HUNGER TASK FORCE OF MILWAUKEE Since 1974

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# Wisconsin WIC Legislative Action Alert

March 25, 1999

To: Wisconsin State Senators
Wisconsin State Representatives

From: Hunger Task Force of Milwaukee
Wisconsin WIC Association

**On behalf of the Women, Infants and Children Special Nutrition Program, we urge your action to support WIC's provision of rural outreach services and access to health care:**

**1) Support Governor Thompson's budget proposal which includes $1 million for the WIC Nutrition Program** to:

- provide individualized nutrition counseling for participants at high nutritional risk
- provide breastfeeding education and support services for pregnant women and parents with new infants
- increase accessibility to the WIC Program for working, rural and non-English speaking families.

*Funding the WIC Program is part of the Governor's effort to assure children birth to age 4 receive the nutrition needed for the optimal brain development necessary for learning in the school years.*

**2) Provide $400,000 for the biennium to the WIC Nutrition Program for a joint WIC and BadgerCare outreach campaign.**

- Wisconsin WIC serves over 82,000 participants that either have no health care coverage or are enrolled in Wisconsin Medicaid. Many of these participants are in households where older siblings and parents have no health care coverage. These are the people BadgerCare has been developed to reach and serve. Local WIC staff can link these people to BadgerCare.
- In a Virginia survey designed to identify ways to reach WIC eligible clients, the two best predictors of participation rates were program outreach efforts and services coordination. A joint outreach effort between WIC and the BadgerCare Program could link low-income families to two services they need to maintain their health and keep working-- a healthy diet and preventive medical care. This joint effort would be extremely valuable in reaching rural families receiving WIC services at satellite clinics.
- Wisconsin WIC is losing federal food dollars due to declining WIC participation rates while local providers of emergency food and shelter services are being increasingly relied upon. Families need to know that WIC services and Wisconsin Medicaid are still available and are not part of the W2 program. We need to maximize the federal dollars available for Wisconsin families.
- This funding will support a regionally-based outreach initiative to bring the WIC and BadgerCare message to the local community level across the state.

WOMAN INFANTS CHILDREN

# WIC

## BUILDING A BETTER FUTURE FOR AMERICA'S CHILDREN

### WIC ACHIEVES THE GOALS OF GOOD HEALTH AND NUTRITION FOR FAMILIES

***The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a short-term intervention program designed to influence lifetime nutrition and health behaviors in a targeted, high-risk population.***

**WIC provides:**
- Quality nutrition education and services.
- Breastfeeding promotion and education.
- A monthly food prescription (package).
- Access to maternal, prenatal and pediatric health-care services.

**WIC serves:**
- Over 7.4 million participants through 10,000 clinics nationwide in 1998.
  - *847,000 pregnant women*
  - *329,000 breastfeeding women*
  - *533,000 postpartum women*
  - *Nearly 1.9 million infants*
  - *Over 3.8 million children monthly*

**WIC requires:**
- Income level has to be less than or equal to 185% of the poverty level.
- Nutrition risk has to be documented.

### SAVINGS DUE TO WIC PARTICIPATION BY PREGNANT WOMEN

***Approximately 22% of all pregnant women in the United States are in WIC. Almost 46% of pregnant women enroll in WIC during their first trimester of pregnancy. At certification, 46% of pregnant women have three or more nutrition risk factors.***

***Numerous studies have shown that pregnant women who participate in WIC have longer pregnancies leading to fewer premature births; have less low and very low birth-weight babies; experience fewer fetal and infant deaths; seek prenatal care earlier in pregnancy and consume more of such key nutrients as iron, protein, calcium and Vitamin C.***

**Cost for a Pregnant Woman in WIC**
- It costs approximately $520 a year for a pregnant woman in WIC.
- Every dollar spent on pregnant women in WIC produces $1.92 to $4.21 in Medicaid savings for newborns and their mothers.

**Cost of Low and Very Low Birth-Weight Babies**
- It costs $22,000 per pound to raise a low (less than 5.5 pounds) and very low (less than 3.25 pounds) birth-weight baby to normal weight (7 pounds).
- It costs $40 per pound to provide WIC prenatal care benefits.
- WIC prenatal care benefits reduce the rate of very low birth-weight babies by 44%.
- Medicaid costs were reduced on average between $12,000 and $15,000 per infant for every very low birth-weight prevented.

### WIC SAVES DOLLARS

***Through states' efforts to contain costs in 1996, $1.2 billion in nontax revenues have been generated through competitive bidding of infant formula to serve nearly 1.7 million participants.***

### WIC BREASTFEEDING

***Breastfeeding helps mothers feel close to their baby, and the breast milk contains all the nutrients infants need to grow and develop. Breastfed infants tend to be healthier since they receive antibodies from the breast milk, which protects them against infection.***

- In Colorado, exclusively breastfeeding a WIC infant saved $160.00 in the first six months of life from lower WIC and Medicaid costs.
- Recent surveys have demonstrated that breastfeeding rates among WIC mothers around the nation have increased between 10% and 25%. In 1994, WIC mothers increased their breastfeeding initiation rates to 44%, from 34% in 1990.

### EFFECTS OF WIC PARTICIPATION ON CHILDREN

***WIC helps to assure children's normal growth, reduces levels of anemia, increases immunization rates, improves access to regular health care and improves diets. In 1996, nearly 49% of all infants born in the United States are in WIC. Nearly 20% of all children in the United States are in WIC. Children are eligible for WIC up until they reach their fifth birthday. At certification in 1996, 87% of all children had one or more nutrition risk factors.***

**Anemia and Cognition**
- Low-income children not enrolled in the WIC Program have a higher prevalence of anemia than those who are enrolled. After analyzing CDC's Pediatric Nutrition Surveillance System data from 1980 to 1992, the anemia rate among children at the WIC six-month recertification is 16% lower than the rate at the WIC initial screening.
- Four- and five-year-olds whose mothers participated in WIC during pregnancy had better vocabulary test scores than children whose mothers had not received WIC benefits. Children who participated in WIC after their first birthday had better digit memory test scores than children who did not participate in WIC.

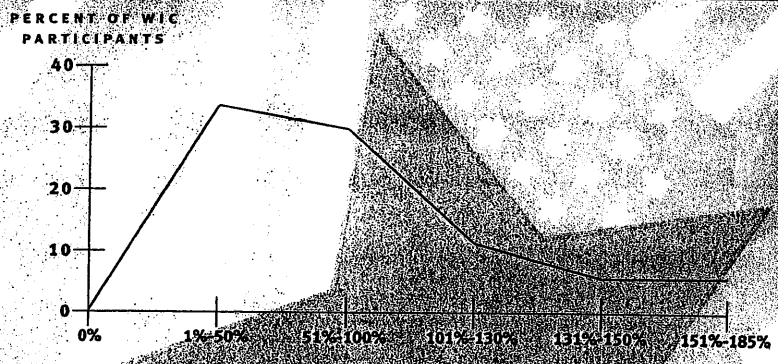
## DEAR FRIEND OF WIC

We hope that this information will help you understand the critical role WIC plays in building a better future for America's children. As we enter the 21st century, WIC provides the competitive edge that will give our nation's future leaders a fair start in life. *Thank you for your support.*

*For further information about the WIC Program, contact your local WIC agency or the NATIONAL ASSOCIATION OF WIC DIRECTORS on 202/232-5492.*

PLEASE FOLD INTO THIRDS, SEAL WITH TAPE AND PLACE A 33¢ STAMP HERE

## UNITED STATES: INCOME OF WIC PARTICIPANTS




Department of Health and Human Services 1996 Poverty Guidelines for a family of four. (Average WIC family size was four in 1996.)

| % Poverty Level | = | Income Level |
|---|---|---|
| 0% | = | $0 |
| 1-50% | = | $156-7,800 |
| 51-100% | = | $7,956-15,600 |
| 101-130% | = | $15,756-20,280 |
| 131-150% | = | $20,436-23,400 |
| 151-185% | = | $23,556-28,860 |

Source: USDA PC Data '96. Numbers may not equal 100% due to incomplete data.

## WIC PARTICIPANTS' FACTS

**Income (see chart above)**
- To be eligible for WIC, participants' income cannot exceed 185% of the poverty level.
- The average number of persons in a WIC family is four.
- The average income of a participant is $10,808.
- Two-thirds of participants live at or below the poverty line.
- More than one-third of participants do not participate in any other federal assistance programs.

**Age Distribution**
- 83% of the pregnant, breastfeeding and postpartum women participants are between the ages of 18 and 34 years.
- Only 16% are under age 17.

**Racial Distribution**
- 40% of all WIC participants are white, 31% are hispanic and 24% are black.

**Education Level**
- On average, women participants have 12 years of education.

## WIC FOOD PRESCRIPTION

WIC provides a monthly prescription of nutritious foods tailored to supplement the dietary needs of participants. The foods are specifically chosen to provide high levels of protein, iron, calcium and vitamins A and C, nutrients that have been scientifically shown to be lacking or needed in extra amounts in the diets of the WIC population.* These five nutrients plus calories and other essential nutrients provided by the WIC Food Prescription are critical for assuring good health, growth and development.

| WIC FOOD | KEY NUTRIENTS PROVIDED | FEDERAL STANDARDS |
|---|---|---|
| MILK | Protein, Calcium, Vitamins A and D, Folate, Riboflavin | USDA requires that each quart of fluid or dry whole, low-fat or non-fat/skim must must contain 400 International Units (IUs) of Vitamin D and 2,000 IUs of Vitamin A. |
| CHEESE | Protein, Calcium, Vitamins A and D, Riboflavin | USDA requires that cheese must be made from milk and not be an imitation product or cheese food. |
| IRON-FORTIFIED CEREAL | Iron, B Vitamins | USDA requires that each serving of dry cereal contain a minimum of 28 milligrams of iron and not more than 6 grams of sugars. |
| JUICE | Vitamin C, Folate | USDA requires that juice be 100% juice and that a 1/2 cup contain at least 36 milligrams of Vitamin C. |
| EGGS | Protein, Vitamins A and D | |
| DRY BEANS/PEANUT BUTTER | Protein, B Vitamins, Folate, Fiber | |
| IRON-FORTIFIED/INFANT FORMULA | If a woman chooses not to breastfeed, then iron-fortified formula is the best alternate source of essential nutrients for her infant. | |
| CARROTS | Beta-Carotene, a form of Vitamin A | |
| TUNA | Protein, Folate | |

WDAIP

Wisconsin Dental Association Insurance Programs, Inc.

APR 01 1999

March 31, 1999

THOMAS A. WITKOWSKI
PRESIDENT

Senator Rodney Moen
P. O. Box 7882
Madison, WI 53707-7882

Dear Senator Moen:

On January 13, 1999, a bill was introduced in the Wisconsin Senate to create a state managed health insurance pool for small employers. The bill would essentially place the State of Wisconsin in the health insurance business.

I am writing to you today, on behalf of the Wisconsin Dental Association Insurance Programs, Inc. (WDAIP), an insurance agency owned by the Wisconsin Dental Association (WDA), to express opposition to this bill.

In 1992, the Wisconsin Legislature passed small group reform legislation to improve access to coverage for small employers. The legislation permitted insurance companies to develop a complex premium rating system called "banding". This, in our opinion, has been a windfall profit opportunity for the insurance companies. Unfortunately, small group reform legislation included association plans and affected them greatly. Prior to 1992, the WDA's group health insurance plan insured over 1,800 dentists and their employees. Small group reform dramatically affected the way our plan was rated. Over time our plan has become less competitive, and we now have only 1,000 members in the program. The insurance companies interpreted this legislation in such a way that it has become more difficult and complex than ever for the small employer to obtain health insurance, even through association plans. Numerous additional forms and underwriting rules have been developed by the insurance companies as a result of "small group reform". Insurance companies use it as a "catch all" when they want to increase premiums. The whole thing is ridiculous. Throw on top of that the federal legislation HIPAA (Kennedy-Kassabaum's Health Insurance Portability and Accountability Act) and you have another reason for insurance companies to increase rates. Currently insurance companies quote an attractive premium to a prospective new client; then, based upon applications submitted by the employer, the final quotation may be up to 85% higher because of employees' medical conditions!

The bottom line is that legislative tinkering by the State and Federal governments has driven up the cost of health insurance, created an affordability problem for small business owners and failed to improve access to health insurance, particularly for independent contractors and individuals. If you don't work for a company that offers health insurance, you're not going to get it if you have pre-existing conditions. Insurance companies operating in Wisconsin are permitted to either accept or decline individuals who apply for coverage, based upon their medical conditions.

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Our position is this. The State of Wisconsin wants to develop a purchasing pool for small employers. In effect, you want to develop an association plan. Why don't you consider removing associations and chamber of commerce plans from the 1992 "small group reform" legislation? That way groups of small businesses can band together like they did prior to 1992 and seek competitive bids from insurance companies. The State of Wisconsin's proposed pool will be restricted by "small group reform" just like association plans are now. You can't just start a pool from scratch and expect it to succeed. The first applicants will be those with medical problems looking for a deal. You might give them a deal in the first year, but the claims will catch up quickly with the premiums paid in. With all due respect, this type of plan is destined for failure.

I belong to a networking group of insurance agency executives that is rather unique. Unique because we all manage insurance agencies or programs that are owned and/or endorsed by associations. I am confident that members of this group would be willing to meet with you individually or collectively to discuss ways in which current legislation could be changed to improve the competitive environment for small businesses.

You're on the right track by considering purchasing pools and we can have that mechanism in place with some changes to existing legislation. Prior to states enacting group insurance reform legislation, we could find 15-20 insurance companies who were willing to bid on our very viable association plan. These companies were either national companies like John Hancock, or in-state insurance companies like Blue Cross. Now, you'd be lucky to find one or two. The insurance markets dried up when these reform laws were put into place. National companies didn't want to deal with individual states reforms.

Let's give association, chamber, and multiple employer plans a chance once again. Repeal small group reform legislation or remove multi-employer plans from its grasp! A state operated pool is not the answer.

In all sincerity,

Tom Witkowski

Thomas A. Witkowski
President

BUDGET BRIEFING BEFORE THE SENATE COMMITTEE ON
HEALTH, UTILITIES, VETERANS AND MILITARY AFFAIRS

SECRETARY JOE LEEAN
DEPARTMENT OF HEALTH AND FAMILY SERVICES

March 24, 1999

Introduction

Thank you for the opportunity to appear before you today. I would like to begin by giving some brief comments on the "state of the state" with respect to health and social conditions. I will then highlight a number of budget items.

The health and social well being of Wisconsin's population is strong in many areas.

- One of the most important—and impressive—outcomes is that Wisconsin has the lowest rate of uninsured population in the nation. In 1997, only 8% of the people in Wisconsin did not have health insurance whereas the national average is double that level--16%.

- The rate of births to teen mothers in Wisconsin is declining and is lower than the national average. The rate of births to teens aged 15-17 in Wisconsin fell from 24.2 per 1000 teen females in 1990 to 22.5 in 1997. Wisconsin's rate is significantly below the national average of 32.6.

- The rate of substantiated child abuse and neglect reports in Wisconsin is lower than the national average. In 1996, the rate of substantiated child abuse and neglect cases in Wisconsin was 12.8 per 1000 children under age 18, compared to the national average of 14.3.

- The publicly funded managed care programs in Wisconsin are producing positive health outcomes for clients. In 1996, the Medicaid HMO program had a higher proportion of children completing Health Check visits lower utilization of emergency room services, and greater frequency of primary care visits than the traditional fee-for-service health programs.

In my written testimony I have included graphs and tables which illustrate these points.

The Governor's 99-01 biennial budget builds on these positive trends and forges further improvements in the quality of life for Wisconsin citizens.

Family Care

The centerpiece of the DHFS portion of the Governor's biennial budget is Family Care, the Department's bold new program to provide long-term care services to people with disabilities and elderly people. Enactment of Family Care is one of the Administration's top priorities.

In the 99-01 biennium, Family Care will be implemented on a pilot basis. Under our plan, there will be 5 primary demonstration sites, 4 alternate sites, and 3 sites with just Resource Centers.

The total projected cost of Family Care is $61.2 million in state fiscal year 2000 and $172.2 million in state fiscal year 2001. The bulk of funding is reallocated from existing programs, particularly Medicaid fee-for-service, Community Options Program, and the Community Aids program. This reallocation reflects the fact that some individuals will be served in the Family Care program rather than these other programs. The amount of new GPR funding needed for Family Care is $5.7 million in fiscal year 2000 and $5.9 million in fiscal year 2001.

The Family Care budget proposal provides funding for: Aging and Disability Resource Centers, Care Management Organizations, the Pathways to Independence/Medicaid Purchase Plan and Employment Initiatives, Medicaid fee for service payments, and program accountability and oversight activities including external advocacy.

The key goals of Family Care are:

- Make the long-term care system more understandable and less fragmented;
- Give people better choices about where they live and what kinds of services and supports they get to meet their needs;
- Improve accountability and measure performance based on quality outcomes;
- Make the system more reliable and fair by guaranteeing access to those with the highest need and assuring that access is consistent from county to county; and
- Make the long-term care system more affordable.

As you may know, some individuals and groups have developed and are advocating for an alternative long-term care proposal. While many of the details of this alternative have not been specified, the alternative proposal appears to be a request for a significant increase in funding to be directed into the existing long-term care programs and service delivery systems, specifically Community Options and the home and community-based waiver programs. In my view, there are a number of drawbacks to this alternative proposal. First, it does not ensure that those with greatest need will have access to flexible services and supports. Waiting lists would be possible. In contrast, access to the flexible Family Care benefit is assured for everyone at the comprehensive level and everyone at the intermediate level who is either MA-eligible or needs Adult Protective Services. A second drawback of the alternative proposal is that it does not address the structural problems of the current system: it continues the institutional bias; maintains the current fragmented and confusing system; and continues a provider-based, rather than client-focused, payment system. In contrast, Family Care is a broad reform of the long-term care system which eliminates institutional bias in long-term care; creates a client-focused system in which "money follows the client"; and simplifies the long-term care system. A third drawback of the alternative proposal is that the amount of new funding required is unknown and may be very large.

Within the next few weeks, we expect to submit to the Joint Finance Committee a package of funding and statutory language corrections and clarifications for the Family Care program, based on developments since the completion of the Governor's budget, including the Department's discussions with federal officials, development of operational components with the pilot counties, and comments received from stakeholder groups.

Medical Assistance

I would like to comment now on another area of the Department's budget: the Medical Assistance (MA) program. MA is the largest program in DHFS and one of largest programs administered by state government.

The highlight in this area of the 99-01 biennium is the implementation of BadgerCare, the Department's new program to provide access to health care to low-income families. BadgerCare ensures access to health care for all children and families with income below 185% of the federal poverty level. Once enrolled, families may remain in BadgerCare until family income exceeds 200% of the FPL. With BadgerCare we will succeed in reducing even further the already low rate of uninsured population in Wisconsin.

Under BadgerCare families with income above 150% of the federal poverty level pay a monthly premium. The BadgerCare statutes allow the Department to set this premium at 3.5%, rather than 3%, of family income with the concurrence of the Joint Finance Committee. I would like to inform the Committee that I will be sending a letter to the Joint Finance Committee this week formally requesting a premium schedule for BadgerCare based on 3.5% of monthly income. Department budget projections indicate that the 3.5% premium level is necessary to provide sufficient funding to cover the number of families expected to be eligible and interested in participating in BadgerCare. A premium level of 3.5% is affordable and reasonable. For example, a family of three, which is the average BadgerCare family size, at 185% FPL would have an income of $25,700 and would pay $70 per month. A family of four at 185% FPL would have an annual income of $30,900 and would pay a premium of $87 per month. In exchange for this premium payment, the family obtains one of the most, if not the most, comprehensive package of health benefits and services offered by public or private insurers in the state.

Under the statutes, the submission of a 3.5% premium schedule triggers a 14-day JFC "passive review" process. I would like to request that if the JFC does not approve the schedule through the 14-day passive review process, that the Committee address this issue in its biennial budget Executive Session on health issues, rather than defer the issue to the June 13.10 meeting. We are scheduled to begin implementation of BadgerCare on July 1. It is important that we come to closure on the issue of the premium level as soon as possible so that we can complete the operational activities needed to meet the July 1 implementation date, such as programming our automated eligibility system and providing training and policy manuals to the eligibility workers.

With respect to other aspects of Medicaid, the Governor's 99-01 biennial budget maintains our broad array of MA benefits. DHFS will work with legislative staff at LFB to assist them in their standard procedure of re-estimating the needs of the MA program, based on the

most up-to-date information available. We request that any savings identified by DHFS, DOA, and LFB staff in this re-estimate, be allocated to high priority funding needs elsewhere in the Department. These high priority needs include:

- Funding for administration of the MA program. Certain administrative costs must be incurred to run the program efficiently and effectively. These include contracts with our fiscal agent for processing payments for the MA program and carrying out other administrative work and for necessary support services, such as actuary analysis, and the Medicaid Evaluation and Decision support system which provides the capability to store and analyze data for policy and management decision-making.

- Funding for administration of the new Badger Care program and funding to initiate and administer new managed care programs for foster care children and SSI recipients. The latter programs will help control future cost increases in providing services to these client groups.

- Operating costs, including the cost of medicine, at the DHFS mental health institutions, DD Centers and Resource Center.

Adult and Child Care Licensing Staff

DHFS has the responsibility for licensing and regulating child day care, child welfare facilities, community based residential facilities (CBRFs), adult family homes, and adult day care facilities in the state. It is important that the Department have an appropriate level of staff to carry out these activities. Insufficient staff resources have a number of negative consequences: the frequency of monitoring and inspection visits deteriorates, investigations of client complaints can not be completed on a timely basis, complaints and enforcement actions are likely to increase, and technical assistance, which serves an important preventive function particularly for new facilities, must be curtailed. As a result, the safety and quality of services for clients in the facilities may be impaired. I recommend that the Committee review this area. We are prepared to work with LFB and DOA staff to examine total workload requirements, including facility growth as well as other factors such as complaint investigation and enforcement actions, of the adult and child care licensing staff to determine the appropriate level of staffing. Increasing the number of licensing staff would not have a GPR effect because non-GPR sources of funding are used to finance licensing staff--federal child care block grant in the case of child care facilities and fee revenue in the case of adult facilities.

The Health Insurance Risk Sharing Plan (HIRSP)

The next issue area I would like to address is the Health Insurance Risk Sharing Plan or HIRSP. HIRSP provides comprehensive health insurance coverage for the state's medically uninsurable population. HIRSP has traditionally been administered as a private insurance plan funded by a combination of policyholder premiums, high coinsurance and deductibles, and insurer assessments. HIRSP was transferred in January 1998 from the Office of the Commissioner of Insurance to DHFS.

Along with the transfer of the program to DHFS, the 97-99 biennial budget made a number of other changes to the HIRSP program. The bill created a very complex funding formula involving GPR funding, insurer assessments, reductions in provider payments ("discounts"), and policyholder premiums. In addition, in an effort to contain costs in the HIRSP program, the bill required DHFS to apply certain Medicaid administrative procedures to HIRSP, including use of the Medicaid fiscal agent and requiring providers to be Medicaid-certified.

These program and funding changes resulted in an administratively complex and cumbersome system. Furthermore, the changes did not enable DHFS to make effective use of the Medicaid fiscal agent because HIRSP was sufficiently different enough from Medicaid that the Medicaid Management System (MMIS) required significant changes. Instead, a number of HIRSP-specific stand-alone management and information system components had to be designed. Finally, the changes created a considerable amount of confusion for policyholders and providers, due, for example, to adopting Medicaid billing and reimbursement policies in certain areas.

The Governor's 99-01 biennial budget includes a provision to generate $2 million of GPR savings annually in the HIRSP budget. DHFS has developed a plan to meet the Governor's intent of generating this level of cost-savings and to simplify the administration of the HIRSP program. The plan enables DHFS to take advantage of the efficient administrative procedures used in Medicaid. It changes provider reimbursement to ensure rates are discounted, but not to as low a level as Medicaid rates. The specific components of the plan are:

- Create HIRSP-specific outpatient rates per visit and inpatient DRGs (diagnosis-related groupings) for hospital reimbursement;
- Continue to pay pharmacists Medicaid fee-for-service rates for dispensing fees and drug products;
- Limit drug coverage to no more than Medicaid;
- Pay physicians and related professionals (such as chiropractors) Medicaid maximum allowable fees plus 41%;
- Eliminate the provider reconciliation process;
- Eliminate coinsurance and deductibles and, instead, institute a simplified prescription drug co-payment and increase policyholder premiums and the premium floor and ceiling to reflect this change. This change would allow the Department to require providers to bill, eliminating policyholder billing;
- Implement a pharmacy point-of-sale system for HIRSP, based on the proposed Medicaid point-of-sale system;
- Create a HIRSP unit of 5 positions funded by HIRSP in DHFS to oversee the plan administrator and perform other statutorily-required HIRSP functions; and
- Create appropriations with the state budget and accounting system for all HIRSP benefit and administrative costs to improve accountability.

I will transmit in writing the details of the proposal to the Committee. I urge you to study it carefully and give it favorable consideration.

Items that Need to Remain in the Budget

Next, I would like to highlight two items that were included in the March 18 Legislative Fiscal Bureau memo as items that are not directly budget related. The first item is the statutory changes in the tuberculosis statutes. Part of these statutory changes do relate directly to the budget DIN in the Governor's budget on TB rates. Without the statutory change the Department would not be able to implement the rates as assumed in this budget DIN. The second item is the statutory language related to supervised release for Sexually Violent Persons. The supervised release program provides treatment to Sexually Violent Persons (known as SVPs) who have been released by the court under supervision of the Department. Although the number of individuals in this program is still small, the cost of individual placements can be very high, as courts order individuals who require 24-hour supervision into the community. The Department currently has one individual on supervised release whose annual costs are $125,000, which is significantly more than the cost of their care in an institution would be (approximately $85,000/year). A second case with similar projected costs is pending. The Governor's budget bill contains language that would allow some measure of fiscal accountability in the supervised release program. It provides that a court cannot place an individual on supervised release whose cost of placement would exceed the cost of the institutional SVP program. Without this statutory language change, the costs of the supervised release program have the potential to become extremely high and the state will be powerless to control costs. I believe that these two measures should remain in the budget bill.

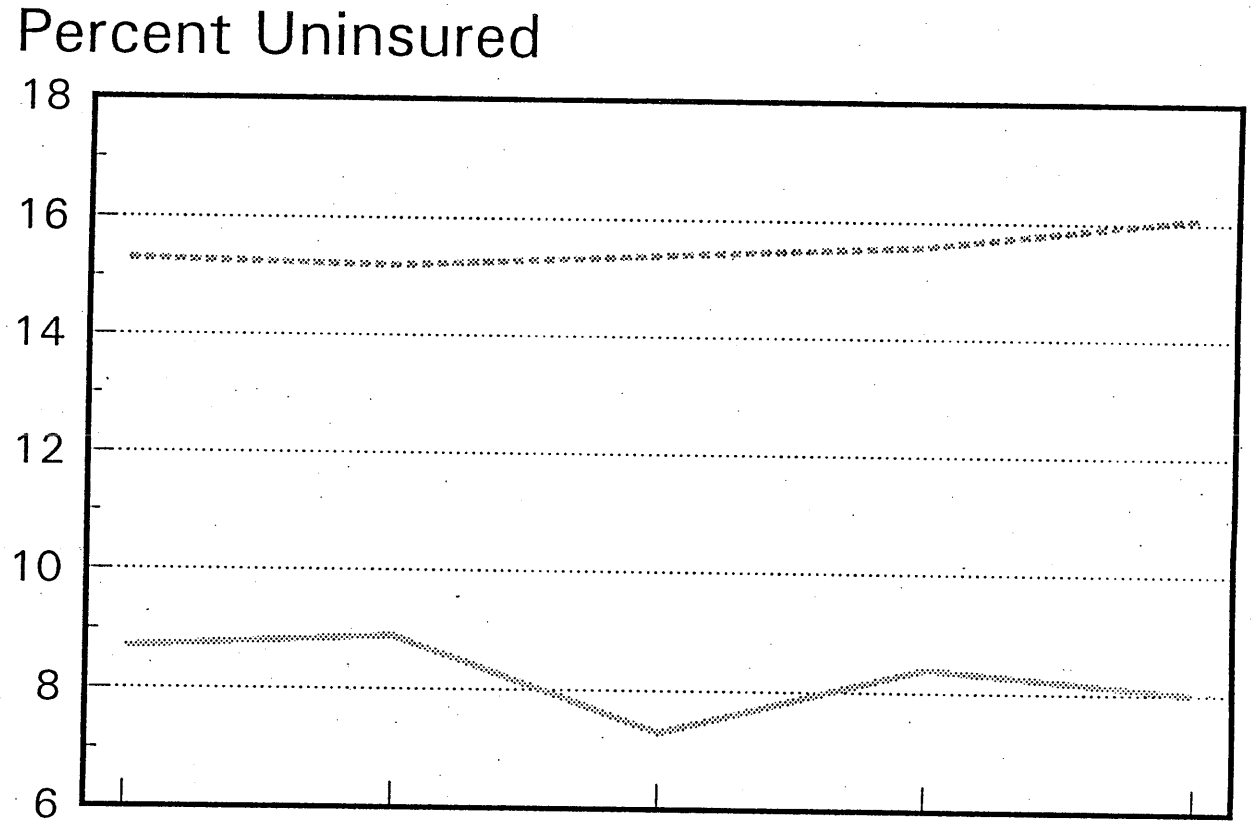
Technical Changes

The final area I would like to address is technical changes. The Department has identified a number of technical changes and corrections. We are working with the Department of Administration to identify those changes that DOA will be submitting as part of its statewide package of budget corrections. It is possible that we may be submitting to the Committee some technical changes with which DOA concurs but that were not included in the DOA budget package.

Conclusion

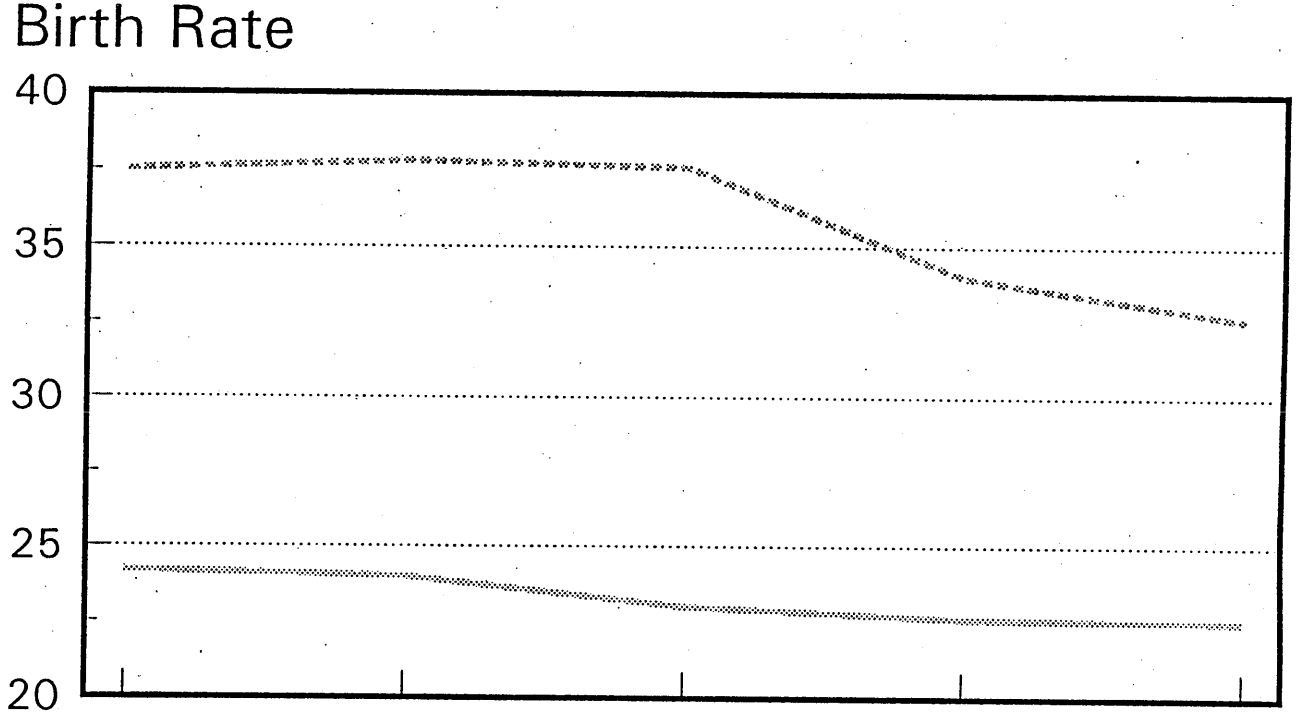
In conclusion, the Governor's 99-01 biennial budget for DHFS seeks to enhance the high quality of health and social services in the state. The budget launches several bold new initiatives, most notably Family Care and BadgerCare. I urge you to give favorable consideration to the Governor's budget proposals for DHFS and to the items I outlined in my testimony today. Thank you. I would be happy to address any questions.

# Percent of Population Without Health Insurance Wisconsin and the U.S. 1993-1997




| Year | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|
| WI | 8.7 | 8.9 | 7.3 | 8.4 | 8.0 |
| US | 15.3 | 15.2 | 15.4 | 15.6 | 16.1 |

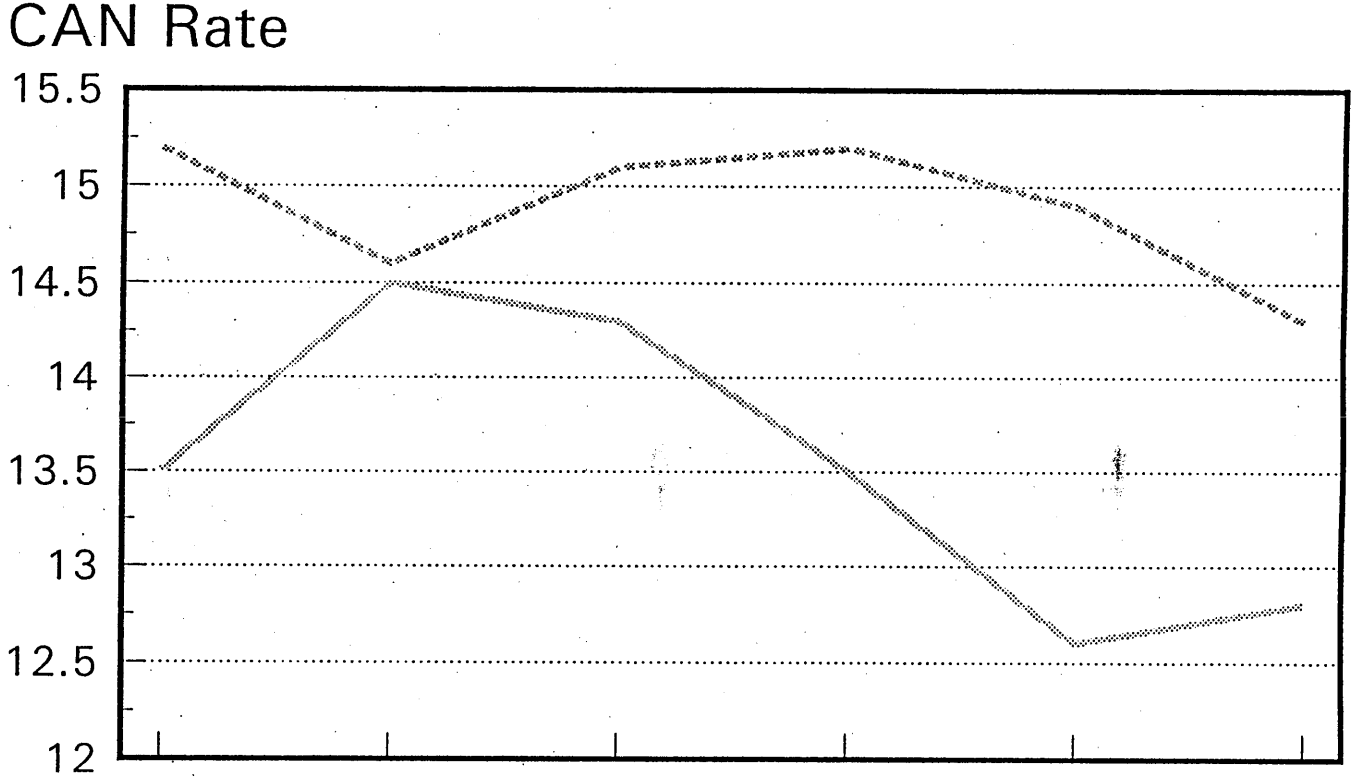
# Birth Rates for 15-17 Year Olds, Wisconsin and the U.S. Selected Years 1990-1997




| Year | 1990 | 1992 | 1994 | 1996 | 1997 |
|---|---|---|---|---|---|
| WI | 24.2 | 24.0 | 23.0 | 22.6 | 22.5 |
| US | 37.5 | 37.8 | 37.6 | 34.0 | 32.6 |

Rate is births per 1,000 females 15-17. WI rate includes births to mothers under 15. The U.S. rate does not include births to mothers <15.

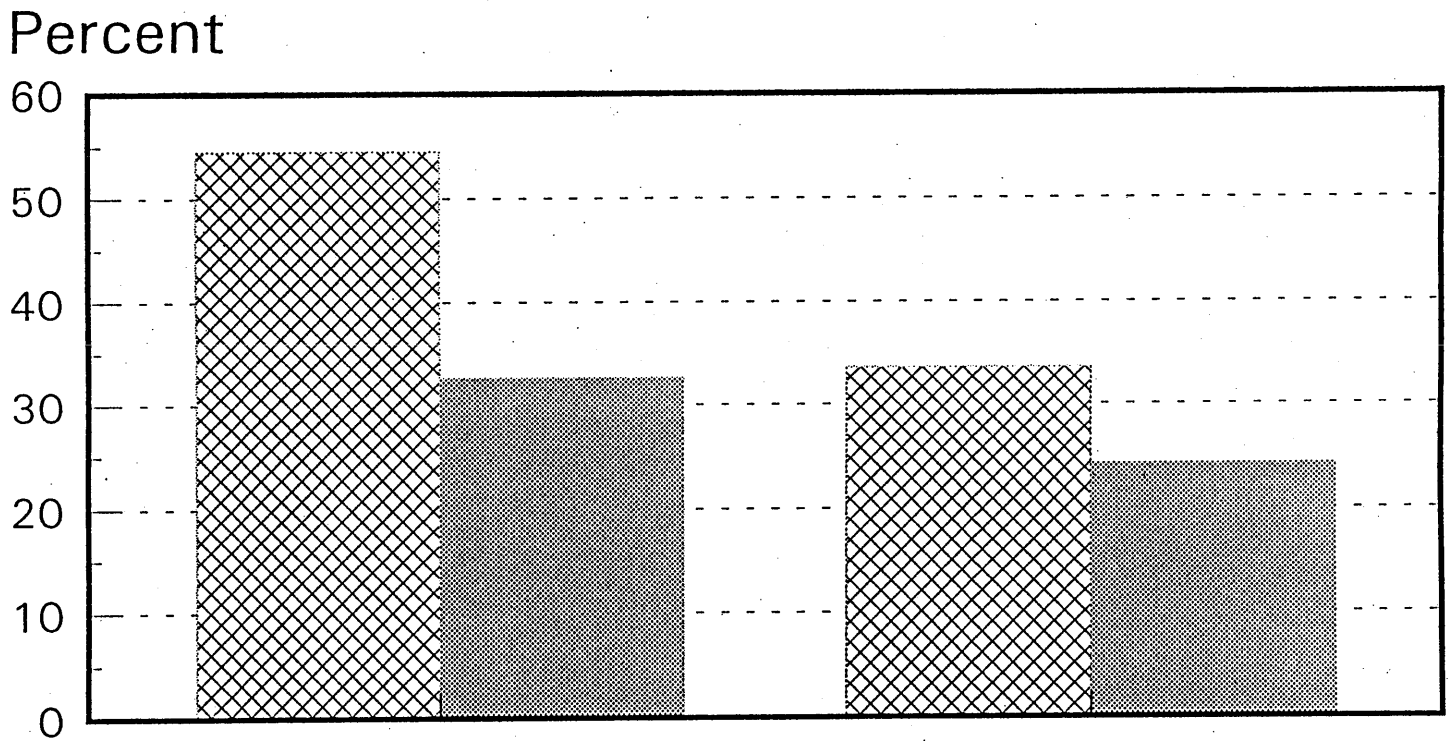
# Substantiated Child Abuse and Neglect Rates
# Wisconsin and the U.S. 1991-1996




| Year | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 |
|---|---|---|---|---|---|---|
| WI | 13.5 | 14.5 | 14.3 | 13.5 | 12.6 | 12.8 |
| US | 15.2 | 14.6 | 15.1 | 15.2 | 14.9 | 14.3 |

Rate is cases per 1,000 population 0-18 years.

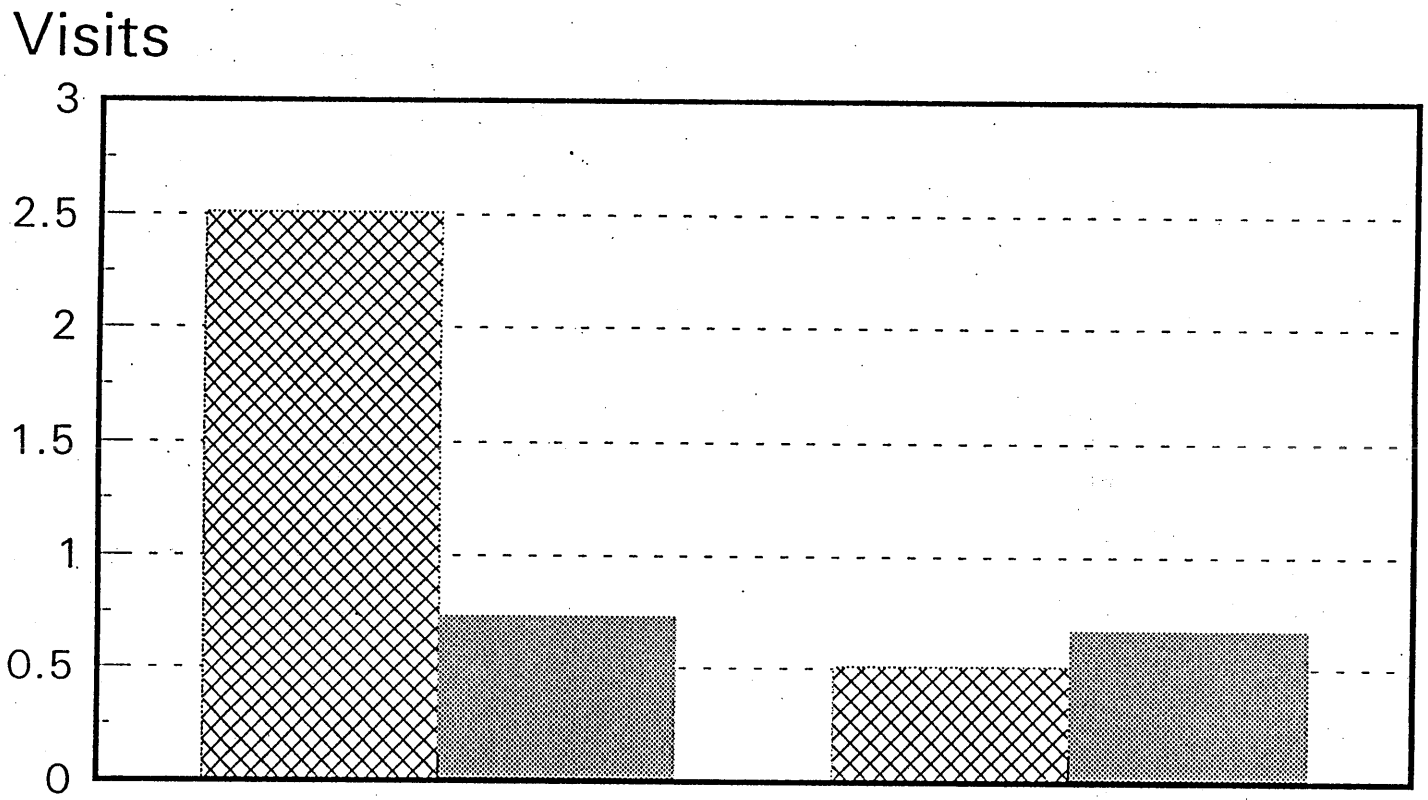
# Percent of Medicaid Children with Health Check Visit and Blood-Lead Test, HMO and Fee-for-Service, 1996




| | % w/Health Check | % w/Blood-Lead Test |
|---|---|---|
| HMO | 54.6 | 33.6 |
| FFS | 32.6 | 24.2 |

Percentage is for children 0-6 years of age.

# Medicaid Primary Care and Emergency Room Visit Rate, HMO and Fee-for-Service 1996




| | Primary Care Visit | ER Visit |
|---|---|---|
| HMO | 2.51 | 0.51 |
| FFS | 0.73 | 0.67 |

Visits are per person per year.

Greater La Crosse
Health Plans, Inc.
*Managed care that works.*

# GOVERNOR'S BUDGET BILL
# HEARING COMMENTS

Date: March 8, 1999

To: Senator Rod Moen
Health, Utilities, Veterans & Military Affairs Committee

From: Thomas M. Lynch, Executive Director
Greater La Crosse Health Plans, Inc.

Re: Point-of-Service Mandate Language

The Wisconsin HMO industry has worked with the marketplace to deliver high quality, cost effective managed care products for nearly two decades. That has been done while achieving one of the highest consumer satisfaction levels in the United States.

1. Need - Point-of-Service products are already available in every county in Wisconsin.

2. Government Interference with Private Business - Requiring private businesses to offer a certain product is contrary to our economic system. Those firms that have the systems, administrative capabilities and desire to offer a given product will offer it. Those that do not should not be required to.

3. Cost – Requiring that point-of-service products be offered by employers to employees will certainly increase the cost of health insurance to state employers with the greatest impact being on small business. Some industry analysts including the Wisconsin Department of Employe Trust Funds have projected a cost impact of

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premium increases approaching 15 percent. This may cause more small businesses to stop providing health insurance benefits. Thus adding to the numbers of people seeking coverage under Badger Care. This would have a negative affect on the Badger Care program.

After years of struggling to control "run away" health care costs, the Wisconsin HMO industry has had a significant positive impact on that issue. Now is not the time to reverse that trend with an unneeded, high cost mandate.

If this issue has merit, please remove it from the Governor's Budget Bill, (Senate Bill SB-45 and Assembly Bill AB-133) and let it be debated as a separate bill in the legislative arena.

Thank you.

State Medical Society of Wisconsin
*Working Together, Physicians Can Determine the Path of Medicine*

TO: State Senator Rodney C. Moen, Chair
Members, Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Jack Lockhart, MD
President-elect

RE: Health Items in the State Budget Bill

DATE: March 8, 1999

Good afternoon. I am Doctor Jack Lockhart. I am a rheumatologist from La Crosse. As incoming president, I am privileged to represent the 8,000 members of the State Medical Society of Wisconsin, and I greatly appreciate the opportunity to address the proposed state budget with you today. Thank you for traveling to La Crosse to take testimony on this critical state issue.

We have reviewed the governor's budget proposal and have numerous issues of concern to discuss with you that affect the ability of physicians to care for their patients. Physicians are hopeful that you will seriously consider these concerns and use your position as the Senate's leaders on health care issues to affect change during the budget process.

Of significant concern to physicians are several of the governor's recommendations regarding the medical assistance program. It is my very grave fear that the punitive nature of these recommendations will force individual physicians to make the difficult decision to stop seeing patients who rely on Medicaid to pay for their health care.

The governor has proposed taking away the due process rights of physicians and other Medicaid providers. The budget provides that the Department of Health and Family Services (DHFS) has the authority to recover monies that it determines were improperly or erroneously paid to a provider without giving the provider an opportunity for a fair hearing prior to the recovery. Also, when DHFS takes action to decertify or restrict a provider's participation in the Medicaid program, the budget bill states that DHFS may immediately stop payments to the provider without a fair hearing if DHFS determines that the provider's continued participation would likely result in the irretrievable loss of public funds. The governor also has proposed the elimination of the right to a fair hearing prior to DHFS reporting provider decertification or suspension to the Medical Examining Board. Physicians recognize the very real need for cracking down on those providers who intentionally defraud our government. The governor's proposal, however, makes the dangerous assumption that a provider is guilty before the provider has the opportunity to establish his/her innocence. This seems in direct conflict with our "innocent until proven guilty" philosophy. We respectfully urge committee members to work to continue the due process rights of Wisconsin physicians.

Other items of concern in the proposed Medicaid budget include: giving DHFS the authority to prescribe conditions of participation and terms of reimbursement for providers and establish guidelines

to determine medical necessity and appropriateness for granting prior authorization without going through the administrative rule process; and requiring providers of specific services to file a surety bond with DHFS as a condition of participation in the program. These proposals, too, just make it more difficult for physicians to continue to participate in the medical assistance program. DHFS should not be given the authority to impose their will on the provider community without seeking input from those providers through the rule-making process.

Patient privacy is an important issue to all physicians, especially in the information age. The physician-patient relationship is built on trust, and that trust is jeopardized for physicians and their Medicaid patients by language contained in the budget bill. Patients usually have the right to give their consent before their health care information is released to anyone. The governor has proposed a significant erosion in that right by giving DHFS and its contractors the right to demand immediate access to patient health care records for the purpose of conducting medical investigations or audits. Physicians urge the committee to ensure that the right to consent to the release of health care information be retained by medical assistance patients. Studies demonstrate that patients are not as forthcoming with their physicians if they fear that information will fall into someone else's hands. The poor and disadvantaged of our society should be able to enjoy the rights that private pay patients enjoy.

The governor has again refused physicians an increase in Medicaid fee-for-service in the first year of the biennium, and only a 1% increase in the second year. Physicians are employers – we are an integral part of the state's economy. If we are to continue to function as viable businesses, we must be able to meet the costs of running our businesses. Remember, shortfalls in Medicaid reimbursement need to be made up. This usually results in cost shifting, but in a managed care era, this opportunity is quickly losing its viability. A Medicaid raise is not about increasing profits, it is about meeting our business expenses and continuing to provide adequate access to a vulnerable segment of our state's population.

Physicians also are very disappointed in the lack of commitment to a comprehensive tobacco reduction and control program. The State Medical Society is an active partner in the TRUST Campaign (Tobacco Reduction Using the SettlemenT). TRUST is seeking $80 million per year from the state's tobacco settlement to fund a comprehensive tobacco reduction and control program. $80 million is the amount that the Centers for Disease Control has determined that Wisconsin needs to fund such a program. TRUST believes the money should be used to fund cessation programs, local initiatives, education and research, and counter-advertising. We hope this committee will send a strong message to the members of the Joint Committee on Finance to dramatically increase the level of funding in this area. Our children's health depends on it.

The governor's budget does have provisions that physicians support. We are pleased to see funding set aside for a position within the Office of the Commissioner of Insurance to address complaints against managed care plans. We hope that this position will assist those of our patients who have difficulties with their managed care plans. The Medical Society also is pleased with the expansion of Badger Care. This represents a tremendous opportunity to ensure that the working poor have access to health care coverage.

Finally, physicians applaud the governor's decision to deny the request by DHFS for position authority for the collection of outpatient claims data. Physicians hope that the Legislature will give careful consideration, as the governor did, to what Act 231 actually requires and the threat it makes to the privacy of our patients.

Thank you for the opportunity to speak to you today. I would be happy to try to answer any questions you might have.

**TESTIMONY OF:**

**THE WISCONSIN HEALTH AND HOSPITAL ASSOCIATION, INC.**

**BEFORE THE WISCONSIN STATE SENATE**
**COMMITTEE ON HEALTH, UTILITIES, VETERANS AND MILITARY AFFAIRS**

**LA CROSSE, WISCONSIN**
**MARCH 8, 1999**

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My name is Peter Peshek. The Wisconsin Health and Hospital Association (WHA) has asked that I provide this Committee some insight regarding what WHA deems to be critical components of the proposed biennial budget. Having worked closely with many of you on health care policy issues for at least a decade, I believe that we will, as we have so often in the past, find that the budget document presents some major challenges as Wisconsin works to formulate its long-term health care vision.

## OVERVIEW

The Governor's biennial budget proposal, as recently submitted to the Legislature, would result in hospitals losing $13.8 million in Medicaid funding and the burden of approximately $23 million in total costs shifting to the private health care users of Wisconsin. Because we feel this is unacceptable, we strongly urge you to take whatever action is necessary to correct the inequity.

By way of review, the Medical Assistance Program's formula provides for 60% federal funding and 40% state funding. Therefore, every $1 lost in state-committed funds results in $1.50 being lost in federal funds. Thus, the impact of the reduction is amplified, which further exacerbates the historical inequity Wisconsin has experienced in terms of federal dollar reimbursement.

## MEDICAID RATE FREEZE

The Governor's budget proposal also calls for a two-year freeze in the Medicaid rate regarding inpatient payments to hospitals (outpatient care receives a 1% increase in FY 01). This freeze would prove particularly difficult for our members, given ever-present inflationary pressures, especially as it relates to the recruitment and retention of qualified employees. Using federally-accepted health care inflationary indices of 2.4% in FY 00 and 2.6% in FY 01, the proposed freeze would result in a loss of $10.2 million in federal dollars and $7.1 million in state dollars. We ask you to support an increase for health care providers that will keep them even with inflation.

Wisconsin Health &
Hospital Association, Inc.

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Madison, WI
53719-1289

608/274-1820

FAX: 608/274-8554

http://www.wha.org

## GRADUATE MEDICAL EDUCATION

As we are all aware, the future of health care delivery in Wisconsin is heavily dependent on an adequate supply of physicians to meet the needs of what is fast becoming an increased elderly population. Wisconsin has always had an excellent track record of retaining the physicians who train in residency programs offered by the University of Wisconsin, the Medical College of Wisconsin (Milwaukee) and programs offered in western Wisconsin by organizations in Minnesota.

The Governor's proposed budget would reduce the funding needed to support these residency programs by $3.6 million in federal funds and $2.5 million in state funds. We believe this reduction will significantly undermine our ability to train and keep physicians and, thereby, significantly negatively impact our continuing struggle to establish Wisconsin as a major center for health and medical research. We urge you to restore this vital funding!

## CONCLUSION

WHA hopes you will give these two aspects of the proposed biennial budget your careful evaluation. For too long now, Wisconsin has made decisions that send federal dollars elsewhere. We believe it is time that the State begins to protect its long-term investment in health care by maximizing any and all opportunities to capture federal funding.

Thank you.

Respectfully submitted,

Peter A. Peshek, Esq.
On Behalf of Wisconsin Health
and Hospital Association

Gundersen Lutheran HEALTH PLAN

**Statement of Gundersen Lutheran Health Plan**
**to the**
**Committee on Health, Utilities, Veterans and Military Affairs**
**Wisconsin Senate**
**in regard to**
**the Point-of-Service (POS) Mandate in the Budget Bill**
**by**
**Patrick F. Killeen, Executive Director**
**Gundersen Lutheran Health Plan**
**March 8, 1999**

I appreciate the opportunity to appear before you today to address a provision in the Budget Bill which could have a serious impact on health insurance premiums and the cost of doing business in Wisconsin. I speak on behalf of the Gundersen Lutheran Health Plan, with the complete support of the Gundersen Lutheran Health System.

The Gundersen Lutheran Health Plan is a not for profit, La Crosse, Wisconsin based health maintenance organization with over 35,000 members. We wish to voice our opposition to the Point-of-Service mandate included in the Budget Bill. This measure would require health maintenance organizations to pay for services received from any health care provider an insured member chooses, even if the provider is not part of the HMO network. This means that employers would lose their right to purchase the type of employee health benefits they want. Our Health Plan offers a POS product to employers who want it and are willing to pay more for it. They should not be required by law to do it. Furthermore, the non-HMO providers could charge any amount they want.

We urge you to remove the POS mandate from the Budget Bill for the following reasons:

1. The POS mandate is probably the single most expensive health care mandate on small business ever proposed in Wisconsin.

**Gundersen Lutheran Health Plan, Inc.**
1836 South Avenue • La Crosse, Wisconsin 54601 • (608) 791-8000 • (800) 370-9718 • Fax (608) 791-8042

2. It is estimated that POS premiums are seven to 10 percent higher than standard HMO premiums.

3. The Department of Employee Trust Funds (DETF) estimates that the POS mandate would increase the State's costs for the State employee plan by $1.5 to 3 million annually (fiscal estimate of 1997 AB 961). DETF estimates that the POS mandate would raise premiums by 15%.
4. The POS mandate will force small employers to drop health care coverage, pushing more working people into the ranks of the uninsured. This could significantly increase the population and cost of the BadgerCare program.

5. A government prescribed POS mandate means higher administrative costs, unrestrained provider charges and the end to the affordable health insurance options demonstrated by Wisconsin's HMO's.

As a health maintenance organization, we support meaningful health reform measures such as those passed in Wisconsin's recently enacted Managed Care Reform Act. However, we must oppose legislation that would negatively impact our members, our employer groups, our state government and Wisconsin's HMO's.

It is for these reasons that we urge you to remove the POS mandate from the Budget Bill and require that it be debated as a separate issue.

Again, thank you for the opportunity to speak to you today.

# TOMMY G. THOMPSON

**Governor**
**State of Wisconsin**

October 16, 1998

Chris Decker, Executive Director
Pharmacy Society of Wisconsin
701 Heartland Trail
Madison, WI 53717

Dear Mr. Decker:

I understand your concern regarding the 1999-2001 biennial budget request from the Department of Health and Family Services to reduce the Medicaid reimbursement rate to pharmacies.

Rest assured I remain committed to protecting the interests of pharmacies throughout the state of Wisconsin and will not approve this request to reduce the Medicaid pharmacist reimbursement in the 1999-2001 biennial budget.

As you know, the State Budget Office is currently reviewing all agency requests for possible inclusion in my 1999-2001 biennial budget I will be submitting to the Legislature. After their review is completed, my staff and I will analyze each budget item and its corresponding recommendations.

I appreciate knowing your thoughts on the request from the Department of Health and Family Services. I have spoken with Secretary Leean regarding his Medicaid drug reimbursement request and he informed me the Department included this in their proposal as a means of meeting the State Budget Office budgetary instructions.

Your contributions to improving and maintaining the health and well being of all Wisconsin residents are truly appreciated.

Sincerely,

Tommy G. Thompson

TOMMY G. THOMPSON
Governor

Room 115 East, State Capitol • P.O. Box 7863, Madison, Wisconsin 53707 • (608) 266-1212 • FAX (608) 267-8983

*Surgical Appliance Consultant*

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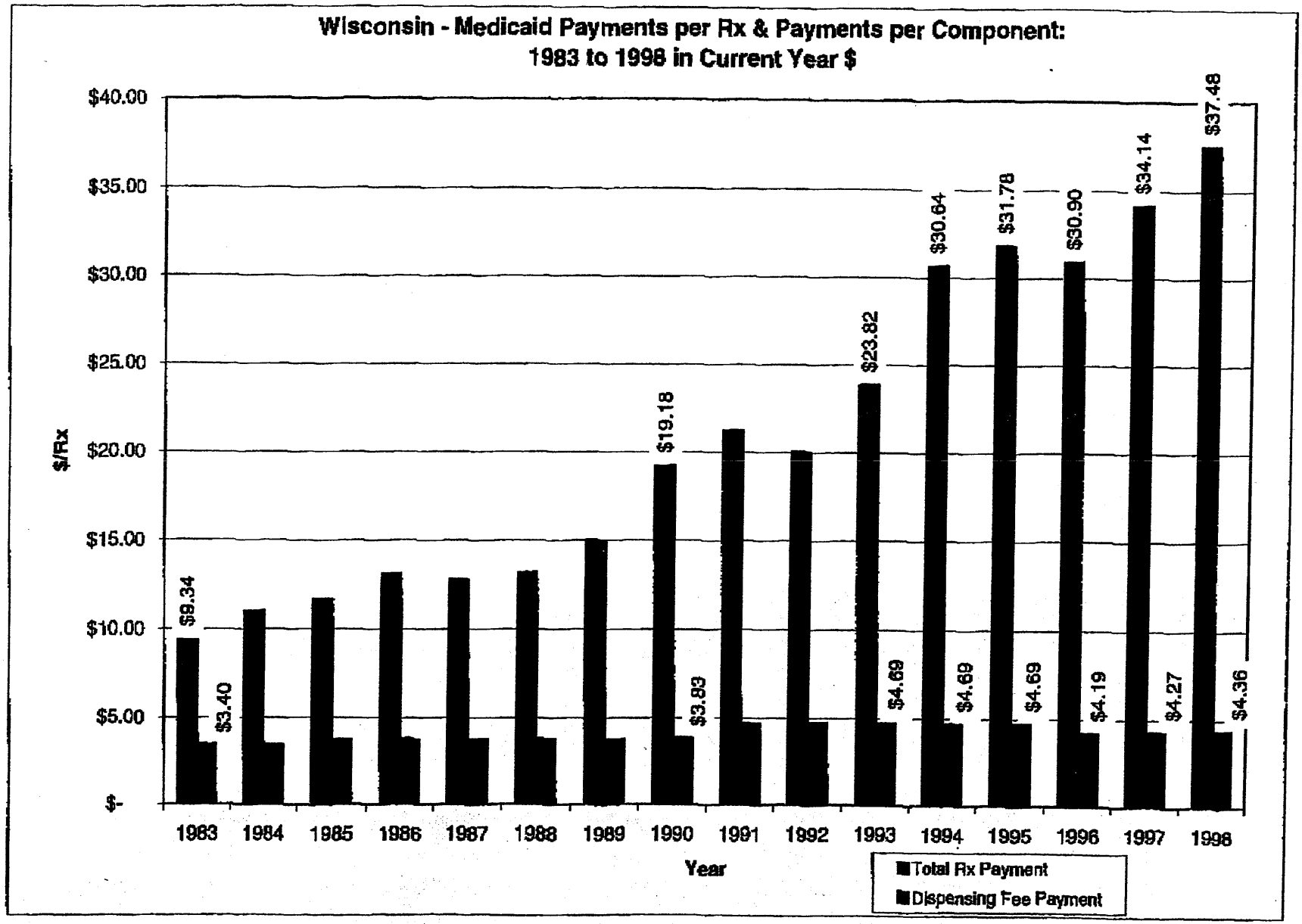
PHONE (920) 437-0206
FAX (920) 437-0276

JEFF KIRCHNER R. Ph.
PHARMACIST CONSULTANT


Wisconsin - Medicaid Payments per Rx & Payments per Component:
1983 to 1998 in Current Year $
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
$-
$/Rx
$8.34
$3.40
$19.18
$3.83
$23.82
$4.69
$30.64
$4.69
$31.78
$4.69
$30.90
$4.19
$34.14
$4.27
$37.48
$4.36
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
Year
Total Rx Payment
Dispensing Fee Payment

Chairman Moen, members of the Health Committee, thank you for the opportunity to address you today. My name is Jeff Kirchner and I am a second generation pharmacist and a partner in an independent pharmacy just up the street from here. Our pharmacy has been around for over 35 years and continues to be a family run business. We currently have 22 employees on staff including four full-time pharmacists, two nurses, and many other various positions. Our store is a high service pharmacy serving skilled nursing facilities, a large number a residential care facilities, and a large walk-in population. I love my job and I get great satisfaction in helping people.

I am here today as a pharmacist but also to represent the Medicaid recipient. We need to raise serious concerns about a budget item that has unfortunately been proposed in the Governor's 1999-2001 budget. This item seeks to cut $7.5 million dollars in state funds from the MA Drug component of the Department of Heath and Family Services' portion of the budget. The total cut to the pharmacy budget actually amounts to $18 million per biennium due to federal matching funds. If this proposed decrease results in a cut to the already low pharmacy reimbursement rates, many pharmacists across the state will no longer be able to service Medicaid recipients.

I am aware that the fastest growing component of Medicaid is the drug component, and that the percentage of national health expenditures spent on prescription drugs has increased by nearly 6 fold since 1980. This amounts to billions of dollars. However, it is important to note that the increase is primarily due to three factors:

1) An increase in the cost of newly developed and marketed drugs.
2) An increase in the utilization of prescription drugs by consumers.
3) Manufacturers price increases for existing drug products.

Unfortunately, during those same years pharmacists have borne the brunt of cost containment initiatives. In an effort to slow the growth of expenditures for the prescription benefit portion of health plans, health plan administrators have reduced payments to pharmacies. However, pharmacies do not control the price of drugs (manufacturers do) this cost containment effort has been largely unsuccessful.

For example, if you look at Wisconsin Medicaid which is still the state's largest third party payer of health care services, the portion paid to pharmacists for services associated with the dispensing of each prescription has remained nearly level over the past 15 years while the cost of drugs has continued to rise. This chart, which I have provided you a copy of, illustrates this point. In 1983, the total average cost of a prescription was $9.34 which included a $3.40 dispensing fee. In 1998, the average prescription cost was 37.48 including the dispensing fee of $4.36. In short, while the dispensing fee rose by less than $1.00, the average cost of a drug rose by nearly $25.00.

As you can clearly see overall expenditures for prescription drugs are not the result of increased reimbursement to pharmacy providers. Cost containment efforts targeting pharmacy reimbursement have done little to slow the growth in prescription drug expenditures. You could reimburse pharmacists nothing and you would still experience the same rate of increase in their pharmacy budgets. Unfortunately, pharmacies have been put in a position of accepting these forced reductions in reimbursement or losing the ability to serve the patients in their communities. The impact is obvious there are less than 5 independent pharmacies in Green Bay today which is less than half of what we had 10 years ago.

I would like to share with you some examples of the services we provide our patients 30% of which are medical assistance recipients. Our pharmacy works very closely with our counties mental health program. Many patients in this program have very complicated drug regimens where compliance with the medications is the difference in living independently or being institutionalized. Our pharmacy in many instances puts the patients' medications in compliance packs on a weekly basis. With these packs patients now can easily take a very complicated drug regimen and never miss a dose. Many Patients receive the medications on a weekly basis. Compliance packs can be easily monitored by case managers or group home managers. Besides the packaging of the medications the medications are often times delivered to the home and often the co-payment of $1.00 per medication has to be charged to a payee. These are just a few services one patient may receive outside of the normal consultation and service. This

is one of many examples of the many services that are available to the Medical assistance recipient and that saves millions of dollars every year by keeping patients out of the hospital or institution.

In conclusion, in a written letter to the Pharmacy Society of Wisconsin last fall, Governor Thompson stated that he would not support the DHFS request to reduce pharmacy reimbursement rate in the budget. He further promised to the pharmacists (through his Chief of Staff) that no further reduction in pharmacy reimbursement would occur at all. Obviously, this promise was not kept.

What is more disturbing, however, is that the proposal forwarded is flawed, unrealistic, and will force many pharmacists to go out of business. This will create a patient-access problem that will be far more costly than the state intends to pay. Many of the services that save the state millions in health care dollars will no longer be available because pharmacies will not receive adequate compensation to provide the services. Either way pharmacies and the patients both end up losers. I guess it concerns me that a cut of this magnitude could happen without any type of study looking at the potential impact this could have on pharmacy or on the Medicaid recipient. Therefore, I respectfully encourage you and your colleagues to oppose this disastrous proposal. While I agree that rising drug costs is a problem, this proposal is not a solution. Thank you again for your time, and I would be pleased to answer any questions.

Sincerely,

Jeff Kirchner R.Ph.

Jeff Kirchner R.Ph.

RESOLUTION #68/6-98

| BOARD ACTION | |
|---|---|
| Adopted: | ✓ |
| For: | unan |
| Against: | |
| Abs/Exed: | 6 |
| Vote Req: | |
| Other Action: | |

TO: HONORABLE MEMBERS OF THE LA CROSSE COUNTY BOARD OF SUPERVISORS

RE: STATE OF WISCONSIN FINANCIAL SUPPORT TO PROTECT THE HEALTH OF THE PUBLIC

WHEREAS, the children of Wisconsin are suffering unnecessary illness from their exposure to lead poisoning, failure to thrive as infants and children as a result of failure of their parents to have access to information and services that would increase the potential healthy outcomes in their children, are exposed to preventable child abuse and neglect, suffer from preventable injury and could be given the opportunity to have a more healthy and productive life by receiving access to services described in Healthier People in Wisconsin: A Public Health Agenda; and,

WHEREAS, the people of Wisconsin look to their government to provide them with information and services that will protect them and their family from preventable disease and death; and,

WHEREAS, county governments across Wisconsin have recognized their responsibility to provide for public health service delivery. The State of Wisconsin has not met its obligation to assure that the delivery of low cost prevention services are provided at needed levels in all parts of the State, while six midwest state governments provide from $.32 to $3.87 per person per year for local public health services, amended by Board of Health 6/8/98.

NOW, THEREFORE, BE IT RESOLVED that the Wisconsin Counties Association support as a high priority State funding to assure that all children in Wisconsin receive needed lead poison prevention screening and treatment, access to adequate nutrition, delivery of nutrition and nursing services to mothers and children in high risk situations regardless of their economic status; and,

BE IT FURTHER RESOLED that the State of Wisconsin allocate $1.00 per person per year to assist Wisconsin counties in the delivery of health services that protect the health of the public along with an additional 2.5 million dollars to be set aside for distribution to local units of government to solve unique problems within their community as described in Healthy People 2000.

Date: June 8, 1998

BOARD OF HEALTH

Date: June 8, 1998

ADMINISTRATIVE/LEGISLATIVE COMM.

| | Approved | Not Approved |
|---|---|---|
| A/C: | ✓ | |
| F/D: | 6-I | |

Requested By: Doug Mormann
Date Requested: May 29, 1998
Drafted By: Jerry Seubert

ADOPTED BY THE LA CROSSE COUNTY BOARD ON THIS 18 DAY OF June, 1998.

STATE OF WISCONSIN )
COUNTY OF LA CROSSE )

I, Sharon M. Lemke, County Clerk of La Crosse County do hereby certify that the attached document is a true and correct copy of the original resolution required by law to be in my custody and which was adopted by the County Board of Supervisors of La Crosse County at a meeting held on the:

18th Day of June 1998.

Sharon M. Lemke, La Crosse County Clerk

RESOLUTION # 98/1-55

| BOARD ACTION | |
|---|---|
| Adopted | |
| For: | 29 |
| Against: | |
| Abs/Exed: | 2 |
| Vote Req: | |
| Other Action: | |

TO: HONORABLE MEMBERS OF THE LA CROSSE COUNTY BOARD OF SUPERVISORS

RE: ALLOCATION OF TOBACCO LIABILITY SETTLEMENT FUNDS TO DISEASE PREVENTION SERVICES

WHEREAS, the State of Wisconsin is expected to receive approximately $150 million/year (about $30/per person in Wisconsin) for the next 25 years from tobacco companies as a result of the national tobacco settlement for tobacco related illness; and,

WHEREAS, La Crosse County residents spend $22 million a year on tobacco products; and,

WHEREAS, the tobacco industry spends an average of $100 million ($20/person) a year in Wisconsin promoting the use of tobacco products; and,

WHEREAS, the average annual expenditure for tobacco related medical services to Wisconsin residents is $1 billion or for La Crosse County residents $19 million ($190/person) a year; and,

WHEREAS, the current allocation of funds spent to reduce tobacco use in Wisconsin is $1.4 million (27 cents/person); and,

WHEREAS, preventing tobacco use by youth is an important long-range strategy to reduce tobacco related illness and death.

NOW, THEREFORE, BE IT RESOLVED that the La Crosse County Board hereby encourages Governor Tommy Thompson, Senator Brian Rude, Representatives Mike Huebsch and Mark Meyer to support legislation that assures a significant portion of the tobacco settlement funds be used to reduce the use of tobacco; and,

BE IT FURTHER RESOLVED that the Wisconsin Counties Association be encouraged to support legislative initiatives that allocate tobacco settlement funds to private and public sector programs to reduce disease and death from tobacco products and that a copy of this Resolution be sent to all Wisconsin counties.

Date: January 11, 1999
BOARD OF HEALTH

Date: January 11, 1999
ADMINISTRATIVE COMMITTEE

Approved Not Approved

Requested By: Doug Mormann
Date Requested: January 5, 1999
Drafted By: Bill Shepherd

F/D: EOI

ADOPTED BY THE LA CROSSE COUNTY BOARD ON THIS 21 DAY OF January, 1999.

H:\th. Allocation of Tobacco.doc

STATE OF WISCONSIN
COUNTY OF LA CROSSE
I, Sharon M. Lemke, County Clerk of La Crosse County do hereby certify that the attached document is a true and correct copy of the original resolution required by law to be in my custody and which was adopted by the County Board of Supervisors of La Crosse County at a meeting held on the:

21 day of January 1999.

Sharon M Lemke, La Crosse County Clerk

ARCW

AIDS RESOURCE CENTER OF WISCONSIN

LEADING WISCONSIN'S RESPONSE TO AIDS

**Life-Saving HIV Prevention Services**
A Blueprint for Stopping AIDS in Wisconsin

*The AIDS Resource Center of Wisconsin encourages the Joint Finance Committee to reinvest $500,000 GPR funds in the 1999-2001 State Budget into effective, community-based HIV prevention services.* This funding is available based on a reestimate in utilization and expenditures for the HIV/AIDS Insurance Continuation Program.

Eighteen years into the AIDS epidemic, the State of Wisconsin reports at least one new person living with HIV each day. Men, women and children across Wisconsin remain at high risk for HIV. In the past four years:

- 1,429 Wisconsin residents have been diagnosed as HIV positive, a 31% increase
- the number of teens with AIDS has increased by 44%, and, nationally, 50% of all new HIV infections occur among youth between the ages of 13 and 24
- the number of women with AIDS in Wisconsin has increased by 63%

The State of Wisconsin HIV Prevention Planning Council has done excellent work in determining the most effective HIV prevention strategies for urban and rural populations at greatest risk of contracting HIV. This initiative will fund professionally trained outreach workers located across Wisconsin to implement the HIV prevention strategies highlighted in the plan, include:

- one-on-one HIV prevention counseling
- HIV prevention case management
- outreach HIV counseling and testing
- peer education and opinion leader strategies
- HIV risk-reduction skills building

**Since 1989, the State of Wisconsin has flat-funded HIV prevention at $180,000 GPR even though reported HIV infections have increased 8-fold.** Wisconsin now spends more money on administering AIDS programs than on preventing new infections.

The reinvestment of these funds into HIV prevention services will not reduce the access to health care through Wisconsin's HIV/AIDS Insurance Continuation Program and is an effective strategy to reduce future State-funded costs for HIV care and treatment which can be as high as $125,000 per person living with HIV.

820 NORTH PLANKINTON AVENUE 53202 PO BOX 510498 53203-0092 MILWAUKEE, WISCONSIN
414-225-1597 800-359-9272 EXT 297 FAX 414-273-2357 WWW.ARCW.ORG AIDSACTION WI@EXECPC.COM
APPLETON EAU CLAIRE GREEN BAY KENOSHA LA CROSSE MADISON MILWAUKEE SUPERIOR WAUSAU

ARCW

AIDS RESOURCE CENTER
OF WISCONSIN

LEADING WISCONSIN'S RESPONSE TO AIDS

**Cost-effective Community-based Care for People with HIV and AIDS**
Life Care Services/Early Intervention Grant

*To adequately address statewide HIV/AIDS caseload expansion and the increasing complexity of service delivery, the AIDS Resource Center of Wisconsin urges the Joint Finance Committee to increase funding for the cost-effective Life Care Services/Early Intervention grant by $196,800, or 10%, in SFY 2000 and maintain that level of funding in SFY 2001.*

Community-based services funded by the Life Care Services/Early Intervention grant have been accessed at record levels, increasing by 20% from 1,947 clients in SFY94 to 2,325 clients in SFY98. This increase in caseload has been fueled both by more people diagnosed with HIV and by declining AIDS death rates that have resulted in clients accessing services for a longer period of time. With at least one new HIV case reported each day and an estimated 8,000 to 12,000 Wisconsin residents with HIV, caseloads are projected to increase in the upcoming biennium.

While new AIDS drug therapies have been successful in reducing Wisconsin's AIDS death rate, adherence to the treatments require significantly greater support. The Life Care Services/Early Intervention Grant provides access to one-on-one effective coordinated case management and support services to achieve the highest level of adherence possible. Each year thousands of clients and families with HIV disease and AIDS are seeking services funded by this grant. While the number of clients has risen significantly, the need for services has increased even more dramatically. Between 1997 and 1998, clients accessing:

- **Housing Assistance** programs that provide rent assistance, housing counseling and project based housing have been access 35% more frequently.
- **Legal and Benefits Counseling** programs that are crucial to assuring continuous health care and assisting with employment related issues have seen a 15% increase in utilization.
- **Food Assistance** including food pantry and nutritional counseling services have experienced a 75% increase in utilization.
- **Transportation** to medical appointments is critical for people with HIV/AIDS who can no longer miss appointments without potentially harming their health status. Access to this program has increased by 139%.

A 10% increase in funding for the Life Care/Early Intervention grant will enable Wisconsin to provide services to thousands of individual and families living with HIV, continue to reduce State MA HIV-related costs and to maintain a lower AIDS death rate.

820 NORTH PLANKINTON AVENUE 53203 PO BOX 92487 53202-0487 MILWAUKEE WISCONSIN
414-273-1991 800-359-9272 FAX 414-273-2357 www.arcw.org

APPLETON EAU CLAIRE GREEN BAY KENOSHA LA CROSSE MILWAUKEE RHINELANDER SUPERIOR WAUSAU

ARCW

AIDS Resource Center
of Wisconsin

Leading Wisconsin's Response to AIDS

**Budget Neutral Expansion of Health Care for People with HIV**
Medicaid Waiver for the Provision of Health Care and Treatment

*The AIDS Resource Center of Wisconsin endorses the Department of Health and Family Services effort to obtain a federal Medicaid waiver to expand coverage for health care for low income people with HIV. However, ARCW encourages the Joint Finance Committee to remove limitations in* ***Section 1436*** *of the budget bill that capitates services under the waiver.*

Waiver

The State of Wisconsin's Medical Assistance (MA) program and the access it provides to comprehensive health care services has been a powerful tool in the fight against AIDS. Unfortunately, eligibility for Wisconsin's MA program, much like other state's Medicaid programs, requires people with HIV to be diagnosed with AIDS before they can access medical care that would be prevented the deterioration of their health status. The proposed federal waiver will remedy this "catch-22" by providing early access to health care and medications for low income people with HIV through the State MA program.

For the waiver to be approved by the federal government, the State must prove cost-neutrality, meaning that over a five year time frame the cost of care under the waiver will not exceed the cost of care absent a waiver. There is significant data nationally demonstrating the cost neutrality of this waiver and at least 4 states are already seeking this type of waiver to extend MA eligibility to low income people with HIV.

Service Caps

ARCW encourages the Joint Finance Committee to remove the health care caps placed on this waiver in Section 1436 of the budget bill for the following reasons:

- Protease inhibitor HIV therapy is most effective in maintaining health and reducing future medical care costs when regular, continuous health care is accessed. The proposed capitated level of care would limit the effectiveness of treatment and potentially harm the health status of HIV+ patients.

- Significant breakthroughs in preventative care for HIV-related illnesses that are the standard of care would be cost-prohibitive under the proposed cap.

**Because approval of the federal waiver is based on demonstrated cost-nuetrality, removal of the cap will not increase State spending.**

820 North Plankinton Avenue 53203 PO Box 92487 53202-0487 Milwaukee Wisconsin
414-273-1991 800-359-9272 FAX 414-273-2357 www.arcw.org

Appleton Eau Claire Green Bay Kenosha La Crosse Milwaukee Rhinelander Superior Wausau

# Position Statement in Opposition to License Fees for Ambulance Providers

The Wisconsin EMS Association opposes the implementation of license fees for Wisconsin ambulance service providers. Many of Wisconsin's ambulance services operate as non-profit, volunteer agencies. Many of these same services continually struggle financially in their operations. They look to community donations and hold fund raisers to purchase needed equipment and supplies, obtain continuing education, and up-grade the level of service that they provide to the community. It was for these reasons that the Funding Assistance Program (FAP) was created in 1990. In this program, the State of Wisconsin provides funding to ambulance services that provide primary emergency response. It is a complete contradiction for the State of Wisconsin to provide funding to an ambulance service and then mandate money be returned to the State of Wisconsin in the form of a provider license fee. This tactic is nothing less than moving money from an expense line of the state budget, to an income line of the state budget, in the form of a fee passed through the ambulance service.

During the past years, The Department of Health and Family Services (DHFS) and the State EMS Board have successfully demonstrated themselves to be friends and supporters of Wisconsin EMS and EMTs. The EMS Board has made it a priority to identify funding for EMS and has charged a committee with working toward this goal. Creating a new fee structure on ambulance providers directly contradicts the efforts of the EMS Board and the population they serve. It also sends a message to the Wisconsin EMS community that the ultimate goal of these two entities is truly not to support and aid Wisconsin's ambulance services.

The Wisconsin EMS Association urges that license fees for Wisconsin ambulance providers not be created. The implementation of an ambulance provider fee contradicts the efforts communities have instituted to generate volunteerism and to control costs associated with providing necessary services to local Wisconsin communities. The funds that might by raised for the State of Wisconsin through such a program are greatly outweighed by the negative impact that will be displayed on Wisconsin ambulance providers and EMTs. The Wisconsin EMS Association requests that this plan be removed immediately from the budget proposal of 1999-2000.

Wisconsin EMS Association

21332 Seven Mile Rd. • Franksville, WI 53126-9769 • 1-800-793-6820 • WEMTA@aol.com

Association of
Wisconsin **HMOs**

APR 0 8 1999

William L. Carr
President

Nancy J. Wenzel
Executive Director

2 East Mifflin Street • Suite 701 • Madison, Wisconsin 53703 • 608-255-8599 • Fax 608-255-8627

April 7, 1999

To: Members, Senate Health, Utilities, Veterans & Military Affairs Committee

From: Gary L. Radloff
Director of Government Affairs

***RE:*** **Opposition to the Point-of-Service (POS) Mandate in the Budget Bill**

**The Association of Wisconsin HMOs strongly opposes the point-of-service (POS) product mandate contained in the Governor's 1999-2001 State Budget Bill. Contrary to the allegations of many provider groups, this mandate has a significant impact on state public policy and on health care costs. The POS product mandate should be removed from the budget as a major policy item.**

Recent statements and position papers by those representing chiropractors, dentists, podiatrists and optometrists grossly misrepresent: what the budget language says; what POS products cost; and what is available in today's marketplace.

## WHAT DOES THE POS BUDGET MANDATE REALLY SAY?

The specific language of the POS mandate says:

- Managed care plans must offer to their enrollees at least one POS coverage option in each geographic service area of the plan;
- Health care plans must reimburse a provider for the cost of services provided to an insured if the provider is appropriately licensed and the services are covered under the health care plan; and
- Enrollees may obtain services from the provider of their choice, regardless of whether or not the provider is a member of their health care plan's network.

Despite provider group rhetoric, the budget language does not:

- Require individuals selecting a POS product to pay all of the costs of a POS product;
- Restrict or contain out-of-network provider charges or inappropriate utilization; or
- Fund the added costs of a POS product mandate for state employees.

## WHAT DO POS PRODUCTS REALLY COST?

**POS products have significantly higher premiums and are more expensive for insurers to offer and to administer.**

- Standard actuarial studies estimate that POS premiums are 7-10% higher because out-of-network provider charges are significantly higher than in-network charges for the same services and because out-of-network utilization of services goes unchecked.

- The Department of Employe Trust Funds (DETF) estimates that a POS mandate would increase the state's costs for the state employee plan by $1.5-$3 million annually (fiscal estimate of 1997 AB 961). DETF estimates a 15% premium difference between a standard HMO plan and a POS product for state employees.

- The Office of the Commissioner of Insurance (OCI) requires HMOs with a POS product to have larger cash reserves to protect against the higher cost of POS. Other major POS costs include: a claims system to process out-of-network charges; additional staff to handle new claims processing; costs associated with OCI licensing requirements; and actuarial costs associated with pricing the POS product.

## WHERE ARE POS PRODUCTS CURRENTLY AVAILABLE TO CONSUMERS?

**OCI statistics from 1998 show POS products are readily available in the marketplace.**

- POS products are available in all 72 Wisconsin counties.

- 16 of 23 Wisconsin HMOs offer some type of POS product.

- 22%, or 331,944 of Wisconsin HMO enrollees had a POS product in 1998.

- Employers with more than 25 full-time employees are required by statute to offer employees a standard fee-for-service or POS product if they offer HMO coverage.

## HOW DOES THE POS MANDATE CONFLICT WITH OTHER STATE PRIORITIES?

- A POS product mandate will be cost prohibitive for many small employers, forcing them to drop health care coverage and pushing more working people into the ranks of the uninsured. This could significantly increase the population and the cost of BadgerCare.

- A POS mandate would negate any cost savings expected by advocates of small business purchasing pools, because it mandates an insurance product with significantly higher premiums.

## WHAT'S REALLY DRIVING THE PUSH FOR A POS MANDATE?

**The POS mandate would allow providers to avoid utilization oversight and would allow providers to charge patients and insurers more for health care services.** The POS mandate is an any willing provider proposal with a different name. Wisconsin HMOs urge you to reject the POS mandate.

W C B
wisconsin council of the blind

MAR 3 1 1999

March 29, 1999

The Hon. Rodney C. Moen
Assistant Majority Leader
Wisconsin State Senate
P.O. Box 7882
Madison, WI 53707

Dear Senator Moen:

I am writing on behalf of the Wisconsin Council of the Blind in hopes of enlisting your support in resolving a serious problem within the Blind Enterprise business Program. The BEP, is a program funded by both federal and state moneys and since the 1930's has been instrumental in providing competitive employment for persons who are blind or visually impaired. Through the Randolph Shepherd Act, states are required to maintain a program that ensures recruitment and training of new persons to the program, as well as the provision of ongoing support for existing vendors.

It has been brought to our attention that several recent events will have a serious impact on the program, and in fact, may threaten its existence. We would like to share our concerns with you at this time.

1. We have learned that two of the three Business Enterprise Specialists are retiring within a month of each other, with the first leaving on April 1, and the second within the next month, thus, leaving one person to supervise the program. The person left, has only been in the position several months and in no way will have the time, nor the experience to adequately ensure supervision or support to the program.

2. Training classes are normally scheduled for June of each year. These classes are designed to provide new vendors with the basic training required to begin in the program. It is our understanding that these classes may not be available, thus complicating any effort to fill existing vacancies.

354 west main street, madison, wisconsin 53703 608.255.1166, fax/tdd 608.255.3301

3. We are not aware of any plans to rectify the situation. We have learned that perhaps limited term employees might be used. As an organization that represents the concerns of blind or visually impaired persons, we are convinced that such an approach could not work. Without proper experience or training, persons filling the vacant positions, will not be able to lend support and direction to the program.

4. We believe from past experience with state government, that too often filling positions takes a long time, and in a situation such as this, the program itself would be placed in jeopardy. We believe that the mandate to carry out the provisions under the Randolph Shepherd Act, necessitates quick action and the need to find a way to fill the vacant positions as soon as possible with qualified persons.

Finally, we urge your support in helping us find a viable solution to this problem. As you know, currently there is about a 70 percent unemployment rate among persons who are disabled, including persons who are blind or visually impaired. The record of the Business Enterprise Program reflects success not only in providing employment opportunities, but as importantly demonstrates that on the average BEP operators bring home an average salary of which itself speaks well of the value of such a program.

Sincerely,

R. P.

Richard Pomo, Executive Director
Wisconsin Council of the Blind

WHYTE
HIRSCHBOECK
DUDEK S.C.

**MEMORANDUM**

WHD
LAW

**To:** Senator Rodney Moen
Chair, Senate Health, Utilities, Veterans and Military Affairs Committee

**From:** Laura Leitch

**Subject:** WI Association of Local Health Departments and Boards (WALHDAB) -- Immunization

**Date:** March 23, 1999

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WALHDAB is seeking adequate funding to ensure that Wisconsin children are properly immunized and that parents and health care providers can determine if a child's immunization records are current. WALHDAB requests your support for immunization funding.

This memo is a summary of WALHDAB's argument in support of providing additional funding to local health departments for immunization services. Included with this memo is a list of the current funding levels received by local health departments, the "Immunization Action Plan" that local health departments must adhere to in order to receive the immunization funding, and a copy of a Legislative Fiscal Bureau Paper written during the 1997 - 1999 budget process.

**Immunization**

- WALHDAB requests $2 million GPR for local health department outreach activities to increase the immunization rates for Wisconsin children under 3 years of age.
- In addition, the $2 million would help local health departments establish the Wisconsin Immunization Reporting System (WIR), enabling Wisconsin parents, health care providers and local health departments to track and keep childhood immunization records up to date.

1997 - 1999 Budget

In the last budget, all GPR funding was eliminated from the immunization program. This was a reduction of $5,320,000 GPR. While approving the Governor's proposed cut, the Joint Finance Committee converted the sum certain appropriation to a capped sum sufficient appropriation dependent on whether federal funds were available for the purchase of vaccines. The availability of federal funds for the purchase of vaccines has not been a problem, however, the funding available to identify children who have not been immunized and to track immunization histories continues to decline.

Federal funds distributed by DHFS to the local health departments for outreach activities was reduced 16 percent in the most recent contract. Further reductions are anticipated in the coming biennium.

Unfunded Mandates

Attached is a copy of the 1999 Immunization Action Plan DHFS requires local health departments to sign before receiving immunization outreach funds. The state requirements are clearly unrealistic given the small amount of funding received by local health departments for these activities.

Goal: Immunize 85 percent of Wisconsin children before their third birthday

The DHFS program goal of an immunization rate of 85 percent for Wisconsin children aged 19 - 35 months is a crucial goal. Because children have more social contacts at younger ages, generally through various day care situations, the opportunity for disease outbreaks is high. We need to be more vigilant to make sure children are immunized against deadly and debilitating yet preventable diseases.

Local health departments provide about one-third of all immunizations in Wisconsin. The immunizations they provide are often to people whose insurance does not cover immunizations and to people who have limited contact with the health care community -- the hardest to reach populations. Without outreach to these people, the children remain unimmunized until they enter school, which may be too late to prevent outbreaks of measles or other preventable diseases.

Iap99cut

12/8/98

**IAP Distribution for CY 1999**

| LHD | IAP+base98 | 16.4% cut99 |
|---|---|---|
| Adams | $3,718 | $3,113 |
| Ashland | $4,371 | $3,659 |
| Barron | $7,228 | $6,047 |
| Bayfield | $3,655 | $3,060 |
| Brown | $31,141 | $26,038 |
| DePere | $4,846 | $4,055 |
| Buffalo | $3,781 | $3,165 |
| Burnett | $3,497 | $2,928 |
| Calumet | $5,520 | $4,619 |
| Chippewa | $9,114 | $7,624 |
| Clark | $6,574 | $5,500 |
| Columbia | $8,745 | $7,315 |
| Crawford | $3,939 | $3,298 |
| Madison * | $58,604 | $49,002 |
| Dodge | $11,644 | $9,738 |
| Door | $5,215 | $4,364 |
| Douglas | $7,533 | $6,302 |
| Dunn | $6,511 | $5,448 |
| Eau Claire | $14,257 | $11,924 |
| Florence | $2,474 | $2,073 |
| Fond du Lac | $13,657 | $11,421 |
| Forest | $3,454 | $2,892 |
| Grant | $7,849 | $6,567 |
| Green | $6,005 | $5,025 |
| Green Lake | $3,971 | $3,324 |
| Iowa | $4,940 | $4,134 |
| Iron | $2,643 | $2,214 |
| Jackson | $4,287 | $3,588 |
| Jefferson | $9,504 | $7,950 |
| Watertown | $4,993 | $4,179 |
| Juneau | $4,919 | $4,117 |
| Kenosha | $23,479 | $19,633 |
| Kewaunee | $4,382 | $3,668 |
| La Crosse | $16,175 | $13,527 |
| Lafayette | $4,087 | $3,421 |
| Langlade | $4,803 | $4,020 |
| Lincoln | $5,615 | $4,699 |
| Manitowoc | $12,539 | $10,487 |
| Marathon | $19,190 | $16,047 |
| Marinette | $7,185 | $6,011 |
| Marquette | $3,454 | $2,892 |
| Monroe | $7,660 | $6,408 |
| Oconto | $6,131 | $5,130 |

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| | | |
|---|---|---|
| Oneida | $5,805 | $4,857 |
| Outagamie | $15,143 | $12,664 |
| Appleton | $12,940 | $10,822 |
| Ozaukee | $12,076 | $10,100 |
| Pepin | $2,843 | $2,381 |
| Pierce | $6,268 | $5,244 |
| Polk | $6,943 | $5,809 |
| Portage | $10,590 | $8,857 |
| Price | $3,908 | $3,271 |
| Racine* | $30,351 | $27,443 |
| Richland | $4,108 | $3,439 |
| Rock | $18,307 | $15,309 |
| Beloit | $9,400 | $7,863 |
| Rusk | $4,340 | $3,632 |
| St Croix | $9,515 | $7,959 |
| Sauk | $9,146 | $7,650 |
| Sawyer | $3,855 | $3,227 |
| Shawano | $6,732 | $5,633 |
| Sheboygan | $16,239 | $13,580 |
| Taylor | $4,603 | $3,853 |
| Trempealeau | $5,510 | $4,610 |
| Vernon | $5,362 | $4,487 |
| Vilas | $4,118 | $3,447 |
| Walworth | $11,591 | $9,694 |
| Washburn | $3,707 | $3,104 |
| Washington | $16,808 | $14,056 |
| Waukesha | $43,768 | $36,595 |
| Waupaca | $8,640 | $7,227 |
| Waushara | $4,371 | $3,659 |
| Winnebago | $8,397 | $7,024 |
| Oshkosh | $11,496 | $9,615 |
| Neenah | $6,585 | $5,509 |
| Menasha | $5,162 | $4,320 |
| Wood | $13,224 | $11,060 |
| North Shore* | $9,936 | $8,333 |
| Wauwatosa | $8,629 | $7,219 |
| West Allis* | $35,511 | $29,718 |
| South Milw (not awarded in 98) | $0 | $3,941 |
| Milwaukee City H.D. | $208,111 | $173,985 |
| LHD Sub-Total | $987,330 | $831,820 |
| | | |
| **Tribal Health** | | |
| Bad River | $2,569 | $2,152 |
| Lac Courte | $2,601 | $2,179 |
| Lac du Flam' | $2,485 | $2,082 |
| F'est Co Pot' | $2,232 | $1,870 |
| Sokagon | $2,169 | $1,817 |
| St. Croix | $2,295 | $1,923 |
| Stockbridge-Mun | $2,274 | $1,905 |

Iap99cut

| | | |
|---|---|---|
| Oneida | $2,559 | $2,143 |
| Red Cliff | $2,379 | $1,994 |
| Ho-Chunk | $2,422 | $2,029 |
| Menominee | $3,497 | $2,928 |
| Tribe Sub-Total | $27,481 | $23,022 |
| FQHC | | |
| Bridge | $3,331 | $2,789 |
| HC for Homeless | $2,688 | $2,252 |
| Johnston | | |
| Kenosha | $6,799 | $5,688 |
| La Clinica | $3,744 | $3,134 |
| Milw Health Services | $6,358 | $5,326 |
| Marshfield Med' | $18,014 | $15,064 |
| Northern Hlth | $2,872 | $2,405 |
| N Woods Medical | $3,560 | $2,981 |
| N.E.W. | $2,367 | $1,983 |
| Scenic Bluff | $2,551 | $2,137 |
| 16 St.Clinic | $10,900 | $9,117 |
| Rainbow | $7,414 | $6,203 |
| FQHC SubTotal | $70,597 | $59,078 |
| GRAND TOTAL | $1,085,407 | $913,919 |

* Madison also represents Dane Co.
* Racine also represents W. Racine ( + $2000 base added in 99)
* West Allis(W.Mil)also represents Cudahy, Franklin, Greendale, Greenfield, St Francis,. and Hales Corners
* Northshore (Browndeer) also represents Shorewood(W.Fish Bay), Glendale Bayside, Fox Pt. and River Hills

Oak Creek declined 1999 IAP funding

# 1999 Immunization Action Plan (IAP) WORKPLAN

**IAP Grant Recipient:** _____ **Contract Administrator:** _____

**Address:** _____ **Regional Office:** _____

_____

**Phone:** _____ **Date of Visit:** _____

**Goal:** By 2000, to reach and maintain 90% vaccination coverage levels among children aged 19-35 months for all vaccines included in the Childhood Immunization Initiative.

**Objective:** By 9/30/99, 85% of children aged 19-35 months who are active users of agency immunization services will have received 4 DTP, 3 Polio, 1 MMR , 3 Hib and 3 Hep B. Receipt of these vaccines will be documented in the child's immunization record at the agency.

| Action Steps | Ongoing or Anticipated Completion Date | Progress on Action Steps |
|---|---|---|

I. Immunization Record Storage System:

Recommended:

___ Establish a computerized immunization record system capable of interfacing with the Wisconsin Immunization Registry (WIR). This will be made a requirement when the WIR is established.

II. Tracking and Recall:

Required:

___ Maintain an active reminder and recall tracking system for parent notification.

___ Obtain and record dates (mm/dd/yy) of immunizations administered by other providers for clients who are now being immunized by your agency.

III. Service Delivery, Access and Assurance:

Required:

___ Assess and remove existing barriers to client's accessing immunization service, e.g., administration charges, missed opportunities, etc.

___ Determine and address the need for special outreach measures to immunize high risk populations.

___ Consult, at least twice yearly, with Health Check and other infant and child health services to ensure effective delivery of all immunization services to their clients.

___ [illegible] people who need immunizations are immunized.

Laura-
There is a copy of the workplan we are expected to complete for the IAP money- Each county receives $7,5 Kay
Thanks
Jeanne

# 1999 Immunization Action Plan (IAP) WORKPLAN (p.2)

| Action Steps | Ongoing or Anticipated Completion Date | Progress on Action Steps |
|---|---|---|
| IV Outreach and Education:<br>Required:<br>___ Work with the private medical community to ensure that immunization services are available to all children in your service area.<br>___ Identify community resources which can enhance immunization efforts.<br>___ Identify methods to sustain enhanced programs in absence of grant sponsorship.<br>Recommended:<br>___ At least one agency member will attend the CDC down-link distance learnng course and updates.<br><br>V. WIC Linkage:<br>Required:<br>___ Assist all local WIC projects to assure that immunization services are available to their clients.<br>___ Establish local policy to link WIC services with immunization services to achieve 90% coverage goal.<br>___ Meet with WIC staff at least once yearly to discuss coordination of immunization services.<br><br>VI. Assessment and Evaluation:<br>Required:<br>___ Conduct annual assessments of the immunization records of children served by the agency using *Win*CASA software according to instructions from the Immunization Program (by 10/30/99).<br>___ Conduct an annual *Win*CASA assessment of at least one private provider (by 10/30/99).<br>___ Track children identified by the above audits as missing immunizations to recall and/or obtain dates of vaccine administered by other providers. | | |

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

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

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.

| Alternative 3 | GPR |
|---|---|
| 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.

| Alternative 4 | GPR |
|---|---|
| 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).

| Alternative 7 | GPR |
|---|---|
| 1997-99 FUNDING (Change to Bill) | $5,320,000 |

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## ATTACHMENT

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

| | 1996-97 | | 1997-98 | | 1998-99 | |
|---|---|---|---|---|---|---|
| | Dosage | Cost | Dosage | Cost | Dosage | Cost |
| Diptheria-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 |
| Hepititus-A | 1,210 | 13,492 | 1,210 | 13,492 | 1,210 | 14,166 |
| Hepititus-B Adult | 6,665 | 163,513 | 6,655 | 163,513 | 6,655 | 171,689 |
| Hepititus-B Pediatric | 201,825 | 1,507,633 | 233,258 | 1,924,768 | 216,843 | 1,867,957 |
| Hepititus-B High Risk | 155,250 | 1,350,675 | 87,746 | 763,386 | 82,398 | 752,702 |
| Hepititus-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-Diptheria (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 | 51,700 | 1,690,590 | 51,700 | 1,690,590 | 51,700 | 1,775,120 |
| TOTAL | 866,545 | $8,748,978 | 830,465 | $8,550,703 | 808,702 | $8,776,332 |