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Health Policy for Low-Income People in Wisconsin

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The key to Wisconsin's health care system is its historically high rate of health insurance coverage. In 1995 only 8.6 percent of the state's nonelderly population was without insurance, compared with the national average of 15.5 percent. While policy intervention has contributed to the high level of insurance, much of the credit belongs to employer-sponsored health care coverage. In part because of the strong union presence in the state, nearly 80 percent of Wisconsin's nonelderly population has employer-sponsored health insurance; nationally, only 66 percent of the population has such insurance. Also contributing to the low level of uninsured is Wisconsin's Medicaid program, which has generous eligibility standards. With limited amounts of uncompensated care, the state's safety net providers are generally in good financial shape.

Wisconsin's health care system is relatively sound: The state has a strong base of private insurance, a fairly extensive Medicaid program, and low numbers of uninsured.

State Characteristics

About 5 million people live in Wisconsin, and a large share (more than 30 percent) reside in rural areas (table 1). Compared with other states, few Wisconsinites are members of racial

or ethnic minority groups—nearly 90 percent of the state's population is non-Hispanic white. Based on several health status indicators, Wisconsinites are relatively healthy. The incidence of AIDS, the rate of low birth-weight births, and the premature death rate (years of potential life lost before age 65 per 1,000 population) are all substantially lower than the national average.

Like many other states, Wisconsin is enjoying a buoyant economy. Indeed Wisconsin's economy appears to be stronger than the average state's: The unemployment rate is nearly two percentage points below the national average. The state's poverty rate is also much lower than elsewhere (9.9 percent versus 14.3 percent nationwide). Further, Wisconsin's growth in per capita income between 1990 and 1995 outpaced the rest of the nation (25.6 percent versus 21.2 percent overall).

For the past decade, state politics have been largely dominated by Republican Governor Tommy Thompson, who took office in 1986. Since becoming governor, Thompson has enjoyed great popularity and has successfully implemented major pieces of legislation. A top priority of the governor in recent years has been local property tax relief. Another has been overhauling the cash welfare

Table 1
State Characteristics

	<u>Wisconsin</u>	<u>United States</u>
Sociodemographic		
Population (1994–95) (in thousands)	5,146	260,202
Percent under 18 (1994–95)	27.9%	26.8%
Percent 65+ (1994–95)	10.3%	12.1%
Percent Hispanic (1994–95)	1.7%	10.7%
Percent Non-Hispanic Black (1994–95)	6.3%	12.5%
Percent Non-Hispanic White (1994–95)	89.4%	72.6%
Percent Non-Hispanic Other (1994–95)	2.6%	4.2%
Percent Noncitizen Immigrant (1996)	2.1%	6.4%
Percent Nonmetropolitan (1994–95)	31.8%	21.8%
Population Growth (1990–95)	4.7%	5.6%
Economic		
Per Capita Income (1995)	\$22,261	\$23,208
Percent Change in Per Capita Personal Income (1990–95)	25.6%	21.2%
Unemployment Rate (1996)	3.5%	5.4%
Percent below Poverty (1994)	9.9%	14.3%
Percent Children below Poverty (1994)	14.4%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	8.6%	15.5%
Percent Medicaid—Nonelderly (1994–95)	7.9%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	78.6%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	4.9%	6.2%
Low Birth-Weight Births (<2,500 g) (1994)	6.4%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	7.4	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	43.7	54.4
Violent Crimes per 100,000 (1995)	281.1	684.6
AIDS Cases Reported per 100,000 (1995)	6.8	27.8
<i>Source: Complete list of sources is available in Health Policy for Low-Income People in Wisconsin (The Urban Institute, 1998).</i>		

system. Wisconsin was one of the pioneers in welfare reform, implementing some of the most sweeping reforms in the nation. In 1996 the state enacted legislation mandating the replacement of Aid to Families with Dependent Children (AFDC). Eventually this mandate brought about the development of the nationally prominent Wisconsin Works, or W-2, program, which began to be implemented statewide on January 1, 1998.

Health care has not been a top policy priority in recent years. This is due in part to the state's pursuit of other policy initiatives, which have limited growth of the health care budget. For example, for the past few years, the Medicaid budget essentially has reflected the level of expenditures needed to maintain the current pro-

gram. Another reason that health care matters have not received much attention is that Wisconsin's health care system is relatively sound: The state has a strong base of private insurance, a fairly extensive Medicaid program, and low numbers of uninsured. State officials report vigorous competition in the health care market. Moreover, at present health care insurers and providers seem generally satisfied and are in solid financial shape. In short, the need for extensive policy intervention has not been as compelling as in other states.

Medicaid

With an enrollment of 640,000 persons and a budget of \$2.5 billion, Medicaid was 14 percent of the total state budget in 1995—a much lower

share than in many other states. Although Wisconsin, like other states, experienced elevated spending growth in the early 1990s, the jump in spending was well below the national average—16.4 percent per year from 1990 to 1992 compared with 27.1 percent for the country overall (table 2). The rate of expenditure increases continued to trail the national average from 1992 to 1995: 6.5 percent per year versus 9.9 percent nationally. Wisconsin was able to contain expenditures largely because of small enrollment increases, on balance, over the first half of the decade.

Wisconsin's Medicaid program is set apart by the high proportion of expenditures directed at long-term care. More than half (53 percent) of spending on benefits was for long-term care, compared with the national average of 40 percent. The dominance of long-term care in the Medicaid budget is reflected in the state's expenditures per elderly enrollee, which averaged \$14,181 in 1995, compared with \$9,738 nationally (table 3). In contrast, expenditures per blind and disabled, adult, and child enrollees were either below the national average or only slightly above.

Medicaid Managed Care

In 1984 Wisconsin was one of the first states to implement a managed care program, based on health maintenance organizations (HMOs), for selected Medicaid groups. The state mandated HMO enrollment of AFDC recipients in Milwaukee and Dane (Madison) Counties. Over the next decade, the HMO program was expanded to other urban counties and to poverty-related (non-AFDC) women and children. In 1996 the state began expanding the program to all parts of the state. Primarily undertaken as a cost-containment strategy, the effort was completed in 1997 with relatively few problems. In about one-third of Wisconsin's counties, HMO enrollment is voluntary or fee-for-service systems remain in place because of a lack of HMOs. While

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Wisconsin and United States
 (Expenditures in Millions)

	Wisconsin			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990-92	1992-95	1995	1990-92	1992-95
Total	\$2,495.3	16.4%	6.5%	\$157,872.5	27.1%	9.9%
Benefits						
Benefits by Service	2,404.1	16.3	6.3	133,434.6	18.8	11.0
Acute Care	1,128.4	18.4	4.0	79,438.5	22.1	13.0
Long-Term Care	1,275.7	14.2	8.5	53,996.1	14.8	8.3
Benefits by Group	2,404.1	16.3	6.3	133,434.6	18.8	11.0
Elderly	926.9	12.9	7.8	40,087.4	16.7	8.1
Acute Care	179.1	13.7	1.0	9,673.7	18.5	11.9
Long-Term Care	747.7	12.6	9.7	30,413.7	16.2	7.0
Blind and Disabled	873.3	20.9	2.7	51,379.4	17.7	12.9
Acute Care	431.4	25.9	1.8	29,760.7	22.8	15.2
Long-Term Care	441.9	16.4	3.6	21,618.7	12.3	10.1
Adults	149.9	8.2	5.1	16,556.9	20.4	9.2
Children	454.0	17.2	11.6	25,410.9	24.3	13.3
Disproportionate Share Hospital Administration	11.6	142.2	10.2	18,988.4	261.5	2.7
	79.6	14.4	13.9	5,449.4	9.8	12.8

Source: The Urban Institute, 1997. Based on Health Care Financing Administration (HCFA) 2082 and HCFA 64 data.

the state hopes to extend managed care to elderly and disabled Medicaid populations in the future, only limited pilot programs exist at present.

Other Publicly Supported Health Programs

Wisconsin operates three relatively small programs designed to provide health care for low-income persons not eligible for Medicaid. The largest is the General Assistance program currently known as the County Relief Block Grant Program. The program has gone through significant changes in the past few years. In 1995 Governor Thompson proposed eliminating the program, which—at the time—provided both cash and medical benefits to beneficiaries. In the end, the legislature converted the program into a block grant program in which counties had the option to participate. (Previously, counties were required by state law to operate a General Assistance program.) As part of the shift to the block grant program, state lawmakers also cut state funding. These changes and cutbacks have had particularly important effects on safety net providers in Mil-

waukee County, which receives the bulk of the program funding. The other two publicly supported health insurance programs in Wisconsin are a high-risk pool established in 1980 (making it one of the country's oldest) and a small program that provides limited outpatient primary care and inpatient maternity and delivery services to eligible individuals in 17 counties with high unemployment rates.

Welfare Reform

As part of welfare reform, Governor Thompson proposed fairly radical changes to the Medicaid program that could have ended entitlement to benefits and reduced eligibility and services for some currently eligible individuals while increasing them for others. Proposed during the national debate on the Medicaid block grant, this plan was highly controversial, and waivers to implement the demonstration were never approved by the federal government.

Because of the extensive changes that were implemented as part of the W-2 program, breaking the link between cash assistance and Medicaid eligibility, as required by the federal 1996 welfare reform law, has had a

particularly profound effect in Wisconsin, with some people eligible for W-2 but not Medicaid, and vice versa. Because Medicaid eligibility rules are more complicated than before, some people who should have retained eligibility have been dropped from the Medicaid rolls, and the state's computer system for eligibility has required a significant overhaul.

Moreover, sharply falling case-loads for W-2, related in part to the robust economy, have had spillover effects on Medicaid rolls, causing them to fall dramatically. Concerned about the possibility that those leaving the rolls are not being covered by alternative sources of insurance, the state has proposed using the mostly federally funded State Children's Health Insurance Program (S-CHIP) to expand Medicaid eligibility for adults as well as children. At this writing, federal approval had not been obtained.

The Health Care Market

The health insurance and delivery markets in Wisconsin appear to be functioning well. Despite the reportedly high level of competition, both insurers and providers are in good financial

Table 3
Medicaid Enrollment and Expenditures
per Enrollee: Contributions to Total Expenditure Growth

	Wisconsin			United States		
	1995	Average Annual Growth		1995	Average Annual Growth	
		1990-92	1992-95		1990-92	1992-95
Elderly						
Total expenditures on benefits (millions)	\$926.9	12.9%	7.8%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	65.4	0.7	-0.6	4,116.6	5.1	3.0
Expenditures per enrollee	\$14,181	12.1	8.4	\$9,738	11.0	5.0
Blind and Disabled						
Total expenditures on benefits (millions)	\$873.3	20.9	2.7	\$51,379.4	17.7	12.9
Enrollment (thousands)	112.3	9.1	5.4	6,405.2	9.8	9.5
Expenditures per enrollee	\$7,774	10.8	-2.5	\$8,022	7.1	3.1
Adults						
Total expenditures on benefits (millions)	\$149.9	8.2	5.1	\$16,556.9	20.4	9.2
Enrollment (thousands)	120.4	-0.6	0.5	9,584.2	11.5	4.6
Expenditures per enrollee	\$1,245	8.9	4.6	\$1,728	8.0	4.4
Children						
Total expenditures on benefits (millions)	\$454.0	17.2	11.6	\$25,410.9	24.3	13.3
Enrollment (thousands)	341.9	6.4	0.7	21,566.0	13.1	4.8
Expenditures per enrollee	\$1,328	10.1	10.8	\$1,178	9.9	8.2

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

shape. Strong competition among insurers has led to generally affordable insurance rates, which have in turn contributed to a high rate of insurance coverage. Wisconsin has a mature managed care market, with 27 percent of the state population enrolled in HMOs as of January 1996. Buyers have successfully demanded high quality from HMOs and simultaneously pressured them for lower rates.

The hospital market is composed primarily of nonprofit facilities; only two hospitals are for-profit, and only three are public. Most hospitals are financially stable despite some overbedding and price-discounting for HMOs. Physicians are in a strong bargaining position vis-à-vis health plans because of physician undersupply in many parts of the state and concentration in large group practices. Hospitals, which have typically participated in multiple networks, may be improving their bargaining position by moving toward limiting the plans with which they contract. A shift in the state's delicate balance of market power among providers, health plans, and buyers could alter the current success of health care markets in Wisconsin.

The Health Care Safety Net

The health care safety net is generally sound in Wisconsin. However, the safety net in Milwaukee County is in a more precarious position, since its population has poorer health status and a lower rate of insurance coverage than the rest of Wisconsin. In addition to pressure from the 1995 overhaul of the state's General Assistance program, Milwaukee safety net providers are feeling strain from the recent closure of the county's only public hospital and the implementation of welfare reform. Early indications are that welfare reform has increased the number of uninsured in the county, while closing the public hospital has brought about a shift in where the poor are served. Nevertheless, providers seem financially stable, and hospitals' charity care burdens remain low compared with those of urban hospitals in other states. Some observers, however, question how safety net providers will fare over the long haul.

Long-Term Care

Long-term care for the elderly and persons with disabilities has been

an area of significant state policy activity, in part because it accounts for a majority of Medicaid expenditures. Although the vast bulk of Wisconsin's long-term care spending is for institutional care, state home care programs (particularly the Community Options Program) have achieved national recognition for their innovative flexibility and client-directed care. In 1997 the Thompson administration put forth an ambitious proposal to integrate acute and long-term care services through managed care organizations, but withdrew it almost immediately because of opposition from the counties—which have considerable authority over long-term care and own many of the nursing homes in the state—and from advocacy groups for the elderly and disabled. A new proposal to redesign the long-term care system, unveiled in May 1998, addresses the concerns expressed about the first plan. The new plan emphasizes consumer choice, relies heavily on the counties to administer the program, promises expanded services, and seeks to integrate long-term care services. Proponents of this plan hope that the legislature will enact it by 1999.

Challenges for the Future

By almost any standard, Wisconsin's health care system is a success. The state has one of the lowest uninsured rates in the nation, largely because of broad employer-sponsored insurance coverage. In addition, the state sponsors a Medicaid program with extensive eligibility and service coverage. Providers, health plans, and large purchasers of health care generally seem satisfied with the Wisconsin health care market. Both insurers and hospitals are financially stable, and physicians are in high demand. Neither poor quality of care nor rapidly escalating health insurance premiums seem to be problems.

Wisconsin's well-functioning health care system is further strengthened by the state's robust economy. However, certain policy priorities may put pressure on the state budget to contain spending in areas like Medicaid. The most important of these priorities is Wisconsin's property tax relief effort, which has consumed a large share of the state's revenue growth in recent years.

Although Wisconsin's health care system has a sound foundation, the state will need to address a host of health policy issues over the next several years. Perhaps the state's primary challenge is how to resolve the separation between the state's major welfare reform initiative, W-2, and Medicaid eligibility. Currently, the two programs do not fit together well, making eligibility rules even more complex than before. Moreover, dramatic decreases in W-2 caseloads have had spillover effects, causing the Medicaid rolls to fall as well. Further declines in Medicaid enrollment could have major implications for the financial health of safety net providers. The state has looked to S-CHIP to counter the possible increase in the number of uninsured persons.

The state may also face some health care market issues in the near future. Any shift in the current balance of power among key actors (e.g., through an increase in exclusive contracting) could

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jeopardize the successful performance of the market. Finally, in the area of long-term care, Wisconsin faces two major issues. First, can the state continue to direct its resources away from institutional care and toward home and community-based services? Second, can long-term care services be better

coordinated and, if so, can they be integrated with acute care services? In sum, Wisconsin faces its future on solid footing, but, like many other states, it will have to meet these health care challenges while continuing efforts to reduce welfare dependency and promote personal responsibility.



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