

To: Joint Committee on Finance

From: Bob Lang, Director  
Legislative Fiscal Bureau

## ISSUE

### **Women's Health Initiative -- Screening and Public Awareness Activities (DHFS--Health)**

[LFB Summary: Page 276, #1(part)]

## CURRENT LAW

The Department of Health and Family Services (DHFS), Division of Health (DOH) supports a number of ongoing statewide efforts to improve the health of women in the state, including breast cancer screening services.

**WWCCP.** The Wisconsin women's cancer control program (WWCCP) is funded by a federal grant DHFS receives from the Center's for Disease Control and Prevention and state GPR. In 1996-97, the WWCCP is supported with \$2.5 million in federal funds and \$422,600 GPR. The major activities of the WWCCP include: (a) payment for breast and cervical cancer screening for eligible women; (b) assurance of appropriate referral; (c) development and implementation of a public education campaign; (d) development and implementation of a health professional education program; and (e) establishment of a quality assurance program.

WWCCP supports breast cancer screenings for women who are age 40 and over. Women who are uninsured and whose family income is below 150% of the federal poverty level (FPL) cannot be charged for the screening services. Women who are uninsured and whose family income is more than 150% of the FPL are charged for the screening services using a sliding fee scale based on family income. Currently, there are approximately 460 providers statewide who participate in the program. Participating providers include hospitals, physicians, federally qualified health centers and clinics.

Prior to 1995 Wisconsin Act 27, these funds were targeted for women in counties which had the highest incidence of late-stage breast cancer. However, Act 27 authorized DHFS to distribute these funds to support breast cancer screening services in all areas of the state.

The WWCCP has been conducting breast and cervical cancer screenings since June 1, 1994. Between June 1, 1994, and January 31, 1996, the program supported 10,000 screenings and served approximately 8,500 women. These screenings were responsible for detecting approximately 17 cases of breast cancer and 20 cases of cervical cancer.

*Mobile Mammography Van -- City of Milwaukee.* The state supports breast cancer screening services by providing a grant to the City of Milwaukee Public Health Department to support the operational costs of a mobile mammography van. The van primarily serves low-income women over the age of 40 in the City of Milwaukee. The van makes scheduled stops at ethnic festivals, health care centers, churches and social service agencies throughout the city. Approximately 2,000 women are screened annually through the use of the van.

Other DHFS health activities which relate to women's health directly or indirectly include: (a) maternal and child health services; (b) occupational health programs; (c) the American stop smoking intervention study (ASSIST) projects; (d) the cardiovascular risk reduction program; (e) the Wisconsin diabetes control program; and (f) communicable disease programs, including the sexually transmitted disease program and the HIV/AIDS program.

## GOVERNOR

Provide \$2,245,000 GPR in 1997-98 and \$1,352,600 GPR in 1998-99 and 1.0 position, beginning in 1997-98, to improve the health of women in the state. The Governor's women's health initiative has several components, as described below.

*Health Care Screening, Referral, Follow-up and Patient Education.* Provide \$1,700,000 in 1997-98 and \$1,200,000 in 1998-99 for DHFS to award funds, on a regional basis as determined by DHFS, to applicants to provide health care screening, referral, follow-up and patient education to low-income, underinsured and uninsured women. In addition, direct DHFS to use this funding to: (a) increase women's awareness of issues that affect their health; (b) reduce the prevalence of chronic and debilitating health conditions that affect women; and (c) distribute funds to applying individuals, institutions, or organizations for the conduct of projects to enhance activities of communities in establishing and maintaining a comprehensive women's health program that addresses all major risk factors for chronic disease for middle-aged and older women.

*Breast Cancer Screening and Services.* Provide \$500,000 in 1997-98 and \$100,000 in 1998-99 for DHFS to award as a single grant to an applying entity for the performance of breast cancer screening activities with the use of a mobile mammography van.

*Women's Health Officer.* Provide \$45,000 in 1997-98 and \$52,600 in 1998-99 to support 1.0 position, beginning in 1997-98, in the Division of Health to serve as a women's health officer to focus on special health care concerns of women.

## DISCUSSION POINTS

1. The Governor's proposal is based on a women's health campaign outlined by the National Governor's Association (NGA). The NGA campaign identifies breast cancer, cardiovascular disease, osteoporosis, menopause and mental health as the primary issues that affect women's health. The NGA campaign brings together Governor's spouses to lead an effort to raise awareness about disease prevention and health promotion for American women through action-driven alliances with state health agencies, professional medical associations, voluntary organizations, industry and others.

2. The women's health campaign was developed during a number of planning workshops attended by Governors' spouses, state health officials, health care providers and nonprofit and industry representatives. These workshops resulted in the identification of specific goals for the campaign, including a focus on women over 40 years of age. NGA identifies four constituencies for the campaign:

- *Governor's spouses*, to provide leadership and guidance, serve as spokespersons, coalesce key members in the community, convene planning meetings and set priorities and campaign agendas;

- *State health agencies*, to track and monitor community health status, deliver programs and services to prevent and control disease, injury, and disability and provide programmatic support to the governor's spouse;

- *National volunteers, community organizations and industry*, to create links to each state's campaign activities through innovations in research, community outreach and education, health services delivery, and product development and distribution, and provide resources and funding for mutually beneficial activities;

- *The National Governor's Association*, to provide national communication, alliance coordination technical assistance, resources and tool development and distribution.

3. As part of the Governor's initiative, Mrs. Thompson would be named the primary spokesperson and advisor in the state on women's health issues. A series of television public service announcements, supported by private foundations, would feature the First Lady discussing the need for annual mammograms after age 40 and the need for women to take the initiative to ensure that they receive these mammograms.

4. A number of issues relating to the administration of the women's health initiative have not yet been resolved by DHFS, including: (a) the manner in which most of the funding would be distributed; (b) how "low-income" and "underinsured" would be defined and how these populations would be targeted for services; and (c) whether or not cost sharing mechanisms, such as copayments, would be implemented.

At this time, DHFS staff indicate that the Department would award the grant funds to agencies which can demonstrate an ability to match public funding with private funding or in-kind contributions. The bill, however, contains no statutory language which would require agencies receiving funding under this initiative to provide a match for the state funds. In order to maximize the value of the women's health funding recommended by the Governor, the Committee may wish to consider establishing a match requirement of at least 25% for entities that receive funding for health screening services, referral, follow up and patient education under the women's health initiative. It should be noted that a 25% match requirement was required under the state's primary health care grant program.

5. Because the budget bill contains very little in the way of statutory directive and details regarding the implementation of the initiative and the distribution of the \$3.5 million GPR grants, the Committee could place all of the funding in its appropriation for release to the Department after the specifics of the initiative have been developed. Once the scope and direction of the program have been determined, the Department could submit its proposal to the Governor and Committee under s. 13.10 for release of funds.

6. The Governor's women's health initiative is targeted toward low-income underinsured and uninsured women aged 45 through 64.

A 1996 report by the DHFS Center for Health Statistics indicated that approximately 10% of women (and the same percentage of men) aged 45 through 64 are uninsured. There are approximately 514,000 women aged 45 through 64 in Wisconsin, therefore, there are approximately 51,400 uninsured women in this age range. The Center's report defined "uninsured" as being without health insurance coverage for all or part of the year. The report also indicated that 95% of uninsured individuals live in families with income less than 200% of the federal poverty level.

7. Under the bill, \$1.0 million annually would be budgeted for the provision of health screens. These funds would be provided proportionately to each of the five DOH regions and awarded through a request for proposal (RFP).

It is estimated that the average cost of an annual health screen for women between the ages of 40 and 65 is \$188. This includes the costs of a physical exam, certain lab procedures and a mammogram. The average cost of a mammogram is \$86. Assuming that all of the grant funding allocated under this bill would be used for the direct costs of health screens, approximately 5,300 health screens could be provided in each year.

8. In addition to the funding provided for conducting health screens, \$700,000 GPR in 1997-98 and \$200,000 GPR in 1998-99 would support a women's health campaign. Of this amount, \$500,000 would be provided in 1997-98 on a one-time basis to support: (a) mini-grants to agencies that would encourage the translation of health research into health practice by disseminating and distributing information to health care providers (\$200,000); and (b) five \$40,000 grants which would be awarded on a competitive basis by each of the five DOH regions to community-based organizations for projects to enhance awareness of women's health issues (\$200,000); and (c) a grant to a single agency that would enlist local and statewide resources to increase awareness of major health problems, including breast cancer, heart disease, osteoporosis, mental health problems, and smoking (\$100,000).

The remaining \$200,000 GPR in each year would be used to strengthen local community activities and to create a statewide comprehensive women's health program that addresses all major risk factors for chronic disease for middle-age and older women. DHFS intends to utilize the infrastructure of outreach and advocacy networks of the WWCCP local coordinators to reach women at risk and provide more comprehensive screenings for the women who use their services.

9. The funding provided in the Governor's proposal could increase awareness about health prevention and the importance of health screenings. In addition, this funding would enable approximately 5,300 women to have an annual health screen, which may assist in the identification of chronic conditions or diseases. However, there is no funding provided as part of the women's health initiative for the diagnosis and treatment of chronic conditions or diseases identified through the health screens.

Based on the experience of the WWCCP program, it is estimated that 0.3% to 0.5% of women screened for breast cancer will actually have cancer. However, the DHFS Bureau of Public Health chief medical officer estimates that approximately 30% to 40% of women in this target population who are screened for all chronic conditions will require additional diagnostic and treatment services. Because this initiative to provide comprehensive health screens is targeted toward low-income uninsured and underinsured women who may have limited resources for diagnostic and treatment services, it is likely that, as a result of these screens, many women will be found to require treatment services they cannot afford.

In order to address this issue, the Committee may wish to consider reallocating a portion of the funds which are allocated for outreach, education and prevention activities toward direct health care services, including treatment.

10. The creation of a women's health officer position is intended to increase the visibility of the importance of the health of women. This position would provide oversight, coordination and encouragement for efforts to improve women's health statewide. Currently, some of these responsibilities are assigned to 1.0 position in the Division of Health whose time is divided between ethnic minority health issues and women's health issues. Providing an

additional position in the Division of Health would enable the current position to increase that position's focus on ethnic minority health issues.

However, DHFS administers a number of programs targeted at medically under-served populations that do not have a designated health officer. Creating a women's health officer position may increase the fragmentation of health issues by increasing the focus of DHFS programs on the health needs of specific targeted groups, rather than at health issues that affect all populations, including men, children and the elderly. The Committee may wish to consider deleting the women's health officer position and, instead, direct DHFS to integrate a women's health perspective into all of its health programs.

11. Currently, there are seven to eight portable mammography providers in the state. These portable mammography providers serve women who are eligible for free or discounted services through WWCCP and private pay clients. For example, the Marshfield Clinic provides mobile mammography services to women in the northern part of the state. These services are provided at work sites, tribal and migrant sites, health clinic and health fairs. A total of 2,300 women are screened annually through the Marshfield program. Approximately 1,000 of these women are covered by the WWCCP.

12. There are two regions of the state which are not currently served by a mobile or portable mammography provider -- the northeastern region of the state, including Green Bay and a section of the southwestern region of the state, beginning in Madison and extending southwest to Platteville.

13. The bill provides \$500,000 GPR in 1997-98 and \$100,000 GPR in 1998-99 for DHFS to provide a grant to an applying entity for the performance of breast cancer screening activities with the use of a mobile mammography van. The cost of a mobile mammography van and equipment is approximately \$300,000 and the annual operating costs of a van are approximately \$100,000. DHFS indicates that approximately \$100,000 GPR in 1997-98 would be expended to support other costs associated with the operation of the van, including publicity.

Taking into consideration the additional funding that is provided in the bill for health screens (\$2.0 million), which include mammograms, and current WWCCP funding which supports breast cancer screening, the Committee could decide that the purchase and operation of an additional mammography van may not be necessary at this time. On the other hand, the Committee may want to reallocate funding so that the purchase of two mammography vans could be supported under the women's health initiative and direct DHFS to allocate the funding to the two areas in the state which are not currently served by a mobile or portable mammography provider.

14. While breast cancer is an important women's health issue, it is one of many health conditions that significantly affects women's health. Heart disease is the leading cause of death for women. In general, issues relating to cardiovascular disease are of particular concern

to women. According to information collected by the Society for the Advancement of Women's Health Research, hypertension, which is a major risk factor for heart disease, is two to three times more common in women than in men. In addition, women who are diagnosed with heart disease are, on average, ten years older and at a more advanced stage than men who are diagnosed with cardiovascular disease. However, heart disease is also the leading cause of death for men. Currently, there are no state-funded programs that focus on the prevention or treatment of heart disease.

It can also be argued that cigarette smoking is the primary health issue for women. According to the American Cancer Society, lung cancer will kill more women in 1997 than breast cancer, yet studies have shown that doctors are more likely to provide anti-smoking information to male patients than female patients, although such advice significantly increases the likelihood of the patient quitting smoking. Lung cancer was the leading cause of cancer death in Wisconsin for men and women in 1994. Cigarette smoking is also a major risk factor for heart disease for men and women.

15. Women's health issues may not be the highest public health priority for every region of the state. Local public health agencies assert that state support for primary care and general public health programs is insufficient to meet their needs. If the Committee determines that local public health agencies are better able to identify the priority health issues in their regions, the Committee may wish to reallocate funding that would be provided for the women's health initiative to the primary health services grant program, which would enable local public health agencies to fund a broad range of primary health care services projects, including direct care services, for various under-served populations, including men, children, women of childbearing age and the elderly. Under this program, which would be repealed under the Governor's bill, local public health departments are required to provide a 25% match of state funds.

#### **ALTERNATIVES TO BILL**

1. Adopt the Governor's recommendation to provide \$97,600 GPR for 1.0 GPR position and \$3.5 million GPR in grants in 1997-99 for the women's health initiative.
2. Modify the Governor's recommendation by placing all funding for grants in the Joint Finance Committee's appropriation, subject to release to DHFS following approval of a plan submitted by the Department which details the budget and criteria to be used in awarding grants for the women's health initiative.
3. Adjust any of the GPR funding levels for items recommended by the Governor.

	<u>1997-98</u>	<u>1998-99</u>
a. Women's health officer position	\$45,000	\$52,600
b. Mini-grants	200,000	0
c. Public awareness grants		
1. regional grants	200,000	0
2. local community activities	200,000	200,000
3. agency to enlist statewide resources	100,000	0
d. Health screening for low-income women aged 45-64	1,000,000	1,000,000
e. Mammography Van		
1. van	400,000	100,000
2. publicity funding	100,000	0

4. Require a 25% match for any or all of the grants identified under Alternatives 1, 2 or 3.
5. Reallocate all, or a portion of, the funding identified in Alternative 3 for the provision of direct health care services, including treatment for low-income women aged 45 through 64.
6. Reallocate all, or a portion of, the funding identified in Alternative 3 for the primary health care services grant program.
7. Delete the Governor's recommendations.

<u>Alternative 7</u>	<u>GPR</u>
1997-99 FUNDING (Change to Bill)	- \$3,597,600
1998-99 POSITIONS (Change to Bill)	- 1.00

Prepared by: Amie Goldman

MO# Alt 2, 4, 5

2	BURKE	Y	N	A
	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
1	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 13 NO 3 ABS

MO# Remove Alt. 4

	BURKE	Y	N	A
	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
2	LINTON	Y	N	A
1	COGGS	Y	N	A

AYE 7 NO 9 ABS

Direct the establish  
Dept. to a procedure  
by which the  
MO# 25 to match  
can be waived

	BURKE	Y	N	A
	DECKER	Y	N	A
	GEORGE	Y	N	A
1	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
2	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 8 NO 8 ABS

Alt 4  
MO# change "require" to "encourage"

	BURKE	Y	N	A
	DECKER	Y	N	A
1	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
2	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 8 NO 8 ABS

Approp. be increased  
to \$4 million

	BURKE	Y	N	A
	DECKER	Y	N	A
1	GEORGE	Y	N	A
2	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 8 NO 8 ABS

Att 4.  
 Change 25% to  
 MO# 10% match

BURKE	(Y)	N	A
DECKER	(Y)	N	A
2 GEORGE	(Y)	N	A
JAUCH	(Y)	N	A
1 WINEKE	(Y)	N	A
SHIBILSKI	(Y)	N	A
COWLES	Y	(N)	A
PANZER	Y	(N)	A
JENSEN	Y	(N)	A
OURADA	Y	(N)	A
HARSDORF	Y	(N)	A
ALBERS	Y	(N)	A
GARD	Y	(N)	A
KAUFERT	Y	(N)	A
LINTON	(Y)	N	A
COGGS	(Y)	N	A

AYE 8 NO 8 ABS \_\_\_\_\_

To: Joint Committee on Finance

From: Bob Lang, Director  
Legislative Fiscal Bureau

## ISSUE

### Women's Health Initiative -- Health Insurance Program for Uninsured Children (DHFS -- Health)

[LFB Summary: Page 276, #1(part)]

## CURRENT LAW

No provision.

## GOVERNOR

Require DHFS, by July 1, 1998, to conduct and report to the Governor the results of a study to explore, on a statewide basis, the possible provision of a health insurance program for uninsured school-age children, as determined by DHFS. If the health insurance program appears feasible, require DHFS to include with the report proposed statutory language necessary to implement the program.

## DISCUSSION POINTS

1. In his testimony before the Committee on the Governor's budget recommendations, the DHFS Secretary indicated that, without federal waivers or changes in federal medical assistance (MA) law that would enable DHFS to implement the W-2 health plan, there would likely be an increase in the number of uninsured families in Wisconsin following the implementation of the Wisconsin Works employment program. Currently, families that receive AFDC are categorically eligible for coverage under the state's MA program. As created in 1995

Wisconsin Act 289, the Wisconsin works health plan was primarily designed to provide coverage for families, rather than for children, exclusively.

With the implementation of W-2, many families that currently qualify for MA will remain eligible for MA, since DHFS is required to use AFDC-related eligibility criteria that were in effect as of July 16, 1996. However, some individuals in subsidized and unsubsidized employment positions will earn a wage that will exceed AFDC and healthy start income standards. Some individuals in these families may lose their MA eligibility. In addition, some jobs available to former AFDC recipients may not offer health coverage and some recipients may choose not to participate in employer-offered health plans.

2. In a letter to the members of the Committee dated April 2, 1997, the DHFS Secretary expressed his views that:

- The state must continue to work on an affordable health insurance product which is available to every uninsured family in Wisconsin;
- Families must accept responsibility to pay for a portion of the costs of health insurance coverage, and that the percentage of the premium copayments should be based on family income;
- Most uninsured children live in homes with educated and employed parents, which argues for the creation of an insurance product that is accessible to families other than families with the lowest income.

Based on the Legislature's interest in providing family-based health insurance coverage, as provided under the provisions of Wisconsin Works health plan, and the administration's interest in developing a family-based health care product, the Committee may wish to amend the provisions in the bill to direct DHFS to explore the possible provision of health insurance for uninsured families, as well as uninsured children, rather than uninsured children, exclusively.

3. In a report issued in June, 1996, the General Accounting Office estimated that approximately 30% of children who are uninsured in the United States are eligible for medical assistance, but are not enrolled in the program. The Committee may wish to amend the scope of the Department's study to: (a) include an evaluation of the effectiveness of the Department's current MA outreach efforts; and (b) include a plan for increasing participation in the MA program among children who are currently eligible for MA.

4. Federal law requires that pregnant women and children up to age six in families with income less than 133% of the federal poverty level (FPL) are MA eligible. At its option, Wisconsin extends this coverage to pregnant women and children up to age six in families with income up to 185% of the FPL. Federal law also requires that children up to age 14 (as of

October 1, 1997) in families with income up to 100% of the FPL are MA eligible. MA eligibility for these groups is commonly referred to as Wisconsin's healthy start program.

Data collected by the DHFS Center for Health Statistics as part of the Department's 1994 annual family health survey indicated that approximately 97% of children in families with income above 200% of the FPL had health insurance for the entire year. This information suggests that the nearly all uninsured children in Wisconsin live in families with income less than 200% of the FPL. Under federal law, Wisconsin could cover more children at higher income levels under MA. For example, DHFS could extend coverage to all children up to age 18 living in families with income up to 100% of the FPL or cover children up to age six in families with income up to 200% of the FPL. These changes would not require a federal MA waiver.

5. The primary advantages of reducing the state's population of uninsured children by expanding MA is that: (a) federal MA matching funds can support approximately 59% of the costs of an MA expansion; and (b) expanding coverage of children under MA is inexpensive compared to other groups of MA eligibles. However, arguments have been made against expanding MA coverage to children, including the argument that MA is an entitlement program which includes numerous federal requirements that restrict the state's ability to: (a) limit coverage of services; (b) share program costs with clients; and (c) target specific geographic areas with high rates of uninsurance.

Under the current HMO expansion for AFDC- and healthy start-related MA eligibles, the MA program is becoming more like an insurer than a payer for health care services. Rather than paying for health care services on a fee-for-service basis, the MA program pays an HMO a monthly capitation payment. The HMO which accepts the capitation payment is then responsible for most of the enrollee's individual health care needs and assumes the financial risk for their health care-related expenses. For these reasons, the Committee may wish to expand the scope of the DHFS study to explore the cost effectiveness of expanding MA eligibility to children, compared with other proposals that would expand health care coverage to children.

6. Under SB 77, the study is to be submitted only to the Governor. Usually, a study of this magnitude is submitted to both the Governor and Legislature.

## ALTERNATIVES TO BILL

1. Adopt the Governor's recommendation to require DHFS, by July 1, 1998, to conduct and report to the Governor on the results of study to explore, on a statewide basis, the possible provision of a health insurance program for uninsured school-age children, as determined by DHFS and to specify that, if the health insurance program appears to be feasible, include with the report proposed statutory language necessary to implement the program.

2. Modify the Governor's recommendation to direct DHFS to broaden the scope of the study to include any or all of the following:

a. Require DHFS to study the provision of a health insurance product to families, in addition to school age children.

b. Require DHFS to evaluate current MA outreach efforts and to make recommendations that would increase the enrollment of children who are currently eligible for MA in the MA program.

c. Require DHFS to study the cost effectiveness of expanding the MA income standard for children.

Require DHFS to compare these approaches to reducing the number of uninsured children in the state, based on the: (a) costs and benefits; (c) number of children that would receive health coverage that are currently uninsured; and (c) administrative feasibility of each approach.

3. Require that the report be submitted to the Governor and Legislature.

4. Delete the provision.

MO# Alt 3.

P.	BURKE	N	A	
	DECKER	N	A	in
	GEORGE	N	A	
	JAUCH	N	A	
	WINEKE	N	A	
	SHIBILSKI	N	A	
	COWLES	N	A	
	PANZER	N	A	
	JENSEN	N	A	
	OURADA	N	A	
	HARSDORF	N	A	
	ALBERS	N	A	
	GARD	N	A	
	KAUFERT	N	A	
	LINTON	N	A	
	COGGS	N	A	

AYE 15 NO 0 ABS 1

MO# Alt 2 abc

2	BURKE	Y	N	A
1	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 9 NO 7 ABS 7

Strike "possible" from Gov's rec. (See Alt. 1)

MO# \_\_\_\_\_

(Amie Goldman has specific language)

BURKE	(Y)	N	A
DECKER	(Y)	N	A
2 GEORGE	(Y)	N	A
1 JAUCH	(Y)	N	A
WINEKE	(Y)	N	A
SHIBILSKI	(Y)	N	A
COWLES	Y	(N)	A
PANZER	Y	N	(A)

JENSEN	Y	(N)	A
OURADA	Y	(N)	A
HARSDORF	Y	(N)	A
ALBERS	Y	(N)	A
GARD	Y	(N)	A
KAUFERT	Y	(N)	A
LINTON	(Y)	N	A
COGGS	(Y)	N	A

AYE 8 NO 7 ABS 1

Extend coverage under  
MO# Healthy Start to all  
children up to age 6 in  
families w/ income up to 200% of the FPL

BURKE	(Y)	N	A
DECKER	(Y)	N	A
1 GEORGE	(Y)	N	A
JAUCH	(Y)	N	A
2 WINEKE	(Y)	N	A
SHIBILSKI	(Y)	N	A
COWLES	Y	(N)	A
PANZER	Y	N	(A)

extend coverage up  
MO# to age 12

friendly motion  
by Wineke to  
change 12  
to 14

Wineke friendly  
effective Jan.  
1998

BURKE	(Y)	N	A
DECKER	(Y)	N	A
GEORGE	(Y)	N	A
JAUCH	(Y)	N	A
WINEKE	(Y)	N	A
SHIBILSKI	(Y)	N	A
COWLES	Y	(N)	A
PANZER	Y	N	(A)

JENSEN	Y	(N)	A
OURADA	Y	(N)	A
HARSDORF	Y	(N)	A
ALBERS	Y	(N)	A
GARD	Y	(N)	A
KAUFERT	Y	(N)	A
LINTON	(Y)	N	A
COGGS	(Y)	N	A

AYE 8 NO 7 ABS 1

JENSEN	Y	(N)	A
OURADA	Y	(N)	A
HARSDORF	Y	(N)	A
ALBERS	Y	(N)	A
GARD	Y	(N)	A
KAUFERT	Y	(N)	A
2 LINTON	(Y)	N	A
1 COGGS	(Y)	N	A

AYE 8 NO 7 ABS 1

**To: Joint Committee on Finance**

**From: Bob Lang, Director  
Legislative Fiscal Bureau**

**ISSUE**

**State Immunization Supplement (DHFS -- Health)**

[LFB Summary: Page 278, #3]

**CURRENT LAW**

The Department of Health and Family Services (DHFS), Division of Health (DOH) carries out a statewide immunization program to eliminate mumps, measles, rubella (German measles), diphtheria, pertussis (whooping cough), poliomyelitis and other diseases that DHFS specifies by rule, and to protect against tetanus. Base funding for the program is \$2,660,000 GPR.

DHFS provides the vaccines without charge, if federal or state funds are available for the vaccines, upon request of a school district or local health department. Individuals may not be charged for vaccines furnished by DHFS.

**GOVERNOR**

Delete \$2,660,000 GPR annually to reflect the elimination of GPR funding for the immunization program. Delete statutory references to state funds budgeted for the immunization program and repeal the GPR immunization appropriation.

## DISCUSSION POINTS

1. There are two sources of federal funds DHFS uses for the purchase of vaccines. First, the federal vaccines for children (VFC) program provides funding for the purchase of vaccines for certain groups of eligible children, including: (a) children eligible for medical assistance (MA); (b) uninsured children; (c) Native American children; and (d) underinsured children. "Underinsured children" are defined as children who have health insurance that does not cover the cost of immunizations. Second, the state receives funds provided under Section 317 of the Public Health Service Act. These funds can be used for the direct purchase of vaccines for any child.

2. In addition, the state receives federal funds, including immunization action plan (IAP) funds and incentive funds that are allocated to local health departments, federally qualified health centers and tribes to build immunization delivery systems. These funds may be used for outreach and to support staff who provide immunizations. Organizations that receive these funds are required to adhere to a work plan. Activities identified in the IAP work plan include: (a) establishment of an immunization record system; (b) notification of parents of children identified as being behind schedule for immunization; (c) assessment and removal of barriers to client's accessing immunization services (for example, assessing clinic hours and staffing patterns); (d) identification of transportation needs of clients; and (d) provision of assistance to clients experiencing difficulty in obtaining up to date records of previous immunizations.

3. The U.S. Centers for Disease Control and Prevention (CDC) conducts an annual phone survey to measure the percentage of vaccinated children under age two in each state. According to the most recent survey, the estimated statewide immunization rate for Wisconsin children in this age group was 77%. The estimated immunization rate for children under the age of two in the City of Milwaukee was 71%. The state and national goal for immunization rates for children in this age group is 90%, based on the federal *Healthy Children 2000* objectives developed by the U.S. Public Health Service.

4. Wisconsin's immunization program currently purchases vaccines using a combination of federal VFC funds (68%), Section 317 funds (16%) and GPR (16%). Staff at the CDC indicate that seven states do not contribute state funds to support vaccine purchases. State support in the remaining 43 states represents, on average, 19% of the states' total immunization funding.

5. In his proposed 1997-98 federal fiscal year budget, the President recommended that federal funding for immunizations be reduced by \$39 million from the amount budgeted in 1996-97. IAP funds would be reduced by \$14 million and Section 317 funds would be reduced by \$25 million. It is expected that a new excise tax exemption for vaccines would offset the \$25 million reduction in funding for the purchase of vaccines with Section 317 funds.

6. Wisconsin's Section 317 award for the direct purchase of vaccines was \$2.5 million in federal fiscal year 1995-96. For the 1996-97 federal fiscal year, Wisconsin requested a \$1.8 million Section 317 award. However, the actual award was \$4 million. The Governor's recommendation to delete GPR support for the state's immunization program assumed that the state would continue to receive \$4 million annually under the Section 317 program in the 1997-99 biennium. If the state continued to receive \$4 million annually under the Section 317 program, it is estimated that total federal funding available to support the purchase of vaccines in 1997-98 and 1998-99 would be sufficient to support the full cost of these purchases without a GPR supplement.

Information has been obtained related to the availability of Section 317 vaccine funding. The CDC national immunization program did not intend to award \$4 million to Wisconsin in federal fiscal year 1996-97. The 1996-97 award was made in error. CDC staff indicate that they do not intend to recoup these funds. Therefore, Wisconsin's total federal vaccine funding for 1996-97 should remain unchanged.

However, this information raises questions about the future availability of federal funding. The national immunization program has indicated that Wisconsin's subsequent Section 317 awards could be between \$1.8 and \$2.5 million, rather than \$4 million annually, as assumed in the Governor's budget. Therefore, if the Committee adopts the Governor's recommendation and eliminates GPR funding for the immunization program, DHFS may not be able to provide the same number of vaccines that have been provided in previous years or the number of vaccines assumed in the administration's estimate.

7. Based on the assumption that federal immunization funding will be \$2.2 million per year, the amount of state funding that would be required to maintain the level of vaccines identified in the DOA estimate has been reestimated. This estimate only relates to direct funding for the purchase of vaccines and does not account for IAP funding reductions included in the President's 1997-98 budget. The DOA estimate assumes that the number of vaccines provided in 1997-98 and 1998-99 will be the same as was provided in 1996-97. However, an adjustment has been made to account for a projected increase in demand for the hepatitis B vaccine and a decrease in demand for the hepatitis B "high risk" vaccine. The attachment provides information on the projected number of vaccine dosages and costs for 1996-97 and the 1997-99 biennium.

In order to maintain the state's current level of vaccine purchases in the next biennium, if federal funding is \$2.2 million rather than \$4.0 million annually, it is estimated that \$1,454,800 GPR in 1997-98 and \$1,540,700 GPR in 1998-99 would be required. The following table provides a summary of this reestimate.

### 1997-99 Vaccine Purchase Reestimate

	<u>1997-98</u>	<u>1998-99</u>
<b>Revenues</b>		
VFC Funding	\$4,895,900	\$5,035,700
Section 317 Funding	<u>2,200,000</u>	<u>2,200,000</u>
<b>Total</b>	<b>\$7,095,900</b>	<b>\$7,235,700</b>
<b>Costs</b>		
Vaccines for VFC Eligible Children	\$4,895,900	\$5,035,700
Vaccines for All Other Children	<u>3,654,800</u>	<u>3,740,700</u>
<b>Total</b>	<b>\$8,550,700</b>	<b>\$8,776,400</b>
<b>Difference (Required GPR Supplement)</b>	<b>\$1,454,800</b>	<b>\$1,540,700</b>

8. GPR immunization funding could be used for various activities, including: (a) the direct purchase of vaccines; (b) outreach activities; and (c) immunization delivery system infrastructure activities. Currently, DHFS uses these funds for the direct purchase of vaccines. While base funding for the immunization program is \$2,660,000 annually, it is estimated that the appropriation will lapse approximately \$3.6 million 1996-97. Therefore, in the 1995-97 biennium, approximately \$1,720,000 GPR was used to purchase vaccines.

9. The state immunization program awards federal funds to local health departments, federally qualified health centers (FQHCs) and tribes on a calendar year basis for outreach and immunization delivery system infrastructure activities. In the past, due to the timing and level of federal immunization awards, local agencies have not been able to expend their entire grant within the calendar year the grant was awarded. Therefore, local agencies have been able to "carryover" funds between calendar years. The CDC has allowed these carryover funds to be awarded in subsequent years. However, in recent years the CDC has encouraged states to "catch up" and expend these funds.

Beginning in calendar year 1996, Wisconsin's immunization program has attempted to "catch up" and expend these funds. In calendar year 1996, \$4.7 million dollars was awarded to local agencies. Approximately \$980,000 of this total was new IAP and incentive funding awarded in 1996. The balance (approximately \$3.7 million) represents funds carried forward from calendar years 1993 through 1995. To date, approximately \$2.0 million has been awarded to local agencies for calendar year 1997. Approximately, \$900,000 of this total is new IAP and incentive funding awarded in 1997. The balance, approximately \$1.1 million, represents funds carried forward from 1996. Therefore, local agencies received \$2.7 million less in 1997 than they received in 1996. As carryover funds continue to diminish, local agencies will continue to receive reduced awards.

It is estimated that carryover funding will be exhausted by calendar year 1998. As previously indicated, the President has recommended a decrease in IAP funding for federal fiscal year 1997-98. In light of projected decreases in future federal funding for the support of immunization delivery systems, the Committee may wish to maintain base funding for the program (\$2,660,000 GPR) or an amount that represents the difference between the estimated 1998 calendar year federal award and the estimated level of funding provided to local agencies in calendar year 1997 (approximately \$1,000,000 GPR annually).

10. Alternatively, the Committee could approve the Governor's recommendation to provide no additional GPR for the immunization program in the 1997-99 biennium, but retain the GPR appropriation and statutory references to GPR support for the program. This alternative would enable DHFS to request a transfer of GPR funds from another appropriation under the process established under s. 13.10 of the statutes if future federal funding is insufficient to support the costs of the state's immunization program.

11. Finally, based on the uncertainty of future Section 317 and IAP funding, the Committee could modify the current GPR immunization appropriation by converting the appropriation from a sum certain to a sum sufficient appropriation and authorizing DHFS to expend up to a specified amount if federal funds are insufficient to maintain the program at its current level.

Specifically, the overall expenditures for the program could be fixed at \$8.6 million in 1997-98 and \$8.8 million in 1998-99 and funded with federal dollars. A GPR sum sufficient appropriation could also be established that would "kick in" only if the federal funds did not materialize. The advantage of this alternative is that the program would be funded at current service levels and GPR dollars would only be utilized if federal dollars are not fully realized. Therefore, the Committee would not need to appropriate specific GPR dollars at this time.

Alternatively, the Committee could establish this amount at \$9.6 million in 1997-98 and \$9.8 million in 1998-99 to purchase vaccines and maintain support for outreach and infrastructure activities.

## **ALTERNATIVES TO BILL**

1. Adopt the Governor's recommendation to delete all GPR support for the state's immunization program, repeal the GPR appropriation for immunizations and delete statutory references to state funds budgeted for the program.

2. Adopt the Governor's recommendations to authorize no additional GPR funds for the program in the 1997-99 biennium, but retain the GPR appropriation for immunizations and statutory references to state funds budgeted for the program.

3. Increase funding by \$1,454,800 GPR in 1997-98 and \$1,540,700 GPR in 1998-99 to fund the estimated costs of purchasing vaccines to meet projected demand for the 1997-99 biennium. In addition, delete the Governor's recommendation to remove references to state funds budgeted for the program and to repeal the GPR immunization appropriation.

<b>Alternative 3</b>	<b>GPR</b>
1997-99 FUNDING (Change to Bill)	\$2,995,500

4. Increase funding by \$2,454,800 GPR in 1997-98 and \$2,540,700 GPR in 1998-99 to fund the estimated costs of purchasing vaccines to meet projected demand for the 1997-99 biennium and maintain support for outreach and infrastructure activities. In addition, delete the Governor's recommendation to remove references to state funds budgeted for the program and to repeal the GPR immunization appropriation.

<b>Alternative 4</b>	<b>GPR</b>
1997-99 FUNDING (Change to Bill)	\$4,995,500

5. Modify the current GPR appropriation for immunizations by converting the appropriation from a sum certain to a sum sufficient appropriation and authorize DHFS to expend an amount from the appropriation such that the sum of available federal funds and GPR funds does not exceed \$8,550,700 in 1997-98 and \$8,776,400 in 1998-99 to purchase vaccines. Require DHFS to use all available federal funds to purchase vaccines prior to expending state funds from this appropriation.

6. Modify the current GPR appropriation for immunizations by converting the appropriation from a sum certain to a sum sufficient appropriation and authorize DHFS to expend an amount from the appropriation such that the sum of available federal funds and GPR funds does not exceed \$9,550,700 in 1997-98 and \$9,776,400 in 1998-99 to purchase vaccines and maintain support for outreach and infrastructure activities. Require DHFS to use all available federal funds to purchase vaccines prior to expending state funds from this appropriation.

7. Maintain current law and base funding for the program (\$2,660,000 annually).

<b>Alternative 7</b>	<b>GPR</b>
1997-99 FUNDING (Change to Bill)	\$5,320,000

Prepared by: Amie T. Goldman

MO# Alt. 6

2	BURKE	Y	N	A
1	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 8 NO 8 ABS

MO# Alt. 5

	BURKE	Y	N	A
	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
1	JENSEN	Y	N	A
2	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 15 NO 1 ABS 0

**ATTACHMENT**

**Estimated Vaccine Dosages and Costs  
State Fiscal Years 1996-97 through 1998-99**

	<u>1996-97</u>		<u>1997-98</u>		<u>1998-99</u>	
	<u>Dosage</u>	<u>Cost</u>	<u>Dosage</u>	<u>Cost</u>	<u>Dosage</u>	<u>Cost</u>
Diphtheria-tetanus (pediatric)	6,490	\$1,788	6,490	\$1,558	6,490	\$1,635
Pertussis	178,868	2,514,884	178,868	2,514,884	178,868	2,640,625
Hepatitis-A	1,210	13,492	1,210	13,492	1,210	14,166
Hepatitis-B Adult	6,665	163,513	6,655	163,513	6,655	171,689
Hepatitis-B Pediatric	201,825	1,507,633	233,258	1,924,768	216,843	1,867,957
Hepatitis-B High Risk	155,250	1,350,675	87,746	763,386	82,398	752,702
Hepatitis-B Immune Globulin	17	677	18	619	18	650
Measles-Mumps-Rubella	45,650	744,552	45,650	744,552	45,650	781,779
Oral Polio Vaccine	69,350	160,892	69,350	160,892	69,350	168,937
Polio, enhanced inactivated	72,135	396,021	72,135	396,021	72,135	415,822
Tetanus-Diphtheria (adult)	43,835	8,329	43,835	8,329	43,835	8,745
Haemophilus Influenzae	33,550	195,932	33,550	168,099	33,550	176,505
Varicella-C Pox	<u>51,700</u>	<u>1,690,590</u>	<u>51,700</u>	<u>1,690,590</u>	<u>51,700</u>	<u>1,775,120</u>
<b>TOTAL</b>	<b>866,545</b>	<b>\$8,748,978</b>	<b>830,465</b>	<b>\$8,550,703</b>	<b>808,702</b>	<b>\$8,776,332</b>

To: Joint Committee on Finance

From: Bob Lang, Director  
Legislative Fiscal Bureau

## ISSUE

### **HIV/AIDS Insurance Program (DHFS -- Health)**

[LFB Summary: Page 279, #5]

## CURRENT LAW

Provisions of the federal Consolidated Omnibus Reconciliation Act of 1986 require employers to allow certain individuals to continue coverage under group health insurance plans. Under these provisions, certain individuals can maintain their coverage for up to 29 months after leaving work. This health insurance extension is commonly referred to as the COBRA continuation provision.

The Department of Health and Family Services (DHFS) administers a program that pays the premium costs for COBRA continuation coverage for individuals who have human immunodeficiency virus (HIV) infection and who are unable to continue work due to their illness. In order to be eligible for the program, an individual must: (a) be a state resident; (b) have a family income that does not exceed 200% of the federal poverty level (FPL); (c) submit to DHFS certification from a physician that the individual has HIV infection and has had their employment terminated or their hours of work reduced because of an illness or medical condition arising from, or related to their HIV infection; and (d) be eligible for continuation coverage. Individuals who are eligible for medicare are not eligible for the continuation program. DHFS is authorized to pay premiums until the individual's continuation coverage ceases or until the expiration of 29 months after his or her continuation coverage began, whichever occurs first.

Base funding for the program is \$235,300 GPR annually. The program currently serves approximately 100 persons.

**GOVERNOR**

Decrease funding by \$1,153,700 (\$449,200 GPR and \$704,500 FED) in 1997-98 and \$2,723,300 (\$1,080,500 GPR and \$1,642,800 FED) in 1998-99 to reflect the net projected cost savings of expanding the state's program for subsidizing group health insurance continuation coverage for individuals with acquired immune deficiency syndrome (AIDS) or HIV. Provide an additional 1.0 GPR position, beginning in 1997-98, to administer the expanded program.

Under the bill, the program would be modified as follows.

*Coverage for Policies Other than Continuation Coverage.* Authorize DHFS to pay the premium costs for any health insurance coverage, including individual or group policies and medicare supplement policies, but not for medicare replacement policies and long-term care insurance policies. In addition, specify that eligible group health plans and individual health policies include policies that provide coverage to a group or individual, whether or not dependents of the members are also covered.

*Delete Time Limits of Premium Subsidy Benefits.* Authorize DHFS to pay premium subsidies for an individual as long as an individual remains eligible for the program and has coverage.

*Income Eligibility.* Limit participation in the program to individuals in families with income up to 300% of the FPL, rather than 200% of the FPL. In addition, direct DHFS to establish a premium contribution schedule for individuals participating in the program in families with income between 200% and 300% of the FPL. Specify that, in developing the premium contribution schedule, DHFS take into consideration both income and family size.

**DISCUSSION POINTS**

1. The percentage of people in Wisconsin with AIDS who are eligible for government-subsidized health care coverage has been increasing. In 1989, 49% of persons hospitalized with AIDS in Wisconsin were eligible for publicly-funded health care, including medical assistance (MA). By 1993 (the most recent year for which data is available), 63% of persons hospitalized with AIDS were eligible for publicly-funded health care.
2. From the state's fiscal perspective, the HIV/AIDS insurance continuation program is cost-effective. The program controls state costs by assuring that individuals continue to be covered by their private insurance, rather than by MA, for as long as possible. The Governor's recommended expansions would extend private insurance coverage, further reducing MA costs to the state.

3. Some of the individuals participating in the insurance continuation coverage program are also eligible for MA. Under some circumstances, MA will pay the premiums for private insurance policies. MA reimbursed the insurance continuation program approximately \$37,700 in 1995-96.

4. There would be three main groups of individuals that would benefit from the proposed expansions.

- The first group includes persons who are self-employed. Self-employed persons are most likely to be covered by individual health care policies at the time they become unable to work. The proposed expansion would authorize DHFS to cover these individual policies.

- The second group includes individuals who become eligible for medicare after 29 months of being without health insurance as a result of job loss. Medicare does not cover prescription drugs and individuals often purchase a medicare supplemental policy which covers prescription drugs. The proposed expansion would cover premiums for these medicare supplemental policies.

- Finally, individuals who are uninsured when they lose their employment would benefit from the expansion. Under the proposal, the insurance program would purchase policies for these individuals through the state's health insurance risk sharing plan (HIRSP).

5. Based on an analysis of the Governor's proposal, it is estimated that the net savings resulting from the Governor's recommendations would be \$310,800 GPR and \$943,900 FED in 1997-98 and \$750,700 GPR and \$2,293,700 FED in 1998-99. This estimate is \$138,400 GPR in 1997-98 and \$329,800 GPR in 1998-99 less than estimated by SB 77 and \$239,400 FED in 1997-98 and \$650,900 FED in 1998-99 more than the budget bill. This is illustrated in the following table.

**Governor's Proposal to Expand Premium Subsidy Program  
Summary of Projected Costs and Savings**

	1997-98		1998-99	
	<u>GPR</u>	<u>FED</u>	<u>GPR</u>	<u>FED</u>
<b>I. Governor's Recommendations</b>				
Costs				
Premium Subsidies				
AIDS Insurance Continuation	\$249,400	\$0	\$576,100	\$0
HIRSP Subsidies	12,500	0	34,600	0
Staff Costs	<u>30,100</u>	<u>0</u>	<u>36,900</u>	<u>0</u>
Subtotal	\$292,000	\$0	\$647,600	\$0
Savings				
Medical Assistance Benefits	-\$741,200	-\$704,500	-\$1,728,100	-\$1,642,800
Net Costs (Savings)	-\$449,200	-\$704,500	-\$1,080,500	-\$1,642,800
<b>II. Reestimate</b>				
Costs				
Premium Subsidies				
AIDS Insurance Continuation	\$318,300	\$0	\$814,300	\$0
HIRSP Subsidies	0	0	0	0
Staff Costs	<u>30,100</u>	<u>0</u>	<u>36,900</u>	<u>0</u>
Subtotal	\$348,400	\$0	\$851,200	\$0
Savings				
Medical Assistance Benefits	-\$659,200	-\$943,900	-\$1,601,900	-\$2,293,700
Net Costs (Savings)	-\$310,800	-\$943,900	-\$750,700	-\$2,293,700
<b>III. Difference (Change to Bill)</b>				
Costs				
Premium Subsidies				
AIDS Insurance Continuation	\$68,900	\$0	\$238,200	\$0
HIRSP Subsidies	-12,500	0	-34,600	0
Staff Costs	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Subtotal	\$56,400	\$0	\$203,600	\$0
Savings				
Medical Assistance Benefits	\$82,000	-\$239,400	\$126,200	-\$650,900
Total Change to Bill	\$138,400	-\$239,400	\$329,800	-\$650,900

The difference between the Governor's estimate and the current estimate is primarily due to the availability of more recent caseload data and information on the cost effectiveness of

HIV/AIDS insurance programs. In addition, the reestimate reflects that the AIDS premium program, rather than the HIRSP program, would incur the additional premium expenses resulting from the expansion to include HIRSP policies.

6. The Governor's recommendation includes a statutory provision which directs DHFS to apply a copayment schedule for individuals whose income is between 200% and 300% of the FPL. This proposal is designed to save program costs by requiring program participants with higher income to pay a share of their income for insurance premiums. In 1997, 200% of the FPL is \$15,780 for a family size one, \$21,220 for a family size of two, \$26,660 for a family size of three, and \$32,100 for a family size of four.

Although the cost estimates of this proposal prepared for the bill do not assume any cost savings from the collection of these premiums, any copayments DHFS is able to collect would result in a corresponding reduction of program costs.

7. While individuals with income between 200% and 300% of the FPL may be able to afford to contribute to the cost of their coverage through a copayment, the costs of administering such a copayment schedule may outweigh any program savings which would be realized.

Data collected two years ago by the Division of Health's AIDS drug reimbursement program indicated that, at the time, 10% of the clients in that program had income between 200% and 300% of FPL. Under the Governor's proposal, the copayments that would actually be collected from a small number of individuals participating in the premium subsidy program with income greater than 200% of the FPL would likely be nominal. In addition, individuals in the insurance continuation program are recently unemployed or underemployed due to illness, and therefore, may have an unstable source of income. For these reasons, the Committee may wish to delete the provision that would authorize DHFS to assess a copayment for individuals in the program with income between 200% and 300% of the FPL.

8. Individuals are ineligible for coverage under HIRSP if their premiums, copayments or deductibles are paid or reimbursed by a federal, state, county or municipal government. Currently, an exception is made for persons whose deductible or coinsurance amounts are paid or reimbursed by the state for vocational rehabilitation, renal disease, hemophilia, cystic fibrosis or maternal and child health services. In order meet the intent of the Governor's proposal, a statutory change is needed so that individuals whose premiums, deductibles and copayments are paid under the HIV/AIDS insurance program would be eligible for HIRSP coverage. This provision would ensure that the HIV/AIDS insurance program could purchase HIRSP policies for individuals who are eligible for the program and are uninsured.

## ALTERNATIVES TO BILL

### Funding

1. Approve the Governor's recommendations. In addition, increase funding for premium subsidies by \$56,400 GPR in 1997-98 and \$203,600 GPR in 1998-99 and increase funding for MA benefits by \$82,000 GPR in 1997-98 and \$126,200 GPR in 1998-99 and delete funding for MA benefits by \$239,400 FED in 1997-98 and \$650,900 FED in 1998-99 to reflect reestimates of program costs and MA benefits savings. Finally, amend the bill to ensure that individuals whose premiums are paid under the AIDS premium subsidy program would be eligible for HIRSP coverage.

<u>Alternative 1</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	\$468,200	- \$890,300	- \$422,100

2. Maintain current law.

<u>Alternative 2</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	\$1,529,700	\$2,347,300	\$3,877,000
1998-99 POSITIONS (Change to Bill)	- 1.00	0.00	- 1.00

### Copayments

1. Adopt the Governor's recommendation to establish and administer a copayment schedule for qualifying individuals where income is between 200% and 300% of the FPL.

2. Delete provision.

Prepared by: Amie T. Goldman

(A) (B)  
 MO# Alt 1 Alt 1

1	BURKE	Y	N	A
	DECKER	X	N	A
	GEORGE	Y	N	A
	JAUCH	X	N	A
	WINEKE	X	N	A
	SHIBILSKI	X	N	A
	COWLES	X	N	A
	PANZER	Y	N	A
2	JENSEN	Y	N	A
	OURADA	X	N	A
	HARSDORF	X	N	A
	ALBERS	X	N	A
	GARD	X	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

AYE 16 NO 0 ABS 0

To: Joint Committee on Finance

From: Bob Lang, Director  
Legislative Fiscal Bureau

## ISSUE

### HIV/AIDS Program Reestimate (DHFS -- Health)

[LFB Summary: Page 280, #6]

## CURRENT LAW

Under current law, the AIDS drug reimbursement program (ADRP) reimburses pharmacies for HIV/AIDS-related drug therapies for eligible individuals with household income at or below 200% of the federal poverty level (FPL). In order to be eligible for the program, an individual must: (a) be a state resident; (b) be certified by a physician to be HIV positive; (c) have a prescription issued by a physician for an approved HIV/AIDS-related drug; (d) have applied for coverage under, and been denied eligibility for, medical assistance within 12 months of application for ADRP; and (e) have no insurance coverage for HIV/AIDS-related drugs or have coverage that is inadequate to meet the full costs of these drugs.

ADRP is currently supported by a combination of GPR funds and federal funds received by DHFS under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. In general, CARE Act funds are used to support services to persons infected with HIV or persons with clinically defined AIDS. These funds are available to support a range of HIV/AIDS services, including drug reimbursement programs. In fiscal year 1996-97, DHFS allocated \$280,400 of these funds to the drug reimbursement program. Additionally, states may receive supplemental funds which can only be used to support HIV/AIDS drug reimbursement programs. In fiscal year 1996-97, DHFS allocated \$268,800 of these funds to the drug reimbursement program.

**GOVERNOR**

Provide \$69,900 GPR in 1997-98 and \$323,800 GPR in 1998-99 to reflect a reestimate of the amount of funding required to support the AIDS drug reimbursement program in the 1997-99 biennium. (A technical amendment is required to properly allocate base funding between the AIDS drug reimbursement program and the general AIDS/HIV services program.)

**DISCUSSION POINTS**

1. The following table summarizes the total funding that would be available for the ADRP based on GPR funding in the bill, current estimates of available federal funding and current estimates of the total ADRP program costs for 1997-98 and 1998-99.

**AIDS Drug Reimbursement Program Funding  
Projected Revenues and Costs  
Fiscal Years 1997-98 and 1998-99**

	<u>1997-98</u>	<u>1998-99</u>
<b>GPR</b>		
Base Funds	\$361,400	\$361,400
Governor's Recommended Increase	<u>69,900</u>	<u>323,800</u>
Subtotal	\$431,300	\$685,200
<b>FED</b>		
Ryan White -- Supplemental Drug Allocation	\$823,000	\$823,000
Ryan White -- General Funds Allocated for Drug Reimbursement	<u>280,400</u>	<u>280,400</u>
Subtotal	\$1,103,400	\$1,103,400
<b>Other</b>		
Drug Rebates	\$28,100	\$23,800
<b>Total Funding Available</b>	<b>\$1,562,800</b>	<b>\$1,812,400</b>
<b>Total Projected Program Costs</b>	<b>\$1,530,800</b>	<b>\$1,715,500</b>
<b>Difference</b>	<b>\$32,000</b>	<b>\$96,900</b>

As this table illustrates, current estimates of the cost of fully funding the program in the 1997-99 biennium are \$32,000 in 1997-98 and \$96,900 in 1998-99 less than funding that would be available for the program under the bill. Consequently, the bill could be amended to reduce

GPR support for the program by \$32,000 GPR in 1997-98 and \$96,900 GPR in 1998-99 to reflect current estimates of the costs to fund the program in the 1997-99 biennium.

2. The current estimates of program costs reflect higher projected caseloads and average costs per client than estimated by the administration. ADRP program enrollment is expected to increase by 40% from 1995-96 to 1996-97. The projected number of individuals who will be enrolled in the program by the end of 1996-97 exceeds the number of individuals that the administration projected would be enrolled by the end of 1997-98. In addition, a recent study published by the National Institute of Health has confirmed that "triple combination drug therapy" should be established as the standard of care for certain HIV/AIDS patients. It is expected that this standard will be more universally adopted, increasing average per client program costs.

3. These projected increases in program costs are slightly more than offset by projected increases in federal revenue that will be available to support the program. The Governor's recommendations were based on an assumption that the state would receive \$268,800 annually in 1997-98 and in 1998-99 for the AIDS drug reimbursement program. Since that time, Wisconsin has been notified that its supplement will likely be \$823,000 in each year. For this reason, federal funding to support this program should be reestimated by \$554,200 FED annually to reflect current estimates.

4. If the Committee chose to maintain the current level of GPR support for the AIDS drug reimbursement program, based on current projections of program costs (\$1,530,800 in 1997-98 and \$1,715,500 in 1998-99), GPR base funding (\$361,400 GPR annually), drug rebate revenues (\$28,100 in 1997-98 and \$23,800 in 1998-99) and available federal funds (\$1,103,400 FED annually), projected program costs would exceed available funding by \$37,900 in 1997-98 and \$226,900 in 1998-99. If the Committee adopted this alternative, DHFS would be required to reduce program costs or allocate a greater share of CARE Act funds to the drug reimbursement program (and reduce funding to AIDS consortia for prevention, education and treatment services by a corresponding amount) to fully fund the drug reimbursement program. If the Committee chose this alternative, it may also wish to modify current statutory provisions relating to the AIDS drug reimbursement program to authorize DHFS to maintain waiting lists for the program.

#### **ALTERNATIVES TO BILL**

1. Modify Governor's recommendation to reflect the reestimate by: (a) reducing GPR support for the program by \$32,000 GPR in 1997-98 and \$96,900 GPR in 1998-99 to reflect reestimates of funding required to support the program; and (b) increasing funding by \$554,200 FED annually to reflect projected increases in funding available for the program under the CARE

Act in the 1997-99 biennium. In addition, make a technical change to properly allocate base funding for the program.

<u>Alternative 1</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$128,900	\$1,108,400	\$1,031,900

2. Reduce funding by \$69,900 GPR in 1997-98 and \$323,800 GPR in 1998-99 to maintain GPR support for the program at its current base (\$361,400 GPR annually). In addition, increase funding by \$554,200 FED annually to reflect projected increase in funding available for the program under the CARE Act in the 1997-99 biennium. In addition, authorize DHFS to maintain a waiting list for the program if DHFS determines that it is necessary to ensure that total program costs do not exceed funding available for the program. Finally, make a technical correction to properly allocate base funding for the program.

<u>Alternative 2</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$393,700	\$1,108,400	\$714,700

Prepared by: Amie T. Goldman

MO# Alt 1

2 BURKE N A  
 DECKER N A  
 GEORGE N A  
 JAUCH N A  
 WINEKE N A  
 SHIBILSKI N A  
 COWLES N A  
 PANZER N A

1 JENSEN N A  
 OURADA N A  
 HARSDORF N A  
 ALBERS N A  
 GARD N A  
 KAUFERT N A  
 LINTON N A  
 COGGS N A

AYE 16 NO 0 ABS 0

HEALTH AND FAMILY SERVICES

HIV/AIDS Insurance Program -- Copayments

Motion:

Move to direct DHFS to submit to the Committee, by November 1, 1997, a cost-benefit analysis of implementing a copayment schedule for the HIV/AIDS insurance program that is comparable to the HIRSP copayment schedule.

Note:

Currently, the HIV/AIDS insurance program pays the premium costs for COBRA continuation coverage for individuals who have HIV infection and are unable to continue work due to their illness. Currently, there is no copayment requirement for this program.

MO# 1525

BURKE	Y	<del>Y</del>	A
DECKER	Y	<del>Y</del>	A
GEORGE	Y	<del>Y</del>	A
JAUCH	Y	<del>Y</del>	A
WINEKE	Y	<del>Y</del>	A
SHIBILSKI	Y	<del>Y</del>	A
COWLES	<del>Y</del>	N	A
PANZER	<del>Y</del>	N	A
2 JENSEN	<del>Y</del>	N	A
OURADA	<del>Y</del>	N	A
HARSDORF	Y	<del>N</del>	A
1 ALBERS	<del>Y</del>	N	A
GARD	<del>Y</del>	N	A
KAUFERT	<del>Y</del>	N	A
LINTON	Y	<del>N</del>	A
COGGS	Y	<del>N</del>	A

AYE 7 NO 9 ABS \_\_\_\_\_

To: Joint Committee on Finance

From: Bob Lang, Director  
Legislative Fiscal Bureau

## ISSUE

### Primary Health Care Service Grants (DHFS--Health)

[LFB Summary: Page 281, #9]

## CURRENT LAW

The Department of Health and Family Services (DHFS), Division of Health is budgeted \$250,000 GPR annually to distribute as grants to local public health agencies to support primary care health services. "Primary health care services" are defined as:

- Services of a physician and, if feasible, services of a physician assistant, nurse practitioner, or public health nurse;
- Diagnostic laboratory and radiological services, if the local public health department provides such services;
- Preventative health services, including eye and ear examinations for children to determine the need for vision or hearing correction, perinatal services, well-child services and family planning services;
- Preventative dental services; and
- Case management services.

As a condition of receiving a grant, local health departments must provide funds or in-kind services that match 25% of the state grant amount. Grant funding may not be used for administrative activities and may not be used to supplant local funds expended for such purposes prior to May 11, 1990.

DHFS is authorized to award grants, based on criteria and procedures developed by the Department, which must promote the development and maintenance of integrated community health services.

## GOVERNOR

Repeal the program and delete \$250,000 GPR annually.

## DISCUSSION POINTS

1. 1995 Wisconsin Act 27 reduced funding for primary grant services from \$750,000 to \$500,000 in 1995-96 and from \$500,000 to \$250,000 in 1996-97. Because primary health care grants are awarded on a calendar year basis, DHFS allocated all of the funding budgeted for 1996-97 during the first half of the fiscal year. As a result, all primary health care grant funds budgeted in the 1995-97 biennium were expended during calendar year 1996 and no new grant amounts were awarded for calendar year 1997.

2. Although it is not known how each local public health agency has responded to the termination of these grants in calendar year 1997, it is likely that some agencies were required to reduce the number of persons served by projects funded through these grants. Other agencies may have been able to maintain support for these projects by identifying alternate funding sources.

3. In calendar year 1996, \$375,000 was allocated to 78 local public health agencies. DHFS awarded primary health care grants on a noncompetitive basis, using a formula which took into account county population, poverty and risk factors, such as infant mortality rates and death rates from cancer, heart disease and stroke. The smallest grant award was \$940 and the largest award was \$56,231. Attachment 1 identifies the 1996 grant award for each agency.

4. The administration argues that the size of each grant award is too small to provide any significant health benefits or to enable local public health agencies to focus on a specific health problem.

5. Attachment 2 provides a summary of statewide local health department expenditures, by source of funds. Attachment 2 shows that, on average, state funding provided under this program has represented less than 1% of total spending by local public health agencies.

However, these funds have been used to support services that might not otherwise be funded. For example, some local public health agencies have used these funds to partially support the costs of primary health care staff, such as a public health nurse to provide screening and assessments for health problems. All of the projects provide services to a specific population

based on age, sex or health risk and many of the projects focus on children. Individuals served by these projects are typically individuals who do not qualify for other public health programs, such as medical assistance.

6. In 1995, at the request of the Committee, the Legislative Audit Bureau (LAB) conducted an evaluation of the primary health care services program to determine its effectiveness in increasing access to primary health care services for low-income individuals. The LAB evaluation concluded that while it was not possible to measure the degree to which the program had increased access, the program appeared to have made services available to a limited number of individuals.

7. While many of these projects were designed to provide assessments and make referrals for direct services, some projects included the provision of direct services. For example, the Grant County Health Department used its grant to expand comprehensive physical examinations, similar to those provided to medical assistance (MA) recipients under the early and periodic, diagnostic testing and screening benefit (HealthCheck) to families not otherwise eligible for the program. Similarly, the Crawford County Public Health Department used its grant to provide prenatal care to families that did not qualify for MA.

8. The primary health care services grant funds represent the only noncategorical GPR funding provided to local health agencies. These funds are discretionary, which enables local health departments to provide services to people who are ineligible for other programs.

9. In light of concerns over the effect such small grant amounts have on the primary health needs of the state's low-income population, the Committee could modify the program by directing DHFS to distribute grants on a competitive basis, rather than through a noncompetitive formula, and authorize DHFS to distribute grants of up to \$50,000 for the provision of primary health care services. Under this alternative, projects previously funded under the program that have demonstrated their effectiveness, as determined by DHFS, could again receive state funding, beginning in calendar year 1998. Because grants are provided on a calendar year basis, \$125,000 GPR in 1997-98 and \$250,000 GPR in 1998-99 could be provided to support such a program.

Alternatively, this same approach could be used under a biennial appropriation of \$250,000 GPR. This would allow the Department flexibility in distributing grants over a longer time period.

## **ALTERNATIVES TO BILL**

1. Adopt the Governor's recommendation to repeal the primary health care services grant program and reduce base funding for the program (\$250,000 GPR annually).

2. Modify the program by: (a) providing \$125,000 GPR in 1997-98 and \$250,000 GPR in 1998-99; and (b) requiring DHFS to award the grants, beginning in calendar year 1998, in amounts up to \$50,000 on a competitive basis for the provision of primary health care services.

<u>Alternative 2</u>	<u>GPR</u>
1997-99 FUNDING (Change to Bill)	\$375,000

3. Modify the program by: (a) providing \$250,000 GPR in 1997-99 under a biennial appropriation; and (b) requiring DHFS to award grants, beginning in calendar year 1998 in amounts up to \$50,000 on a competitive basis for the provision of health care services.

<u>Alternative 3</u>	<u>GPR</u>
1997-99 FUNDING (Change to Bill)	\$250,000

4. Maintain current law.

<u>Alternative 3</u>	<u>GPR</u>
1997-99 FUNDING (Change to Bill)	\$500,000

Prepared by: Amie T. Goldman

MO#

AT 2

2 BURKE	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
1 DECKER	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
GEORGE	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
JAUCH	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
WINEKE	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
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OURADA	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
HARSDORF	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
ALBERS	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
GARD	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
KAUFERT	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
LINTON	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A
COGGS	<input checked="" type="radio"/>	<input checked="" type="radio"/>	N	A

AYE 7 NO 9 ABS

Senator George  
Senator Burke  
Representative Coggs

HEALTH AND FAMILY SERVICES

Primary Health Care Service Grants

Motion:

Move to delete the Governor's recommendation to repeal the primary health care service grants program. In addition, modify the program by: (a) providing \$1.0 million GPR annually; and (b) requiring DHFS to award the grants in amounts up to \$50,000 on a competitive basis for the provision of primary health care services.

[Change to Bill: \$2,000,000 GPR]

MO# 548

2 BURKE	<input checked="" type="radio"/>	N	A
DECKER	<input checked="" type="radio"/>	N	A
GEORGE	<input checked="" type="radio"/>	N	A
JAUCH	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
WINEKE	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
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JENSEN	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
OURADA	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
HARSDORF	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
ALBERS	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
GARD	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
KAUFERT	<input checked="" type="radio"/>	<input checked="" type="radio"/>	A
LINTON	<input checked="" type="radio"/>	N	A
COGGS	<input checked="" type="radio"/>	N	A

AYE 5 NO 11 ABS \_\_\_\_\_

# ATTACHMENT 1

## Primary Health Care Service Grant Allocations Calendar Year 1996

<u>Local Public Health Agency</u>	<u>1996 Award</u>	<u>Local Public Health Agency</u>	<u>1996 Award</u>
Adams County Health Department	\$1,277	Pepin County Health Department	\$1,000
Ashland County Health Department	1,493	Pierce County Health Department	2,866
Barron County Health Department	3,518	Polk County Health Department	2,951
Bayfield County Health Department	1,433	Portage County Human Services Department	4,711
Brown County Health Department	12,610	Price County Health Department	1,576
Burnett County Health Department	1,347	Richland County Health Department	1,475
Calumet County Health Department	2,070	Rock County Public Health Department	7,935
Chippewa County Health Department	4,528	Rusk County Dept. HHS	1,605
Clark County Health Department	3,842	St. Croix County Dept. HSS	3,534
Columbia County Health Department	3,532	Sauk County Public Health Department	3,642
Crawford County Health Department	1,868	Sawyer County Health Department	1,525
Dane County Human Services Department	9,894	Shawano County Health Department	3,349
Dodge County Health & Human Services Department	5,478	Sheboygan County Div. Public Health	6,377
Door County Health Department	1,807	Taylor County Human Services Dept.	1,957
Douglas County Health Department	3,301	Trempealeau County Health Department	2,453
Dunn County Health Department	3,287	Vernon County Health Department	2,583
Florence County Health Department	1,000	Vilas County Health Department	1,401
Fond du Lac County Health Department	6,211	Walworth County Public Health Nursing	5,140
Forest County Health Department	1,000	Washburn County Health Department	1,232
Grant County Health Department	4,910	Washington County Comm. Health Nursing	6,107
Green County Health Department	2,552	Waukesha County Public Health Division	15,343
Green Lake County Nursing Service	1,484	Waupaca County Human Services	3,504
Iowa County Health Department	1,916	Waushara County Health Department	1,691
Iron County Health Department	1,000	Winnebago County Health Department	6,333
Jefferson County Health Department	3,512	Wood County Health Department	5,627
Juneau County Health Department	1,988		
Kenosha County Health Department	20,323	City of Madison	10,410
Kewaunee County Health Department	1,490	Milwaukee Health Department	56,231
LaCrosse County Health Department	6,407	Eau Claire City/County Health Department	6,407
Lafayette County Health Department	1,626	Menasha Health Department	940
Langlade County Health Department	1,919	West Allis Health Department	6,639
Lincoln County Health Department	2,262	Beloit Health Department	2,677
Manitowoc County Health Department	4,981	Racine Health Department	6,834
Marathon County Health Department	8,704	Appleton Health Department	4,505
Marinette County Health Department	3,180	De Pere Dept. Public Health	1,177
Marquette County Health Department	1,282	Greenfield Health Department	24,451
Monroe County Health Department	3,139	Neenah Dept. Public Health	1,516
Oconto County Dept. Human Services	2,865	Watertown Dept. of Public Health	1,379
Oneida County Health Department	2,076		
Outagamie County Dept. Human Services	5,132		
Ozaukee County Public Health Department	3,683	TOTAL	\$375,000

## ATTACHMENT 2

### 1995 Total Statewide Local Health Department Expenditures by Source of Funds

<u>Source of Funds</u>	<u>Expenditures</u>	<u>Percent</u>
<b>Local Taxes</b>		
County, City or Villages Taxes	\$48,891,786	58.6%
<b>Fees for Services</b>		
Community Options Program	\$93,692	0.1%
Jail Health	582,467	0.7
Title 18 (Medicare)	205,365	0.2
Title 19 (including HealthCheck & Prenatal Care Coordination)	2,036,305	2.4
Other Personal Health Fees	2,026,363	2.4
Environmental health Fees	1,136,900	1.4
Laboratory Service Fees	804,045	1.0
License Fees	2,902,540	3.5
School Health Fees	1,168,075	1.4
Other	<u>815,628</u>	<u>1.0</u>
Subtotal	\$11,771,380	14.1%
<b>Block Grants</b>		
Maternal and Child Health Prevention	\$3,212,656	3.8%
	1,195,539	1.4
<i>Primary Care (GPR)</i>	<i>690,176</i>	<i>0.8</i>
WIC	7,220,795	8.7
Other	<u>1,925,367</u>	<u>2.3</u>
Subtotal	\$14,244,533	17.1%
<b>Other Categorical Funds</b>		
School Health Grants	\$152,133	0.2%
HIV/AIDS	723,706	0.9
Birth-to-Three	479,366	0.6
Cancer	1,171,525	1.4
Lead Screening	2,027,342	2.4
Immunization	1,935,937	2.3
Other	<u>976,817</u>	<u>1.2</u>
Subtotal	\$7,466,826	8.9%
<b>Other</b>		
Donations	337,472	0.4
Other Sources	<u>666,715</u>	<u>0.8</u>
Subtotal	\$1,004,187	1.2%
<b>TOTAL</b>	<b>\$883,474,054</b>	<b>100.0%</b>

NOTE: Two of the state's 98 LHDs did not report expenditures by funding sources.  
Source: DHFS Center for Health Statistics.

To: Joint Committee on Finance

From: Bob Lang, Director  
Legislative Fiscal Bureau

## ISSUE

### **Women, Infants and Children Supplemental Food Program Grant Match (DHFS -- Health)**

[LFB Summary: Page 281, #10]

## CURRENT LAW

The Department of Health and Family Services distributes federal funds the state receives from the U.S. Department of Agriculture to local agencies that provide food and nutritional educational services at no cost to persons enrolled in the women, infants and children (WIC) supplemental food program. Pregnant, postpartum and breastfeeding women, infants and children under age five in households with income under 185% of the federal poverty level who are identified as being a nutritional "risk" are eligible for the program. Average monthly participation in the program was approximately 110,000 individuals in 1995-96.

1995 Wisconsin Act 27 eliminated the state GPR supplement to the WIC program. Although no GPR funding was budgeted for the program in the 1995-97 biennium, DHFS was authorized to continue to spend down the balance of the GPR continuing appropriation until the funding previously budgeted for the program was completely exhausted. As of April 1, 1997, the balance of this appropriation was approximately \$750,000.

The farmer's market nutrition program (FMNP) grant is a separate federal WIC grant that requires a 30% state match. The FMNP allows WIC recipients to purchase fresh fruit and vegetables from authorized farmers' markets. The FMNP food package is provided to families in addition to the WIC food package issued to WIC recipients. The program currently operates in Dane, Eau Claire and Milwaukee Counties.

## **GOVERNOR**

Provide \$112,000 GPR in 1997-98 and 1998-99 to enable the state to continue to participate in the FMNP after the balance of the GPR WIC appropriation is completely exhausted.

## **DISCUSSION POINTS**

1. DHFS first applied for an FMNP grant for the 1995 farmer's market season (June through October). The original grant request would have been sufficient to support the program in five counties, one in each region of the state, and to provide each recipient with a \$20 FMNP food package, which families could use during the farmers' market season.

However, the actual 1995 grant award was less than the amount requested by DHFS. Consequently, DHFS determined that available grant funding would be sufficient to support the program in three counties, with each participating WIC family receiving a \$16 FMNP food package. The three participating counties were selected based on risk, the presence of active farmers' market associations, regular scheduled market days, and sufficient numbers of participating farmers to serve the needs of the WIC recipients. Currently, 16 farmers' markets and 200 farmers participate in the program in these three counties.

2. In the 1997 season, each participating family will receive a \$15 FMNP food package to be used for the purchase of locally grown fresh fruits, vegetables and herbs during the farmers market season. Under federal program rules, a WIC FMNP food package cannot exceed \$20 per person.

3. Participant and farmer satisfaction surveys indicate that the program has met its two goals: (1) increasing consumption of fruits and vegetables among WIC families; and (2) increasing sales at farmers' markets. In addition, the farmer's survey indicated that, given the opportunity, 95% of participating farmers would continue to participate in the program.

4. Two counties that are not currently served by the FMNP program, Brown County and Marathon County, have expressed an interest in participating in the program. The Governor's budget would not provide sufficient funding to expand the program to these counties.

5. Federal funding budgeted for the FMNP program has totaled \$6.75 million for each of the past three years. These funds are prorated among states which have participated in the program in prior years, with consideration of funding requests from states which have not participated in the past and increased grant requests from currently participating states.

6. The President's 1998 budget would provide almost twice as much funding for the program in federal fiscal year 1997-98 (\$12.0 million) as was provided in federal fiscal year

1996-97 (\$6.75 million). Consequently, additional federal funding may be available if Wisconsin chose to expand its program.

For example, if the program were expanded to include Brown and Marathon County and each WIC family received a \$15 FMNP food package, the additional annual cost would be approximately \$37,000. Due to the availability of a 70% federal match, the GPR share of these costs would be \$11,000. This expansion would enable approximately 2,500 additional families to participate in the program.

Alternatively, the Committee could provide enough GPR to fund the program in these two counties and increase the FMNP food package to \$20 per family in all five counties. The additional annual cost of this expansion would be \$174,000. The GPR share of these costs would be approximately \$52,100 annually.

7. As previously indicated, Wisconsin's 1995-97 biennial budget eliminated the GPR supplement for the WIC program. A review of the program's 1996-97 expenditures to date suggests that the program will completely exhaust the carryover balance from the GPR appropriation. In fact, it appears that the program may experience a \$0.5 million shortfall in 1996-97. If the Governor's recommendations are approved, the FMNP GPR funds budgeted for 1997-98 would be used as the match for this year's farmers market program. If the Committee deletes the Governor's recommendations, the federal funding which DHFS has already received for the 1997 season would have to be returned to the U.S. Department of Agriculture.

8. The Committee could delete the Governor's recommendation and GPR funding for the FMNP program. Under this alternative, DHFS would be required to return federal funds the state received for the 1997 season and WIC families in those three counties would not be able to participate in the program during the 1997 farmers' market season. However, these families would still retain the standard WIC food package that is available to WIC participants in all other counties in the state.

## ALTERNATIVES TO BILL

1. Approve the Governor's recommendation to provide \$112,000 GPR in each year to be used as the state match for the FMNP grant.

2. Increase funding recommended by the Governor by \$11,000 GPR and \$26,000 FED in 1997-98 and 1998-99 to enable DHFS to expand the FMNP to two additional counties, beginning with the 1998 farmers' market season.

<u>Alternative 2</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	\$22,000	\$52,000	\$74,000

3. Increase funding recommended by the Governor by \$52,000 GPR and \$122,000 FED annually to enable DHFS to: (a) expand the FMNP to two additional counties, beginning with the 1998 farmers' market season; and (b) increase the food package amount for all participating FMNP families from \$15 to \$20, beginning with the 1998 farmers' market season.

<u>Alternative 3</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	\$104,000	\$244,000	\$348,000

4. Maintain current law.

<u>Alternative 4</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	-\$224,000	-\$522,100	-\$746,100

Prepared by: Amie T. Goldman

MO# Alt. 3(b) <sup>-only</sup> (Not A)

1 BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
2 COGGS	Y	N	A

AYE 8 NO 8 ABS \_\_\_\_\_