Assessing the New Federalism

An Urban Institute Program to Assess Changing Social Policies

THE URBAN INSTITUTE

State Update No. 25, March 2002

Recent Changes in Health Policy for Low-Income People in Wisconsin

Brian K. Bruen and Joshua M. Wiener

Wisconsin has one of the highest rates of private insurance coverage in the nation, but the state also supports a number of health care programs for people without access to private coverage.

Overview

Wisconsin is one of America's leading "laboratories of reform."[1] Former Governor Tommy Thompson was a motivating force for change throughout the 1990s, championing policies that favored work and self-reliance. Although health care was not a top priority of the state, Wisconsin implemented some major health care initiatives. BadgerCare, the state's publicly subsidized health program for low-income families with incomes too high to qualify for Medicaid, is often touted as a model for how other states could expand coverage. Wisconsin also has been a national leader in long-term care, especially in the development of flexible home- and community-based services. The latest major initiative is Family Care, which consolidates funding for long-term care through use of care management organizations.

Political and Budgetary Developments

Wisconsin has new political leadership and is facing a very different fiscal environment than it had during the late 1990s. With the departure of Governor Tommy Thompson to head the U.S. Department of Health and Human Services, the new governor is Scott McCallum, a conservative Republican whose priorities are tax reduction and education. The economic slowdown, which has deepened in the aftermath of September 11, has exacerbated a large structural budget deficit and created substantial financial pressures, which the state addressed by relying on a creative repackaging of tobacco settlement funds and vastly expanding its Medicaid intergovernmental transfer program. Despite the financial pressures, Medicaid and other health programs were cut only very slightly in the budget that passed in 2001 and new funds were found to create a new prescription drug assistance program for senior citizens. Falling revenues and increasing expenditures may force budget cuts or postponement of some new initiatives.

Major State-Funded Health Programs for Low-Income People

Wisconsin has one of the lowest rates of uninsurance in the country, due in large part to a very high rate of private insurance coverage, leaving the state with a smaller gap to fill with public programs. Wisconsin's Medicaid program is one of the country's most extensive in terms of covered benefits and eligibility, although it is less than 14 percent of the state budget. Nevertheless, there is strong upward pressure on the Medicaid budget due to increasing enrollment, higher prescription drug costs, and demands for provider rate increases.

A major innovation in Wisconsin has been the implementation of BadgerCare, which is funded through a combination of a Medicaid waiver and a State Children's Health Insurance Program (SCHIP) waiver. In these waivers, the state proposed to cover certain parents through SCHIP rather than Medicaid (and thereby receive a higher federal match), arguing that it would make enrollment of children easier since their parents could benefit as well. The U.S. Department of Health and Human Services ultimately granted the waivers, but the process of obtaining them

was politically contentious and difficult. Observers generally viewed BadgerCare as an unqualified success, pointing to rapid enrollment growth and broad public and political support for the program.

Acute Care for the Low-Income Population

Going into the 2001–2003 budget process, Wisconsin policymakers faced intense pressure to provide prescription drug coverage for older people. After considerable political wrangling, the legislature enacted a new program that will be one of the most generous in the country, covering older people with incomes up to 240 percent of the federal poverty level (FPL). An 18-cent increase in the cigarette tax funds the program.

Managed care is well established in Wisconsin, long mandatory for nondisabled, nonelderly Medicaid recipients in much of the state, and now also for BadgerCare. The commercial market is competitive but stable, with little turnover in plans and not much change in market penetration in recent years. State regulation of managed care plans is extensive, but it is generally viewed as preventive rather than a response to current practices. Most commercial health maintenance organizations (HMOs) serve public enrollees, and there are no Medicaid-only plans. HMOs incurred losses in the late 1990s but returned to modest profitability in 2000 after raising commercial premiums and winning substantial rate increases for public programs in negotiations with the state.

Overall, Wisconsin hospitals are operating at a profit, but their margins are down. Modest merger activity has strengthened the bargaining position of hospitals, but has not diminished the industry's historically good relations with HMOs or the state. Hospitals are concerned about short- and long-term staffing problems and Medicare payment rates. Benefiting from the low numbers of uninsured, expenditures for uncompensated care are a small percentage of gross patient revenue.

Wisconsin's Medicaid program has made little use of the disproportionate share hospital (DSH) payments either to increase federal revenues or to provide aid to hospitals with large amounts of uncompensated care. The state has, however, made heavy use of supplemental payments, which are very much like DSH.

Long-Term Care

Long-term care has a high political and policy profile in Wisconsin, partly reflecting that a majority of Medicaid expenditures are for these services. The state has a national reputation for flexible, consumer-directed home- and community-based services in its Community Options Program (COP). The COP program has very long waiting lists, which are politically controversial and may make the state vulnerable to lawsuits resulting from the Supreme Court's *Olmstead* decision, which established a limited right to noninstitutional services. Most observers, however, believe that the state's substantial home- and community-based programs make them immune from legal problems.

The state's nursing home industry is under substantial stress with a number of facilities in bankruptcy proceedings, falling occupancy rates, facilities closing, and beds being taken out of service. Recruitment and retention of staff is a major problem and quality of care concerns are increasing. The nursing home industry blames low Medicaid reimbursement for its problems and has lobbied hard for rate increases. While it is unclear what the impact of the repeal of federal minimum standards for Medicaid reimbursement of nursing homes has been, the state has tightened reimbursement over the last few years.

To provide the funds for rate increases, the nursing home industry proposed and the governor and legislature agreed to a major restructuring of the state's Medicaid intergovernmental transfer (IGT) program. Under the approved plan, three counties borrow funds from a financial institution and transfer them to the state, which then returns the funds to the counties and certifies the returned funds as Medicaid expenditures for nursing facilities, enabling the state to claim federal matching funds equal to about 60 percent of the amount initially transferred. This new plan could potentially bring $604 million in federal funds to Wisconsin during the 2001–2003 biennium. Virtually all of these funds are slated to be used to increase payments to nursing facilities, particularly facilities that are run by

TABLE 1. Selected Wisconsin Characteristics

	Wisconsin	United States
Population Characteristics		
Population (2000) (in thousands)[a]	5,364	281,422
Percent under age 18 (1999)[a]	25.5%	25.7%
Percent Hispanic (1999)[b]	2.7%	12.5%
Percent black (1999)[b]	6.1%	12.8%
Percent Asian (1999)[b]	1.8%	4.1%
Percent nonmetropolitan (1999)[b]	32.4%	20.3%
State Economic Characteristics		
Per capita income (2000)[c]	$28,232	$29,676
Percent change per capita income (1995–1999)[d]	11.0%	10.8%
Unemployment rate (2001)[e]	4.2%	4.5%
Family Profile		
Percent children in poverty (1998)[f]	9.7%	17.5%
Percent change children in poverty (1996–1998)[f]	–16.4%	–15.0%
Percent adults in poverty (1998)[f]	6.9%	11.2%
Percent change adults in poverty (1996–1998)[f]	–10.4%	–10.4%
Political		
Governor's affiliation (2001)[g]	Republican	NA
Party composition of senate (2001)[h]	18D-15R	NA
Party composition of assembly (2001)[h]	43D-56R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC)[i]	76.7%	59.3%
1998 (TANF)[i]	*	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996[j,k]	113%	124%
1998[j,l]	127%	178%
2000[j,m]	185%	205%

Table 1 notes begin on page 26.
*This percentage cannot be calculated because Wisconsin no longer counts Child-Only and SSI cases as part of the TANF caseload.

counties. The IGT program is controversial, but even critics of the IGT approach admit that the state does not have any other politically viable options to generate the same level of funding for nursing facilities that the IGT affords.

Motivation

To examine how states have responded to both federal constraints and state flexibility during the last half decade, this study of Wisconsin—along with concurrent studies of 12 other states—examines state priority setting and program operations in health policy affecting the low-income population.[2] The past five years have given states new opportunities in health policy for low-income people, yet also put new pressures on policy formulation. Many developments increased state flexibility, including welfare reform and delinking of Medicaid from cash assistance, new funding for children's health insurance coverage in the form of the SCHIP program, repeal of federal minimum standards for nursing home and hospital payments, and increased federal willingness to grant waivers under Medicaid (and now under SCHIP as well). Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

On the other hand, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support that was believed to be abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown. Additional spending pressure arose from

political demands to provide coverage for the uninsured, the Supreme Court's *Olmstead* decision that detailed a right to home- and community-based services under the Americans with Disabilities Act, and rapid growth in pharmaceutical spending. The terrorist attacks of September 11, 2001, accelerated the economic downturn that was already beginning to affect Wisconsin. This deterioration in the economy will likely deepen the fiscal problems that were already beginning to be felt and may increase the budget pressure on Medicaid and other health programs for the low-income population.

This report focuses on developments in health care policy in Wisconsin beginning in the late 1990s through 2001, building on an earlier baseline study.[3] Information for this study was obtained from publicly available documents, newspapers, Web sites, and interviews with state officials, provider organizations, consumer advocates, and other stakeholders. The authors conducted in-person interviews in Madison, Wisconsin, in April 2001. Questions were asked using an open-ended interview protocol. To encourage the respondents to speak freely, they were told that they would not be quoted by name.

Background

Sociodemographics

In 2000, Wisconsin had a population of 5.36 million people (see table 1). The vast majority of the state's population is non-Hispanic white—in 1999, less than 3 percent of the population was Hispanic and 6.1 percent was black. Relatively few Wisconsinites are poor—in 1998, 1 in 10 children (9.7 percent) and 1 in 15 adults (6.9 percent) lived in families with incomes below the federal poverty level (FPL). By comparison, 17.5 percent of children and 11.2 percent of adults in the United States lived in poverty in 1998. Compared to the rest of the nation, a large share of Wisconsin's population (32.4 percent) lives in nonmetropolitan areas.

Economic Indicators

Even more than the rest of the country, Wisconsin's economy boomed in the 1990s. In recent years, unemployment has been very low, making it very difficult to fill jobs.[4] However, the national economic slowdown had a significant impact on Wisconsin's economy. In June 1999, the state's unemployment rate was 3.0 percent, but by April 2001 it had risen to 4.2 percent, only slightly below the national average. Wisconsin's Department of Revenue predicts that employment growth in Wisconsin will be slightly weaker than the national rate of growth from 2001 to 2006. Per capita income in 2000 was $28,232, slightly below the national average of $29,676 (see table 1).

Health Insurance

Wisconsin is noted for its low numbers of uninsured residents. The Urban Institute's National Survey of America's Families (NSAF) shows that Wisconsin consistently had lower percentages of uninsured people relative to national averages in 1999 (see table 2). Wisconsin's low rate of uninsurance is largely due to high levels of employer-sponsored coverage, particularly for low-income families. Among people with family incomes below 200 percent of the FPL, the share of the population with employer-sponsored coverage was considerably higher in Wisconsin than in the nation for both children (55 percent compared to 39 percent) and adults (53 percent compared to 42 percent). In part due to these higher levels of employer-sponsored coverage, a smaller percentage of Wisconsin residents rely on public coverage (such as Medicaid, SCHIP, or other state-funded coverage) compared with the national average.

Political Developments

Throughout the 1990s, the dominant political force in Wisconsin was the state's Republican governor, Tommy Thompson, who first won election in 1986 and remained in office until January 2001 when he became secretary of the U.S. Department of Health and Human Services. Thompson gained national recognition for Wisconsin Works, or W-2,

TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, Wisconsin and the United States, 1999

	Children (Ages 0–18)[a] (%)		Adults (Ages 19–64)[b] (%)	
	Wisconsin	**United States**	**Wisconsin**	**United States**
Below 200% FPL				
Employer-sponsored	**55.4**	38.7	**53.2**	41.7
Medicaid/SCHIP/state	**25.6**	35.2	**10.5**	14.7
Other coverage	**5.4**	3.8	10.2	8.8
Uninsured	**13.7**	22.4	**26.1**	34.9
Above 200% FPL				
Employer-sponsored	**89.6**	85.3	**89.1**	83.7
Medicaid/SCHIP/state	**2.2**	3.8	**0.5**	1.1
Other coverage	**3.5**	4.9	5.0	5.8
Uninsured	4.7	6.0	**5.4**	9.4
All Incomes				
Employer-sponsored	**79.4**	66.7	**81.7**	72.3
Medicaid/SCHIP/state	**9.1**	16.4	**2.6**	4.8
Other coverage	4.1	4.5	6.1	6.6
Uninsured	**7.4**	12.5	**9.7**	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.

Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program

which replaced the state's cash-benefit welfare system with a work-based program requiring all participants to work or hold public service jobs as a condition of receiving cash grants or other types of public assistance. Thompson pressed for legislative and federal approval of BadgerCare, which offers health care to children and their parents with family incomes at or below 185 percent of the FPL. He also supported Family Care, a pilot program designed to create a capitated, community-based long-term care system, which recently began in several counties.

Scott McCallum, who was lieutenant governor for all 14 years of the Thompson administration, took over as governor when Thompson resigned. Despite his many years in public office, McCallum was something of an unknown. Some respondents predicted very little change in policy as a result of this change, while others—especially consumer advocates—worried that McCallum has less of a commitment to Thompson initiatives such as BadgerCare and Family Care. During the 2001 budget debate, McCallum's priorities appeared to be lowering taxes, limiting government expenditures, and maintaining the state's relatively high level of funding for education. However, most respondents believed that the dip in the economy and the state's budget crisis had a greater political impact than the change in governor, at least for the current budget cycle.

Although Republicans have held the governor's office for more than 14 years, Democrats hold many important offices in Wisconsin, including both U.S. Senate seats and five out of the state's nine seats in the U.S. House of Representatives. The 2001–2002 Wisconsin legislature is split, with a Democratic majority in the senate (18–15) and a

Republican majority in the assembly (56–43) (see table 1). Historically, the senate moderated some of the more conservative elements of Governor Thompson's proposals.

Fiscal Circumstances of the State

General Fiscal Condition and Budget Priorities

The strength of Wisconsin's economy during the 1990s led to budget surpluses that allowed for both increased expenditures for public programs and tax cuts. Total state expenditures—including federal aid—grew from $16.1 billion in fiscal year (FY) 1995 to an estimated $20.6 billion in FY 2000 (see table 3, p.8).

Funding for elementary and secondary education is the largest component of the state's budget, accounting for 44 percent of the state's general fund expenditures in FY 2000. In 1996, Governor Thompson dramatically increased state spending for K–12 education when he committed the state to pick up two-thirds of all local school costs. There is some concern that the state may not be able to sustain this level of funding for public schools in the long run.[5] Medicaid was 13 percent of total expenditures in 2000, considerably less than many other states. Other significant budget items, particularly when federal aid is counted, include corrections and higher education.

Wisconsin's budget outlook soured early in 2001, when lawmakers faced a major shortfall in the state's biennial budget. Governor McCallum touted the 2001–03 budget that he submitted in January 2001 as "contain[ing] the smallest growth in Wisconsin state spending in 30 years."[6] In May, the state's Legislative Fiscal Bureau released revenue estimates that projected that the governor's budget would be $620 million out of balance. Officials attributed the projected shortfall to tax cuts enacted in recent years that reduced individual income tax revenues and the economic slowdown that reduced sales and corporate tax revenues. Adding to the state's fiscal woes, the Legislative Fiscal Bureau projected that the state would need $1.1 billion in additional revenue just to sustain existing levels of spending.

Over the next several months, Republicans and Democrats waged a largely partisan battle over the 2001–03 budget, with significant differences in the areas of taxes, spending controls, school choice, and prescription drug relief for seniors. Key health-related provisions in the final budget compromise that the governor signed into law in August 2001 include prescription drug assistance for seniors and full funding for BadgerCare. Although Governor McCallum has broad veto authority, he did not trim any major health programs. He did, however, veto funds for expansion of Family Care, the state's long-term care demonstration.

Two initiatives provided substantial new revenue that served to lessen the budget pressures. One initiative replaces the state's existing Medicaid intergovernmental transfer (IGT) program with a new IGT program that, according to initial estimates, will enable the state to draw down more than $600 million in federal funds in the 2001–03 biennium. Under the plan, three counties (Rock, Sheboygan, and Walworth) borrow funds from financial institutions and wire those funds to the state. The state then makes special supplemental Medicaid payments for nursing home care to those counties that equal the amounts transferred. Based on its federal medical assistance percentage (FMAP), the state receives federal matching funds equal to about 60 percent of these payments, thereby drawing down federal funds without incurring additional state costs. These funds will free up state dollars that can be used as the state share of future Medicaid payments, once again drawing down federal funds without incurring additional state costs. In May 2001, Wisconsin's plan to change its IGT claiming methods received approval from the Centers for Medicare & Medicaid Services (CMS). This approval gave Wisconsin an additional $255 million in federal funds for 2001, but ongoing federal efforts to limit use of such IGT programs makes it unclear whether the state will be able to obtain the remainder of the $604 million in federal funds originally estimated to be obtainable in the 2001–03 budget.

The second initiative is a novel approach to the tobacco settlement funds. As one of the states included in the Attorneys General Master Tobacco Settlement Agreement of

November 1998, Wisconsin receives payments from tobacco companies. As of January 2001, the state had received $207.5 million in unrestricted tobacco settlement payments. Current projections are that Wisconsin will receive $5.57 billion in payments from 2002 through 2032. Effectively, all of these settlement revenues are deposited to the general fund. The state transferred the first $21.5 million received to the tobacco control fund to fund the tobacco control board's activities. In addition, a small portion of the funds received to this point has been earmarked for BadgerCare and smoking prevention and research activities.[7]

The 2001–03 budget securitizes most of the state's tobacco settlement and uses some of the proceeds to help balance the budget. The bill allows the Department of Administration to sell, transfer, or assign the state's rights to 25 years of tobacco settlement payments to the Wisconsin Health and Educational Facilities Authority (WHEFA) or to another nonstock, nonprofit corporation formed by WHEFA or the state. WHEFA (or the other corporation) would use the tobacco settlement revenue to support the issuance of revenue bonds. In return for future tobacco settlement payments, the corporation would give the state the proceeds from the sale of those bonds, estimated to total $1.3 billion. Although the tobacco settlement sell-off generated considerable controversy when it was proposed, it gained support as a way to plug the budget deficit. The final budget compromise earmarks $450 million of the proceeds from these bonds to be deposited to the general fund in 2001–02 to help alleviate the state's current budget crisis. The remaining proceeds would be deposited to an endowment fund to be invested by the State of Wisconsin Investment Board, with a portion of any investment earnings of the endowment fund earmarked for the tobacco control board.[8]

As the economy has continued to slow, especially after September 11, there are increasing concerns over the state's fiscal circumstances. The current spending plan will create at least a $780 million deficit in the 2003–05 budget cycle based on current revenue and expenditure estimates. In part, the shortfall is due to lawmakers shifting earlier expenditures into the 2003–05 budget cycle and financing ongoing spending with one-time financing mechanisms in 2001–02 such as the new IGT program, a significant increase in the state's tobacco tax, and the sell-off of tobacco settlement funds. Governor McCallum has already stated publicly that maintaining new spending established in the current budget will "[make] it extremely difficult to fund growth in existing programs such as school aids, medical assistance, and the University of Wisconsin" in the next budget cycle.[9]

Major State-Funded Health Programs for Low-Income People

Wisconsin has one of the highest rates of private insurance coverage in the nation, but the state also supports a number of health care programs for people without access to private coverage. The two largest publicly funded programs for low-income people are Medicaid and BadgerCare. Another important program is the Health Insurance Risk-Sharing Pool (HIRSP), one of the nation's oldest high-risk pools.

Medicaid

Wisconsin operates one of the most inclusive Medicaid programs in the country, with relatively generous eligibility standards and an extensive array of covered services. The program supports the costs of providing acute and long-term care to persons who are aged, blind, disabled, children, members of families with dependent children, and pregnant women who meet specified financial and nonfinancial criteria.

Eligibility. Medicaid eligibility for pregnant women and families with dependent children was historically tied to eligibility for Aid to Families with Dependent Children (AFDC). While AFDC has been replaced with Temporary Assistance for Needy Families (TANF), Medicaid eligibility for low-income families is still based on AFDC eligibility standards from July 16, 1996. Wisconsin had relatively generous AFDC eligibility standards, so the state's Medicaid program covers families with dependent children up to higher income levels than many other states. Even so, income eligibility standards for

TABLE 3. Wisconsin Spending by Category, 1995 and 2000 ($ in Millions)

Program	State General-Fund Expenditures[a] Actual 1995	Estimated 2000	Annual Growth (%) WI	U.S.	Total Expenditures[b] Actual 1995	Estimated 2000	Annual Growth (%) WI	U.S.
Total	$7,791	$10,612	6	5	$16,076	$20,611	5	6
Medicaid[c,d]	$844	$988	3	5	$2,294	$2,778	4	4
% of Total	11%	9%			14%	13%		
K–12 Education	$2,798	$4,698	11	7	$3,254	$5,139	10	7
% of Total	36%	44%			20%	25%		
Higher Education	$1,037	$1,144	2	5	$2,697	$3,096	3	5
% of Total	13%	11%			17%	15%		
Public Assistance	$280	$200	–7	–6	$494	$264	–12	–5
% of Total	4%	2%			3%	1%		
AFDC/TANF	*$143*	*$70*	*–13*	*–9*	*$357*	*$94*	*–23*	*–7*
% of Total	*2%*	*1%*			*2%*	*0%*		
Corrections	$338	$673	15	6	$368	$812	17	6
% of Total	4%	6%			2%	4%		
Transportation	–	–	–	5	$1,428	$1,974	7	6
% of Total	0%	0%			9%	10%		
All Other[e]	$2,494	$2,910	3	5	$5,541	$6,550	3	8
% of Total	12%	14%			34%	32%		

Source: National Association of State Budget Officers 1997. *1996 State Expenditure Report* and 2000. *1999 State Expenditure Report.*
a. State general-fund expenditures exclude other state funds and bond expenditures.
b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.
c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as other state funds. In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.
d. Total Medicaid spending will differ from data reported on the HCFA-64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA-64.
e. This category could include spending for the SCHIP, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

Note: Figures may not add to totals shown due to rounding.

these families are still well below the FPL and, since these standards are not adjusted for inflation, they are decreasing as a percentage of the FPL over time. In 2000, Wisconsin provided Medicaid coverage to families with dependent children with incomes ranging from 45 percent to 59 percent of the FPL, depending on family size. (Parents and children with incomes up to 185 percent of the FPL are eligible for BadgerCare; see below.) Under Medicaid, families are also limited to $1,000 in financial assets, although children may still qualify if the family has more assets.[10]

In the 1980s, the federal government expanded Medicaid to more low-income pregnant women and children. Called "Healthy Start" in Wisconsin, these expansions extend Medicaid coverage to pregnant women, infants, and children up to age 6 with family incomes at or below 185 percent of the FPL, and to children ages 6 through 18 with family incomes at or below 100 percent of the FPL. Parents of these children are not eligible for Medicaid, although they are eligible for BadgerCare. There is no limit on the amount of financial assets that Healthy Start participants may have. Wisconsin also offers presumptive eligibility for low-income pregnant women, which allows them to receive prenatal care while their applications are being processed.

Wisconsin's eligibility standards for aged, blind, and disabled populations are also relatively generous. Medicaid covers all Supplemental Security Income (SSI) recipients, and Wisconsin also covers individuals who receive state supplemental payments to SSI and individuals who are eligible for SSI but do not receive a payment. These options extend eligibility to certain aged, blind, and disabled individuals with incomes up to 86 percent of the FPL and couples with incomes up to 99 percent of the FPL.[11] For long-term care beneficiaries in home- and community-based services waiver programs, Medicaid eligibility is based on a higher income standard, which is 300 percent of the federal SSI payment.

Wisconsin covers spend-down options for certain groups of low-income children and pregnant women, as well as aged and disabled people, whose income or resources exceed financial limits for cash assistance. Parents of dependent children may not become eligible through spend down. If people in eligible groups have large medical bills, they can also become eligible for Medicaid if medical expenses reduce their family's income below the "medically needy" income standard for their family size. Its standard for couples has been the same since 1988 and its standard for individuals reached the federally allowed maximum in 2000. Beneficiaries must also reduce their assets to meet the respective limits for their family size; in 2001, these asset limits ranged from $2,000 for individuals up to $4,800 for a family of eight. Unlike some states, Wisconsin entitles spend-down beneficiaries to the full range of covered services, including nursing home care.

Covered Benefits. Wisconsin's Medicaid program covers all of the optional services identified under federal law except those provided by Christian Science nurses, making it one of the most comprehensive programs in the country. Prior legislative efforts to cut back on optional services in Wisconsin have all failed. In general, there are no predetermined limits on Medicaid services, although some services require prior authorization and there is a second surgical opinion requirement for certain nonemergency procedures. Wisconsin requires nominal copayments (ranging from $0.50 to $3.00) for a large number of covered services, including inpatient hospital, physician, dental, and chiropractic services; hearing aids; ambulatory surgery; and prescription drugs.

Enrollment Trends. Between federal fiscal year (FFY) 1995 and FFY 1998, Wisconsin's Medicaid enrollment fell by nearly 85,000 people.[12] Although Medicaid enrollment declined in most states over this period, Wisconsin's 6.0 percent average annual decline was much faster than the average decline nationwide (see table 4). The change in total enrollment was the result of significant declines in the number of nonelderly, nondisabled adults and children. Some respondents attributed these drops to the sharp decline in cash welfare beneficiaries. In addition, they argued that the switch from AFDC to TANF caused confusion within the low-income population regarding Medicaid eligibility, and that administrative barriers discouraged Medicaid enrollment. Federal welfare reform severed the historical linkage between Medicaid and cash assistance—some people eligible for cash assistance were not eligible for Medicaid and some people not eligible for cash assistance were. Other respondents noted that the decline in enrollment began prior to the establishment of TANF and attributed the drop to the strong economy and declining unemployment. In contrast to the rapid declines in enrollment of families and children, enrollment of elderly and disabled individuals grew slowly from 1995 to 1998 (see table 4).

Enrollment data from Wisconsin's Department of Health and Family Services indicate that enrollment leveled off in 1999 and began to creep upward in 2000 and early 2001.[13] Respondents attributed the turnaround to the extensive outreach and enrollment efforts for BadgerCare, Wisconsin's SCHIP program that started in mid-1999, and the integrated eligibility determination system established to screen applicants for both BadgerCare and Medicaid. Originally, state officials estimated that Medicaid enrollment would grow by about 7,000 people due to applications to BadgerCare by persons eligible for Medicaid, but by April 2001 this figure was closer to 30,000 persons. In addition to the rebound in enrollment of nondisabled adults and children, enrollment of disabled and elderly individuals continues to grow slowly but steadily. By June 2001, total Medicaid enrollment was back to 1995 levels.

TABLE 4. Medicaid Enrollment and Expenditures in Wisconsin, 1998

	Wisconsin, 1998			Average Annual Growth (%), 1995–1998					
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
				Wisconsin	United States	Wisconsin	United States	Wisconsin	United States
Total Expenditures	**$2,830**	**–**	**–**	**4.3**	**3.9**	**–**	**–**	**–**	**–**
Medical Services									
By Eligible Group	**$2,708**	**413**	**$6,564**	**4.0**	**5.1**	**–6.0**	**–1.0**	**10.7**	**6.1**
Elderly	$976	55	$17,852	1.7	4.3	0.5	0.1	1.2	4.2
Blind and disabled	$1,291	116	$11,156	8.5	8.5	1.7	3.6	6.7	4.7
Adults	**$130**	**53**	$2,468	–10.5	–1.4	–18.0	–4.4	9.2	3.1
Cash assistance	$50	26	$1,951	–24.8	–10.4	–23.6	–14.9	–1.5	5.3
Other enrollees	$80	27	$2,952	7.6	7.8	–10.8	9.3	20.6	–1.4
Children	**$311**	**189**	$1,641	3.1	2.7	–7.3	–1.5	11.2	4.3
Cash assistance	$94	65	$1,447	–20.1	–8.8	–23.2	–12.2	4.1	3.9
Other enrollees	$217	124	$1,743	29.7	12.4	9.8	9.8	18.2	2.4
By Type of Service	**$2,708**	**–**	**–**	**4.0**	**5.1**	**–**	**–**	**–**	**–**
Acute care	$1,199	–	–	2.1	4.0	–	–	–	–
Long-term care	$1,509	–	–	5.8	6.5	–	–	–	–
DSH	**$11**	**–**	**–**	**–1.3**	**–7.3**	**–**	**–**	**–**	**–**
Administration	**$111**	**–**	**–**	**11.6**	**8.5**	**–**	**–**	**–**	**–**

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare."Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

Note: Figures may not add to totals due to rounding.

Expenditure Trends. Wisconsin's Medicaid expenditures increased from $2.5 billion in FFY 1995 to $2.8 billion in FFY 1998, an average increase of 4.3 percent per year (see table 4).[14] The state's total expenditures grew at a rate comparable to the national average, but spending for most service types grew more slowly (or fell more quickly) than national averages. Increased use of managed care and reductions in AFDC-related enrollment may have slowed acute care growth, while greater availability of and access to home- and community-based services may have reduced hospitalizations and nursing home use.

Wisconsin spends a larger share of its total Medicaid expenditures for long-term care than most states.[15] In FFY 1998, 53 percent of Wisconsin's Medicaid expenditures was for long-term care (see table 4); the average share nationwide was 37 percent (data not shown). Dramatic growth in home care expenditures—which grew from $228 million in FFY 1995 to $435 million in FFY 1998—reflects Wisconsin's recent efforts to expand home- and community-based care (data not shown). By comparison, spending for institutional long-term care services was practically unchanged over this period (data not shown).

Consistent with the state's broad benefit package and its larger share of spending devoted to long-term care, Wisconsin's Medicaid expenditures per enrollee are much higher than the national average. The state's $6,564 average spending per enrollee was 35 percent higher than the U.S. average of $4,857 in FFY 1998.[16] Expenditures per enrollee also grew faster from 1995 to 1998 in Wisconsin than in the United States.

Additional data suggest that the rate of growth of Wisconsin's Medicaid spending accelerated in 1998. A recent report by Wisconsin's Legislative Fiscal Bureau shows that Medicaid expenditures grew by 10.4 percent in state fiscal year (SFY) 1999–00, compared to rates of 3.4 percent, 2.6 percent, and 3.4 percent in the previous three fiscal years.[17]

Budgetary Perspective and Expectations for the Future. Wisconsin does not spend a large percentage of its budget on Medicaid. In SFY 2000, Medicaid expenditures (including federal funds) accounted for 13.5 percent of the total budget in Wisconsin (see table 3).[18] By comparison, the national average is 18.9 percent (including federal funds).[19] Excluding federal funding, Medicaid accounted for 9 percent of state general-fund expenditures. Despite Wisconsin's current budget crisis and the recent acceleration of expenditure growth, respondents did not view Medicaid as out of control or a budget buster. Rather, they viewed the program as something that needs to be carefully monitored and managed. Several respondents noted that a prolonged economic slowdown or ongoing budget crisis would draw more attention to the Medicaid budget.

Wisconsin is making efforts to limit Medicaid expenditure growth, but there are several upward pressures on the Medicaid budget. Prescription drugs are a major factor driving increased expenditures. The state's 2001–03 budget reduces the reimbursement rate to pharmacies for brand name prescription drugs purchased by Medicaid, changing from average wholesale price (AWP) minus a 10 percent discount plus a dispensing fee to AWP minus an 11.25 percent discount plus a dispensing fee. The governor and the state assembly proposed a discount of 12.5 percent but compromised on the lower reduction due to opposition from the senate and pharmacists, who argued that the cuts reduced payments to pharmacists without changing the costs that pharmacists pay to the drug companies. The budget also increases the copayment paid by Medicaid recipients for brand name drugs from $1.00 to $2.00.

Other factors affecting spending growth are increasing enrollment and provider rate increases. Total Medicaid enrollment is projected to increase at a rate of 2.8 percent per year during 2001–03, primarily due to projected increases in enrollment in Medicaid's Healthy Start program.[20] The current Medicaid budget includes provider rate increases already legislated for HMOs in 2000. Wisconsin's 2001–03 budget includes an expanded Medicaid IGT program to draw down significant amounts of federal funding to support significant rate increases for nursing facilities—especially county-owned facilities—and smaller increases for hospitals and noninstitutional providers.

Medicaid, W-2, and the Origins of BadgerCare

Wisconsin has a long history of welfare reform experiments. Former Governor Tommy Thompson gained national recognition as an advocate of tough welfare-to-work programs. Wisconsin began its welfare reform efforts in 1987, and over the next 10 years the state's AFDC caseload dropped from 287,488 persons to 94,802 persons.[21] The biggest change to the state's welfare system began in 1995, when Governor Thompson proposed Wisconsin Works, or W-2. In a politically controversial move, the Clinton administration approved the waivers to implement the changes to cash welfare, but not to Medicaid. In July 1996, federal welfare reform—in the form of the Personal Responsibility and Work Opportunity Reconciliation Act—replaced AFDC with TANF and delinked eligibility for Medicaid and cash assistance. In October 1996, Wisconsin implemented W-2 as its TANF program.

As part of its welfare reform, Wisconsin requested a federal Medicaid research and demonstration waiver that would have allowed the state to implement a health care component for W-2, dramatically changing the state's Medicaid program. The W-2 Health Plan would have eliminated the entitlement to benefits, reduced eligibility for some groups that were eligible for Medicaid at the time, imposed premiums for all enrollees, and reduced the number of covered services. Federal officials rejected the proposal.

After the W-2 Health Plan failed to receive a waiver, state officials began work on a program that would be more acceptable to the Clinton administration. After Congress created SCHIP as part of the Balanced Budget Act of 1997, the state proposed to use SCHIP funds to cover parents of eligible children. Wisconsin believed that covering parents would make it easier to enroll children in the new program because parents could make insurance decisions for the whole family and would directly benefit from the program. They also hoped that by tightly linking Medicaid and SCHIP that the some of the start-up problems experienced by other states could be avoided, that beneficiaries would be able to easily move back and forth between Medicaid and SCHIP as their financial status changed, and that the stigma traditionally associated with Medicaid could be reduced.

The waiver proposal was rejected in August 1998, based on concerns that allowing Wisconsin to use SCHIP funds to provide coverage for parents would violate the intent of the SCHIP legislation to provide health insurance for children and would set an undesirable precedent. The federal statute only allowed SCHIP funds to be used to provide health insurance for parents if very strict cost-effectiveness conditions were met. In January 1999, HCFA (now CMS) approved Wisconsin's waiver request for expansion of eligibility for parents as a Medicaid demonstration.

Two years later, after the initial success of BadgerCare, the state received federal approval of a second research and demonstration waiver to use SCHIP funding for some parents in BadgerCare, allowing the state to claim a much higher federal match. By that time, HCFA had changed its mind about the desirability of covering parents as a strategy for increasing enrollment of children.

State officials, consumer advocates, and health industry representatives expressed considerable frustration with the waiver approval process for BadgerCare, which they generally viewed as burdensome and overly politicized. Nevertheless, some consumer advocates commented that the negotiations with HCFA improved BadgerCare by taking away some of its "rough edges."

BadgerCare

On July 1, 1999, Wisconsin began enrolling people in BadgerCare, the state's SCHIP program that provides coverage to uninsured families with dependent children who are not eligible for Medicaid. BadgerCare is funded under both the SCHIP program and Medicaid and therefore the program operates under the federal requirements for both programs. There are close ties between the two programs in terms of eligibility, benefits, service

delivery, and administration. Indeed, the state prides itself on the seamlessness of the two programs. However, they are separate programs and the state budgets them individually.

Eligibility. Families with dependent children qualify for coverage under BadgerCare if they are not eligible for Medicaid and if their incomes are at or below 185 percent of the FPL. Once enrolled, a family's income may increase to 200 percent of the FPL before the family is no longer eligible. There is no financial asset limit for eligibility. Participants with family incomes above 150 percent of the FPL are required to pay monthly premiums for coverage, which are about 3 percent of family income. Families that have health insurance or who have access to a group insurance plan for which their employer subsidizes at least 80 percent of the monthly premium are not eligible for BadgerCare. In addition, individuals who have health insurance or had health insurance any time during the three months before they apply for BadgerCare are also not eligible. Unlike Medicaid, BadgerCare is not an entitlement and enrollment can be capped if expenditures are projected to exceed budgeted levels. However, as described below, there is a significant financial disincentive to the state to do so.

Covered Services. BadgerCare services are identical to the services provided by Medicaid and may be obtained from Medicaid providers. Approximately 70 percent of participants are enrolled in HMOs. As a way to ensure that all members of a family can have the same health plan, these managed care organizations are required to serve both Medicaid and BadgerCare clients.[22] The requirement that HMOs participate in both programs was controversial at first because HMOs felt payment rates for BadgerCare were too low, and several plans threatened to drop out of both programs. To maintain sufficient provider capacity, the state negotiated higher rates with the health plans in 2000.

Enrollment Trends. Enrollment grew rapidly after the program was implemented, quickly exceeding initial projections. In May 2001, over 83,000 individuals were enrolled in BadgerCare, including 56,700 adults and 26,500 children.[23] The vast majority (87 percent in May 2001) of enrollees are from families with countable incomes under 150 percent of the FPL and therefore do not pay monthly premiums. Critics argue that this is evidence that the premiums are too high and discourage some families from participating.

Observers indicated that, despite some early glitches, the state's integrated Medicaid and BadgerCare eligibility system seems to be working well. The state has outstationed eligibility workers, and consumer advocates are currently pushing the state to allow mail-in applications. The state has gone to considerable effort to make transitions between Medicaid and BadgerCare as seamless as possible—for example, participants receive the same eligibility card and may not even know which program they are enrolled in—which reportedly reduces the stigma associated with Medicaid.

When BadgerCare was implemented, there was significant concern that it might cause small employers to drop coverage—that public coverage might crowd out the private, employer-sponsored insurance. To ensure that this does not occur, the state has a thorough screening process to verify that BadgerCare enrollees do not have access to employer-provided insurance. State officials noted that they have not found evidence of crowd-out. Nevertheless, crowd-out remains a concern among certain insurance companies and lawmakers.

Some observers argued that the requirement that families cannot have private coverage in the three months prior to applying for BadgerCare prevents people from getting health coverage when they need it. Other stakeholders viewed the screening process for other health insurance as too costly and time consuming to be worthwhile—BadgerCare covers very few families by buying into employer-sponsored insurance. Nonetheless, because of lingering concerns about potential crowd-out and growing program costs, Governor McCallum and the assembly proposed to include provisions in the budget to screen BadgerCare applicants for insurance coverage *before* enrolling them in the program—people are currently covered during this process—and to lengthen the waiting

period before people can enroll after having private coverage to six months instead of three. Neither of these provisions was enacted in 2001.

Expenditure Trends. Both Medicaid and SCHIP fund BadgerCare. Federal Medicaid funds cover about 59 percent of the expenditures for services for adults with family incomes at or below 100 percent of the FPL. Federal SCHIP funds cover about 71 percent of expenditures for services for children enrolled in BadgerCare. In January 2001, HCFA approved a research and demonstration waiver that allows Wisconsin to cover parents with incomes above 100 percent of the FPL under SCHIP, giving the state the advantage of a higher federal matching rate for this population. A very small amount of the program's funding comes from premiums paid by participants.

Since BadgerCare is not an entitlement, funding is limited to the amount the state appropriates for the program. The state allocated $63.6 million to BadgerCare in 1999–2000 and $134.2 million in 2000–2001. If funding for BadgerCare is not sufficient to cover projected costs, state law requires that the income eligibility for BadgerCare must be lowered to a level no greater than necessary to ensure that the amounts appropriated are sufficient to cover projected costs. This provision is commonly referred to as the "enrollment trigger." However, the second federal waiver for BadgerCare—the one that allows Wisconsin to use SCHIP funds at a much higher federal matching rate to cover parents—is automatically terminated if the state uses the enrollment trigger to lower eligibility criteria. This provision is a powerful financial incentive for the state not to invoke the enrollment trigger.

BadgerCare enrollment grew more rapidly than expected at the outset of the program. In the spring of 2000, BadgerCare funding was projected to be $13.5 million below the projected program expenditures in the 1999–2001 biennium. Rather than turning to the enrollment trigger, the legislature passed and Governor Thompson signed 2001 Wisconsin Act 1, which increased funding.

The growing cost of BadgerCare is a concern to some lawmakers and some other stakeholders. The program has already exceeded its budget once and required additional funding. The state recently increased its payment rates to HMOs to account for case-mix differences between Medicaid and BadgerCare populations, and enrollment continues to grow, so expenditures will continue to increase. Wisconsin's current budget also includes a provision to limit overall growth of year-to-year appropriations of general purpose funds based on the projected annual increase in state personal income, starting with the 2003–05 budget. Given the state's budget woes, insistence on tax cuts and limiting government expenditures from the governor and Republicans in the assembly, and the likelihood that expenditure growth for Medicaid and BadgerCare will outpace state personal income growth, there may be battles over Medicaid and BadgerCare funding in the future.

Health Insurance Risk-Sharing Plan

Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP) is one of the country's oldest high-risk pools. The program provides health insurance coverage to medically uninsurable Wisconsin residents who cannot get affordable health care coverage from the private sector. HIRSP participation fell from over 12,700 enrollees in 1992 to 7,240 enrollees in July 1998, but grew to almost 9,300 enrollees as of August 2000.

HIRSP offers coverage through two plans, a comprehensive benefits package and a Medicare wraparound product for people with disabilities under age 65.[24] The comprehensive plan qualifies HIRSP as an insurer of last resort under the federal Health Insurance Portability and Affordability Act of 1996 (HIPAA). There are subsidies to help low-income participants pay premiums and deductibles. Enrollees must receive services from Medicaid-participating providers.

There are three sources of funding for HIRSP: state general-purpose revenues, premiums paid by participants, and assessments on all insurers in the state. In addition, provider payment rates are less than commercial payment levels. Enrollee premiums are

set to cover 60 percent of the projected costs. Recently, HIRSP drew criticism for proposals to raise premiums by 18 percent despite a surplus of $11.4 million. A reason for the premium increase is that state law requires HIRSP premiums to be no less than 150 percent of the cost of standard policies in the private sector, and the costs of those policies are increasing. State officials also noted that the HIRSP surplus is not as large as figures suggest because of accounting procedures used in the program.

Issues Related to Acute Care for Low-Income Populations

Wisconsin policymakers face a number of acute care issues, including pharmaceutical assistance for the aged and disabled, managed care, hospital financial status, health care staffing shortages, and Medicaid DSH payments.

Pharmaceutical Assistance for the Aged

Going into the 2001–03 budget process, Wisconsin policymakers faced intense pressure to provide prescription drug coverage to seniors. Drug coverage had been a major topic of debate over the past two legislative sessions and was the top priority of advocates for the aged. State lawmakers considered three pharmaceutical assistance plans during the 2001–03 budget debate. Governor McCallum proposed to provide coverage for seniors with incomes up to 185 percent of the FPL who had no drug coverage for the previous 12 months. It was projected to cover 82,600 people at a cost of $25 million, but the governor did not include funding for the plan in his budget and many stakeholders did not view it as a serious proposal. The Republican-dominated assembly plan would have covered all seniors below 185 percent of the FPL, while the Democratic-dominated senate plan would have covered all seniors below 300 percent of the FPL.

Despite the state's budget problem, the 2001–03 budget compromise provides Wisconsin's seniors with one of the most generous drug benefit programs in the nation. The compromise plan will cover individuals age 65 and older who are ineligible for Medicaid and who have incomes up to 240 percent of the FPL. There will be a $500 deductible for people with incomes over 160 percent of the FPL, but no deductible for seniors with lower incomes. All enrollees will pay a $20 annual enrollment fee and copayments of $5 for generic drugs and $15 for brand-name medicines. The Wisconsin Legislative Fiscal Bureau estimates that 260,000 seniors will be eligible for the program and projects that 160,000 persons will enroll after the plan starts in September 2002.[25] Raising Wisconsin's cigarette tax from 59 cents per pack to 77 cents per pack will fund the plan, which is projected to cost $78 million per year.

Medicaid Managed Care

Wisconsin was one of the first states to implement an HMO-based managed care program for selected Medicaid groups. The state mandated HMO enrollment of AFDC beneficiaries in Milwaukee and Dane Counties in 1984 and extended mandatory HMO enrollment to other urban counties over the next decade. In 1996, Wisconsin initiated a statewide expansion of mandatory Medicaid managed care that was completed in mid-1997. Enrollment is mandated for low-income families and children that live in certain counties (or ZIP codes within counties) with two or more participating HMOs. Of the state's 72 counties, 46 have mandatory enrollment and the rest have a combination of managed care or fee-for-service delivery systems.

Managed care is a critical component of BadgerCare and Medicaid. In 1999, 18 of the 24 licensed HMOs in the state participated in Medicaid and 10 HMOs had contracts to participate in BadgerCare. Fewer HMOs initially participated in BadgerCare because plans were concerned about the utilization and health care profile of the BadgerCare population. In addition, many HMOs in Wisconsin experienced financial losses in 1999, which made them less willing to take on additional risk.

Starting in January 2000, all HMOs serving Medicaid enrollees were required to serve BadgerCare enrollees as well. Wisconsin planned to pay HMOs the same capitation rates to serve BadgerCare enrollees that they paid them to serve Medicaid enrollees, but several plans would not renew their contracts for 2000 based on the proposed rates. The plans claimed the average cost of serving BadgerCare enrollees would be higher because there was a higher percentage of adults and more adverse selection in BadgerCare than Medicaid, which would lead to higher costs per enrollee. In negotiations with the plans, the state agreed to increase rates for BadgerCare by 12 percent over 1999 rates for plans willing to accept full risk or by 8 percent over 1999 rates for plans that wanted the state to share financial responsibility for losses incurred by the HMO from serving BadgerCare enrollees. The state also raised payments for Medicaid enrollees by 3 percent.

Of the 16 HMOs participating in Medicaid and BadgerCare at the time, 11 chose the 12 percent rate increase, 4 accepted the 8 percent increase with risk-sharing, and 1 declined to renew its contract.[26] Compcare, owned by Blue Cross & Blue Shield United of Wisconsin, was the only plan to pull out of Medicaid and BadgerCare entirely. Two of the HMOs that accepted the rate increase subsequently reduced involvement in BadgerCare and Medicaid. All three of these plans cited low reimbursement rates as the primary reason for their decisions.

Commercial Health Plans

Wisconsin has a well established commercial managed care market, with 32 percent of the state's population enrolled in managed care plans as of January 2000. Managed care penetration rates vary widely across counties, ranging from a high of 66 percent in Dane County (where Madison is located) to lows under 10 percent in 6 of the state's 72 counties.[27] Respondents indicated that enrollment has been fairly constant in recent years. There are two national chains, and all the rest are Wisconsin-based, with a substantial proportion being nonprofit organizations. There has not been a lot of merger or consolidation activity in recent years.

Managed Care Regulation. Wisconsin's regulation of HMOs is extensive. State law provides HMO enrollees with significant consumer protections, including a patient bill of rights that provides for external review of HMO decisions. HMOs and insurers must provide a wide range of mandated benefits, including mental health services, alcohol and other drug abuse treatment, and chiropractic and dental care. Stakeholders generally viewed the state's regulations as responses to national trends rather than to demonstrated problems in Wisconsin.

Most observers believe that quality of care is not a serious problem in Wisconsin's managed care industry, although consumer advocates argue that the lack of complaints about managed care may signal that there are few ways for people to complain. Several observers suggest that the fact that most of the state's managed care plans are Wisconsin-based and provider-owned and -operated improves quality of care by making them more responsive to local concerns. State law also requires HMOs to be licensed insurance companies, which may help to ensure that HMOs have the financial resources and management structure necessary to operate effectively.

Competition and Financial Health. Respondents generally agreed that Wisconsin's insurance market is highly competitive. Two signs of strong competition among insurers are that each insurer's market share is low—the top group accident and health insurer covered 9.3 percent of the market in 2000—and medical loss ratios are fairly high, averaging 89 percent for group insurance.[28] While groups benefit from this high level of competition, the individual market is much smaller and less competitive. As a result, individual purchasers face higher premiums relative to claims payments, with loss ratios in the individual market averaging 70 percent.[29]

After earning $6.7 million in 1998 and $12.8 million in 1997, Wisconsin's HMOs lost $58.5 million in 1999—their highest combined losses ever.[30] Sixteen of Wisconsin's 23

HMOs lost money in 1999. The losses came despite growing enrollment and higher total revenues. Industry representatives attributed the losses to several factors including rising health care costs—particularly soaring expenditures for pharmaceuticals—and pressures to limit premium increases.

Many plans raised rates in 2000 in response to their 1999 losses, but health plan representatives were quick to point out that these increases "were not necessarily as big as needed" because of the state's competitive market. The net result was that the industry turned a small profit of $2.7 million in 2000, although 10 of the 23 HMOs in the state still lost money.[31] To cut costs, HMOs are focusing on prescription drugs and shifting more costs to consumers. Several plans have moved to three-tiered benefits for drugs, and they are also offering more options for employee cost-sharing, and higher out-of-pocket costs.

Hospital Financial Status

According to data from the American Hospital Association, Wisconsin had 3.0 hospital beds per 1,000 population in 1999, slightly below the national average.[32] Of the 123 community hospitals in the state, about half are rural, and nearly half of these hospitals have fewer than 100 beds. Sixty-four of Wisconsin's 72 counties have at least one general hospital, but just 15 counties have three or more.[33]

Almost all hospitals in Wisconsin are private, nonprofit facilities; there is only one investor-owned general hospital and two public general hospitals.[34] Almost half of Wisconsin's hospitals are part of a health system—they belong to a larger corporate body that owns or manages health facilities. These systems rarely own a majority of the hospitals in any locality. About one-third of hospitals in the state are affiliated with networks—groups that may include other hospitals, physicians, other providers, insurers, and community agencies that work together to deliver a wider range of services.[35] Respondents indicated that there has been a moderate level of merger activity in recent years, but there have been few hospital closings. The most notable closing was the 1995 closure of Milwaukee County's public hospital—Doyne Hospital—previously the largest provider of charity care in the state.[36]

Financially, hospitals in Wisconsin are still operating at a profit, although overall margins are down. The average overall profit margin for general hospitals in Wisconsin fell from 5.0 percent in 1995 to 4.4 percent in 1999, and a fifth of the state's hospitals lost money in 1999.[37] Uncompensated care grew from $257.3 million in FY 1998 to $301 million in FY 1999, but remained about the same as a percentage of gross patient revenue (2.9 percent in FY 1998, 3.0 percent in FY 1999).[38] Hospitals in Milwaukee County accounted for nearly 36 percent of all uncompensated health care in FY 1999.[39] In spite of mildly negative trends, observers thought that hospitals in Wisconsin are probably in better financial shape than those in other states.

Among the reasons given for the relatively sound financial status of Wisconsin's hospitals are low numbers of uninsured, increasing consolidation, and low penetration of large, national chain HMOs. Since most of the state's HMOs are local, hospitals are in a stronger bargaining position and the HMOs themselves are more responsive to local concerns. Moreover, provider-owned managed care plans are common in Wisconsin and tend to have good relationships with hospitals. HMO representatives remarked that HMOs are finding it hard to negotiate with hospitals because of limited competition among hospitals arising from recent merger activity. This attribution to merger activity was strongly disputed by hospital representatives, who argued that hospitals have taken a harder line in negotiations because they believe managed care contracts do not increase patient volume.

Several stakeholders indicated that Medicare payment rates are a contentious issue for Wisconsin's hospitals and HMOs. Hospital representatives believe that the Medicare payment reductions from the Balanced Budget Act of 1997 were excessive and that Medicare payments for HMOs unfairly punish Wisconsin for its relatively efficient delivery system. As a result of low payment rates, the Medicare HMO market is virtually nonexistent.

Respondents claimed that cuts in Medicare reimbursement may be part of the reason for recent increases in private health insurance costs, as hospitals shifted costs to other payers. The state is now working with other upper Midwestern states to get increases in Medicare reimbursements.

Staffing Shortages

Hospitals, nursing facilities, and other providers are very concerned about both short- and long-term staffing shortages for nurses, nurse's aides, and physicians. Many areas in Wisconsin suffer from an undersupply of physicians and other health care providers. In 1999, 76.4 percent of Wisconsin counties were designated as whole or partial primary care health professional shortage areas (HPSAs), compared to 64.6 percent of counties nationwide.[40] The state and industry associations have made efforts to address the shortages, but respondents acknowledge that the situation cannot be changed quickly. Consequently, some observers speculate that hospitals and nursing facilities may have to learn to operate with dramatically smaller staffs in the future.

Medicaid DSH Payments

Federal law requires that state Medicaid programs consider the special payment needs of hospitals that serve a large share of Medicaid and uninsured patients when determining payment rates for inpatient hospital care. This requirement is known as the Medicaid disproportionate share hospital (DSH) payment adjustment. In the early 1990s, several states began to use the DSH program as a way to leverage additional federal Medicaid matching dollars while incurring very limited additional state expense.[41]

Wisconsin did not aggressively maximize DSH funding prior to the establishment of federal limits on these payments; as a result, DSH payments account for a very small share of Wisconsin's Medicaid expenditures. In SFY 1999–2000, 26 hospitals (including 8 out-of-state) qualified for disproportionate share adjustments. Federal law limited the state's federal DSH funding to $7 million in SFY 1999–2000, or a total of approximately $12 million including the state matching funds.[42]

When asked why Wisconsin did not pursue the DSH payments more extensively as a way of maximizing federal reimbursement, one official responded that they were "honest fools." While the notion of using DSH more extensively was discussed among state policymakers, it was decided that the DSH financing mechanism was in conflict with Wisconsin's history of conservative budgeting. Even the state hospital association was against getting more involved in DSH payments because it believed that the federal government would eventually curtail DSH spending and, in the end, the state and hospitals would be worse off.

While Wisconsin did not aggressively use DSH payments, the state developed Medicaid supplemental payment programs that operate like some DSH programs. In these programs, Wisconsin claims the unreimbursed expenditures of publicly owned nursing facilities as the state match for federal Medicaid funds, a practice commonly referred to as the state's intergovernmental transfer (IGT) program. Wisconsin Medicaid spends significantly more on these programs than on DSH. The payments are reported as regular Medicaid expenditures, not as DSH payments. As such, they do not count against the state's federal DSH allotment or against hospital-specific DSH caps. These IGT programs are discussed in greater detail later in this report.

Long-Term Care for the Elderly and Younger People with Disabilities

Wisconsin maintains a large and diverse long-term care system for older people and younger adults with disabilities. The state is a national leader in innovative home- and community-based services, including consumer-directed home care and nonmedical residential facilities. At the same time, nursing home and intermediate care facilities for the mentally retarded account for a large share of Medicaid long-term care expenditures.

Politically powerful counties and interest groups representing both providers and consumers influence the long-term care debate in Wisconsin. Much of the current debate centers on the balance between institutional and home- and community-based services. The nursing home lobby is widely regarded as powerful, but consumer advocates for the elderly and disabled seem to be an effective counterbalance. Counties have a strong voice in the debate about long-term care policy because they play an extremely important role in designing and administering home- and community-based services, and many of them run nursing facilities.

Background

Wisconsin has a much higher than average supply of beds in nursing homes and nonmedical residential facilities, as well as a substantial number of home health agencies. In 1998, the state had 48,135 beds in 429 licensed skilled nursing facilities.[43] The ratio of licensed beds per 1,000 population aged 65 and older in Wisconsin (69.7) was much higher than the national average (52.5).[44] This above-average supply remains despite certificate of need (CON) requirements and a moratorium on new nursing homes that has been in place since 1981. There were no construction restrictions on residential care, assisted living facilities, home health care, hospice, or adult day care in 2001. Wisconsin has 23,853 licensed beds in 1,922 nonmedical residential care facilities, an average of 34.5 beds per 1,000 population age 65 and over, compared to the U.S. average of 25.5 beds per 1,000.[45] The state had 192 licensed home health agencies.[46]

Even more than in other states, long-term care has a large impact on Wisconsin's Medicaid program. The state's Medicaid program spent $1.5 billion on long-term care services in federal fiscal year 1998, accounting for 53 percent of total Medicaid spending (see table 4). Nationwide, the average share of Medicaid expenditures for long-term care services was 37 percent (data not shown).[47]

Home- and Community-Based Services

Medicaid is the dominant source of financing for home- and community-based services in Wisconsin, but state-funded programs cover a substantial amount of services. The three main sources of Medicaid funding for noninstitutional long-term care services for older people and younger adults with physical disabilities in Wisconsin are the Medicaid home health and personal care benefits and a home- and community-based services waiver—the Community Options Program-Waiver (COP-W). Many persons receiving waiver services also receive "card" services (i.e., regular Medicaid services), as do persons on the waiver waiting lists. In 1999, there were 5,500 personal care beneficiaries and 13,900 COP-W clients.

Wisconsin's primary state-funded (non-Medicaid) programs financing home- and community-based services are the regular Community Options Program (COP-R) and, to a lesser extent, the Community Aids program. While COP-R mostly targets the same functional disability level as COP-W, it also serves some persons who do not meet the nursing home level-of-care criteria, as well as persons with a somewhat higher financial status. The COP-R program began in 1981, and in 1987 the state shifted those program recipients eligible for Medicaid into the new COP-W program. The Community Aids program is a block grant to the counties to fund a variety of social, mental health, alcohol/drug abuse, and disability services.

The state also has two Program of All-inclusive Care of the Elderly (PACE) sites and four Wisconsin Partnership Program sites. PACE is a capitated delivery system that integrates acute and long-term care services for older people who need a nursing home level of care. It functions as a staff-model HMO and includes a large adult day health component. The Wisconsin Partnership Program is a variant of the PACE model, which does not require day care attendance and allows enrollees to maintain their own doctors. Unlike

PACE, it serves both older and younger people with disabilities. As of 2000, average monthly enrollment in the two programs was approximately 1,200 persons.[48]

The COP-W and COP-R programs have been the principal focus of Wisconsin policy attention and advocacy over the years. Flexibility of services and consumer orientation have been the hallmarks of the programs and help account for their political popularity. According to consumer advocates, one of the best things about COP-R is that it cuts across disability groups. As one observer put it, "the emphasis is on the functional assessment rather than slotting people into a label with a predetermined set of services." Except for reimbursement issues, the Medicaid personal care option and home health receive relatively little policy attention.

Services (but not room and board) in nonmedical residential facilities, such as assisted living facilities, are covered by the Medicaid home- and community-based services waiver, although most residents in these facilities pay privately for their care. COP-R also funds most of these services. A number of these facilities have grown substantially in recent years.

Unlike some states, such as Oregon and Washington, which have embraced nonmedical residential settings as a desirable setting for some persons with disabilities (particularly those needing extensive supervision), Wisconsin has been more ambivalent about their use because COP is supposed to be a home care program. Several observers criticized community-based residential facilities as being too large and too much like "little nursing homes," but the need for full-time care pushes the system toward residential care.

Another innovation is that the Medicaid home- and community-based services waiver and the COP-R program allow consumers to direct their own services, that is, they allow consumers to hire, direct, and fire their workers rather than depend on agencies to perform these functions. However, Medicaid home health and personal care services are only available through agencies. As part of consumer-directed care, counties may use Medicaid waiver funds and COP-R to pay informal caregivers. State officials believe this is an effective way of finding personnel to work the often odd hours that are needed for people with disabilities, which typically involve assisting a person out of bed early in the morning or assisting them into bed late in the evening.

Despite substantial expansion of home- and community-based services over the past decade, Wisconsin still has large waiting lists for services, which has been politically controversial and has resulted in large demonstrations at the state capitol for increased funding.[49] As of January 1, 2000, there were approximately 11,353 people on waiting lists for COP, roughly the same as the number of people actually receiving COP services.[50] This represents roughly a 33 percent increase in the number of people on the waiting list since 1997. Of the waiting list population, about half were older people, nearly a fifth were people with physical disabilities, and the rest were persons with developmental disabilities and other conditions.[51]

In 1999, the U.S. Supreme Court ruled in *Olmstead vs. L.C.* that inappropriate institutionalization in state-run public long-term care programs is discrimination against people with disabilities as defined by the Americans with Disabilities Act. Thus, there is, to some extent, a right to home- and community-based services. Although the *Olmstead* case was specifically about plaintiffs with mental disabilities, the court decision applies to persons with all types of disabilities. The Court did not lay down detailed standards as to what constitutes compliance with its decision, but it did emphasize the importance of a "comprehensive, effectively working plan" and a "waiting list that moved at a reasonable pace," both of which Wisconsin lacks. Nonetheless, state officials believe that the state's strong record of innovation in home- and community-based services and its substantial funding of these services protect it against possible lawsuits.

Nursing Facilities

Background. Government officials, industry representatives, and consumer advocates described the state's nursing home- industry as being "in crisis." About one-seventh of

nursing homes were in bankruptcy proceedings; 5 percent of facilities had closed since 1997; other facilities had reduced their number of beds or left them unstaffed; and staffing shortages (which existed for home- and community-based services as well) were endemic.[52] The industry has warned that providing high-quality care is extremely difficult under these conditions. State officials suggested that the state had too many nursing facility beds and that the reduced number had not affected access. According to a study funded by the Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging, the industry's problems were largely attributable to low Medicaid payments.[53] In 1999, the study argues, 83 percent of all facilities were not fully paid for the cost of serving Medicaid residents.

The state has tightened nursing home payment rates in recent years, mostly by reducing payment ceilings by cost center and by limiting inflation adjustments. Nursing home payment rates averaged $91.70 per day in 1998, slightly below the national average of $95.72.[54] In an analysis for the nursing home industry, BDO Seidman claimed that Wisconsin's Medicaid payment ceilings relative to costs were the lowest of any state in 2000–01.[55] It is unclear what impact the Balanced Budget Act of 1997's repeal of federal minimum requirements for nursing home reimbursement, known as the Boren Amendment, has had on reimbursement levels. The state also eliminated its own law that required it to pay nursing homes the costs that must be incurred by an economically and efficiently operated facility. On one hand, the Medicaid payment ceilings for virtually all expense categories were reduced in the period following the repeal of the federal standards.[56] On the other hand, several respondents characterized the nursing home industry as having significant political clout and benefiting from rate increases that other providers did not receive.

Wisconsin's county-owned nursing facilities seem to be under particular pressure. A report issued by Wisconsin's Legislative Audit Bureau in January 2000 found that state and federal Medicaid funding provided to county nursing homes had not kept pace with expenditures, with 44 of the 47 county-owned facilities in the state running deficits.[57] The Audit Bureau found that county-owned nursing facilities reported higher percentages of residents with challenging behaviors than did other facilities, which might justify higher costs, and they also had higher staffing levels and higher worker compensation costs.

Medicaid IGT Programs Used to Increase Nursing Facility Payments. Wisconsin reimburses nursing homes for services provided to Medicaid recipients using a per diem rate based on historical costs, subject to maximum payment limits based on statewide median costs. As a result, some facilities are not reimbursed for all of their costs of serving Medicaid patients. In the case of county- and municipal-owned facilities, local governments bear the additional costs. Because local government spending may be used as the state match for federal Medicaid funding, Wisconsin has used these local contributions to county- and municipal-owned nursing homes to claim federal funds since 1985. This practice is referred to as the state's IGT program. Federal funds from this program have historically been used for supplemental payments (i.e., higher Medicaid reimbursement rates) to publicly owned nursing facilities and to support general nursing home rate increases.

Entering the 2001–03 budget debate, policymakers faced considerable pressure to increase nursing home rates. The state responded by replacing the existing IGT program with a new IGT program, the basic design of which was proposed by the nursing home industry. The wire transfer methodology used in the new program was described earlier in this report (see "Fiscal Circumstances of the State," p.6). As part of an agreement between the Department of Administration, the Wisconsin Department of Health and Family Services, the Wisconsin Counties Association, and the two associations representing nursing homes in Wisconsin, the state agreed to "devote all new IGT funds to the Medicaid program" and to use "the vast majority of IGT funds…to address nursing home funding needs."[58]

In March 2001, three counties transferred a total of $637 million to the state and received an identical amount of supplemental Medicaid payments in return—enough to

support a total claim of up to $376.9 million in additional federal matching funds.[59] Most of the new federal funds will be used to create a Medicaid trust fund to increase payments to nursing homes. Using the trust fund, the state budgeted an additional $40 million for county nursing homes and $75 million for all nursing homes as supplemental rates in 2002, and a 4 percent increase in payment rates for all facilities in 2003. The trust fund also will be used to maintain current levels of supplemental payments to publicly owned nursing homes and to offset state Medicaid costs attributable to prior rate increases for nursing homes. The state will use a small portion of the trust fund to increase payments for outpatient hospital services and other noninstitutional providers in 2001–03.

The IGT program is controversial. The funding mechanism was commonly referred to as a "scam" or a "scheme," yet critics of the IGT approach admit that the state does not have any other politically viable options to generate the same level of funding for nursing facilities. There is also a possibility that the state may not get all of the projected federal funding using the new IGT. Use of this mechanism has increased among the states in recent years as a way of circumventing federal restrictions on DSH payments. CMS (formerly HCFA) issued a regulation on January 12, 2001, limiting use of such programs. Language in the January rule and a subsequent proposed rule issued April 3, 2001, may prevent Wisconsin from drawing down all of the federal funds initially thought possible under the new IGT plan. In addition, there are unresolved questions about whether a provision in the federal 2000–01 budget law that extends the transition period for several states can be applied to Wisconsin. When asked how the state would fill the budget gap if the federal funds available from the IGT program were significantly reduced, state officials responded that they would "cross that bridge when [they came] to it."

Redesigning Long-Term Care: Family Care

Starting in 1999, the Thompson administration proposed to dramatically redesign its long-term care system by integrating the financing and delivery of long-term care through a new program called Family Care, which is one of the nation's most ambitious demonstration projects. The main goals of Family Care are to end the institutional bias, consolidate funding, establish coordinated care, increase consumer choice, improve access, and establish a more efficient system of care. Family Care was initially limited to five counties; funding to expand Family Care to additional counties was vetoed by Governor McCallum in 2001 on the grounds that money was tight and that further expansion should await the outcome of the ongoing evaluation of the initial demonstration counties, a decision that angered many counties and advocates for older people.

Family Care has two major components—aging and disability resource centers and care management organizations, both of which are run by the counties. The resource centers offer a wide range of information and counseling on long-term care services and providers, conduct functional assessments and determine financial eligibility for Family Care and other public programs, and, if appropriate and chosen by the client, assist with enrollment into a care management organization. The goal is for the resource centers to provide "one-stop" shopping and a "single point of entry" into the entire long-term care system for persons of all income levels.

Care management organizations serve as capitated, managed care organizations for institutional and noninstitutional long-term care services. Funding for long-term care from Medicaid card services, the Medicaid home- and community-based service waiver, COP-R, Community Aids, county funds, and many other smaller programs are consolidated into single monthly capitated payments to care management organizations. The goal is one "pot" of money that can be used to create a seamless system in which individuals' needs dictate service provision, rather than program demarcation. The capitation payment is related to the individual's level of functional disability. The state and the care management organization share financial risk.

To consumer advocates, a major advantage of Family Care over the existing system is that it provides an entitlement to a comprehensive array of flexible home- and community-based services to everyone who meets certain criteria. Indeed, the waiting lists in the demonstration counties have been eliminated.

Individuals are free to choose whether or not to enroll in a care management organization. Medicaid-eligible beneficiaries will have the option of obtaining services through the Medicaid fee-for-service system, which will continue to offer the current range of benefits available under the regular Medicaid program. However, the new flexible Family Care benefit will be available only through care management organizations, creating a strong incentive for beneficiaries to enroll in care management organizations. Where a care management organization is available, COP-R and the Medicaid home- and community-based service waiver will not operate as separate programs. Thus, individuals who do not enroll in a care management organization will not be eligible for those services.

A key issue is that the state will only be able to substantially increase the number of people receiving home- and community-based services without dramatically increasing expenditures if it can significantly reduce the number of people using nursing home care. Based on the experience of Oregon, state officials believe that this is achievable, a contention that is hotly disputed by the nursing home industry.

Quality Assurance

Wisconsin nursing homes generally have a good reputation for quality of care, with fewer than the national average of citations for abuse, care planning, pressure ulcers, malnutrition, dehydration, and unnecessary drugs.[60] Wisconsin nursing homes have slightly higher staffing than the nation. Despite these positive indicators, there is some evidence that quality of care has deteriorated in recent years. For example, the number of Wisconsin nursing homes with immediate jeopardy citations, the citation issued when a resident is threatened with serious injury or death, increased from 2 in 1997 to 27 in 2000.[61] As noted above, the nursing home industry strongly argues that low Medicaid reimbursement rates make the provision of high quality care difficult, if not impossible.

Home care regulation is generally not as extensive as it is for nursing home care. As part of the COP-R and COP-W programs, the state emphasizes a consumer-oriented definition of quality, with a focus on respectful relationships, self-worth, empowerment, community involvement, and independence. As part of the quality assurance process, 400 to 500 clients are surveyed per year to determine their program satisfaction. Nonskilled home care workers are certified by the county that they meet state Medicaid waiver standards.

Some types of nonmedical residential facilities are highly regulated, while others have little regulation. Recent media stories have reported that large majorities of assisted living facilities have been cited for caregiving issues.[62]

A major issue in Wisconsin is the shortage of paraprofessional workers across all types of long-term care providers, which is affecting access to services and may be affecting quality of care. Most informants used the term "crisis" to describe the staffing situation. According to one provider, "paraprofessional long-term care workers can do better at McDonald's, but there is a shortage of registered nurses as well." During the 1999–2001 biennium, the legislature enacted a wage increase for nursing home- and personal care workers.

Conclusion

Wisconsin provides an extensive range of services to the low-income population through Medicaid and BadgerCare. The state is also an innovator in long-term care, both in its Community Options Program and in its Family Care demonstration. As Wisconsin looks to the future, it faces four major challenges.

First, the state's fiscal condition has deteriorated, placing strong pressures on the state's budget. Creative budgeting with the state's tobacco settlement funds and manipulation of intergovernmental transfers in Medicaid helped to prevent major health care program cutbacks in 2001. However, if revenues continue to decline, the state may face having to raise taxes or cut programs in the future.

Second, Medicaid and BadgerCare are under fiscal pressures to be more efficient while at the same time maintaining their broad set of benefits and eligibility. Enrollment in both programs is growing. Increases in prescription drug utilization and costs are creating upward fiscal pressures. A number of providers are pushing for payment rate increases. Wisconsin has not experienced either the commercial or Medicaid managed care problems of other states, but budgetary problems and higher medical costs could destabilize the market.

Third, the state must implement its major new prescription drug program for older people. Enrolling large numbers of persons and controlling expenditures in the face of continued escalation in prescription drug costs might be difficult.

Finally, in the area of long-term care, the state faces a number of challenges. First, despite the expansion of funding, there are still long waiting lists for home- and community-based services in most counties. Labor shortages for these and other long-term care services make increasing services difficult and may undermine quality of care. Second, the nursing home industry is under substantial stress and is fiscally unstable. The Medicaid rate increases in 2001 may help stabilize the industry, but it is unclear whether the state will be able to get all of the federal Medicaid funds on which these increases depend. Finally, the state must decide whether Family Care is a success and should be expanded to the rest of the state.

Endnotes

1. Barone, Michael, and Grant Ujifusa. 1999. *The Almanac of American Politics, 2000*. Washington, D.C.: The National Journal Group, Inc., p. 1726.

2. The other 12 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, and Washington. The 13 states studied were selected to present a balanced view of state activity and its impact on low-income families. See Kondratas, Anna, Alan Weil, and Naomi Goldstein. 1998. "Assessing the New Federalism: An Introduction." *Health Affairs* 17(3): 17–24.

3. The prior study was based on interviews conducted during two site visits to Wisconsin in mid-1997 and subsequent telephone interviews. It was somewhat more extensive in scope and contained more historical information. See Coughlin, Teresa A., Joshua M. Wiener, Jill A. Marsteller, David G. Stevenson, Susan Wallin, and Debra J. Lipson. 1998. *Health Policy for Low-Income People in Wisconsin*. Washington, D.C.: The Urban Institute. *Assessing the New Federalism,* September.

4. Wisconsin Department of Workforce Development. 2001. "Wisconsin Projections, 1998–2008: Labor Force, Industries, Occupations." Madison: Wisconsin Department of Workforce Development, Division of Workforce Excellence, Bureau of Labor Market Information and Customer Services.

5. Comments of Todd Berry, executive director of the Wisconsin Taxpayers. Quoted in Walters, Stephen. 2000. "Thompson's Legacy: Governor's Leadership Style Broke the Mold." *Milwaukee Journal Sentinel Online*, http://www.jsonline.com/news/state/dec00/legacy24122300a.asp, updated December 23.

6. Wisconsin Office of the Governor. 2001. "Governor Presents Budget with Lowest Spending Increase in 30 Years." Press release from the Office of the Governor, released February 20. Madison.

7. National Conference of State Legislatures. 2001. Health Policy Tracking Service. "News from the States: Wisconsin." http://www.hpts.org. [date accessed: March 14, 2001].

8. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Discussion of Tobacco Securitization (Tobacco Settlement Securitization)." *Budget Paper* No. 885. Madison. April 26.

9. Comments of Governor McCallum. Quoted in Chaptman, Dennis. 2001. "McCallum Signs Off on $47 Billion Budget." *Milwaukee Journal Sentinel Online*, http://www.jsonline.com/news/state/aug01/bud31083001.asp, updated August 1.

10. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Medical Assistance & BadgerCare." *Informational Paper* No. 43. Madison. January.

11. Ibid.

12. Urban Institute estimates based on data from the Centers for Medicare and Medicaid Services (CMS). Due to delays in the collection and processing of the federal data, these estimates are the most recent data available that allow comparison of trends in Wisconsin's Medicaid program to national trends.

13. Wisconsin Department of Health and Family Services. 2001. "Medicaid/BadgerCare Caseload Statistics." http://www.dhfs.state.wi.us/Medicaid1/caseload/481-caseload.htm. [date accessed: December 3, 2001].

14. Urban Institute estimates based on data from CMS. Due to delays in the collection and processing of the federal data, these estimates are the most recent data available that allow comparison of trends in Wisconsin's Medicaid program to national trends.

15. Based on Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured. 2001. http://www.kff.org/docs/state/medicaiddata/. [date accessed: December 3, 2001].

16. Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

17. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Medical Assistance & BadgerCare." *Informational Paper* No. 43. Madison. January.

18. National Association of State Budget Officers. 2000. "1999 State Expenditure Report." Washington, D.C.

19. Ibid.

20. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Comparative Summary of Budget Recommendations: Governor and Joint Committee on Finance." Madison. June.

21. Sirica, Coimbra. 2001. "The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP)." New York: Millbank Memorial Fund.

22. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Medical Assistance & BadgerCare." *Informational Paper* No. 43. Madison. January.

23. Wisconsin BadgerCare caseload statistics from the Wisconsin Department of Health and Family Services. http://www.dhfs.state.wi.us/badgercare/html/enrollmentstats.htm. [date accessed: June 12, 2001].

24. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Health Insurance Risk-Sharing Plan." *Informational Paper* No. 53. Madison. January.

25. Chaptman, Dennis, John Fauber, and Richard P. Jones. 2001. "Drug Aid for Seniors OK'd." *Milwaukee Journal Sentinel Online*, http://www.jsonline.com/news/state/jul01/drug25072401.asp, updated July 25.

26. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Medical Assistance & BadgerCare." *Informational Paper* No. 43. Madison. January.

27. State of Wisconsin Office of the Commissioner of Insurance. 2000. *Consumer's Guide to Managed Care Health Plans in Wisconsin.* Madison. Managed care penetration rates in this publication are percentages of people enrolled in either health maintenance organizations (HMOs) or point-of-service (POS) plans.

28. State of Wisconsin Office of the Commissioner of Insurance. 2001. *Wisconsin Insurance Report (Business of 2000).* Madison.

29. Ibid.

30. State of Wisconsin Office of the Commissioner of Insurance. 2000. "1999 HMO Financial Results." News release from March 22.

31. State of Wisconsin Office of the Commissioner of Insurance. 2001. "HMO Quarterly Statement Summary, Fourth Quarter 2000." http://badger.state.wi.us/agencies/oci/hmo_info/quarstat/quar4_00.htm. [date accessed: May 18, 2001].

32. American Hospital Association. 2001. *Hospital Statistics.* Chicago: Health Forum.

33. Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services. 1999. "Health Care Data Report: Guidebook to the 1998 Quarterly Reports." http://www.dhfs.state.wi.us/healthcareinfo/downloadable/98gdbk.pdf. [date accessed: May 18, 2001].

34. American Hospital Association. 2001. *Hospital Statistics.* Chicago: Health Forum.

35. Ibid.

36. For more information on the reasons for and impact of the closure of Doyne Hospital in Milwaukee, see Bovbjerg, Randall R., Jill A. Marsteller, and Frank C. Ullman. 2000. *Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion.* Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper No. 39.

37. Sources: Bureau of Health Information (BHI). n.d. "Outpatient, Charity Care, and Profit Margin Data, 1995." http://www.dhfs.state.wi.us/healthcareinfo/index95/i95e.htm (1995 data). [date accessed: May 23, 2001]. Wisconsin Health and Hospital Association press release, August 18, 2001 (1999 data).

38. BHI. 2001. "Uncompensated Health Care Report, Fiscal Year 1999." Madison: PHC 5283.

39. Ibid.

40. U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). 2001. Data from the HRSA State Profiles Web site (http://stateprofiles.hrsa.gov/StateProfilesIndex.html). [date accessed: June 6, 2001].

41. Coughlin, Teresa A., and David Liska. 1997. "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Policy Brief A-14.

42. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Medical Assistance & BadgerCare." *Informational Paper* No. 43. Madison. January.

43. Harrington, Charlene, James H. Swan, Valerie Wellin, Wendy Clemena, and Helen R. Carrillo. 1999. *1998 State Data Book on Long Term Care Program and Market Characteristics*. San Francisco: University of California.

44. Ibid.

45. Ibid.

46. Ibid.

47. Urban Institute estimates based on data from HCFA-64 reports.

48. Megna, Richard. 2001. *Community-Based Long-Term Care Programs.* Madison: Wisconsin Legislative Fiscal Bureau.

49. Chaptman, Dennis. 2001. "Hundreds Rally at Capitol to Help Seniors, Disabled." *Milwaukee Journal Sentinel.* April 25.

50. Megna, Richard. 2001. *Community-Based Long-Term Care Programs.* Madison: Wisconsin Legislative Fiscal Bureau.

51. Wisconsin Department of Health and Family Services. 2001. "Why Older People Need Family Care." http://www.dhfs.state.wi.us/LTCare/whyolder.htm. [date accessed: July 18, 2001]. Wisconsin Department of Health and Family Services. 2001. "Why Younger People with Physical Disabilities Need Family Care." http://www.dhfs.state.wi.us/LTCare/whypd.htm. [date accessed: July 18, 2001].

52. Manning, Joe. 2001. "Nursing Homes Barely Hang On." *Milwaukee Journal Sentinel.* August 27.

53. BDO Seidman, LLP. 2000. "Special Report on the Financial Condition of Nursing Homes in Wisconsin." http://www.wahsa.org/bdorpt.htm. [date accessed: July 18, 2001].

54. Harrington, Charlene, James H. Swan, Valerie Wellin, Wendy Clemena, and Helen M. Carrillo. 1999. *1998 State Data Book on Long Term Care Program and Market Characteristics.* San Francisco: University of California.

55. Ibid.

56. BDO Seidman, LLP. 2000. "Special Report on the Financial Condition of Nursing Homes in Wisconsin." http://www.wahsa.org/bdorpt.htm. [date accessed: July 18, 2001].

57. Stuiber, Paul, Kate Wade, James Chrisman, Tamarine Cornelius, and Sarah Dunning. 2000. "An Evaluation: County Nursing Home Funding." Madison: Wisconsin Legislative Audit Bureau.

58. Wisconsin Department of Health and Family Services (DHFS). 2001. "WCA/WAHSA/WHCA IGT Agreement with DOA/DHFS." Madison. February 2.

59. State of Wisconsin, Legislative Fiscal Bureau. 2001. "Estimated IGT Revenues and Creation of IGT Trust Account." Paper No. 467. Madison. June 4.

60. American Health Care Association. 1999. *Facts and Trends: The Nursing Facility Sourcebook, 1999.* Washington, D.C.

61. Manning, Joe. 2001. "Nursing Homes Barely Hang On." *Milwaukee Journal Sentinel.* August 27.

62. Zahn, Mary. 2001. "Lapses in Care Lead to Deaths, Records Show." *Milwaukee Journal Sentinel.* August 25.

Table 1 Notes

a. U.S. Census Bureau. 2001. *Profiles of General Demographic Characteristics 2000*. http://www.census.gov/Press-Release/www/2001/2khus.pdf.

b. Urban Institute calculations derived from the *1999 National Survey of America's Families*. Note: All calculations only include residents under age 65.

c. U.S. Department of Commerce, Bureau of Economic Analysis. 2001. News Release: "State Personal Income and State Per Capita Personal Income: 2000. State Personal Income: Fourth Quarter 2000." April 24. http://www.bea.doc.gov/bea/newsrel/spi0401.htm.

d. U.S. Department of Commerce, Bureau of Economic Analysis. 2000. News Release: "1999 State Per Capita Personal Income Revised." Table 1: Per Capita Personal Income, by State and Region, 1995–1999 (Dollars). September 12. http://www.bea.doc.gov/bea/newsrel/spi0900.htm. Note: Percent change calculated in inflation-adjusted dollars by The Urban Institute based upon the CPI-U as published in the *Economic Report of the President*. 2000. Table B-60. Washington, D.C.: U.S. Government Printing Office, February.

e. U.S. Department of Labor, Bureau of Labor Statistics. 2001. "Regional and State Employment and Unemployment: April 2001." Table 3. ftp://ftp.bls.gov/pub/news.release/History/laus.05182001.news.

f. Zedlewski, Sheila. 2000. "Family Economic Well-Being." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute. Notes: Percent change in poverty rates (1996–1998) calculated by the Labor and Social Policy Center, The Urban Institute. 1998 national and state adult and child poverty estimates show statistically significant decreases from the 1996 estimates at the 0.10 confidence level, calculated by the *Assessing the New Federalism* project, The Urban Institute.

g. The National Governors' Association. 2001. "The Governors, Political Affiliations, and Terms of Office, 2001." http://www.nga.org/cda/files/govlist2001.pdf.

h. The National Conference of State Legislatures. 2001. http://www.ncsl.org/ncsldb/elect98/partcomp.cfm?yearsel=2001. Note: D indicates Democrat, R indicates Republican, I indicates Independent, O indicates other, V indicates Vacant.

i. Two Urban Institute calculations: (1) Average monthly number of AFDC 1996 recipient children divided by number of children in poverty in 1996: U.S. Department of Health and Human Services. Administration for Children and Families. 1997. *Characteristics and Financial Circumstances of AFDC Recipients FY 1996*. Table 18. "Percent Distribution of AFDC Recipient Children by Age (October 1995–September 1996)"; (2) Average monthly number of TANF 1998 recipient children divided by number of children in poverty in 1998: U.S. Department of Health and Human Services. Administration for Children and Families. 1999. *Second Annual Report to Congress August 1999*. Table 9:22. "Percent Distribution of TANF Recipient Children by Age Group (October 1997–September 1998)." The numbers of children in poverty in 1996 and 1998 are Urban Institute calculations from the *National Survey of America's Families II*.

j. Based on three sources: (1) Urban Institute's TRIM [Transfer Income Model]; (2) Smith, Vernon K. 1999. "Enrollment Increases in State CHIP Programs: December 1998 to June 1999." Health Management Associates, July; (3) Urban Institute analysis of *1999 SCHIP [State Children's Health Insurance Program] Annual Report*. Rules for 1996 and 1998 are policies in place the majority of the year. Rules for 2000 represent plans approved as of January 1, 2000.

k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

About the Authors

Brian K. Bruen is a research associate in the Urban Institute's Health Policy Center. He manages the Urban Institute's Medicaid database and has coauthored studies of Medicaid expenditures and enrollment trends, Medicaid eligibility, and the Children's Health Insurance Program (CHIP).

Joshua M. Wiener is a principal research associate at the Urban Institute's Health Policy Center, where he specializes in research on health care for the elderly, Medicaid, and long-term care. His recent projects include research on the long-term care workforce, the Urban Institute's *Assessing the New Federalism* project, Medicaid home- and community-based services, consumer-directed home care, and Medicaid and end-of-life care.

THE URBAN INSTITUTE
2100 M Street, N.W.
Washington, D.C. 20037

Address Service Requested

This state update is a product of *Assessing the New Federalism*, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

Recent Changes in Health Policy for Low-Income People received special funding from the Robert Wood Johnson Foundation as part of the Urban Institute's *Assessing the New Federalism* project. The project received additional financial support from The Annie E. Casey Foundation, the W. K. Kellogg Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The David and Lucile Packard Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, the Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

THE URBAN INSTITUTE
2100 M Street, N.W.
Washington, D.C. 20037

Phone: (202) 833-7200
Fax: (202) 728-0232
E-mail: pubs@ui.urban.org

This state update was prepared for the *Assessing the New Federalism* project. The views expressed are those of the authors and do not necessarily reflect those of the Urban Institute, its board, its sponsors, or other authors in the series.

The authors would like to thank all of the government and program officials whose willingness to share their time and expertise have contributed to this state update.