health survey is a telephone survey of Wisconsin residents that collects information on health insurance coverage, health status, health problems and the use of health care services. More detailed information on the survey is provided above.

The Medical Expenditure Panel Survey (MEPS) is an annual survey conducted by the U.S. Agency for Healthcare Research and Quality (AHRQ). The data used under the SPG was derived from the MEPS Insurance Component, which is a survey of employers. The sample size for Wisconsin is 800 employers. Much of the data is based on the survey that was conducted in 1999 with questions for the 1998 calendar year. Special tabulations for 1998 were released in 2001. The survey collects data at the establishment level, rather than the firm level. The firm generally refers to the entire company, including the headquarters and all establishment sites, while the establishment refers to one location site.

APPENDIX IV

State of Wisconsin
Office of Private Employer Health Care Coverage

Small Group Underwriting
Health Plan Market Research

Final Report
October 22, 2001

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EXECUTIVE SUMMARY

The Wisconsin legislature created the Private Employer Health Care Coverage Program (PEHCCP) in 1999. The goal of the program is to create a voluntary, private sector health insurance purchasing pool for small businesses. In addition, the Department of Health and Family Services was provided State Planning Grant funds to support a broad array of research projects that support the development of policy options for the uninsured. The State of Wisconsin Office of Private Employer Health Care Coverage requested Deloitte & Touche's assistance in obtaining and compiling information regarding current small group (2-50 lives) underwriting practices and procedures. A summary of our findings and observations is included in this report.

Based on our research as well as our industry experience, overall underwriting practices vary little in the small group market. However, health plans do have the ability to modify some procedures. State law mandates many of the practices that must be followed.

While the review of historical claims experience is a common way to underwrite large group business, the evaluation of individual health history information on prospective groups is standard practice in the small group market. This would include the evaluation of medical information on eligible dependents, as well. The medical information obtained is used by the plan to determine rates for each group. The method of evaluating the health history forms is at the discretion of the plan, but must be a standard procedure for each group that requests a quote for coverage. Plans must work within some legislative parameters in the initial rate setting process. Under current Wisconsin law (as of July 2001), insurers may not vary new group rates based on health status, claims experience or duration of coverage (collectively, "risk characteristics") more than 30% above or below a midpoint (median) rate for groups with similar "case characteristics" (age, sex, geographic location and occupation) and benefit design characteristics. At the time of this writing, a proposal is before Wisconsin's Governor to tighten this "rate band" to plus or minus 10% from the midpoint and to include occupation within "risk characteristics."

Each insurer has the right to choose which factors will be used in its underwriting processes, but these factors must be applied uniformly. Standard factors that affect the underwriting process include:

- Demographics (age/sex, size of group and family composition)
- Geographic area (area where care is most likely to occur, which could mean more or less access to network providers)
- Industry or occupation (SIC codes are generally used)
- Minimum participation and employer contribution requirements

The insurer is not required to provide a first-year rate guarantee for new business. However, even though the plan has the ability to change the rates mid-year, it is not common practice and can be a significant administrative and financial burden for employers.

The renewal process for small group insurance is distinctive because it generally has two separate components. Initially, the plan will evaluate the experience of its small group block of business to determine "trend" (the rate at which underlying health care costs influence premiums) and use this information to set base rates. Secondly, the plan will obtain claims experience for the group in lieu of requesting new health history forms. Analyzing the claims experience will allow the plan to determine an estimated potential risk. Because this claims experience is typically less credible for small groups than large groups, State regulations limit the use of this information in setting renewal rates. The portion of a particular small group's rate increase attributable to their health status and claims experience (as distinct from "trend" and demographic factors) cannot exceed 15%.

The most prevalent form of marketing in small group business is through the use of a traditional agent/broker relationship. Commissions are used to reimburse the agent/broker for their services and are typically based on the number of enrollees. Depending on the size of the plan, insurers may also use captive agents or a direct marketing approach.

Understanding the current environment in which small employer group plans are offered provides a baseline of knowledge. Any health insurance purchasing program developed will have to operate in light of, or in spite of, the existing environment. The primary goals of the purchasing pool and the resources available to achieve those goals will be the strongest determinant to the development of a strong and successful program.

BACKGROUND

The Wisconsin legislature created the Private Employer Health Care Coverage Program (PEHCCP) in 1999. The goal of the program is to create a voluntary, private sector health insurance purchasing pool for small businesses. In addition, the Department of Health and Family Services was provided State Planning Grant funds to support a broad array of research projects that support the development of policy options for the uninsured. The State of Wisconsin Office of Private Employer Health Care Coverage requested Deloitte & Touche's assistance in obtaining and compiling information regarding current small group (2-50 lives) underwriting practices and procedures.

The worksteps included:

1) *Determining the health plans to be surveyed*
2) *Developing a survey tool*
3) *Conducting the survey*
4) *Summarizing and compiling the findings*
5) *Drafting report*

METHODS

Plan Selection

Based on input from the PEHCCP, Deloitte & Touche initially compiled a list of 25 health plans, which represent both managed care and indemnity type plans. The primary source of this list was the 1998 *Small Employers' Market Share Ranks* list that was obtained from the State of Wisconsin, Office of the Commissioner of Insurance website. (The 1998 list was the most recent available.) See Appendix A for *Market Share Ranks* list. The list represents plans that serve the entire State of Wisconsin as well as those that are available only in specific geographic areas. The top 25 plans on the list in market share percent order were chosen to participate in the study. Atrium Health Plan was an addition to the original list due to its participation in the State of Wisconsin Employee Health Plan (administered by Wisconsin Department of Employee Trust Funds). The health plans are listed alphabetically below:

1) *Atrium Health Plan*
2) *Aetna (fka Prudential)*
3) *BCBS*
4) *Compcare*
5) *Dean Health Plan*
6) *Emphesys*
7) *Employers Health*
8) *Employers Insurance of Wausau*
9) *Family Health Plan*
10) *Federated Mutual*
11) *Fortis Insurance*
12) *Group Health Care*
13) *John Alden Life*
14) *Midwest Security Life*
15) *Network Health Plan*
16) *North Central*
17) *Physicians Plus*
18) *Prevea Health Plan*
19) *Principal Life*
20) *Security Health Plan*
21) *Touchpoint HP*
22) *United HealthCare Insurance*
23) *United Healthcare of Wisconsin*
24) *United Wisconsin Life*
25) *Unity Health Plans*
26) *Wisconsin Physician Service*

Questionnaire/Survey Approach

Deloitte & Touche received a questionnaire drafted by PEHCCP, which addressed four specific underwriting policy categories:

- Small group medical underwriting practices
- Underwriting adjustments
- Other rating factors
- Marketing/payment policies

Although the topic of current and proposed Wisconsin small group insurance statutes was generally discussed while conducting the interviews, questions about Wisconsin law were not included on the questionnaire. Together, PEHCCP and Deloitte & Touche staff finalized the questionnaire. See Appendix B for a copy of the survey.

Plan Contacts

The finalized list of selected plans was cross-referenced with plans that provide coverage for employees of the State of Wisconsin. Deloitte & Touche utilized an existing list of contact names for those plans that participate in the State employees' program. For those plans that do not participate in the State employees' program, cold calling was necessary to identify the appropriate individuals to interview regarding underwriting practices.

All 26 plans were contacted by phone regarding their participation in the survey. The majority (nine) of the surveys were conducted over the phone while three health plans preferred to view the survey first and return it completed.

Twelve (12) plans completed the survey:

- Atrium Health Plan
- BCBSUW
- Compcare Blue
- Dean Health Plan
- Group Health Cooperative - SC
- Midwest Security Life Ins. Company
- Network Health Plan Of Wisconsin
- Physicians Plus Ins. Corp.
- Prevea Health Insurance Plan, Inc.
- Security Health Plan of Wisconsin
- United Healthcare of Wisconsin
- Unity Health Plans

Four (4) plans declined to participate in the survey:

- Fortis Insurance Company
- John Alden Life Insurance (a Fortis Company)
- Principal Life Insurance
- Wisconsin Physicians Service Insurance

Three (3) plans are no longer in the small group health insurance market

- Aetna (fka Prudential)
- Employers Insurance of Wausau
- North Central Health Protection Plan

Seven (7) plans did not respond to repeated attempts at contact or have merged with other plans on the list:

- TouchPoint Health Plan
- Federated Mutual Insurance Company
- United Wisconsin Life Insurance
- Emphesys Wisconsin Insurance now dba Humana Employers Health
- Employers Health Insurance Company now dba Humana Employers Health
- Family Health Plan Cooperative now dba Compcare Blue
- United Healthcare Insurance Company dba United Healthcare of Wisconsin

FINDINGS

Small Group Medical Underwriting Practices

Each insurer we interviewed conducts health underwriting on their small group business, which is defined as groups of at least two but not more than 50 employees. Although most health history forms differ in format, they are similar in content. Practices vary as to how the information gathered is employed by each health plan.

- One-half (six) of responding plans apply a variable in their use of the health history forms.
  - Four use an abbreviated form for groups with 26-50 employees
  - and one uses an abbreviated form for groups with 10-50 employees.
  - One plan places a 10-year time span on the underwriting history for groups of 2-25 employees and a five-year time span for groups of 26-50 employees.

- Four insurers (33%) also utilize condition-specific questionnaires to gather needed additional information if a health history form indicates potential high-risk exposure. These conditions may include, for example, cancer, diabetes, and heart disease.

- Once the health history forms are received by the plan and the underwriting process has begun, occasionally there is a need to gather additional information to complete the process.

  - All responding plans indicated that they would utilize sales and/or underwriting staff and agents/brokers to gather further information, generally through phone interviews with the prospective members.
  - One plan indicated that its underwriting staff generally has access to medical records and that the enrollee signs a release on the application for the plan to gather additional information, if needed.
  - One plan indicated that it reserved the right to request medical exams and perform HIV testing on all subscribers age 18-50.

- It is standard practice among all interviewed plans to gather information on dependents applying for coverage.
  - Three plans indicated that it is routine procedure to obtain health information on those waiving coverage.
  - Two additional plans only seek health underwriting information on employees or dependents waiving coverage if those individuals were covered under the prior insurer.

- Reported approaches to the evaluation of health questionnaires vary by insurer.
  - Ten insurers built their systems internally or with the help of purchased manuals and information obtained through others in the industry.
    - Five plans (42%) utilize a debit system, which they then equate to a dollar amount, to evaluate potential risk exposure.
    - Three plans (25%) have developed an expected cost of care by specific health condition.
    - Two (17%) base their evaluation on prior claims data received from the prospective groups.
    - Of the remaining two responding insurers, one utilized an outside actuarial firm to evaluate the health history forms and one relied on purchased small group underwriting guidelines/manuals.
- All but one interviewed insurer retains internal underwriting staff to evaluate health history forms. The remaining plan has nursing

staff, the medical director or the director of marketing perform an initial medical review prior to sending the form to an outside actuarial firm to complete the evaluation.

- Plans indicated varying degrees of underwriting staff experience, based on the level and responsibility of the individual.

  - Plans with internal underwriting staff indicated that college degrees are preferred, but that industry experience is generally more valuable, due to the tight employment market and limited plan resources to train college students.
  - Junior level underwriters typically evaluate "clean cases," with few or no complexities, while senior level underwriters, with at least three years of industry experience, evaluate more complicated cases.
  - Three plans indicated that they require education or experience in nursing or medicine. Plans without this requirement generally have access to medical personnel when needed.

Underwriting Adjustments

The most common underwriting factors used for small group underwriting are:

- Age
- Sex
- Geographic location
- Occupation/Industry (SIC code)
- Family composition

- All but one of the plans surveyed (92%) use both age and sex as underwriting factors, the remaining plan uses age but not sex.

- Seven plans (58%) used geographic location as a rate-setting factor. Using geographic location to set rates becomes less important the smaller the plan's service area. Plans which cover a large portion of the State will find that their underlying provider reimbursements vary significantly based on the provider and regional location and will need to account for such differences in their rating practices.

- Occupation is used by eight (67%) of the plans interviewed. The future use of this factor may change if proposed legislation becomes law. See Executive Summary for details.

- Eight plans also use group size as a factor in setting rates:

- One plan uses group size to adjust administrative costs and another applies a small surcharge to rates for groups of five or fewer employees and a credit to rates for those over 50 employees.

- Family composition was used as a rating factor by only three responding insurers (25%).

A review of current Wisconsin law was not included in the scope of this project, but interviewed plans indicated that they are allowed under law to require minimum employer contribution towards employee coverage and minimum participation based on the number of eligible employees.

- Small group employers are defined by statute as having not less than two and not more than 50 employees. A self-employed individual and her or his spouse may be considered a group of two if both individuals are legitimate employees (i.e., drawing a wage and paying taxes).

- One insurer offered a separate product for self-employed individuals, which is similar to an individual product but underwritten as a small group plan.

  - Four responding plans (33%) differentiate farm families from typical small group business.
  - Two offer a unique agri-business product to address the specific needs of farm families.
  - The remaining two underwrite farm families as individuals and sell them individual rather than small group products.

Other Rating Practices

New Business

- All but one interviewed plan provides preliminary ("book") rates prior to receiving medical information from prospective groups. Preliminary rates are based on census data received from the group.

- Once final rates are quoted and accepted by a group, 10 of the plans surveyed guarantee those rates for 12 months.

  - One plan retains the right to change rates mid-year in the case of radical changes in the group census or misrepresentation.
  - One plan renews month to month and offers no guarantee; however, in practice they generally do not adjust rates for 12 months.

- Several plans indicated that they felt that the marketplace was generally moving toward age/sex rating vs. composite rating.
  - Three plans offer only age/sex rating.
  - Three plans offer only composite rating, but indicated a desire to move to age/sex rating.
  - Two plans offer each new group a choice of age/sex or composite rates.
  - Three plans determine whether to offer age/sex or composite rates based on group size, though these plans differ in the specifics of their approaches:

    * 2–25 employees = age/sex; 26+ employees = composite
    * 2–15 employees = age/sex; 16+ employees = composite
    * 2–9 employees = age/sex; 10–50 employees = composite

- When asked about family composition tiers, only one plan responded that three-tier rating (employee, employee plus one dependent, and full family) is mandatory for all its small groups, although that plan is thinking of moving to mandatory four-tier rating.

Small Group Renewals

- All but one responding plan analyzes group-specific claims data to identify future potential risk and set renewal rates. The portion of a group's renewal increase attributable to a specific group's health status and claims experience is capped at 15% under Wisconsin law. Any increase attributable to the potential risk identified with the group is then added to the insurer's "trend" factor (reflecting underlying health care costs and the experience of the small group pool) to determine a final rate.

- Seven plans (58%) indicate that they blend group-specific risk factors with the experience of the pool to determine renewal rates.

- Two responding insurers analyze claims by individual insured rather than aggregating each group's claims.

- One insurer indicated that, since their plan had only recently implemented age/sex rating, their renewal analysis only takes into account age and sex; however, in the future this plan will use group-specific claims, as well.

- Some plans were reluctant to share with us their targeted or actual loss ratios. Of those that responded, targeted loss ratios were approximately 75%, while actual loss ratios ranged from 85% to 90%.

Marketing/Payment Policies

- All 12 responding plans rely on agents to market and sell their small group products.

- Seven (58%) use only traditional agents or brokers.

- Five (42%) engage a combination of traditional, captive and/or direct agents.

- Under Wisconsin law, insurers are allowed to cancel a group for nonpayment of premium if the required grace period for nonpayment has expired. In such cases, the insurer may require the group to re-apply as new business. There was wide disparity in how responding plans implement nonpayment policies.

  - One plan retains the right to require electronic funds transfer for future payments.
  - One plan imposes a reinstatement fee.
  - One plan retains the right to impose a 12-month waiting period to re-underwrite as new business after cancellation for nonpayment.

OBSERVATIONS ON THE FUTURE OF SMALL GROUP BUSINESS

All interviewees, when asked about the future of small group health insurance, expressed concern that proposed changes in Wisconsin law could have a dramatic effect on how they do business. Several interviewees also observed an increased demand for "stripped down" product models with a lower level of benefits at a reduced premium. These lower level benefit plans are becoming increasingly popular for several reasons. Giving employees more choice in health care options allows them the freedom to choose the option that will best

address their individual health care needs. These stripped down models allow employers to offer a lower benefit, lower cost plan along side a more comprehensive, higher premium plan. The lower cost option can also be tied to a defined contribution approach with the employer setting their contribution levels based on the cost of the low option plan and requiring a "buy-up" from employees to move to the high option plan.

With the rising of health care costs over the past few years, employers are also finding it increasingly necessary to creatively manage these costs. Some of these cost management strategies include plan design changes, contracting with lower cost vendors, and targeted interventions such as health management. In a tight labor market, employers are generally more resistant to passing on health care cost increases to their employees. However, with the continuing acceleration of medical cost trend, there is evidence, that many employers are considering increased cost sharing arrangements such as copayments and coinsurance or raising employee premium contributions.

Most respondents indicated that their underwriting and rating procedures are continually changing to keep pace with a dynamic marketplace. These procedures are evaluated regularly to determine if changes (i.e., moving from composite to age/sex rating, instituting additional rating variables such as geographic and/or industry factors) are necessary to remain competitive.

Interviewees mentioned that it is always important for plans to look for ways to cut costs while maintaining or improving the quality of service to their customers. They observed the use of internet-based tools as an alternative to traditional paper-based models has become more common over the last couple of years.

CONSIDERATIONS FOR THE CREATION OF A PURCHASING POOL

The findings of this survey provide a fundamental understanding of the current underwriting practices representative of a wide range of insurance market leaders in Wisconsin. The common themes include the use of medical history, geographic location, and demographic factors as the foundation for the development of pricing models in the small group market. These practices are further confined within the current regulated environment. The knowledge gained from the survey provides a clearer understanding of the current "playing field" in the State, which is an important foundation in the development of a purchasing pool concept. A successful program must operate in light of the current practices used in the marketplace.

The development of a strategic goal will drive many of the decisions necessary to a successful purchasing pool approach:

- What primary need will be met by a purchasing pool?

- Is the goal of the purchasing pool to simply provide another insurance plan offering to the employers in the State?
- Is it the goal of the purchasing pool to expand the availability of plans currently offered?
- Should the purchasing pool provide "guaranteed" access to health care for small employers?
- Is the goal to provide the most cost effective small group health coverage in the State?

- What methods will be used to meet the primary goal(s)?
  - Is a subsidy needed?
  - Will economies of scale be enough?
  - Is additional legislation necessary?
  - Mandatory participation of health plans?
  - Permission to form a self insurance pool?
  - Statewide network or a series of regional solutions?
  - How can current technology benefit the program administration and reduction in cost?

The funding of the plan will be another critical decision. The purchasing pool will need to decide on what financial approach to take, i.e., self-insuring versus contracting with the insurance carriers on a fully insured basis. Either approach leads to additional decision-making. Self-insuring may require an allocation of money to help support the plan start-up, ongoing administration and direct plan costs. A fully insured approach would require the development of strict rules governing the participating plans. Mandatory participation of health plans would be beneficial in a fully insured environment.

Benefit plan design is another important consideration in the development of the purchasing pool. The trend of rising health care costs has caused employers as well as employees to look for alternative choices in plan design and levels of coverage in order to better manage their overall expenses.

Lastly, how will the purchasing pool deliver and market its program? The survey results indicated that health plans utilize the agent/broker community to deliver their current products to the market. An assessment of the current agent/broker community would be necessary to determine how they will positively or negatively affect the program's success. An employers' reaction to this approach will vary based on the services provided and the resources of the employer. The use of brokers/agents in the marketing of the plan will also add additional costs that will need to be considered in the rating of each group.

APPENDICES

A. 1998 Small Employers' Market Share Ranks List

B. Survey Tool

APPENDIX V

Wisconsin State Planning Grant Briefing Papers

The following briefing papers were prepared to provide information about Wisconsin State Planning Grant activities. The following seven papers are attached:

1) Employer-Based Health Insurance Coverage in Wisconsin

2) Health Insurance Needs of Farm Families

3) Findings from Focus Groups: Select Populations in Dane County

4) Health Insurance and the Young Adult Population in Wisconsin

5) Milwaukee County General Assistance Medical Program

6) Health Insurance and Health Care Utilization in Wisconsin

7) Health Insurance Coverage for Non-Elderly Adults Living in Households Without Children

[1] The tax credit that was discussed was based on the credit proposed by the Bush Administration. It was explained to the employers that individuals purchasing single coverage would receive a $1,000 credit and those purchasing family coverage would receive a $2,000 credit. It was also explained that the credit would operate like a subsidy in that the individual would receive the appropriate amount on a monthly basis to offset the cost of the individual's insurance premium.

[2] J.S. Weissman, P. Dryfoos and K. London. (July/August 1999). "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals." *Health Affairs*. 18(4): 156-166.

[3] Bureau of Health Information. (March 2001) *Uncompensated Health Care: Wisconsin Hospitals, Fiscal Year 1999*. Madison, WI: Division of Health Care Financing, Department of Health and Family Services.

[4] For this analysis, respondents to the MEPS survey were categorized into six industry sector categories: (1) retail trade; (2) agriculture, personal services and wholesale trade; (3) manufacturing; (4) transportation and construction; (5) business services and finance; and (6) other services.

[5] New questions regarding employer-sponsored health care coverage were added to survey beginning in January 2001. The survey is conducted on an ongoing basis throughout the year. These figures represent findings from surveys conducted in the first six months of the year (January through June 2001). Final data will be available in 2002.

[6] Twenty Wisconsin counties have been designated metropolitan counties by the federal Office of Management and Budget. They are: Brown, Calumet, Chippewa, Dane, Douglas, Eau Claire, Kenosha, La Crosse, Marathon, Milwaukee, Outagamie, Ozaukee, Pierce, Racine, Rock, St. Croix, Sheboygan, Washington, Waukesha and Winnebago.

[7] *Employer Health Benefits: 2001 Annual Survey*. The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, 2001. See p. 35 and Exhibit 3.6, p. 41.

[8] The employers discussed the behavior of their lower-wage employees, and in those instances where the employer knew he or she was the employee's sole source of employment, their lower-income employees. For purposes of the discussion, we asked the employers to think about those employees who earned approximately $10 an hour or less.

[9] The tax credit that was discussed was based on the credit proposed by the Bush Administration. It was explained to the employers that individuals purchasing single coverage would receive a $1,000 credit and those purchasing family coverage would receive a $2,000 credit. It was also explained that the credit would operate like a subsidy in that the individual would receive the appropriate amount on a monthly basis to offset the cost of the individual's insurance premium.

[10] When employers expressed this concern, it was explained that the tax credit would be refundable under the Bush Administration proposal.

[11] The employers generally assumed that their employees would purchase policies that provided at least some degree of coverage. They did not perceive that, if an individual tax credit were made available, insurance companies would develop products that would be priced to match the level of the tax credit available.

[12] At this point, the employers were not addressing how much the tax credit might have to vary from one employer to the other to reflect differences in their premiums attributable to their employees' age, health status, etc. but instead what percent of premium the credit might need to cover.

[13] Not all the employers thought about the potential problems they might encounter with meeting carrier participation requirements under such a scenario. When this issue was explained to one employer, he responded that he would probably have to fire any employee who refused to cooperate.

[14] U.S. Census Bureau. (May 2001) *Profile of General Demographic Characteristics: 2000 Census of Population and Housing, Wisconsin*.

[15] Ibid.

[16] Dalaker, Joseph. (September 2001) *Poverty in the United States: 2000*. U.S. Census Bureau, Current Population Reports, Series P60-214.

[17] Wisconsin Department of Workforce Development. (September 2001) Non-Farm Wage and Salary Data, Current Employment Statistics.

Employer-Based Health Insurance Coverage in Wisconsin

Wisconsin is one of 20 states that received a grant in 2000-01 from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, to explore new approaches to increasing access to health insurance for state residents. Research under the Wisconsin State Planning Grant has focused on several topics, including analyses of employer-based coverage in the state.

Access to health insurance in Wisconsin is at an unprecedented high level. According to the 1999 Wisconsin Family Health Survey, a point-in-time estimate of the number of uninsured individuals in Wisconsin was approximately 340,000—just 7% of the state's population. Based on the survey, approximately 86% of Wisconsin household residents under age 65 were covered by private health insurance. The majority of this coverage was employer-based coverage.

This briefing paper provides detailed information about employer-based health insurance in Wisconsin. The availability of coverage by various employer characteristics is examined, and employee eligibility and enrollment are discussed. In addition, the costs of health insurance and employer contributions toward coverage for their workers are examined. The information in this briefing paper is based on the 1998 Medical Expenditure Panel Survey, conducted by the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. The 1998 survey is the most current information available. More details regarding this survey are provided in the "About the Data" section of this briefing paper.

Employers Who Offer Coverage

Table 1 provides information about the estimated number of private establishments and employees in Wisconsin. The data is provided for both small employers (businesses that employ 50 or fewer workers) and large employers (businesses with more than 50 employees).

Table 1. Number of Establishments and Employees in Wisconsin, 1998

		Employer Size	
	Total	Small	Large
Establishments	130,100	79%	21%
Employees	2,393,000	34%	66%

Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component, 1998.

As shown in the table, there were approximately 130,100 private business establishments in Wisconsin employing nearly 2.4 million people in 1998. Small employers accounted for 79% (nearly 103,000) of all establishments, and approximately 814,000 employees in Wisconsin worked for these small businesses. It is interesting to note that although there were considerably fewer large employers as compared to small employers in Wisconsin, 66% of the state's workforce was employed by large employers.

Approximately 90% of Wisconsin's workforce were employed by an establishment that offered health insurance to some or all of its employees in 1998 (Table 2). Of the remaining 10% of employees that did not work for establishments that offered insurance, 95% worked for small employers. Indeed, the vast majority of the establishments that offered health insurance were large employers. Nearly all large establishments (98%) offered health insurance, while less than half (46%) of small employers offered insurance.

Employee Eligibility and Enrollment

Employees Eligible for Employer-Offered Insurance

As shown in Table 2, about 1.65 million employees were eligible for the insurance offered by their employer. Employees who work for small employers are less likely to be offered coverage. Nearly 79% of employees who work for large employers are eligible for the insurance

Table 2. Establishments That Offer Health Insurance and Their Employees.

	Total	Small Employers	Large Employers
Establishments in Wisconsin	130,100	102,800	27,300
Number That Offer Health Insurance	73,700 (57%)	46,800 (46%)	26,900 (98%)
Employees in Wisconsin	2,393,400	805,200	1,588,200
In Establishments That Offer Health Insurance	2,161,200 (90%)	585,400 (73%)	1,575,600 (99%)
Eligible for Employer-Offered Insurance	1,659,800 (69%)	409,800 (51%)	1,249,400 (79%)
Declined Employer Offer	267,200 (11%)	122,100 (15%)	144,900 (9%)
Accepted Employer Insurance	1,392,600 (58%)	287,700 (36%)	1,104,500 (70%)

Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component, 1998.

offered by their employer, but only 51% of employees who work for small employers are eligible.

When examining specific industry categories, manufacturing and construction establishments appear to have a larger share of employees who are eligible for insurance coverage. Although 33% of all employees worked in manufacturing and construction, 40% of all employees eligible for the insurance offered by their employer worked for a business in this category. Further, although 28% of all employees worked in a retail or trade establishment, only 21% of employees working in establishments in this category were eligible for employer-offered insurance. The business service establishments appear to have a proportionate number of employees eligible for employer-based insurance coverage as compared to their share of all employees. This data is shown in Table 3.

Table 3. Employees Eligible for Employer-Offered Insurance by Industry.

	Percent of all employees	Percent of Employees Eligible for Employer Offered Insurance
Manufacturing & Construction	33%	40%
Retail or Trade	28%	21%
Business Service	39%	39%
Total	100%	100%

Source Medical Expenditure Panel Survey (MEPS), 1998

Employees Not Eligible

Although 90% (about 2.2 million) of all employees worked for businesses that offer health insurance, over 23% (about 500,000) of these employees were not eligible for the coverage offered by their employer. Of these, approximately 35% (175,600) work for small employers.

Declined or Accepted Coverage

In addition to those who were not eligible, a significant number of employees within establishments that offered insurance declined the coverage offered. Approximately 267,200 workers declined coverage when offered.

In total, nearly 1.4 million of the 2.4 million employees in the state were covered by health insurance through their own employer in 1998, and approximately 1.0 million were not covered by health insurance through their own job. As compared to employees of small employers, employees of large employers are more likely to have insurance through their own employer.

Employees who decline or are not offered coverage by their own employer are not necessarily uninsured. They may be covered by health insurance through a spouse or other family member. Alternatively, they may be covered by a public program, such as Medicaid or BadgerCare.

Health Insurance Premium Costs

Looking closer at total health insurance premium costs (including both the employer and employee share) for employees who were eligible for health insurance through their employer, overall the premiums faced by small employers were slightly higher than those for

Table 3. Average Premiums and Employer Contributions for the Lowest Cost Policy in Establishments that Offer Health Insurance

	Wisconsin	Small Employers	Large Employers
Average Annual Premium for Single Coverage	$2,185	$2,375	$2,121
Employer Contribution for Single Coverage	81%	80%	81%
Average Annual Premium for Family Coverage	$5,537	$5,726	$5,474
Employer Contribution for Family Coverage	74%	69%	75%

Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component, 1998.

large employers (Table 3). Further, the manufacturing and construction industry category faced the lowest average cost for health insurance. It is important to note that the unit of analysis is the establishment's most comprehensive plan with the lowest out-of-pocket premium cost to the employee.

In 1998, the average total premium cost for single coverage was $182.11 per month or $2,185 annually. Premiums for family coverage averaged $461.39 per month or $5,537 annually. These amounts were slightly higher than the national averages of $2,080 annually for single coverage and $5,273 annually for family coverage.

Employer and Employee Contributions

On average, employers paid 81% of the cost for the most comprehensive, lowest-cost single coverage policy they offered their employees. Employer contributions were 74% on average for the cost of family coverage. The percent of the costs contributed by the employer did not vary significantly by employer size for single coverage, but smaller employers contributed less toward family coverage (Table 3). There appears to be a correlation between wages and health benefit levels. The 1998 MEPS data indicate that the employer contribution toward coverage varied by the wages of the establishment's employees. High-wage employers (those with over 50% of their workers earning more than $15.00 per hour) contributed more on average toward the cost of coverage than did modest-wage or low-wage employers for both single and family coverage. Consequently, employees of high-wage establishments pay less for their coverage. In fact, according to the MEPS data, employees working in low-wage establishments were asked to contribute more than twice as much for coverage on average as employees working in high-wage establishments.

For all establishments, the average monthly contribution by the employee for family coverage was $117.08 per month or $1,405 annually. However, there was wide variation among employers, with 5% of eligible employees facing a required contribution of more than $304.66 per month ($3,656 annually) for the most comprehensive, lowest-cost family plan offered by their employer. The average monthly employee contribution for single coverage was $32.66, or $392 per year. As with family coverage, there was wide variation among employee contributions for single coverage, with 5% of eligible employees in small establishments facing a required contribution of more than $150 per month ($1,800 annually).

Some employers paid the entire cost of health insurance premiums for their employees. As compared to family coverage, businesses were nearly twice as likely to cover the full costs of single coverage. For all establishments, 27% of eligible workers were not required to pay anything toward their single coverage, but only 14% were not required to pay anything toward family coverage. Surprisingly, smaller establishments had a higher percentage of eligible workers who did not have to pay anything toward their health insurance coverage. Just over 40% of eligible small business employees did not have to contribute toward their single coverage and 30% did not have to contribute toward their family coverage.

High-wage employers also had a large percentage of employees who had access to

no-cost coverage, as did employees in the manufacturing and construction industry category (see "About the Data" section for explanation). Of all employees who did not have to contribute toward their health insurance, more than 40% were in the manufacturing and construction industry category.

Summary

Although the overall level of employer-based health insurance in Wisconsin is among the highest nationwide, there is significant variation in offer rates and contributions toward insurance premiums among employers in the state. Employees are more likely to be offered coverage and more likely to have health insurance through their job if they are employed by a large employer. Less than half of all small employers in the state offer health insurance to some or all of their employees.

Compared to large employers, small employers contribute less on average toward family coverage, although the percent of the premium costs paid by the employer does not vary significantly by employer size for single coverage. Employees of small employers who are eligible for health insurance offered through their employer are more likely to not have to pay anything toward their coverage. However, when they are required to pay toward their coverage, they contribute more. Consequently, employees of small employers are paying more, on average, for their coverage than employees of large employers. (It should be noted that due to small sample sizes, these differences are not statistically significant at the 90% confidence level.) Both small and large employers tend to contribute a larger share of the cost of single coverage as compared to family coverage. Employers tend to pay a larger percentage of the cost of health insurance premiums as their overall wage levels increase. As a result, we find that employees working in low-wage establishments contribute on average twice as much for coverage as employees working in high-wage establishments.

Overall, low-wage employees and employees of small employers have a more difficult time accessing affordable health insurance coverage. Thus, the research conducted under the Wisconsin State Planning Grant that focuses on the particular circumstances of small employers and their employees will help inform any efforts to expand health insurance access through employers.

About the Data

Background:

The Medical Expenditure Panel Survey (MEPS) is conducted annually by the U.S. Agency for Healthcare Research and Quality (AHRQ). All data in this report is derived from the MEPS Insurance Component, which is a survey of employers. The sample size for Wisconsin is 800 employers. The data in this paper are based on the survey that was conducted in 1999 with questions for the 1998 calendar year. The special tabulations described in this paper were released in 2001.

The survey collects data at the establishment level, rather than the firm level. The firm generally refers to the entire company, including the headquarters and all the establishment sites, while the establishment refers to one location or site.

Definitions:

For the purposes of this analysis, businesses were grouped into three industry categories:

- **Retail and Trade**—includes retail trade, personal services (beauty shops, etc.), wholesale trade, and agriculture/forestry.
- **Manufacturing and Construction**—includes manufacturing, transportation (also communication, electric, gas or sanitary services), construction and mining.
- **Business Services**—includes legal, health and finance services, real estate and insurance.

Establishments were also grouped into three wage categories:

- **Low-wage**—includes establishments where over 50% of the employees at the business

location responding to the survey earned less than $6.50 per hour.

- **Modest-wage**—includes establishments where more than 50% of the employees at the business location responding to the survey earned between $6.50 and $15.00 per hours.
- **High-wage**—includes establishments where over 50% of the employees at the business location responding to the survey earned more than $15.00 per hour.

The unit of analysis for each establishment was their most comprehensive plan with the lowest out-of-pocket premium costs to the employees. As such, the plans included in this analysis do not necessarily cover the same benefit package.

For more information about this briefing paper or other activities under the Wisconsin State Planning Grant, contact:

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Health Insurance Needs of Farm Families

Wisconsin is one of 20 states that received a grant in 2000-01 from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services to explore new approaches to increasing access to health insurance for state residents. Research under Wisconsin's State Planning Grant has focused on several topics, including understanding the particular circumstances of farmers in accessing health insurance coverage.

This briefing paper provides information about the health insurance needs of Wisconsin farmers and their families. Characteristics of farm families including their uninsured rate, their health circumstances, and insurance availability and affordability are examined. In addition, the results of two short surveys of farmers and their families are presented. While these surveys cannot represent the experience of farm families statewide, due to their small sample size and limited geographic perspective, both provide information about the health insurance needs of some Wisconsin farmers.

Wisconsin Farmers

Wisconsin farmers are important to the state's character and economy. According to 1997 U.S. Census Bureau data, Wisconsin ranked eleventh in the nation for the number of farms in the state.[1] That same year, the market value of all agricultural products sold in Wisconsin totaled $5.6 billion, the tenth highest in the nation. Wisconsin also ranked second in the nation for the annual value of all dairy products sold for the year at $2.75 billion.[2]

Current information regarding the number of people involved in farming in Wisconsin, including farm owners, operators, workers and their families is not available. However, the National Agricultural Statistics Service publishes statistics on the number of farm workers in Wisconsin, Minnesota and Michigan collectively. In April 2001, there were 43,000 agricultural workers across the three states.[3] This represents a reduction of 10,000 workers compared to April 2000. These employees work an average of 36.5 hours per week, expect to be employed for 150 days or more this year and were paid an average wage of $9.57 per hour. This data does not include farm owners and operators.

Information on the number of farms in Wisconsin is more readily available. In 2000, there were about 78,000 farms in the state covering a total of 16.3 million acres. The average size farm was 210 acres.[4] As Table 1 illustrates, both the number of farms and total land of farms have decreased since 1980. The average farm size increased by 10% between 1980 and 1990, decreased between 1990 and 1995, but has remained constant since then. Nonetheless, the average Wisconsin farm in 2000 is 5% larger than it was in 1980.

Table 1. Number of Farms, Farms Size and Total Farm Land in Wisconsin, 1980 - 1999.

Year	Number Farms	Average Farm Size (acres)	Farm Land (million acres)
1980	93,000	200	18.6
1985	83,000	216	17.9
1990	80,000	220	17.6
1995	80,000	210	16.8
2000	77,000	210	16.3

Source: Wisconsin Agriculture Statistics Service
February 2000

Health Insurance Coverage of Farmers

Based on the 2000 Wisconsin Family Health Survey data, individuals residing on farms are significantly more likely to be uninsured than non-farm household residents in Wisconsin. The uninsured rate for farm residents is 10% as compared to 6.0% for non-farm residents.[5]

There are a number of factors that may account for higher uninsured rates of farm families. Like other self-employed business owners, farmers may not have access to affordable insurance in the group market. There are also a number of occupational risks associated with farming that make the purchase of health care coverage in the individual market a costly endeavor. Finally, some farm families may be precluded from eligibility for public insurance programs such as Medicaid and BadgerCare due to excess income related to farm equipment depreciation.

Health Insurance: Farmers' Perspectives

Two regional surveys of Wisconsin farmers have been conducted to better understand their health insurance needs. While these surveys cannot present a representative statewide picture of farmers, due to their small sample size and limited geographic perspective, both provide information about the health insurance needs of some Wisconsin farmers.

Dairy Farmers in Barron County

In September 2000, the Barron County Health Department conducted a survey of dairy producers in Barron County.[6] Surveys were mailed to 809 dairy farmers identified through the Farm Service Agency. The survey achieved a 28% response rate with 228 surveys returned. The respondents were not asked about farm size. The respondents were asked to report on their own insurance coverage and that of their families where applicable. The most common reason cited for lack of insurance was that the insurance coverage available to respondents had high premiums and high deductibles with modest coverage. Some respondents reported purchasing major medical coverage at a good initial price, but within a few years the premium increased to a point that made it unaffordable.

Farmers may seek off-farm work for the purpose of accessing employer-sponsored health insurance. According to Census of Agriculture data, nearly half of the farm operators in Wisconsin worked off-farm in 1997.[7] Among the 189 Barron County dairy farmers that did have insurance for themselves or their families, approximately 30% had health insurance through a job off the farm. The remaining 70% of the insured survey respondents purchased their own insurance. Both price and coverage differences were reported between the policies available to these two groups.

Health insurance premiums and deductibles were considerably higher for Barron County dairy farm families who purchased their own coverage as compared to those who obtained coverage through off-farm employment. Over 42% of the dairy farmers reported annual deductibles in excess of $1,000, while only 4% with access to employer-sponsored coverage off the farm reported annual deductibles over $1,000. In addition, while over 70% of the dairy farmers with access to off-farm employer-sponsored coverage reported monthly premiums between $50 and $200, 82% that purchase their own coverage reported monthly premiums in excess of $200.

The insured Barron County dairy farmers also reported coverage differences depending on the source of their coverage. Farmers who obtained their coverage through non-farm employment were more likely to report coverage of primary care services, such as annual physicals and immunizations. Primary care services were less likely to be reported as covered under the self-purchased policies. For example, only 21% of the farmers with self-purchased insurance reported coverage of immunizations, compared to 81% of those with non-farm employer-sponsored insurance. Figure 1 (page 3) compares coverage for primary care services reported by the Barron County respondents who purchased their own health insurance with those who obtained coverage through off-farm employment.

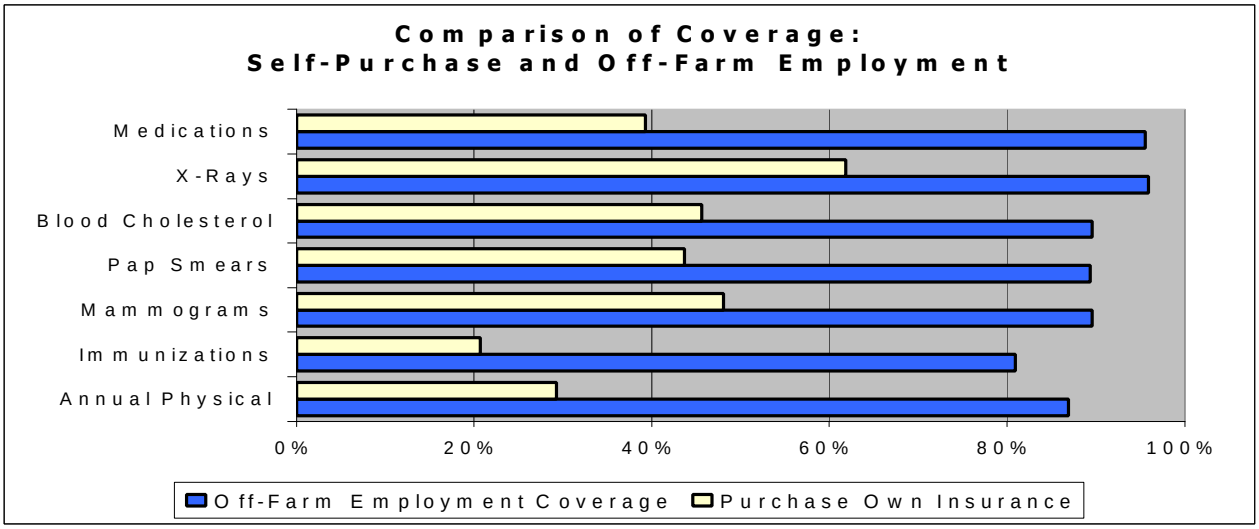
Family Health Center of Marshfield, Inc.

A second survey was conducted by the Family Health Center of Marshfield, Inc. (FHC) in July 2001. This survey was mailed to 68 farmers who participate in the Family Health Center of Marshfield, Inc. The Family Health Center provides health care services to individuals in eleven counties in Wisconsin. Members pay a monthly premium on a sliding-fee scale that is based on income, and all must have income at or below 200% of the federal poverty guideline. Members are generally not eligible for other programs such as Medicaid or BadgerCare.

The survey was returned by 34 farmers or 50% of the sample. Nearly all of the respondents reported being full-time farmers as opposed to part-time. Over two-thirds of the respondents were married, and 80% of these farmers reported farming as the primary occupation of their spouse. Nearly all of the respondents were owners of small farms and had fewer than three employees. None of the respondents was under the age of 35.

Approximately 50% of the respondents reported at least one family member being uninsured. Of those who reported a reason for not having health insurance, all indicated that they did not have health insurance because they could not afford it and all but one rated having health insurance coverage as either "very important" or "important".

Figure 1. Percent of Respondents Who Purchase Own Insurance Who Reported Coverage of Primary Care Services, Compared to Percent of Respondents With Insurance Through Off-Farm Employment.



Source: Barron County Health Department, 2000

Respondents were asked, if they or someone in their family did not have health insurance but would like insurance, where they would want to obtain coverage. Respondents were given choices of government-sponsored; employer-sponsored; purchase directly themselves from insurance agents; purchase from a farmer's trade association, fraternal order or cooperative; or from some other source. For those who indicated a preference, about three-fourths of the farmers indicated that they would prefer government-sponsored insurance. The remaining one-quarter indicated they would prefer to purchase insurance through a farmer trade association, fraternal order or cooperative.

Like the Barron County dairy farmers, these farmers reported high out-of-pocket costs for their coverage. A total of eight respondents reported self-purchase of coverage in the private market. The monthly premium amounts for these individuals ranged from $93.50 to $884. The individual with the lower premium had purchased single coverage and reported having an uninsured spouse and child in the household. The $844 premium provided coverage for a respondent and her spouse, both of whom were between the ages of 55 and 64. Four of the eight reported annual deductibles: one at $1,000, one at $2,500 and two at $5,000.

While data is not available on whether or not the policies cited cover primary care services, the farmers' participation in the FHC (with its emphasis on primary care) suggest that they do not. Like the Barron County dairy farmers, this group appears to be paying for expensive, but limited health care coverage.

The survey also asked farmers about their attitudes towards health insurance generally and about certain features of, and experiences with, health insurance.

The farmers surveyed almost unanimously agree (97%) that having health insurance is important.[8] Health insurance is a matter of concern among the majority of those surveyed, with 85% indicating that they worry about not having health insurance. Furthermore, 47% reported difficulty in obtaining insurance for themselves and/or their families, but over one-quarter reported they did not face such difficulty.

Separate questions were asked about whether respondents believed it was an employer's responsibility to provide coverage for their employees and whether it is the government's responsibility to provide health insurance for its citizens. About 53% of the respondents agreed that employers should provide insurance, while 61% agreed that the government should provide insurance to its citizens.[9]

Summary

Farm families in Wisconsin are more likely to be uninsured than the general population. There can be significant consequences to being uninsured for farm families. Similar to the general population, a lack of health insurance can lead to lack of access to health care services. Farmers who do not have any health insurance or who have high deductibles are not likely to seek treatment for minor accidents or chronic conditions. Farmers who are members of the FHC and who responded to a recent survey also indicated that poor health status can have direct economic consequences, resulting in the loss of their farm and livelihood.

In general, the farmers who responded to the surveys discussed in this paper reported high out-of-pocket costs for health care coverage that did not provide comprehensive coverage for primary care services. In addition, farmers participating in the FHC had higher rates of uninsurance and reported difficulties obtaining affordable coverage on their own. While not a statewide representation, these two surveys provide insights into the perspectives of some Wisconsin farmers.

About the Family Health Center of Marshfield, Inc.

The Family Health Center of Marshfield, Inc. (FHC) is a federally funded Community Health Center that has been in existence since 1974. The Family Health Center provides primary care and community health services to low-income, uninsured or underinsured residents in north central Wisconsin. An eleven member Board of Directors, the majority of whom are or were participants of the program, governs FHC.

Medical care is provided through a contractual arrangement with Marshfield Clinic. In addition to Marshfield Clinic, FHC has an affiliated network of physicians, hospitals, pharmacies, and dentists to assist in providing comprehensive care throughout an expansive 7,372 square mile predominantly rural service area. The Family Health Center also operates a mail order pharmacy for its members.

Notes

1. U.S. Department of Agriculture, National Agricultural Statistics Service. 1997 Census of Agriculture. Released February 1999.
2. The definition of a farm for census purposes is any place from which $1,000 or more of agricultural products were produced and sold, or normally would have been sold, during the census year
3. U.S. Department of Agriculture, National Agricultural Statistics Service, Agricultural Statistics Board. "Farm Labor". Washington D.C. May 18, 2001.
4. Wisconsin Agricultural Statistics Service. "Number of Farms – 2000". February 28, 2001.
5. Wisconsin Family Health Survey, 2000. Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. September 2001. The Family Health Survey is a representative survey of Wisconsin's household residents conducted each year.
6. Newmann, Kathleen. Barron County Health Department. "Health Care Survey Results: Barron County Dairy Producers". Survey conducted September 2000. Barron County is located in Northwest Wisconsin.
7. U.S. Department of Agriculture, National Agricultural Statistics Service. 1997 Census of Agriculture. Released February 1999.
8. The survey asked whether respondents strongly agree, agree, neither agree nor disagree, disagree or strongly disagree with several statements.
9. Respondents were asked to indicate whether they strongly agree, agree, neither agree nor disagree, disagree or strongly disagree with these statements.

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Findings from Focus Groups: Select Populations in Dane County

Wisconsin is one of 20 states that received a grant in 2000-01 from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, to explore new approaches to increasing access to health insurance for state residents. Research under Wisconsin's State Planning Grant has focused on several topics, including an understanding of various barriers to accessing health insurance coverage.

This briefing paper provides detailed information from five focus groups conducted in partnership with the Dane County Health Council. The focus groups were designed to study health insurance coverage where access to health insurance may be restricted due to language or other cultural barriers. Participants in the focus groups were recruited from the Latino, Hmong and African American communities in Dane County. In addition to questions about access to health insurance, focus group participants responded to various questions about access to health care.

The results discussed in this briefing paper represent the views of focus group participants only and should not be construed as representing the views of all Dane County communities.

Uninsured Rates in Wisconsin and Dane County

An estimated 7% of the Wisconsin population was uninsured in 1999, based on Wisconsin Family Health Survey questions regarding health insurance coverage at the time of the survey interview (point-in-time). However, the data show some disparity in uninsured rates based on race and ethnicity, with 6% of the white, non-Hispanic population estimated to be uninsured compared to 11% for black, non-Hispanic residents and 17% for persons of Hispanic or Latino origin.[1]

Based on the Wisconsin Family Health Survey, the estimated point-in-time uninsured rate in Dane County is the same as that for the state as a whole - 7%. Based on combined 1996-1999 Wisconsin Family Health Survey data, in Dane County, there is also a large difference in the uninsured rate of white residents as compared to non-white residents, with the uninsured rate for non-whites being as much as four times that of the white population.[2]

Race and Ethnicity in Wisconsin and Dane County

Wisconsin

Wisconsin is home to nearly 5.4 million people. Based on the 2000 Census, non-white persons make up 11.1% of the state's total population, an increase of 3.3% compared to 1990. Table 1 shows Wisconsin's population by race and ethnicity. The Census Bureau uses racial categories for all but the Hispanic category, which is considered an ethnicity.[3]

Wisconsin's African American population is the second largest racial group in the state, representing 5.7% of the state's population. The African American population increased 24.5% from 1990 to 2000.[4]

Table 1. Wisconsin Population by Race and Ethnicity, 2000.[5]

	Number	Percent
Wisconsin Total	5,363,700	100%
White	4,769,900	88.9%
African American	304,500	5.7%
Asian	88,800	1.7%
American Indian and Alaska Native	47,200	0.9%
Other Race	84,800	1.6%
Two or More Races	66,900	1.2%
Hispanic or Latino[3] (of all races)	192,900	3.6%

Source: U.S. Census Bureau, Census 2000, Summary File 1.

Asians are the third largest racial group in the state, representing 1.7% of the overall population. Nearly 40% of the Asian population in the state is Hmong.[6]

The Hispanic or Latino population in Wisconsin increased by 107% from 1990 to 2000, the largest increase of any racial or ethnic group. As a percentage of the total population, the Hispanic or Latino population is 3.6% in 2000 compared to 1.9% in 1990.[7]

Dane County

About 426,500 people reside in Dane County, representing approximately 8% of Wisconsin's total population. Dane County includes the city of Madison, the second most populous city in Wisconsin.

Table 2 shows the Dane County population by race and ethnicity for the year 2000. Dane County is similar to the state population in terms of its overall diversity, with approximately 11% of the population being non-white. The Hispanic or Latino population accounts for a similar share of the state and the county population. However, this population grew faster in Dane county than in the state, increasing 150% from 1990 to 2000.[8] Dane County has a lower percentage of African-American residents compared to the state, and a higher percentage of Asian residents.

Table 2. Dane County Population by Race and Ethnicity, 2000.

	Number	Percent
Dane County Total	426,500	100%
White	379,400	89.0%
African American	17,100	4.0%
Asian	14,700	3.5%
American Indian and Alaska Native	1,400	0.3%
Other Race	6,100	1.4%
Multiracial	7,600	1.8%
Hispanic (all races)	14,400	3.4%

Source: U.S. Census Bureau, Census 2000, Summary File 1.

Dane County is one of only 11 counties in the state that have populations that are less than 90% white. It is one of only four counties in the state that has more than 10,000 Latino residents. The county has the third largest African American population in Wisconsin, and the second largest Asian population.[9] Over 15% of the Asian population in the county are Hmong.[10]

Focus Group Participants

Dane County is similar to the state population as a whole in terms of overall uninsured rates and in disparities in insurance rates between the white and non-white populations. Given its diversity, the county provides a good location to begin to understand more fully health insurance coverage among the non-white population. Focus groups with Hmong, Latino and African American residents in the county were conducted in May 2001. The participants in these focus groups provided information about their barriers to accessing health insurance.

Five focus groups were conducted.[11] Three focus groups were with Latino residents: two with persons who did not have health insurance and one with individuals who had health insurance. One focus group was conducted with African American residents who did not have health insurance. Finally, one focus group was conducted with Hmong residents who had health insurance. Having insurance was defined as having third-party coverage (private or public) for primary health care services.

The recruitment process was not random. Most focus group participants knew their recruiter, as it was determined that participation would be higher if participants trusted the recruiter. All focus groups were conducted at locations accessible and familiar to participants. In addition, all focus groups were conducted in each population's native language, with moderators that were well known and trusted members of the respective communities, and in some cases were interpreters and other staff of providers.

In total there were 41 participants.[12] Twenty-five people participated in the focus groups of Latino residents who were uninsured; five people participated in the groups of Latino residents who had health insurance; six people participated in the African American focus group; and five people participated in the Hmong focus group.

Participants were not screened for gender, marital status or other demographic criteria apart from race or ethnicity. Over 75% of the Latino participants were female. Most Latino participants were married. Nearly all of the Latino participants

were between the ages of 18 and 36, and the majority had lived in Dane County for more than one year. About half of the Latino participants reported that they were not currently employed, one reported having more than one job, three reported working part-time, and three reported working full-time.

The majority of the African American participants also were female. Most were not married, and all African American participants were between the ages of 36 and 55. The majority had lived in Dane County for more than one year. Only one African American participant reported being unemployed, three participants had more than one job, and the majority of the participants worked full-time.

Nearly 80% of the Hmong participants were female, and all were married. The Hmong participants were all age 45 or younger and the majority had lived in Dane County for more than two years. Although none of the Hmong participants reported numbers of hours worked in a week, three of the five participants reported having employment, two reported being unemployed and one reported having more than one job.[13]

Health Insurance: The Perspective of the Uninsured

Three focus groups were completed with people who did not have health insurance. Two of these were conducted with Latino residents, and one with African American residents. These focus group participants shared their experiences with, and their thoughts about, accessing insurance coverage.[14]

Latino Participants

Language is a significant barrier to obtaining health insurance for the Latino participants. Participants identified a lack of information about health insurance. Little information is provided in Spanish, and when it is provided it is very difficult to understand.

In general, participants experienced some confusion about how the health insurance system works in the United States. For example, some participants were not sure whether employers were required to offer health insurance and what they were required to provide. Others indicated that it was difficult to understand the benefits under different insurance policies. Still others experienced difficulty understanding billing systems.

Despite these barriers, participants expressed a desire to learn about health insurance. Most participants felt that interpreters provided an invaluable service. In addition, some suggested the need for workshops where health insurance representatives could come and talk about insurance options. Others suggested that a telephone hotline staffed with Spanish-speaking individuals who could answer questions about health care and health insurance would be useful.

In addition to language barriers, and a lack of information, some participants indicated that their immigration status prohibited them from obtaining health insurance. Participants expressed fear of being fired from their jobs and concern that if they signed up for health insurance, they would be reported as undocumented.

Although no participant had been denied medical care because they were uninsured, all participants expressed a belief that there is value in having health insurance because it provides some security in case of an accident or serious illness. Participants believed that lack of insurance was the biggest barrier preventing them from seeking care through a doctor or clinic. Most participants expressed a preference for care provided by a doctor or in a clinic instead of going to the emergency room as many of them do now.

All participants indicated they would be willing to pay for health insurance. In general, participants did not expect health care or insurance to be free. As one participant said when discussing the cost of care, "Not free because we are all aware that things cost money and the doctors need to have their income in order to survive."

However, many expressed the opinion that there was little value in having insurance that does not cover all or most of the costs of care. For example, one woman indicated that her husband's insurance covered only $30 of a $210 bill for x-rays. She felt that it was not worth having to pay a premium each month if she still would have to pay for a large portion of the cost of her care.

A few participants had been offered insurance through an employer but turned down the insurance because the coverage appeared to be minimal relative to their premium costs. In referring to her husband's employer-sponsored insurance, one woman summed up her feelings,

"He was going to have a deduction [from salary] of $60, and then I have to pay $20 for each appointment and on top of that extra expenses. Then what's the benefit of having insurance?"

African American Participants

The six African American participants in the focus group did not indicate that either race or culture was a barrier to accessing health care or health insurance. Although the majority of them were employed and working full-time, they stated that cost was the primary barrier to obtaining health insurance. All participants indicated that they wanted insurance for themselves and their children. As one African American woman stated, "You would have a safety net. It's peace of mind." However, participants indicated that insurance was either not available or too expensive.

Lacking access to employer-sponsored insurance, some participants sought insurance through the individual market, these attempts generally were unsuccessful. For example, one participant said that initial price quotes were low, and when it came time to purchase the insurance, premiums were much higher than the initial quotes.

African American participants did not seem to feel that a special phone line or additional workshops were needed because they did not have difficulty knowing where to seek health insurance. All felt that people in general were aware of health insurance, but simply could not afford it.

Compared to the uninsured Latino participants, African American focus group participants were more likely to seek medical treatment from the emergency room. The Latino focus group participants on the other hand, indicated a preference for going to community clinics to obtain care. The African American participants indicated that the emergency room was preferential because of it's "promptness, efficiency, and quick service." Attempts to seek care in a clinic setting were frustrating due to difficulties in scheduling appointments.

Health Insurance: The Perspective of the Insured

One focus group was conducted with Latino residents who had health insurance, and another group was conducted with Hmong residents who had health insurance. These participants shared their thoughts about health insurance coverage.[14]

Latino Participants

The Latino participants felt that it is very important to have health insurance in the United States. Like the uninsured participants, insured Latino residents value the security of health insurance. Although difficult to assess, it appears that Latino residents who have insurance may have been in situations where they received more information from their employers and elsewhere as compared to residents who are uninsured. One person explained, "When you apply for a job, and if you are accepted, they explain all your benefits, and also medical insurance."

One insured participant expressed that her health is a high priority – "… for me, my health is first" - something not expressed by uninsured participants. Further, most insured participants indicated that they receive regular annual check-ups, mammograms, and other preventive health care services. When asked, none of the participants in the focus group with uninsured Latino residents indicated that they receive these services regularly, if at all.

None of the insured participants expressed concerns about immigration status. It is not known if any of them are undocumented.

However, similar to the uninsured Latino participants, some insured participants expressed confusion about the health insurance system in the United States. For example, one person wondered if it was a requirement that all people have health insurance.

Further, insurance coverage did not guarantee access for this group as insured participants indicated some level of difficulty in accessing health services and using their insurance. Language also appears to be a barrier for this group in terms of understanding what is covered under their insurance policies, how to use the policy and where to go for services covered under the policy. Many use interpreters for assistance.

Lack of information can have a high cost. For example, one person went to a clinic for services only to find that the clinic was not covered under that person's health plan and ended up paying out-of-pocket for services that otherwise would have been covered under their insurance plan.

Similar to uninsured focus group participants, insured participants used interpreters, which helped to alleviate some confusion. They

suggested that a phone line for Spanish-speaking individuals could help provide information about health insurance. The group generated other ideas about community-based support, such as workshops.

Hmong Participants

Like all of the other focus group participants, both insured and uninsured, the five Hmong focus group participants like the security that insurance affords them. Most participants learned of health insurance through their job or from the state for coverage under the Medicaid and BadgerCare programs.

Unlike participants in other groups, some Hmong participants indicated that they would not want to work for an employer that did not offer insurance, even if the employer paid a higher wage. This was made clear as they were the only participants that indicated that they prefer to pay for insurance through payroll deduction. Without it, they stated that they would likely spend the money on something other than health insurance coverage.

None of the Hmong participants talked about receiving annual checkups or preventive care services, although they were all insured. Participants expressed some confusion about having a regular doctor, indicated they had difficulty making appointments, and appeared to wait until they were very sick to go to the doctor.

Cultural and language barriers impact Hmong participants. These participants were the only focus group participants that expressed some concerns about discrimination. When discussing promptness of care in the emergency room, one woman stated, "I feel that maybe, like myself, I feel I am different people so they don't acknowledge and work with me."

Participants generally agreed that the biggest problem they faced was the language barrier. They indicated that even documents translated into Hmong were of little use, especially for their parents. According to the Office of Refugee Services in Wisconsin[15], the Hmong culture traditionally placed a heavy emphasis on oral communication as opposed to written language. Thus, language barriers are often compounded by low literacy levels. Although the Office of Refugee Services indicates that this appears to be changing for the Hmong community, focus group participants still expressed concerns for older generations.

As a result, Hmong participants have experienced difficulties in completing insurance forms and understanding billing procedures. Further, as with Latino residents, language issues have resulted in misunderstandings about covered services. Focus group participants expressed confusion about why health insurance does not cover all services and medicine, and why there are co-payments and deductibles. Hmong participants expressed the need for more interpreters and other services to help alleviate these problems.

Summary

Five focus groups conducted in Dane County were intended to gather information about barriers to accessing health insurance, with a particular focus on language or cultural barriers.

In general, Latino and Hmong focus group participants, both insured and uninsured, indicated that language is a barrier to accessing insurance and understanding coverage options and billing procedures. The Latino residents who were uninsured also identified immigration status as a concern. Secondarily, the cost of insurance was identified as a barrier.

By contrast, uninsured African American participants indicated that cost was the main barrier to accessing care and insurance, coupled with the fact that their employers do not offer insurance. Cultural issues were not of major concern to these participants.

Insured participants were more likely to report having a regular doctor and receiving preventive care services such as regular tests and check-ups. Hmong and Latino insured participants were also more likely to have received information about health insurance through an employer or some other source as compared to the uninsured Latino participants. Although African American residents generally did not express that lack of information as a concern, Hmong and Latino residents indicated a need for more information about health insurance.

Confusion about health insurance coverage and the health care system is not unique to non-

English speaking residents, or to new immigrants. However, the ability to ask questions, to be understood, and to understand what is being communicated can alleviate confusion. Many focus group participants indicated that interpreters were useful in communicating with doctors and in understanding insurance papers. Further, most indicated a willingness to attend workshops about health care and health insurance.

Comments from focus group participants suggest that the cost of health insurance coverage remains problematic for most people who are uninsured, regardless of race or ethnicity. Many are employed, as the African American participants, but insurance coverage is not offered through their employer. Furthermore, focus group participants who sought coverage through the individual market often found the insurance options unaffordable.

Notes

1. Wisconsin Health Insurance Coverage 1999. Bureau of Health Information, Division of Health Care Financing, Wisconsin Department of Health and Family Services. September 2000.

2. 1996-1999 Wisconsin Family Health Survey Data. Prepared by Innovative Resource Group, (a contractor on State Planning Grant activities), Madison, Wisconsin. May 2001.

3. As noted, in data from the U.S. Census Bureau, Hispanic is an ethnic, not a racial, category. The Hispanic persons represented in the data can be of any race. Further, the Census Bureau uses the term Hispanic. The term Latino is used interchangeably with the term Hispanic in this report.

4. Wisconsin's Racial and Ethnic Diversity: Census 2000 Population and Percentages. University of Wisconsin Extension and Applied Population Laboratory. June 24-26, 2001.

5. In 1990, the Asian category included Native Hawaiian and Other Pacific Islander. In the 2000 Census, Native Hawaiian and Other Pacific Islander is a separate category. This category is not shown in the table as less than 0.04% of the population was reported in this category.

6. U.S. Census Bureau. Census 2000, Summary File 1 (SF-1). August 2001

7. Wisconsin's Hispanic or Latino Population: Census 2000 Population and Trends. University of Wisconsin Extension and Applied Population Laboratory, Madison, Wisconsin. March 29, 2001.

8. Wisconsin's Hispanic or Latino Population: Census 2000 Population and Trends. University of Wisconsin Extension and Applied Population Laboratory, Madison, Wisconsin. March 29, 2001.

9. Wisconsin's Racial and Ethnic Diversity: Census 2000 Population and Percentages. University of Wisconsin Extension and Applied Population Laboratory. June 24-26, 2001.

10. U.S. Census Bureau. Census 2000, Summary File 1 (SF-1). August 2001.

11. Originally, seven focus groups were planned. However, one African American group consisting of people who had health insurance, and one Hmong group consisting of people who were uninsured were not conducted due to a lack of participants.

12. Two groups with uninsured African American participants were conducted. The original focus group consisted of thirteen participants. However, due to recording equipment failure, a second session was conducted. Six of the original thirteen participants agreed to return for the second session. Based on data availability, the participant profile is based on the original thirteen participants: however, the description of the results is based on the points of view of the six participants who returned for the second group.

13. The participant profile is taken from a summation report prepared by Jan Wilson, Independent Researcher and Analyst. July 5, 2001.

14. The results from the focus groups are primarily based on written transcripts. Secondarily, results are based on a summation report prepared by Jan Wilson, Independent Researcher and Analyst. July 5, 2001.

15. Levy, Susan, Director. Office of Refugee Services, Wisconsin Department of Workforce Development. Personal Communication. August 2001.

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Health Insurance and the Young Adult Population in Wisconsin

Wisconsin is one of 20 states that received a grant in 2000-01 from the federal Department of Health and Human Services, Health Resources and Services Administration (HRSA) to explore new approaches to increasing access to health insurance for state residents. Wisconsin was notified of the grant award in September 2000. Research under Wisconsin's State Planning Grant has focused on several topics, including the particular circumstances of young adults in accessing health insurance coverage.

Historically, Wisconsin has had a low uninsured rate and a high rate of employer-sponsored and public coverage for the non-elderly population. However, rates of insurance vary by age group, with young adults between the ages of 18 and 24 having the highest uninsured rate in the state. This briefing paper takes a closer look at the insurance status of Wisconsin's young adult population. Specifically, the paper presents results of a survey of 18 to 24 year-old individuals. While the survey is not necessarily representative of the experiences of 18 to 24 year-olds statewide, it provides additional information about an age group often considered vulnerable with respect to access to insurance. In addition, because many young adults are pursuing post-secondary education, more in-depth information about student insurance options at colleges and universities in Wisconsin is provided.

Young Adults in Wisconsin

Wisconsin is home to approximately 520,000 young adults (18 to 24 year-olds).[1] They comprise almost 10% of the state's total population and approximately eleven percent of Wisconsin's non-elderly population.

Most of what is known about the education, employment, and income of people in this age group comes from national data. In the fall of 2000, 35% of all 18 to 24 year-olds in the nation were enrolled in college, with 83% of those enrolled full-time.[2] In addition to attending classes, a large proportion of college enrollees were employed: 19% worked full-time and 39% were employed part-time. Full-time students also balanced school and employment, with 11% of all full-time students working full-time and 41% of all full-time students working part-time.[3]

Compared to adults age 25 years and over, more young adults tend to work in jobs in the wholesale or retail trade category, work fewer hours, and have lower earnings. The largest share of young adult workers, approximately 40%, work in the wholesale or retail trade industry, compared to 18% of workers 25 and over.[4] An additional one-third of young adult workers are employed in the service industry.[5] Young adults nationally tend to work fewer hours overall than the rest of the adult population, most likely because they are students or work in seasonal or part-time occupations. Young adult workers average 34.8 hours of work per week; while workers 25 and over average 40.9 hours of work per week.[6] Among full-time wage and salary workers, earnings are also lower for 18 to 24 year-olds whose median weekly earnings were $361 in 2000, compared to $620 for people age 25 and over.[7]

Nationally, young adults have higher than average uninsurance rates. This is true for young adults in Wisconsin as well. Table 1 shows the uninsured rates for the non-elderly population in Wisconsin by age group, based on Wisconsin Family Health Survey data.[8] The survey creates a snapshot of the uninsured at a point-in-time by asking respondents several questions about their health insurance coverage at the time of the survey interview.

Table 1. Uninsured Rates by Age for the Non-Elderly Population in Wisconsin

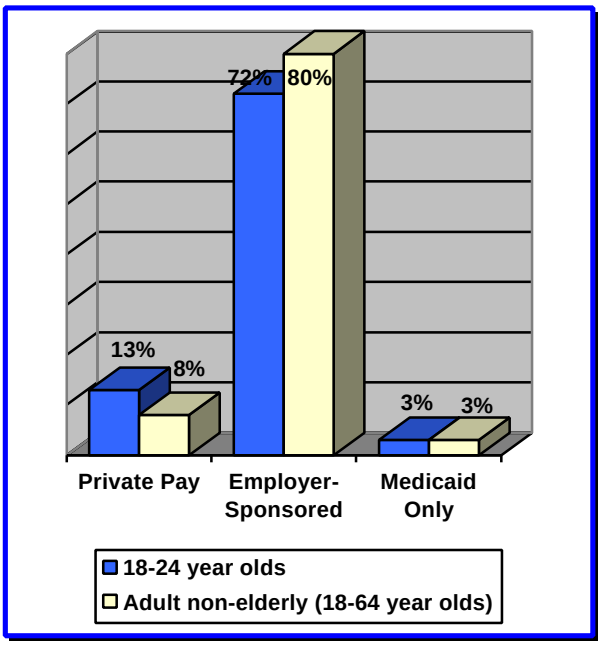
Age	1995	2000
0-17	8%	5%
18-24	**19%**	**11%**
25-44	11%	6%
45-64	9%	7%
All Non-Elderly	10%	7%
Adult Non-Elderly	11%	7%

Source: 1995 and 2000 Wisconsin Family Health Survey, Wisconsin Department of Health and Family Services, Point-in-Time or "Current" Estimates.

Health Insurance Options for Young Adults

Figure 1 shows rates of private-pay, employer-sponsored and Medicaid coverage for young adults in Wisconsin as compared to the entire adult non-elderly population. As shown in the figure, 18 to 24 year-olds have a higher rate of private pay coverage than the average for the entire adult non-elderly population.

Figure 1. Source of Health Insurance by Age, 1999



Source: Wisconsin Family Health Survey, Wisconsin Department of Health and Family Services, 2000.

An important source of private coverage for young adults is that provided through a parent's policy. Because coverage through a parent was not a separate category, it is not clear if this circumstance is reported under the private-pay category or the employer-sponsored category shown in Figure 1. For most insurance carriers, young adults are typically eligible to be covered as a dependent under their parents' coverage until they reach the age of 25 if they are a full-time student.[9] Young adults who are not full-time students are typically covered through age 19.

Young adults in the labor force who do not have access to coverage through a parent may be eligible for employer-sponsored insurance. However, as shown Figure 1, young adults have lower rates of employer-sponsored health insurance as compared to the entire adult non-elderly population. One reason for this is that young adults are more likely to be in school. Further, if employed, young adults have a greater tendency to work in part-time, temporary, or seasonal jobs in which they are often not eligible for insurance through their employer.[10] Finally, even if they are working in a permanent full-time job, young adults may work for employers who do not offer insurance coverage. This is particularly true if the person works for a small employer.

Publicly funded insurance options for young adults vary by the applicant's age and other characteristics. Eighteen year-olds with or without minor children of their own could be eligible for Medicaid or BadgerCare. The same is true for 19 year-olds and older with minor children. Nineteen year-olds without minor children of their own are not eligible for BadgerCare but could be eligible for Medicaid if they meet certain eligibility criteria for persons with disabilities. In July 2001, there were 14,100 eighteen and nineteen year olds on Medicaid and BadgerCare.

Young adults in Wisconsin who do not have access to health insurance coverage through a parent's policy, an employer or a public program, have few remaining options. Under Wisconsin State Planning Grant research, access to insurance for 18 to 24 year-olds in the state was examined through a case study with the Family Health Center of Marshfield, Inc and by exploring health insurance options offered through Wisconsin colleges and universities.

Case Study: The Family Health Center of Marshfield, Inc.

The Family Health Center of Marshfield, Inc. (FHC) provides health care services to individuals in eleven counties in Wisconsin. Members pay a monthly premium on a sliding-fee scale that is based on income, and all must have income at or below 200% of the federal poverty guideline. Members are generally not eligible for other public programs such as BadgerCare or Medicaid. Although participants sometimes view FHC membership as having health insurance, the FHC is a federally funded community health center or safety net provider, not a health insurance policy.

In order to better understand the particular circumstances of young adults in Wisconsin, the Department of Health and Family Services in cooperation with the Family Health Center of Marshfield, Inc. conducted a brief survey of 18 to 24 year-olds who use the FHC. Questions were asked about employment, student status, availability of insurance (other than Family Health Center membership), and barriers to obtaining health insurance. While the survey is not representative of 18 to 24 year-olds in the state, it provides additional information about an age group often considered vulnerable with respect to access to insurance.

A 40% response rate was achieved, with 72 of the 179 mailed surveys being returned. Of those responding to the survey, nearly 28% were employed full-time and about 49% were employed part-time. The majority of the respondents indicated they were attending school: approximately 42% reported full-time student status and 10% reported part-time student status. Thus, nearly half of all respondents both worked and attended school, either full or part-time.

Table 2 provides more detailed information about respondents who were working and attending school. Of those working full-time, about 15% were full-time students and another 15% were part-time students. Of those working part-time, about half were also full-time students, and one-fifth were also going to school part-time.

When asked if they would like health insurance coverage and what prevents them from getting health insurance, about half of the respondents indicated they would like to have insurance coverage in addition to their FHC membership. Survey respondents indicated the FHC is an important resource for them. The most common reason for disinterest in insurance coverage was that they liked the services they received from the FHC and that the FHC covered all of their current needs. In addition, respondents indicated that they could not afford other insurance coverage.

However, the FHC does have some limitations. Respondents generally indicated they would like more comprehensive services. Of those who responded that they would like to have health insurance coverage, 48% indicated that they would like to have coverage for hospitalization, about 32% indicated they would like to have dental coverage, and about 19% indicated they would like to have added coverage in general. A few respondents indicated that they would like to have coverage that extended beyond the Marshfield area, particularly when they are in school.

Table 2. Survey Responses: Employment Status and Student Status

Surveys Sent	179
Number Respondents	72
Response Rate	40%
Of the Respondents	
% Working Full-Time	28%
% Working Part-Time	49%
Of Those Working Full-Time	
% Full-Time Student	15%
% Part-Time Student	15%
Of Those Working Part-Time	
% Full-Time Student	49%
% Part-Time Student	19%

Source: Wisconsin Department of Health and Family Services and the Family Health Center of Marshfield, Inc.

The cost of obtaining health insurance is a major barrier for young adults responding to the survey. Approximately 67% of the young adult respondents indicated that they are prevented from getting health insurance elsewhere because they cannot afford it. In addition, the part-time employment status of many respondents means that they most likely cannot access group coverage through their employer. About 23% of the young adult respondents indicated that they work part-time and are ineligible for their employer's insurance. Another 18% of the respondents indicated that they are unable to get insurance through their job either because their employer does not offer it, they are a temporary employee, or for some other reason.

About 15% of respondents indicated that they expect to have health insurance coverage in the next 6 or 12 months, of which more than half indicated they expect to have health insurance through their job.

Only 13% of the young adults who responded to the survey currently have health insurance in addition to their FHC membership. Each of the

young adults who have insurance coverage is employed either full- or part-time. However, the majority did not obtain insurance through their employer, but rather through their parents, as they are also full-time students. One respondent indicated that she is self-employed and pays for a major medical policy in order to have in-patient hospital coverage for her family. Another respondent indicated that he gets athletic insurance through his college during football season.

Research at the national level suggests that 18 to 24 year-olds have higher uninsurance rates due to a number of factors, including: loss of Medicaid, because they are no longer age or categorically eligible; loss of private coverage through parents due to age restrictions; lower labor force participation and thus less access to employer-sponsored insurance; a greater tendency than other adults to work jobs where benefits are not offered or where they are not likely to be eligible; and a lower take-up rate when insurance is offered.[11]

The Family Health Center survey results generally concur with what is known about young adults and health insurance at the national level. The young adults who responded to the survey are not eligible for BadgerCare or Medicaid. The majority of those who have insurance coverage are covered under their parents' policy. Over 40% of the survey respondents indicated that they are not eligible for insurance through their job either because it is not offered or they are not eligible due to their seasonal, part-time or temporary status. Finally, nearly two-thirds of the young adults who responded indicated that they would have trouble affording more comprehensive coverage.

Student Insurance Options

Currently there is limited information available regarding the rates of insurance coverage for young adults who are students. The University of Wisconsin-Madison estimates that approximately 20% of its students are uninsured. This number, however, includes graduate students and others who are not in the 18 to 24 year-old age range.

The Department of Health and Family Services conducted an informal survey of colleges and universities in the state to determine the extent of school-based insurance options for the student population.[12] Colleges and universities in Wisconsin, including technical colleges,[13] currently do not require the purchase of health insurance through the school or other entity. With the exception of those attending technical colleges, primary and preventive health care services are generally provided to students through an on-campus clinic. A few campuses have made arrangements for students to receive these services through a local health department. Most campuses, including the technical colleges, offer a major medical insurance product to their students and their dependents. Annual premiums for these products average $484 for single coverage (student only) and $2,494 for family coverage (student, spouse and children).[14]

A Closer Look: Student Insurance at the University of Wisconsin-Madison

The University of Wisconsin at Madison (UW-Madison) is unique among post-secondary institutions in the state, in that it offers its students health insurance that covers primary and preventive care, known as the Student Health Insurance Plan (SHIP). All students are offered SHIP, but students are not required to participate in the plan even if they are otherwise uninsured.[15] During the 2000 school year, approximately 2,050 students were enrolled in SHIP at sometime during the course of the year and approximately 1,600 were enrolled at any point in time.[16] Annual premiums for the 2000 school year were $879 ($73.25 per month) for single coverage and $3,206 ($267.17 per month) for family coverage.[17]

Under this voluntary enrollment system, the University has been experiencing adverse selection – students with high medical risks and utilization tend to enroll in SHIP, while those with low medical risks and utilization tend not to enroll. As a result, from the 2000 school year to the 2001 school year, the university expected premium increases of 142% for the same benefit package.[18] To avoid incurring such large premium increases UW-Madison opted to trim the benefits package and implement greater cost sharing. Consequently, annual premiums for the 2001 school year increased by 13% to $996 for single coverage and by 14% to $3,659 for family coverage. Examples of reduced benefits and increased cost-sharing under 2001 SHIP plan include a $500 per person cap on prescription

drugs where previously there was no maximum and a $300 deductible for in-network benefits where previously there was no deductible on in-network utilization.[19]

Over the longer term, UW-Madison is investigating the feasibility of implementing an automatic enrollment policy. The policy under consideration would include an "opt-out" mechanism, under which the failure to opt-out of the insurance plan would result in the student being automatically enrolled in and billed for the SHIP program. Various opt-out mechanisms are being examined. University of Wisconsin System researchers are also investigating the feasibility of implementing a similar coverage policy at all of its campuses.

Summary

Young adults in Wisconsin have relatively high uninsured rates: 13% compared to 7% for the entire adult non-elderly population. Access to insurance for select young adults was examined through a case study with the Family Health Center of Marshfield, Inc. While the survey is not necessarily representative of the experiences of 18 to 24 year-olds statewide, it provides additional information about an age group often considered vulnerable with respect to access to insurance. In addition, because many young adults are pursuing post-secondary education, insurance options available through Wisconsin colleges and universities were also examined.

The results of the case study, which included a brief survey of 18 to 24 year-old Family Health Center members, generally concur with what is known about young adults and health insurance at the national level. The young adults who responded to the survey are not eligible for BadgerCare or Medicaid. The majority of those who have other insurance coverage are covered under their parents insurance. Over 40% of the survey respondents indicated that they are not eligible for insurance through their job either because it is not offered or they are not eligible due to their seasonal, part-time or temporary status. Finally, nearly two-thirds of the young adults who responded indicated that they would have trouble affording more comprehensive coverage.

Young adults in Wisconsin who do not have access to health insurance coverage through a parent's policy, an employer or a public program have few remaining options. Because many young adults are pursuing post-secondary education, insurance options available through colleges and universities can be an important source of private group coverage. Wisconsin's colleges and universities typically offer optional, major medical coverage, which excludes primary care coverage. These plans often have high premiums and deductibles, and can impose significant cost sharing on students. Institutions that offer a more complete insurance product have experienced problems with adverse selection, such that an automatic enrollment policy may be necessary to promote viable distribution of risk and to promote reasonable premium increases for a comprehensive health benefit package.

About the Family Health Center of Marshfield, Inc.

The Family Health Center of Marshfield, Inc. (FHC) is a federally funded Community Health Center that has been in existence since 1974. The Family Health Center provides primary care and community health services to low-income, uninsured or underinsured residents in north central Wisconsin. An eleven member Board of Directors, the majority of whom are or were participants of the program, governs FHC. Medical care is provided through a contractual arrangement with Marshfield Clinic. In addition to Marshfield Clinic, FHC has an affiliated network of physicians, hospitals, pharmacies, and dentists to assist in providing comprehensive care throughout an expansive 7,372 square mile predominantly rural service area. The Family Health Center also operates a mail order pharmacy for its members.

Notes

1. U. S. Census Bureau. Profile of General Demographic Characteristics: Census 2000 for Wisconsin. May 23, 2001.

2. U.S. Census Bureau. School Enrollment – Social and Economic Characteristics of Students: October 2000 (PPL-148). Table 1. Internet release date June 1, 2001

3. U.S. Census Bureau. School Enrollment – Social and Economic Characteristics of Students: October 2000 (PPL-148), Table 11. Internet release date June 1, 2001.

4. U.S. Bureau of Labor Statistics. "Labor Force Statistics for the Current Population Survey, Annual Average Tables" Table 14. Employment and Earnings. January 2001. The data includes 16-24 year-olds, as 16 and 17 year-olds could not be separated out.

5. U.S. Bureau of Labor Statistics. "Labor Force Statistics for the Current Population Survey, Annual Average Tables" Employment and Earnings. January 2001. The Current Population Survey defines the "service industry" to include automobile and repair services, entertainment and recreation services, health services, educational services, social services, and other professional services, such as legal services, accounting and public relations.

6. U.S. Bureau of Labor Statistics. "Labor Force Statistics for the Current Population Survey, Annual Average Tables" Table 22. Employment and Earnings. January, 2001.

7. U.S. Bureau of Labor Statistics. "Labor Force Statistics for the Current Population Survey, Annual Average Tables" Table 37. Employment and Earnings. January 2001. The data includes 16-24 year-olds, as 16 and 17 year-olds could not be separated out.

8. Wisconsin Family Health Survey, 2000. Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. September 2001. The Family Health Survey is a representative survey of Wisconsin's household residents conducted each year.

9. However, some dependent coverage may have limited provider networks that create geographic coverage limitations.

10. U.S. Bureau of Labor Statistics. "Labor Force Statistics for the Current Population Survey, Annual Average Tables" Tables 3 & 8. Employment and Earnings. January 2001

11. Cunningham, Peter J. "Next Steps in Incremental Health Insurance Expansions: Who is Most Deserving." Issue Brief #12. Washington, DC: Center for Studying Health System Change. April 1998

12. The department did not contact each institution of higher learning in the state; however, data was gathered from institutions in the state that account for approximately 95% of post-secondary enrollment in Wisconsin. Not all post-secondary students in the state are residents. Data on the share of post-secondary students attending Wisconsin institutions who are not Wisconsin residents was not available.

13. According to data from the Wisconsin Technical College System Board, approximately 400,000 students were enrolled in an associate degree, technical diploma or vocational program at one of Wisconsin's sixteen technical colleges during the 1990-2000 school year.

14. Premium data for insurance products offered at Wisconsin's technical colleges were not available and are not included in the tabulations to determine the average premium.

15. All international students, however, are required to purchase health insurance through SHIP. The data in this section apply only to domestic students enrolled at the University of Wisconsin-Madison.

16. Harter, David. Personal communication. University of Wisconsin at Madison, University Health Services, June 28, 2001. The data in this section apply only to domestic students enrolled at the University of Wisconsin-Madison.

17. "SHIP Domestic 2000-2001". Plan Summary prepared by University Health Services, University of Wisconsin-Madison.

18. "UW Student Access to Affordable Health Insurance in Jeopardy". University Health Services, University of Wisconsin-Madison. Not dated. Printed May 3, 2001 from the world wide web.

19. "SHIP Domestic, 2000-2001" and "SHIP Domestic: 2001-2002". Plan Summaries prepared by University Health Services, University of Wisconsin, Madison.

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Milwaukee County General Assistance Medical Program

Wisconsin is one of 20 states that has received a grant from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services to explore new approaches to increasing access to health insurance for state residents. Wisconsin was notified of the grant award in September 2000. Research under Wisconsin's State Planning Grant has focused on several topics, including the health care costs and utilization of participants in the Milwaukee County General Assistance Medical Program (GAMP).

The GAMP program is a community safety net system serving uninsured residents of Milwaukee County. In calendar year 2000, GAMP served over 20,000 individuals and total payments under the program were $36 million. GAMP is funded with state and federal Medicaid revenues as well as Milwaukee County tax levy. The program is administered by Milwaukee County.

This briefing paper provides an overview of the Milwaukee GAMP program and its participants. Recent trends in cost and utilization under the program are also examined.

GAMP Program Overview

GAMP provides health care coverage to indigent persons residing in Milwaukee County who are not eligible for any other public assistance programs providing medical benefits and are not covered under private insurance. The majority of GAMP participants reside in the City of Milwaukee. However, 5% of the enrollees report a zip code outside of the city reflecting the need for medical services among uninsured, low-income individuals and families in suburban areas of the county.

Eligibility and Enrollment

To be eligible for GAMP, individuals must have income below a specified income threshold for their family size. GAMP considers the total gross income of all family members. For the purposes of GAMP eligibility, income is equal to the applicant's current income for IRS income tax purposes. Assets are not considered when determining eligibility.

For a family size of one, the GAMP income limit is just under 125% of the federal poverty level (FPL). For a family size of three, the GAMP limit is just over 115% of the FPL. Table 1 summarizes the financial eligibility requirements for GAMP.

Unlike a standard health insurance benefit where enrollment is often limited to "open enrollment" periods, individuals apply for GAMP whenever they are in need of health care services. Individuals may only apply when they present themselves for health care services at a primary care clinic participating in GAMP, or in the case of emergency, at a hospital emergency room.

Table 1. GAMP Monthly Income Eligibility Limits – Calendar Year 2000

Family Size	Gross Income Limit
1	$ 882
2	1,146
3	1,409
4	1,677
5	1,946
6	2,218
7	2,484
8	2,758
9	3,033
10	3,306

Source: GAMP Program and Policy Manual

In calendar year 1999, almost 90% of GAMP participants applied for the program at an outpatient setting. The other 10% applied through a hospital in either an emergency room or inpatient setting. In calendar year 2000, hospital applications almost doubled, with 19% of the participants presenting in an emergency room or inpatient setting.

This increase in applications originating at hospital emergency rooms has been attributed to two factors by GAMP program staff. First, GAMP staff believe that some of the increase is due to the recent loss of

an urgent care provider in the City of Milwaukee, which allowed individuals to seek medical care in a non-emergency room setting. Second, because GAMP clients are seeking care when applying for services, fluxes in community-wide medical issues, such as influenza epidemics, influence emergency room activities.

While hospital applications have recently increased, the historical trend has been a significant decrease in the number of hospital applications and a corresponding increase in the number of community clinic applications. In 1998, GAMP implemented a community-based primary care model, which moved services and program responsibility from inpatient to outpatient settings. Prior to that time, hospital applications (inpatient and emergency room) accounted for over 48% of total applications to the program.

Provider Network

The GAMP network is comprised of community-based clinics and hospitals within the County. GAMP contracts with 16 providers including all the Federally Qualified Healthcare Centers (FQHC) and FQHC "look-alikes" in the county, private practices, community health agencies and other medical providers. Services are provided at 23 different clinic sites operated by these providers throughout the county.

GAMP clients are required to select one of the participating clinics as their primary medical provider. This clinic is considered the "medical home" of the patient and the clinic is then responsible for providing and coordinating health care services on behalf of that client. The program follows the principles of a care management model with the community clinics acting in a "gatekeeper" role.

Each contracted community-based clinic is responsible for arranging necessary services that any GAMP participant presenting for care might need. Through relationships with other medical providers, such as specialists and hospitals, the community-based providers are able to coordinate a full array of health care services on behalf of GAMP participants.

Covered Services and Cost Controls

GAMP covered services include, but are not limited to: primary care and clinic services, inpatient and outpatient hospital, laboratory services, pharmacy services and specialty care. State law limits covered health care services under GAMP to those approved as Medicaid services, but prohibits GAMP payments for mental health or other alcohol or drug abuse treatment services. The county also has the ability to reduce or otherwise limit services covered under GAMP. For example, Medicaid covers a full range of dental services, but GAMP limits payment for dental services to emergency extractions.

GAMP providers agree to accept a maximum amount of funding from the program for all services provided to GAMP participants, regardless of costs or number of services provided. This cap on aggregate provider payments ensures that GAMP will not exceed authorized funding amounts for the year, regardless of service utilization. The provider is prohibited from seeking additional payment for services from either the county or the participant.

The County has developed a number of policies to control costs by reducing emergency room (ER) utilization. For example, GAMP participants are assessed a $20 co-payment for each ER visit regardless of the nature of the visit to encourage applicants to address their health care needs before they become an emergency. Control over ER costs are also achieved by prohibiting payment to hospitals for emergency room services unless the service was necessary due to a life or limb-threatening condition.

Milwaukee County has also developed a Utilization Management (UM) program for GAMP services. The goal of the UM program is to assure that care is delivered in an appropriate setting using appropriate resources and to monitor the quality of services. The UM program includes reviews and authorization for inpatient admissions (emergency and non-emergency), use of specialty care service consultations and referral requirements for specified services, such as home health care and durable medical equipment.

The UM program, in addition to providing general oversight of utilization patterns, also provides a quality assurance mechanism for services provided by clinics. The UM staff visit each medical provider and review charts for adherence to medical record and service standards established by the National Council on Quality Standards. These reviews are performed at least annually.

GAMP Participants

County-administered medical assistance programs are typically thought of as programs for single males, but the reality is quite different for Milwaukee GAMP. In calendar year 2000, 47% of the approximately 20,000 GAMP participants were female and 53% were male. Female enrollment was slightly higher in 1999 at 52%. While the majority of applicants report being single at the time of application, nearly 30% report being currently married or married at some point in time (i.e. divorced, separated or widowed). Male applicants are more likely to report being single than female applicants. Table 2 provides more information on the marital status of GAMP eligibles at the time of application in calendar year 2000.

Table 2. GAMP Eligibles Marital Status Calendar Year 2000

Marital Status	Male	Female	Total
Single	77%	65%	72%
Married	10%	14%	12%
Other*	13%	21%	16%
TOTAL	100%	100%	100%

Source: GAMP Management Reports[1]
*Other includes divorced, separated and widowed.

The age distribution of the eligible population was very similar in 1999 and 2000. In both years, a larger percentage of the male population was between the ages of 18 and 39. The female population was more likely to be between the ages of 50 and 64. Table 3 summarizes the age and sex distribution of the eligible population for calendar year 2000.

Individuals who apply for GAMP are screened for Medicaid and BadgerCare eligibility before they can be certified for GAMP. Even though the financial eligibility requirements for BadgerCare are more generous than those for GAMP, there are a number of reasons someone could be eligible for GAMP, but not for BadgerCare, including: (a) absence of dependent children; (b) immigration status; or (c) access to employer-sponsored insurance. In order to be eligible for BadgerCare, the applicant must have dependent children and cannot have access to certain types of employer sponsored insurance. BadgerCare participants must be also United States citizens or qualified legal immigrants.

In calendar year 2000, just over 1,000 children participated in GAMP. This represented a significant increase over 1999. The number of children enrolled in GAMP increased by 32% from calendar year 1999 to calendar year 2000. GAMP staff took a closer look at the children eligible during calendar year 2000 and found that many did not have a social security number in the GAMP eligibility system. This suggests that a number of these children may be undocumented aliens, which would make them ineligible for Medicaid or BadgerCare.

Table 3. GAMP Eligibles by Age and Sex Calendar Year 2000

Age	Female	Male	Total
0-17	6%	4%	5%
18-29	29%	31%	30%
30-39	20%	27%	23%
40-49	24%	24%	24%
50-59	15%	11%	13%
60-64	5%	3%	4%
65-69	< 1%	< 1%	< 1%
Over 70	< 1%	< 1%	< 1%
TOTAL	100%	100%	100%

Source: GAMP Management Reports

Applicants who meet the GAMP eligibility criteria are certified for six months of coverage. Eligibility can be renewed for an indefinite number of six-month periods if the individual continues to meet the program's eligibility requirements. GAMP eligibles may select a new primary care provider at the end of each six-month period.

GAMP appears to be filling a need for short-term health care coverage. GAMP participants, on average, do not spend extended periods of time on the program. During calendar year 2000, 35% of the participants had only one six-month eligibility segment on file. Another 38% have had 12-18 months of eligibility. Approximately 10% had more

than three years of eligibility on file. These eligibility segments were not necessarily consecutive.

While GAMP does provide temporary, immediate medical access for over one third of the caseload, there are indications that a portion of the caseload is seeking treatment for chronic medical conditions, which require long-term medical services. For example, a significant portion of the program's pharmaceutical costs is related to the treatment of chronic medical conditions such as diabetes, hypertension and asthma.

The GAMP monthly caseload declined in every month of calendar year 1999 and then rose dramatically for the first seven months of calendar year 2000. In January 2000,the caseload was only 10,539, but by July 2000 it had increased to 19,827. The calendar year 2000 caseload increase may be attributable to a revision in the income eligibility guidelines for the program, which became effective that year. The gross income limit for a single household was increased from $800 to $882 with similar adjustments for other sized households. This change represents the first adjustment to the income eligibility guidelines since a September 1997 change in the federal minimum wage law. The income adjustment allowed individuals who were working in minimum wage positions to access the program for the first time since 1994.

While average monthly membership in GAMP has fluctuated considerably over the last two years, the total number of people served in calendar year 1999 and calendar year 2000 was virtually the same. The lower monthly caseload in calendar year 1999 suggests that there was more turnover in the program that year with many participants not seeking additional care through re-approval for GAMP eligibility. In calendar year 2000, it appears that participants stayed on the program for longer periods of time through re-application to the program at six-month intervals.

GAMP Health Care Costs and Utilization

Health care cost and utilization data is available for many of the services covered by GAMP, including:

- Primary Care
- Specialty Services[2]
- Pharmacy
- Inpatient Hospital
- Outpatient Hospital
- Emergency Room
- Overlay Services[3]

Hospital services account for the largest percentage of paid claims under GAMP. In calendar year 2000, GAMP paid approximately $25.3 million in hospital claims of which the majority, almost 75%, was for inpatient services. Total claims for clinic services (primary and specialty care) were $15.1 million and pharmacy service claims were $7.2 million.

Table 4 provides additional detail on calendar year 2000 claims costs by service category. The per-user and per- member costs reported represent an average monthly cost for the year. Members are defined as anyone eligible for coverage during the month. Users are defined as the individuals who actually utilized the particular service in that month. The per-member cost is calculated by averaging the total payments for a service across all program participants not just those using the service.

When reviewing this data, it is important to remember that GAMP participants apply for the program at a time when they are in need of health care services. Consequently, unlike other insurance programs where the number of individuals seeking care is smaller than the number of program participants, all GAMP enrollees will receive some level of health care services while on the program. This would account for higher per member costs under GAMP as compared to other populations.

Table 4.GAMP Monthly and Total Costs by Service Category -Calendar Year 2000

Service Category	Per User Cost*	Per Member Cost*	Total Cost (millions)
Primary Care	$ 118.01	$ 21.67	$ 7.2
Specialty Care	253.09	58.21	11.0
Inpatient Hospital	5,405.76	100.57	18.7
Outpatient Hospital	239.37	26.15	4.9
Emergency Room	351.57	8.69	1.6
Pharmacy	139.89	38.10	7.2
Overlay	218.94	9.24	1.7

Source: GAMP Management Reports
* Per User and Per Member Costs represent a monthly average

Examining per user and per member costs provides insight into the intensity of health care resource

utilization. For example, the per-user cost for emergency room (ER) services is higher than the per user cost for specialty care, reflecting that ER services are more resource intensive than specialty services.

The total cost for specialty services is more than twice that of outpatient hospital costs, but per-user costs are very similar for both service categories. This suggests that the resource utilization for providing specialty services is, on average, similar to outpatient services, but that more people are receiving specialty services.

A comparison of calendar year 1999 and 2000 costs shows that average per member per month costs for both inpatient and outpatient hospital services have declined. Average per member costs for overlay services have also declined over this time period. Utilization management activities and the success of efforts to shift from a hospital-based model to a community-based, primary care model likely accounted for these reductions.

Similar to trends in the health care marketplace for both private and publicly funded insurance programs, GAMP has been experiencing increasing pharmacy costs over the last two years. Total claims paid amounts and per user costs have both continued to rise with total pharmacy payments increasing by 24% between 1999 and 2000.

GAMP staff have tracked pharmacy expenditures for nearly two years and have found that a growing number of pharmacy claims have contributed to the program's rising pharmacy costs. The number of processed pharmacy claims increased by 10% from calendar year 1999 to calendar year 2000. The average cost per claim also increased from $35.84 to $41.16 over that time period. The rise in total costs can be attributed to the combined effect of a higher volume of prescriptions and increases in pharmaceutical costs.

Table 5 provides information on the average monthly claims cost and per user costs for pharmacy services in calendar years 1999 and 2000 at six-month intervals.

Table 5. Average GAMP Pharmacy Costs Calendar Years 1999 and 2000

Date of Service	Monthly Per User Cost	Average Monthly Cost
Jan.-June 1999	$118	$439,109
July -Dec. 1999	127	528,746
Jan.-June 2000	134	574,294
July-Dec. 2000	146	628,126

Source: GAMP Management Reports

As shown in the table, the average monthly per user cost increased by 24% from January 1999 to December 2000, while the average monthly cost increased by 43%. However, when reviewing the program's budget, it is important to remember that the use of pharmaceuticals can be a mechanism for managing the health of individuals with chronic medical conditions and can be cost-effective by reducing the need for more resource intensive services, such as hospital services.

Summary

Over the last two years, Milwaukee GAMP has been serving approximately 20,000 individuals annually, nearly all of whom live in the City of Milwaukee. Just under one third of the caseload is between the ages of 18 and 29. Another 47% are between the ages of 30 and 49. Most of the applicants report being single and nearly half are female. While GAMP participants would meet the financial eligibility requirements for Medicaid and BadgerCare, they do not meet other non-financial requirements.

Inpatient hospital and specialty services constitute the majority of the GAMP budget although, the program has successfully used primary care services provided in community based clinics and selective utilization management techniques to control and reduce inpatient and outpatient hospital costs over the last two years. Program staff have also worked to educated participants about, and improve access to, preventive service to further manage program costs. Like the health care marketplace generally, GAMP has been

experiencing significant increases in pharmacy costs.

Individuals access the GAMP program when they are in need of health care services. As a result, one would expect their health care utilization to be higher than the general population. Therefore, average per member and per user costs for GAMP participants are not an accurate portrayal of the average health care costs of the uninsured. However, this data does provide valuable information on the costs of providing short-term health care coverage to uninsured, low-income residents who are seeking treatment for an illness. These data also provide insight into the magnitude of out-of-pocket health care costs that individuals without access to comprehensive health insurance might be required to pay.

[1] Data for this paper was compiled from GAMP internal management reports and special reports prepared for the Department of Health and Family Services under the State Planning Grant.

[2] Each community clinic varies in the ability of meeting a client's specific medical needs with in-house physician staff. For GAMP specialty services include a full range of services not available by a contracted community clinic. This includes typical specialty services such as orthopedic services, neurology, or cancer specialties but may include other forms of medical care from a physician not on staff at the community clinic.

[3] Overlay services includes all medical services not provided by physicians or hospitals, such as nursing home care and durable medical equipment.

For more information about this briefing paper or other activities under the Wisconsin State Planning Grant, contact:
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Health Insurance and Health Care Utilization in Wisconsin

As one of 20 states that received a grant from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Wisconsin is exploring new ways to increase health insurance access for its residents. Research under Wisconsin's State Planning Grant (SPG) has focused on understanding the particular circumstances of Wisconsin residents in gaining access to health insurance coverage.

This paper describes analyses about the relationship between health insurance and the utilization of health care by Wisconsin residents. The presence or absence of health insurance is one of several factors that influence health care utilization. Thus, the analyses describe the relationship between insurance and utilization within the context of other individual and family characteristics, such as health status and income, that could affect utilization.

This paper summarizes research conducted at the Institute for Research on Poverty, University of Wisconsin-Madison, using 1998 and 1999 Wisconsin Family Health Survey (FHS) data.

Health Care Utilization: An Overview

Four measures of health care utilization are used in this analysis: visits to a physician, registered nurse, or physician assistant in the last year; scheduled health check-ups in the last year; dental visits in the last year; and having a usual source of medical care. Overall rates of health care utilization differed substantially across the four measures. Whereas 96 percent of Wisconsin residents were reported as having a usual source of care, 84 percent visited a provider in the last year, 60 percent had a scheduled check-up and 72 percent visited a dentist.

Table 1 shows the percentages of Wisconsin residents for each utilization measure, tabulated by insurance coverage over the past year. The results suggest a relationship between health insurance coverage and health care utilization. Compared to those who were insured all year, those who were uninsured all year (see "None" column) were less likely to visit a physician or a dentist, have had a check-up, or have a usual source of care. Compared to those insured all year, those insured part of the year were no less likely to have seen a physician, only slightly less likely to have had a scheduled check-up or have a usual source of care, but much less likely to have visited a dentist.

Table 1. Utilization of Health Care by Insurance Status, Wisconsin, 1998 and 1999

	Insurance Coverage		
	None	Part year	All year
%Visiting a Doctor, RN or PA in the Last Year	63.9	85.2	85.5
% Having a Check-Up in the Last Year	37.6	56.6	63:9
% Visiting a Dentist in the Last Year	45.4	57.3	76.3
% Having a Usual Source of Care	78.7	91.3	97.3

Source: 1998-1999 Family Health Survey, Wisconsin Department of Health and Family Services

Factors Affecting Health Care Utilization

Does the presence or absence of health insurance influence the utilization of health care? Table 1 shows that utilization rates vary with insurance coverage. However, other factors besides insurance coverage can have an effect on health

care utilization. Further analysis of the insurance-utilization relationship included controls for the effects of other factors that are related to use of health care services: age, gender, race, education, household structure, residential location, poverty status, and health status.

"Controlling for" the effects of other factors means that their effects are held constant while each individual factor is analyzed. For example, older people are more likely to use health care services than younger people. Analysis of the relationship between insurance and use of health care services, controlling for age, would indicate whether insurance has an effect on utilization that is independent of age.

Results indicate that the following factors were statistically significant, when controlling for the effects of the other factors listed above:

Insurance status. People with no insurance coverage in the preceding year were significantly less likely to have a doctor visit, a dental visit, a scheduled check-up, or have had a usual source of care, compared to those with insurance for the entire preceding year, after controlling for other factors. In fact, they were only about one-fourth as likely to have visited a doctor, three-tenths as likely to have had a check-up, and one-sixth as likely to have visited a dentist. Those with insurance coverage for part of the preceding year were no less likely to have visited a doctor than those with coverage for the whole year. However, they were significantly less likely to have visited a dentist, had a check-up, or had a usual source of health care.

Age. Compared to children aged 6-17, children under 6 were nearly 11 times more likely to have visited a doctor and 9 times more likely to have had a check-up. Children aged 6-17 were less likely to have had any type of medical care than were working aged adults. Controlling for other differences, the elderly were no less likely to have visited a doctor or had a check-up but were less likely to report a dental visit than children ages 6-17.

Gender. Men were significantly less likely than women to engage in all forms of utilization, holding other factors constant. Men were only about 41 percent as likely as women to have visited a doctor and only about 23 percent as likely as women to have a usual source of care, holding other factors constant.

Race. African Americans were no more likely to have visited a doctor or have a usual source of health care than were whites. African Americans were more likely to have visited a dentist or had a scheduled check-up than were whites, holding other factors constant.

Education. Education operates generally as might be expected. Controlling for other factors, households in which the respondents were without a high school diploma were less likely to have visited a doctor or a dentist or have a usual source of health care than households with a respondent who had a college degree. Residents of households whose respondent did not have a high school diploma were only about one-quarter as likely to have visited a dentist as residents of households whose respondent had a college degree.

Household structure. Those residing in households composed of a single parent with children were about as likely to have visited a doctor, had a checkup, or visited a dentist, as were those in married couple households with children, holding other factors constant. Controlling for age and other factors, single people without children were less likely to have a doctor or dental visit, or a checkup, compared to persons in married couple households with children.

Residential location. Those who lived on farms were significantly less likely to have visited a doctor; their odds of doing so were about 74 percent of those who did not live on a farm, controlling for other differences. The other measures of utilization were not significantly different between those who did and did not live on farms.

Residents of Milwaukee County were less likely to have visited a dentist or to have a usual source of care, but more likely to have visited a doctor, than were residents of other metropolitan counties.

Poverty status. Controlling for other measured differences, those with incomes below 100% of the federal poverty level were no less likely to have visited a doctor or had a check-up than those with incomes more than twice the poverty level. Poor people were less likely to have visited a dentist, compared to persons with incomes more than twice poverty.

Those with incomes between 100 and 200 percent of poverty fared worst on three measures of utilization. Controlling for other factors, they were

significantly less likely to have visited a doctor, have had a check-up, or visited a dentist than were those with incomes more than twice poverty.

Health condition. Holding other differences constant, those with indications of poor health (i.e., those who reported "fair" or "poor" health status, or reported a limiting or chronic condition), were more likely to have visited a doctor and to have had a checkup, compared to those with "good", "very good" or "excellent" health. Those in poor health were about as likely to have visited a dentist or had a usual source of care as those who were in good to excellent health.

Summary

A relationship between health insurance and use of health services persists, even when controlling for other factors, such as age and poverty status. Having insurance coverage for a full year increases the likelihood that people will have seen a doctor, had a check-up, visited a dentist in the last year, and have had a usual source of health care. Education, residential location (that is, living on a farm or in metropolitan or non- metropolitan counties), age, and gender also have independent, statistically significant effects on utilization.

Levels of utilization differ among the various utilization measures. Except for those without insurance, most people had a usual source of health care. However, the extent to which they reported check-ups and dental visits varied by age, education, household structure, and poverty level.

Differences between those with full and part-year coverage are less dramatic, but still matter. Those with health insurance for only part of the year were about as likely to have seen a doctor as those with insurance for the full year. Those with insurance for only part of the previous year and those with no insurance in the preceding year were significantly less likely than those with insurance for the full year to obtain dental care and routine check-ups.

About the Data

This briefing paper is a summary of the report "Health Insurance and Health Care Utilization in Wisconsin," prepared by Karen Holden, Thomas Kaplan, Elise Gould and Audra Wenzlow at the Institute for Research on Poverty, University of Wisconsin-Madison. Their analysis of the Family Health Survey was conducted under contract with the Wisconsin Department of Health and Family Services, Bureau of Health Information and funded by the State Planning Grant. This briefing paper was prepared by Catherine Frey.

The Wisconsin Family Health Survey (FHS) is a random sample telephone survey of Wisconsin households, designed to provided estimates of health care coverage, various health problems, and use of health care services by people across the state. The person in each sampled household who knows the most about the health of all household members is selected to answer all survey questions during the telephone interview. The FHS is directed by the Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information.

The combined sample for 1998 and 1999, used for this analysis, was 12,928 individuals or 4,894 households. Data are weighted so that all results may be considered to be representative of Wisconsin's household population.
The FHS asks about each household member's health insurance coverage over the year prior to the survey interview. Both private and public sources of insurance were included in the question. The response categories, also shown in Table 1, were:

- No insurance coverage during the last 12 months;
- Insured part of the last 12 months and uninsured part of that time;
- Insured for the entire 12-month period.

To obtain a copy of the Wisconsin Family Health Survey annual report:
Visit the Department of Health and Family Services web site at:
http://www.dhfs.state.wi.us/stats/index.htm

Or Contact:
Wisconsin Department of Health and Family Services
Division of Health Care Financing
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To obtain a copy of the original research paper, contact:
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Health Insurance Coverage For Non-Elderly Adults Living in Households without Children

As one of 20 states that received a grant from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Wisconsin is exploring new approaches to increasing access to health insurance access for Wisconsin residents. Research under Wisconsin's State Planning Grant (SPG) has focused on several topics, including understanding the particular circumstances of non-elderly adults in accessing health insurance coverage.

This paper presents selected findings on characteristics of the uninsured in Wisconsin, from research conducted at the Center for Health Policy and Program Evaluation, University of Wisconsin-Madison. The research was conducted with 1998 and 1999 Wisconsin Family Health Survey data. The purpose of the research is to provide information about uninsured Wisconsin residents, particularly adults living in households without any children.

Uninsured Adults Ages 18-64 in Households without Children

This paper provides information about health insurance coverage of Wisconsin adults ages 18 to 64 living in households without children under age 19.

Most national policy discussions about the uninsured have focused on families with children. However, non-elderly adults (ages 18-64) living in households without children also deserve close attention. Many of these adults may be parents with grown children not living in the household; some may have minor children not currently living with them.

In Wisconsin, an estimated 124,000 adults ages 18 to 64 living in households with no children were uninsured during 1998-99. These uninsured adults accounted for about 40 percent of all the uninsured in Wisconsin (312,000 state residents were uninsured). There were 81,000 uninsured ages 18-44 and 42,000 uninsured ages 45-64 living in households without children.

Table 1 shows that one out of five adults living in low-income households (below 200% of the poverty level) without children are uninsured. Specifically, an estimated 23.4 percent of low-income adults ages 18-44 living without children are uninsured; 22.1 percent of older (45-64 years) low-income adults without children in their household are uninsured. These two groups total 52,000 uninsured adults ages 18-64 living in low-income households without children.

The proportions uninsured are much lower among adults living in higher-income households, above 200 percent of the poverty level. Among adults 18 to 44 living without children in higher-income households, 8.3 percent are uninsured. The comparable proportion among adults ages 45 to 64 is 2.5 percent. There were an estimated 66,000 uninsured higher-income adults ages 18-64 in households without children.

Table 1. Characteristics of Adults in Households without Children, Wisconsin 1998-1999

	Proportion currently uninsured	
	Age 18-44	Age 45-64
Less than 200% of Poverty	23.4%	22.1%
Greater than 200% of Poverty	8.3%	2.5%
No Physical Limitations	10.9%	4.3%
One or More Physical Limitations	13.4%	7.9%
Employed Full Time	9.3%	3.0%

Source: 1998-1999 Wisconsin Family Health Survey, Department of Health and Family Services.

Physical Limitations

Physical limitations are self-reports of any limitations due to a health problem in walking, climbing, bending, lifting or doing vigorous exercise; in working or attending school; and in eating, dressing, bathing, and using the toilet. In households without children, 13.4 percent of adults ages 18-44 who reported one or more physical limitations were uninsured (Table 1). Among those ages 45-64, 7.9 percent with limitations were uninsured.

Employment Status

Among full-time employed adults ages 18-64 living in households without children, 66,000 were uninsured.

Summary

Uninsured Wisconsin adults living in households without children make up 40% of all uninsured in the state.

Unlike low-income parents living with their minor children, adults in low-income households without children do not qualify for publicly-funded health insurance initiatives. Many adults living in households without children are low-income, however, with 52,000 statewide.

About the Data

This briefing paper is a summary of the report "Wisconsin Health Insurance Coverage" by Kevin W. Welch, Center for Health Policy and Program Evaluation, University of Wisconsin-Madison. His analysis was conducted under contract with the Wisconsin Department of Health and Family Services, Bureau of Health Information, and funded by the State Planning Grant, HRSA.

The Wisconsin Family Health Survey (FHS) is a random sample telephone survey of Wisconsin households, designed to provided estimates of health care coverage, various health problems, and use of health care services by people across the state. The person in each sampled household who knows the most about the health of all household members is selected to answer all survey questions during the telephone interview.

The combined FHS sample for 1998 and 1999, used in this analysis, was 12,928 people. Data are weighted so that all results may be considered to be representative of Wisconsin's household population. The FHS asks about each household member's health insurance coverage at the time of the telephone interview. A person is considered to be uninsured if he/she has no private or employer-based insurance, nor any Medicaid, BadgerCare, Healthy Start, or Medicare. This estimate of the uninsured is a point-in-time estimate, representing the uninsured at any given moment during 1998-1999. Overall, 6% of Wisconsin residents were uninsured at any given point in time.

To obtain a copy of the Wisconsin Family Health Survey annual report, visit the Department of Health and Family Services web site at:

http:\\ www.dhfs.state.wi.us/stats/index.htm

Or contact:

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