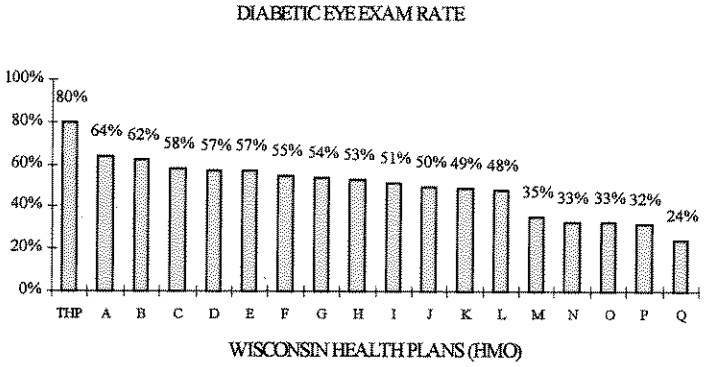
touchpoint HEALTH PLAN

# Statewide Benchmark Data

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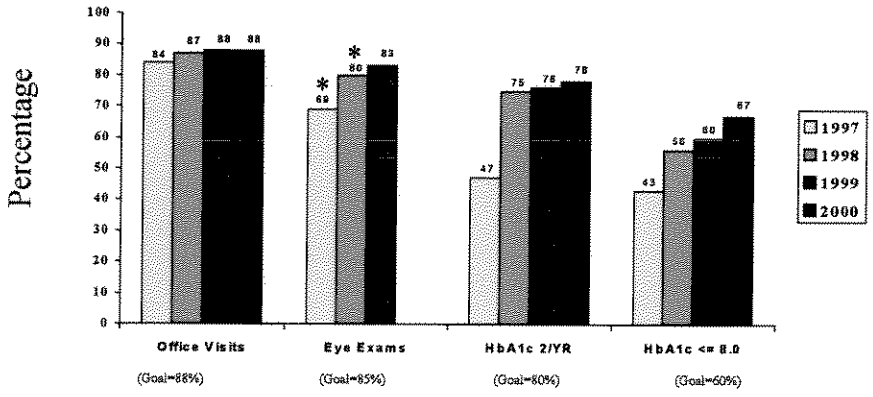
# Diabetes Clinical Measures




*National Benchmark for Diabetic Eye Exam

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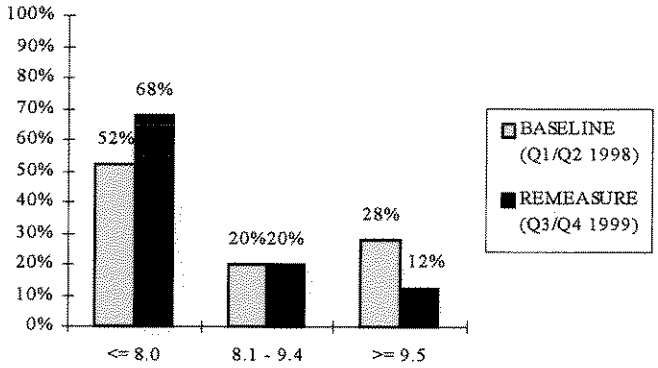
# HbA1c Breakdown



# IMPACT OF PROPOSED MEDICAID RX REIMBURSEMENT CUTS AT THREE PRICE LEVELS

PRESCRIPTION WITH A $20.00 AVERAGE WHOLESALE PRICE

| CURRENT: | | BUDGET PROPOSAL: | |
|---|---|---|---|
| AWP | 20.00 | AWP | $20.00 |
| Less 10% | -2.00 | Less 15% | -3.00 |
| | $18.00 | | $17.00 |
| Plus Disp Fee | 4.38 | Plus Disp Fee | 4.38 |
| Total | $22.38 | Total | $21.38 |

**$1.00 reduction in Gross Margin $**

**PRESCRIPTION WITH A $60.00 AWP (Current Brand Rx Average)**

| CURRENT: | | BUDGET PROPOSAL: | |
|---|---|---|---|
| AWP | $60.00 | AWP | $60.00 |
| Less 10% | -6.00 | Less 15% | -9.00 |
| | $54.00 | | $51.00 |
| Plus Fee | 4.38 | Plus Fee | 4.38 |
| Total | $58.38 | Total | $55.38 |

**$3.00 reduction in Gross Margin $ Based on average $7.25 Gross Margin per prescription yields a 40% Reduction in Gross Margin**

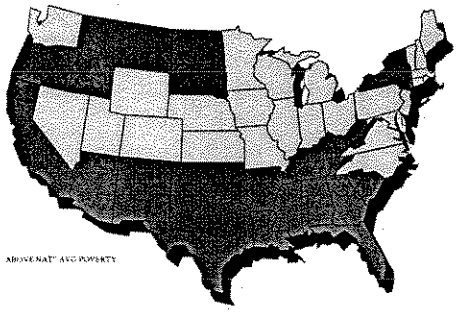
PRESCRIPTION WITH A $100.00 AVERAGE WHOLESALE PRICE

| CURRENT: | | BUDGET PROPOSAL: | |
|---|---|---|---|
| AWP | $100.00 | AWP | $100.00 |
| Less 10% | -10.00 | Less 10% | -15.00 |
| | $90.00 | | $85.00 |
| Plus Fee | 4.38 | Plus Fee | 4.38 |
| Total | $94.38 | Total | $89.38 |

**$5.00 reduction in Gross Margin $**

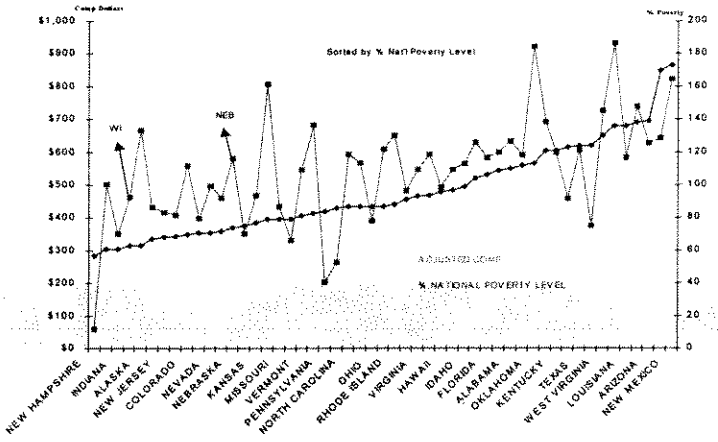
Average Gross Margin Per Prescription is between $7.00 and $8.00
Average Cost of Dispensing Per Prescription is between $5.00 and $7.00

REDUCING THE AVERAGE GROSS MARGIN PER RX BY $2.00 BRINGS THE REIMBURSEMENT BELOW THE AVERAGE COST TO DISPENSE A PRESCRIPTION



The adjacent map depicts National Poverty Level. Areas in Blue are below the national average for poverty, while areas in Red are above the national average.

Data obtained from the U.S. Census Bureau




This graph shows the correlation between the National Poverty Level (shown in blue) and how VA Compensation (Shown in pink) correlates to poverty level by state. Wisconsin is the black arrow shown furthest to the left.

Data obtained from the US Census Bureau and the USDVA.

You will note the significant degree of correlation seen in these maps and graphs. Areas that are below the national average for income, and above the national average for poverty, have a correspondingly above average receipt of VA Compensation dollars. This, we believe, follows a common sense approach to the issue. If you have a greater need to pursue income from all available sources, you will in turn seek out federal VA Compensation monies.

# Legislative Testimony Outline

## Assistive Technology Proposal by ILC's

- ✓ Assistive Technology (AT) is a critical aspect of independent living for many people with disabilities. Some common examples are:
  - Wheelchairs and various mobility devices
  - Telecommunications devices for those with hearing loss
  - Adaptations for driving and van lifts
- ✓ What about other things such as:
  - Eating utensils & daily living activities devices
  - Lifting devices to reduce physical lifting during transfers and eliminate potential for injury
  - Computers and adaptive software and input devices such as voice dictation and typing devices
- ✓ The cost for AT can be several dollars or several thousands of dollars.
- ✓ There is an endless array of technology available today and it is increasing at an incredible rate. How do people with disabilities know what **is available AND appropriate for them**?
- ✓ The ILC's have been providing AT assessment & try-out of equipment under the State's WisTech Program for 10 years . That program is ending.
- ▫ ***We believe that it is critical to provide Accurate and appropriate AT information to people with disabilities. Funding could be through GPR or Wisconsin Advanced Technology Foundation. Funding must be ongoing.***

## Personal Care Workers Funding

- ✓ First, I would like to thank the Legislature and former Governor Thompson for increasing PCW reimbursement rate last year. This increase helped keep some agencies in business and to continue to provide this service.
- ✓ However, there are still many problems getting PCW services, primarily early in the morning and later evening. These are to peak hours when the majority of people needing PCW services want the service. Agencies providing PCW services have no problem providing it between 10:00 am and 5:00 PM. Many PCW's can earn comparable pay in retail or fast food restaurants. There is no pressure. No early hours or late evenings or both.
- ✓ Wse must attract more people to this profession. As Wisconsin's people grow older, the need for PCW services will grow also.
- ▫ ***I ask that you consider reviewing this rate and increasing it to make this type of job attractive to people.***

## Family Care Independent Advocacy

- ✓ Governor McCallum's budget has limited expansion funds for Family Care and it completely eliminated funding for the Independent Advocacy positions. When Family Care was developed, the State, many in the legislature and especially those working with Family Care felt very strongly about the inclusion of Independent Advocate position as an essential part of Family Care. This individual plays a critical role for Family Care Enrollee's, for families and even the Care Management Organization. The Independent advocate has been very involved to date in each of the Family Care pilot counties. They ensure that the service delivery system is working and that people with disabilities are getting appropriate and timely services they choose.
- ▫ ***I strongly encourage you to fund to Independent Advocacy Position in Family Care.***

## Waiting lists (COP, CIP, Family Support, and Brain Injury Services)

- ✓ This is an ongoing issue that the legislature and Governor must deal with. It happens every budget period. The Governor traditionally includes a small number of new slots for these programs. The Legislature increases that amount during budget deliberations. And in the end, the number is usually increased somewhat. The Loser – people on the waiting lists for services. Because of **significant proportions**, many times those in certain disability categories can at least have hope to receive some level of service. However, certain categories [physical and developmental] have absolutely no movement at all unless new slots are created. And because these proportions are smaller, they get the fewest new slots. New funding must go into the system. These individuals are either ending up in institutions or dying. If you have a physical disability, have a waiting list number such as 100, it is akin to being number 10, 000 on the Packer list. There is no hope.
- ✓ Do you want to pay the higher cost for institution care? Do you want to be forced into funding these categories because of the OLMSTEAD DECISION? Wisconsin has boasted about being a progressive State when it comes to disability and the elderly services. Recent funding for these programs certainly does not give this State the right to boast about being a leader on disability and elderly services.
- ▫ ***Yes, Wisconsin does certainly have a structural deficit! And it begins with services for its citizens! I ask you to take a good hard look at the funding levels of these programs. Look at it as if you had a relative waiting on this list! Increase funding and eliminate Wisconsin's biggest deficit, invest in Wisconsin's people.***

# Independent Living Assistive Technology Proposal

## Purpose

The purpose of the Independent Living Assistive Technology Proposal is to provide resources and technical assistance regarding assistive technology to persons of all disabilities and all ages in the state of Wisconsin.

The proposal we are suggesting is General Purpose Revenue (GPR) funding of $800,000.

| | |
|---|---|
| 1. Independent Living Centers (ILC's) for the eight Wisconsin ILC's ($60,000 ea.) | $480,000 |
| 2. Wisconsin Coalition for Advocacy (WCA) | $120,000 |
| 3. Office for Persons with Physical Disabilities (OPPD) | $60,000 |
| 4. Agrability | $60,000 |
| 5. Wheelchair Recycling Program (WRC) | $80,000 |

**Detailed Distribution**

**ILC's-** The $60,000 to each ILC would be used for the Assistive Technology/Adaptive Equipment Program. The Assistive Technology Specialist would provide information, resources and assessments for person's assistive technology needs. This would be based on the existing and latest information and products available. The Assistive Technology Specialist would maintain and update the equipment loan closet for test trials that would allow persons with disabilities to make informed decisions regarding their assistive technology needs.

**WCA-** The $120,000 would allow WCA to provide statewide systemic advocacy on assistive technology issues. WCA would focus on assessing systemic barriers to the provision of technology in school systems, human service programs, businesses, and public and private insurance programs. WCA will develop education, training, technical assistance, and advocacy services to overcome the barriers.

**OPPD-** The $60,000 to OPPD would provide the ability to administer the state funding, develop statewide reporting mechanisms, contract performance evaluation, training and additional resource development. Specifically, in the area of resource development, OPPD would work with assistive technology/adaptive equipment vendors to obtain equipment to maintain and update the trial equipment.

**Agrability** - The $60,000 to Easter Seals Society of Wisconsin to continue providing their unique program of providing persons with disabilities in the agricultural industry, living in the state of Wisconsin, with specialized assistance regarding adaptations/modifications to continue their chosen profession.

**WRC Program** - The $80,000 would allow WRC the ability to provide recycled medical equipment directly to consumers and programs in need and for equipment parts, maintenance, and distribution costs.

**Historic perspective:**

In 1990, the National Technology Act provided funding to all 50 states to develop a central resource in each state for the dissemination of assistive technology/adaptive equipment information. In 1992, Wisconsin obtained a $640,000 annual grant extended to 10 years, to create the WisTech Program located at the Division of Vocational Rehabilitation (DVR). The idea of WisTech was that subcontracting to each of the eight ILC's, WCA, and Agrability provides Wisconsin with regional "technology" experts.

The WisTech program met the need of DVR, schools and local businesses to have a centralized resource for assistive technology/adaptive equipment information. The project was, and is, a perfect fit for ILC's, as technology/adaptive equipment is available and needed by persons of all disabilities and of all ages. Not only did WisTech fund ILC staff, but also, over the past 9 years it has helped each of the ILC's build an inventory of approximately $35,000 of assistive technology/adaptive equipment. Since 1994, WisTech has also funded WCA's Assistive Technology Advocacy Program, and WCA has worked with the ILC's and other AT partners to identify and remove funding barriers.

Together, we have built an incredibly successful infrastructure for the provision of providing quality cost effective assistive technology services in the state. Without new resources, this important infrastructure will wither on the vine. Funds are needed to retain AT staff that are needed by: DVR, Department of Workforce Development (DWD) One-Stop Shops, and integral to the success of Governor Thompson's Pathways Initiative, implementation of new Work Incentives Act (WIAA) initiatives, and likely important for the success of the Family Care initiative.

**General discussion points:**

1. Technology/adaptive equipment specialists save money for DVR, Medicaid, Insurance, etc. By getting good information and test trials, individuals obtain equipment that works for them, not stuff doesn't work and gets put in the closet.
2. Technology/Adaptive Equipment allows individuals to be employed and less dependent upon paid help or institutional care.
3. New state initiatives, such as Pathways and Family Care, are dependent on technology to help individuals to be independent and minimize care and support of others.
4. The Agrability resource allows for the specialized expertise needed to assist farmers with disabilities to continue their chosen career.
5. The systemic efforts of WCA create a long term cost effective solution related to technology in schools, human services, and the business community.

**SENATOR MOEN, MEMBERS of the Committee:**

My name is Patricia Finder-Stone. Thank you for the opportunity to present to you today. As a member of the Wisconsin Tobacco Control Board, I feel privileged and obligated to try to promote awareness of the tobacco burden in Wisconsin.

All of us here today are concerned about health, and likewise, everyone here is concerned about health care costs. Yet much of our budget is spent on issues directly or indirectly related to health. I believe there is no better way to cut the budget than to prevent the illnesses that escalate health care costs and human misery.

Over and over, we have heard the message that tobacco use is the single most preventable cause of death and disease in our society. It's not just lung cancer...it's heart disease and asthma...and just about every organ in our bodies...Just think, without tobacco, our prescription drug costs could be cut exponentially!!!

I have a handout for you with some current figures about the toll of tobacco in Wisconsin, and a page which identifies where our settlement dollars are going, and it compares our expenditures with a couple other states.

You probably saw our anti-tobacco media messages this past week emphasizing that 2nd hand smoke kills, but ads alone won't end the tobacco burden..especially when the tobacco companies spend $100 m on ads in WI alone each year, and more of that is spent on telling the public how charitable they are rather than what is actually given to the charities!

The focus of all our activities are community based, and school-based, too. Between 1996-1998, Florida reduced its h.s. tobacco use by 24%. At the same time, WI youth rates went up 6%!.

And pregnant women...Wisconsin...32% higher than the national average...one out of every 6 smoke. So we've started a pilot program for pregnant women.

We know that we have a lot of work to do. You saw the headlines this week...tobacco killing twice as many women as in 1965.

**We need your help**...We are concerned about the unfunded mandate of the Thomas T. Melvin program, which is being transitioned from state general funds to TCB funds....500K in the 1st year, and the whole million in the 2nd year....so that is a 1.5 m. decrease in our funding over the biennium. That means that our funds would have to come from our current funded programs., and that will threaten the effectiveness of our existing programs.

Also, as you compare the programs in the other states (handout), please compare staff levels... we have 2 ... We requested 7 in our agency request, and we are allocated 4. The numbers speak for themselves!

As I stated, **we need your help**...each of you on this committee ***so directly*** addressing health issues. We need long term and adequate funding for tobacco prevention and control! We will succeed if our effort is maintained and strengthened over time.

Thank you for the opportunity to share my concerns.

**Patricia Finder-Stone, MS, RN, Wisconsin Tobacco Control Board**
985 N. Broadway, De Pere, WI 54115 (920)336-4187 stone@netnet.net

# Wisconsin Tobacco Control Board

Allocation Comparison:
Massachusetts, Minnesota, and Wisconsin

| Plan Component<br>*Focus of Activity* | MA | MN<br>*(Youth Only)* | WI |
|---|---|---|---|
| 1. Media and Countermarketing | $14,515,000 | $7,700,000 | $6,500,000 |
| 2. Community Coalitions | | | |
| Community Coalition Grants | $9,775,000 | $4,800,000 | $5,750,000 |
| 3. Youth Preventention | | | |
| Youth-Led Movement | $3,488,000 | $1,100,000 | $800,000 |
| School Grants | NA | NA | $1,250,000 |
| Thomas T. Melvin | NA | NA | $1,000,000 |
| 4. Cessation Support | $8,079,000 | NA | $800,000 |
| 5. Statewide Programs | NA | $3,100,000 | $900,000 |
| Ethnic Network and Local Grants to Communities of Color | $2,565,000 | $1,200,000 | $600,000 |
| 6. Resource Clearinghouse | $230,000 | NA | $200,000 |
| 7. Monitoring and Evaluation | $3,404,000 | NA | $1,500,000 |
| Center for Tobacco Research and Intervention | | $10,200,000 | $1,000,000 |
| Medical College of Wisconsin | | *Minnesota Partnership for Action Against Tobacco (MPAAT)* (Adult Focus) | $500,000 |
| 8. Program Support | $2,056,000<br>33 staff | $1,400,000<br>36 staff | $400,000<br>2 staff |
| Total | $44,314,000 | $29,500,000 | $21,200,000 |

# The Toll of Tobacco in Wisconsin*

Tobacco use in Wisconsin
High school students who smoke - **36%**
High school males who use smokeless tobacco - **19%**
Kids under 18 who become new daily smokers each year - **26,000**
Kids exposed to 2nd hand smoke at home - **428,000**
Packs of cigarettes illegally sold to WI kids each year - **5.3 million**
Adults in Wisconsin who smoke - **23%**
Pregnant women in Wisconsin who smoke - **32%**

## Deaths in Wisconsin From Smoking

# of people who die each year in Wisconsin from smoking - **7,800**
# of Wisconsin kids under 18 who will die from smoking If current trends continue - **117,000**

## Second-Hand Smoke Statistics

Lower respiratory tract infections age under 18 months ea.yr. **150,000 to 300,000**
" " " " hospitalizations " " " " **7,500 to 15,000**
#of deaths from 2nd hand smoke in U.S. - **53,000**

## Tobacco-Related Monetary Costs in Wisconsin

Annual health-care expenditures directly related to tobacco use - **$1.3 billion**
Residents' state and federal tax burden caused by tobacco-related health costs - **$620 million**
Wisconsin government Medicaid payments directly related to tobacco use - **$190 million**
Additional annual expenditures in WI for baby health problems caused by mother smoking or being exposed to second hand smoke during pregnancy - **$ 38 to $109 million**

## Tobacco Industry Influence

Yearly tobacco industry advertising & marketing expenditures nationally **$5.2 billion**
Estimated portion spent for Wisconsin advetising each year - **$100 million**

*Information from Campaign for Tobacco Free Kids , 24 March 2001
Sources listed at <www.tobaccofreekids.org>

Excellent recommended site for current tobacco information:
Tobacco Control Resource Center for Wisconsin <www.tobwis.org>

# CVSO ASSOCIATION OF WISCONSIN

# POSITION STATEMENT

# WDVA BIENNIAL BUDGET-2001-2003

## WE SUPPORT

ADDITIONAL EDUCATION GRANT REQUESTS –IMPROVING THE EDUCATION REIMBUSEMENT RATE FOR THE TUITION & FEE REIMBURSEMENT PROGRAM AND PART-TIME STUDY GRANT PROGRAM FROM 65% TO 100%

DISABLED VETERANS TRANSPORTATION GRANT – AN AMENDMENT WILL BE OFFERED TO EXPAND THIS GRANT TO ASSIST COUNTIES WHO DO NOT HAVE, OR HAVE LIMITED ACCESS TO THE DAV PROGRAM.

FUNDING FOR LEGAL CLAIMS TRAINING FOR CVSOS AND WDVA STAFF. ALSO PURCHASE OF VAN AND LAPTOP COMPUTER FOR OUTREACH EFFORTS

FUNDING INCREASE FOR THE SUBSISTENCE AID GRANT

REDUCING THE RESIDENCY REQUIREMENT FOR WDVA BENEFITS FROM 5 YEARS TO 1 YEAR

VETERANS HOME STAFFING INCREASES

## WE OPPOSE:

OUTREACH INITIATIVE – STAFFING SIX NEW REGIONAL CENTERS AND A VIDEO CONFERENCING SYSTEM (DUPLICATION OF EXISTING SERVICES)

MILITARY HONORS FUNERAL COSTS FUNDING FROM THE TRUST FUND. WE BELIEVE THIS SHOULD BE SHIFTED TO GPR.

LIMITING THE USE OF THE HEALTH CARE AID GRANT

VETERANS EDUCATION CENTER AND MUSEUM FUNDING FROM THE TRUST FUND. WE BELIEVE THIS SHOULD COME FROM OTHER SOURCES.

SHIFTING SOME MUSEUM COSTS BACK TO THE TRUST FUND. THIS SHOULD REMAIN WITH GPR.

# CVSO ASSOCIATION OF WISCONSIN

## POSITION PAPER

## WDVA BIENNIAL BUDGET – 2001-2003

THE CVSO ASSOCIATION OF WISCONSIN WISHES TO OFFER THE FOLLOWING STATEMENTS AND RECOMMENDATIONS REGARDING ITS POSITION ON THE WDVA BIENNIAL BUDGET. THESE STATEMENTSS NOT ONLY REPRESENT THE VIEWS OF CVSOS STATEWIDE, BUT ALSO THE VETERANS, DEPENDENTS AND WIDOWS WE SERVE.

***DISABLED VETERANS TRANSPORTATION GRANT

WE SUPPORT THIS INITIATIVE, HOWEVER WISH TO OFFER AN AMENDMENT. A SURVEY OF COUNTY TRANSPORTATION PROGRAMS CONDUCTED IN NOVEMBER, 2000 SHOWED THAT ONLY 1/3 OF THE COUNTIES IN WISCONSIN ARE ABLE TO ACCESS THE DAV PROGRAM FOR TRANSPORTING VETERANS TO VA HOSPITALS AND CLINICS.

RECOMMENDATION: ADD $100,000 TO THE BUDGET FROM THE TRUST FUND TO PROVIDE GRANTS TO COUNTIES THAT UTILIZE OTHER METHODS AND SOURCES FOR TRANSPORTING VETERANS. WITH THE INCREASED ENROLLMENT OF VETERANS SEEKING VA HEALTH CARE SERVICES, THIS GRANT WOULD ASSIST COUNTIES GREATLY IN MEETING THEIR INCREASED DEMANDS FOR TRANSPORTATION SERVICES.

***OUTREACH INITIATIVE

WE STRONGLY OPPOSE THIS INITIATIVE. WE BELIEVE THAT WDVA HAS OVER-STATED THE POTENTIAL FOR BRINGING FEDERAL COMPENSATION AND PENSION DOLLARS INTO WISCONSIN. OUR OWN STUDY, MORE COMPREHENSIVE IN NATURE, POINTS OUT A CLEARER AND MORE ACCURATE PICTURE OF WHY WISCONSIN IS BELOW NATIONAL AVERAGES IN THESE PROGRAMS AND THE TRUE POTENTIAL FOR MORE FEDERAL DOLLARS. THE ESTABLISHMENT OF 6 NEW REGIONAL CENTERS AND 9 POSITIONS IS "SIMPLY A DUPLICATION OF EFFORT AND FRAGMENTATION OF THE CURRENT SYSTEM OF CVSO SUPPORT IN EACH COUNTY AND A VAST WASTE OF TRUST FUND DOLLARS!"

RECOMMENDATION: WDVA CURRENTLY HAS 4 REGIONAL COORDINATORS ON STAFF WHO COULD EASILY BE TRAINED TO DO COMP AND PENSION CLAIMS. THESE INDIVIDUALS COULD THEN BE OUTSTATIONED AT SITES WHICH WOULD COMPLEMENT CVSO EFFORTS. SUCH SITES ARE: THE SOUTHERN CENTER, VA HOSPITALS AND CLINICS AND INNER CITY MILWAUKEE.

***HEALTH CARE AID GRANT

THIS PROGRAM HAS LONG SERVED AS A NEED BASED PROGRAM FOR VETERANS, DEPENDENTS AND WIDOWS WITH LIMITED INCOME AND LITTLE OR NO HEALTH INSURANCE. TO LIMIT THIS PROGRAM TO EYE CARE, HEARING AIDS AND DENTAL IS UNCONSIONABLE. THE HEALTH CARE AID GRANT HAS HELPED MANY IN MEETING NECESSARY OUTPATIENT/IN-PATIENT MEDICAL COSTS. TO NOW LIMIT THE USE OF THIS GRANT WOULD DENY BASIC MEDICAL NEEDS OF THESE LOW INCOME PERSONS.

RECOMMENDATION: INCREASE FUNDING TO $2,000,000 FROM THE VETERANS TRUST FUND AND MAINTAIN AND EXPAND CURRENT PURPOSES. UTILIZE THE PROPOSED ELIGIBILITY GUIDELINES BY WDVA FOR INCOME AND ASSSETS.

***MILITARY HONORS FUNERAL COSTS

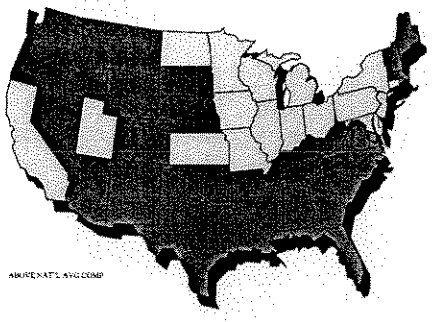
***VETERANS EDUCATION CENTER

***MUSEUM INITIATIVES

FUNDING OF THESE INITIATIVES FROM THE VETERANS TRUST FUND IS OPPOSED.

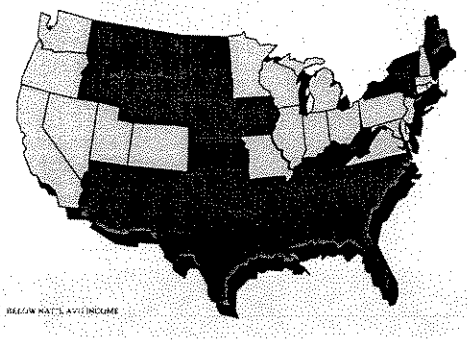
RECOMMENDATIONS: IF WISCONSIN TRULY WISHES TO RECOGNIZE THE SERVICES OF ITS VETERANS AND THEIR CONTRIBUTIONS, IT SHOULD FUND THESE PROGRAMS WITH GPR!

THE CVSO ASSOCIATION OF WISCONSIN THANKS YOU, OUR LEGISLATORS, FOR YOUR CONSIDERATION AND SUPPORT OF OUR POSITION. LET US JOIN TOGETHER TO BRING THE BEST PROGRAMS AND SERVICES WE CAN TO THE VETERANS OF OUR STATE!



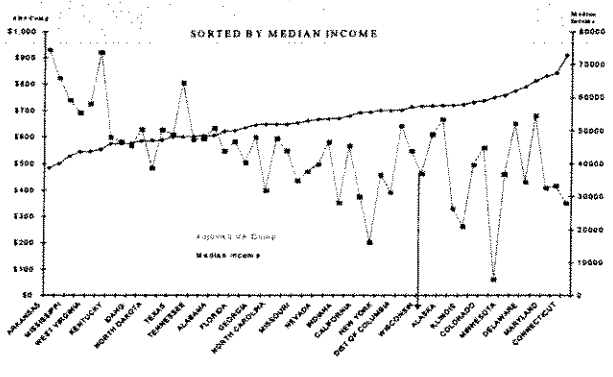
Federal Compensation Dollars are distributed as indicated by the adjacent map. Areas in Red are at or above the national average, while areas in Blue are below the national average.

Data obtained from The U.S. Department of Veterans Affairs



The adjacent map shows the median income of a family of four. Areas in Blue are above the national average, while areas in Red are below the national average.

Data obtained from the U.S. Census Bureau



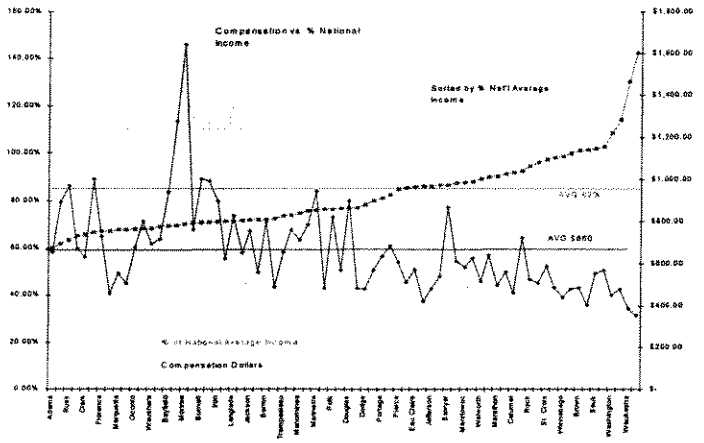

This graph depicts the correlation of VA Compensation (shown in pink) to the median income for all states, which are graphed in blue. The Vertical black line shows Wisconsin.

The adjacent map depicts the median income levels for the counties of our state. Areas in Blue are below the national average income for a family of four, while areas in White are above the national average.

Data obtained from the U.S. Census Bureau

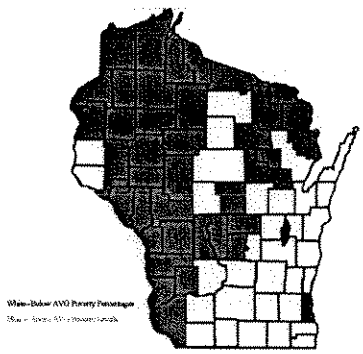
The adjacent map depicts the distribution of VA Compensation dollars within the State of Wisconsin. Areas in Blue are above the national average, while areas in White are below the national average.

Data obtained from the U.S. Department of Veterans Affairs.



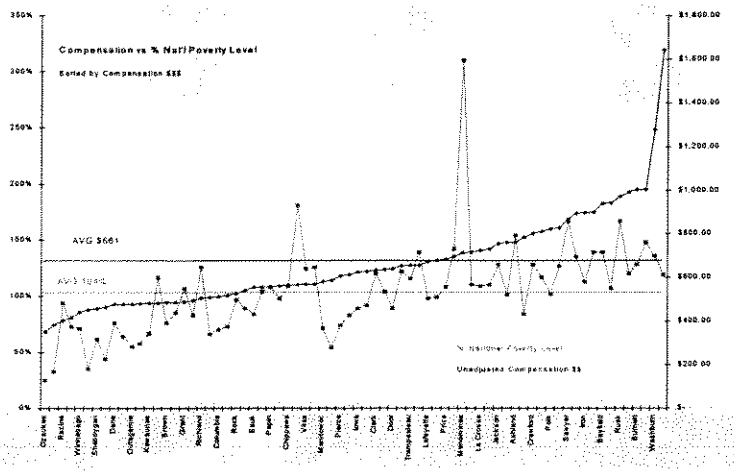

The pink line depicts the % of national income level for a given county within the State of Wisconsin, the blue line shows the corresponding level of VA Compensation for that county.

Data obtained from WDVA and the USDVA.



The adjacent map depicts the areas within the state that are above the national average for people living at or below the poverty level in Blue. Areas depicted in White are below the national average.

Data obtained from the U.S. Census Bureau




The blue line in the graph, represents the level of VA Compensation for a given county. The pink line shows the corresponding poverty level for that county.

Data obtained from WDVA and the USDVA.

Once again, you will note the significant correlation between income level, poverty level, and the receipt of federal VA Compensation dollars even at the county level.

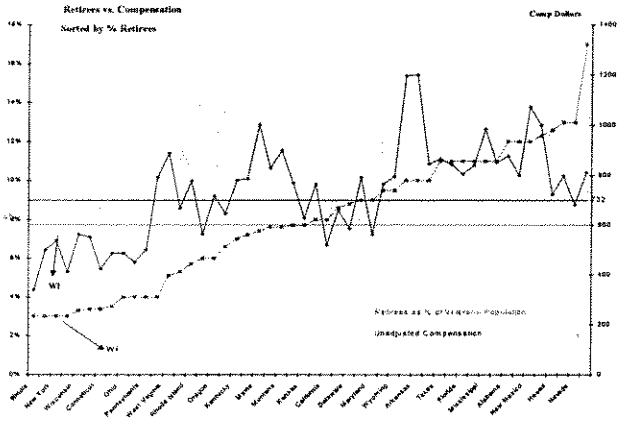
This correlation is not only evident, but it also follows our "common-sense" analysis.

Other issues that affect the level of VA Compensation in any given area were analyzed. These included the number of military retirees residing in a given state.

Military retirees were specifically addressed because the high number of retirees who are receiving VA Compensation.

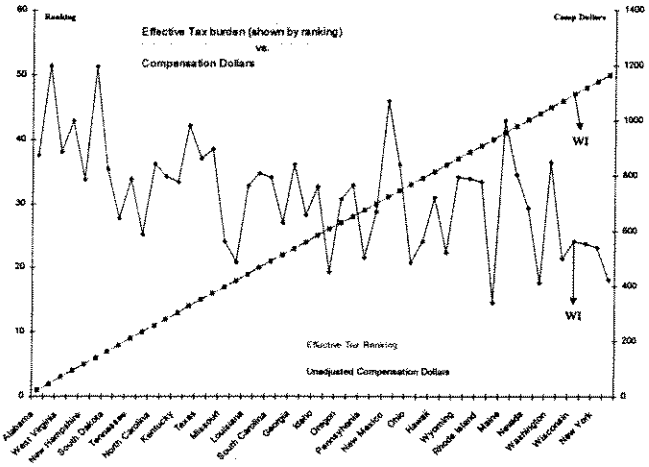
When looking at the average veteran population, who serves less than 20 years (generally 4-6 years), you will find that approximately 9% of those veterans receive VA Compensation.

When looking at military retirees, you will find that approximately 33% of those individuals are receiving VA Compensation.




This graph shows the correlation between the % of military retirees residing in a given state (pink line) and the level of VA Compensation (blue line), received within that state

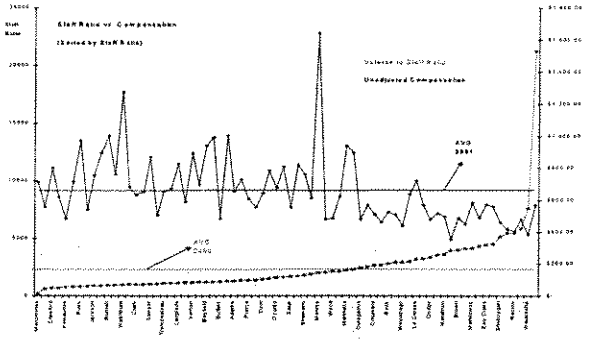
We also evaluated the affect of Total Tax Burden present in any given state, and how that related to the overall "picture" of VA Compensation.




This graph depicts the correlation between the relative tax burden of a given state (pink line) and the level of VA Compensation (blue line) for that state.

Tax "rankings" obtained from the National Tax Foundation.

The Wisconsin Department of Veterans Affairs has contended that the sole reason the State of Wisconsin is below the national average in terms of Compensation receipt lies in the lack of staffing in the local County Veterans Service Offices. A review of the chart below shows that the correlation between staffing and Compensation receipt is minimal.



The Blue line shows the amount of VA Compensation dollars received by county within the state.
The Pink line shows the staff to veteran ratio for each county

Our Association does not pretend to believe that our local offices are 100% successful in reaching every veteran within our respective counties. We have in fact asked the WDVA for assistance in this area by providing advertising to assist our own out-reach efforts. WDVA has made a beginning in this area.

**Our association believes that only with a sustained and concerted advertising effort, can we be reasonably sure of reaching the maximum possible number of veterans, and thereby be able to inform them of benefits to which they are entitled and may be eligible to receive. The language of these advertisements must be carefully crafted, so to insure there are no misinterpretations of the availability of benefits, and the requirements for obtaining them.**

We also believe that our local offices are much better suited to dealing with the veterans in our communities. We have a better understanding of the needs and desires of our veteran population, because we are in contact with them on a continuing basis.

We believe that the creation of "regional service delivery centers" is an unnecessary and misguided use of Veterans Trust Fund dollars.

Our organization firmly believes that if the veteran comes to/ contacts our offices, we will serve those individuals in a professional and caring manner.

We appreciate the time you have taken to review our presentation. We ask that you reflect on all of the information presented, and assist us in re-directing the efforts of WDVA.

## 10 Reasons Why Regional Service Delivery Centers are not Needed...

- WDVA's flawed analysis of the potential unclaimed compensation dollars greatly exaggerates the number of successful claims that potentially exist.

- Their analysis ignores the most likely effects of military retiree demographics and historic economic factors in depressing VA spending in the state. Per capita VA spending is down in all states where there are few retirees and high median incomes.

- WDVA analysis also ignores the fact that 18 million WWII and Korean War veterans service medical records were burnt in the July 12, 1973 National Personnel Records Center fire, making unclaimed service related disability claims by half of the veterans living in the state virtually impossible to win. The VA requires these medical records as proof the disability began in service. Those who filed a VA compensation claim before 1973 have records. Those that didn't are generally our of luck.

- All new veterans since 1990 have been redundantly contacted by the military, WDVA and CVSO's about their compensation rights and responsibilities. There is no need for a new bureaucracy to inform these veterans and future veterans of their rights.

- This leaves only uninformed Vietnam veterans and peacetime veterans with any medical records to substantiate future new disability claims. There are very few peacetime disability claims and Vietnam veterans in the state seem to be already statistically well represented among those who are already receiving VA compensation. There is not much business here either.

- A CVSO Association promoted temporary outreach program, characterized by a WDVA funded, locally directed mass media prime time commercial advertising campaign, is sufficient to reach that small remainder of veterans who may have legitimate disability claims not yet filed, AND, who are unaware that they can file a disability claim many years after serving in the military.

- The most promising area where VA disability spending might be improved in the state is to have veterans, who already are getting VA compensation, to ask for a reevaluation exam. If their conditions have worsened, they get more money from the VA. It's that simple. We don't need a new state bureaucracy to reach these people either. We need temporary project workers to help search through existing state and county records and private VSO records to contact each service disabled veteran, who is already getting VA compensation and advise them that if their disabilities are worse they can automatically get a reevaluation exam from the VA – no questions asked.

- Assuming that the current triple level DOD ( TAP/ DTAP), WDVA and County Veterans Service Officer redundant outreach efforts continues for all veterans from 1990 onward into the distant future, it can safely be assumed that there will be not be a special need for a new bureaucracy to reach current and future veterans. After a person has been informed of their veterans rights three times, an element of personal responsibility must be exercised by these veterans. To paraphrase, "You can lead a veteran to veterans benefits information, but you can't make them apply".

- With 1,100 WWII veterans dying daily, a new permanent state veterans bureaucracy is not needed as the veterans population will gradually shrink by almost half over the next 10 -15years.

- The WDVA should not permanently commit Veterans Trust Fund dollars to a permanently expanded WDVA payroll to meet a small and shrinking need for additional outreach. Trust Fund dollars should be going instead to fund existing WDVA programs that will be of direct and immediate help to veterans.

# SENATE HEALTH COMMITTEE PUBLIC HEARING
# ON 2001-03 STATE BUDGET

Tuesday, April 3 - Green Bay

Senator Moen and committee members ... thank you for this opportunity to comment on the 2001-2003 state budget. I am Helen Isferding ... I work as a staff representative for the American Federation of State, County and Municipal Employees, commonly known as AFSCME.

I'm here today to urge you to support an effort in the governor's budget proposal that would increase Medicaid funding for the state's nursing homes. I represent approximately 400 workers in Sheboygan County health care facilities who face an often uncertain future because of the precarious state of nursing home funding in Wisconsin.

**I hope you will support increasing the Medicaid reimbursement formula through changes in the Intergovernmental Transfer program, as proposed by the governor.**

County nursing homes in the state have been struggling for quite some time to deal with reimbursement rates that do not sufficiently cover their costs. According to last year's Audit Bureau report, 44 of the 47 county nursing homes in Wisconsin reported deficits in fiscal year 1999 totalling about $67 million dollars.

Compared to those in private nursing homes, residents at county facilities generally have more behavioral problems and are more likely to be diagnosed with acute illnesses, including mental illness. This substantially increases our direct care costs, which are not fully reimbursed under Medicaid. The deficits that result force counties to either make up the difference by increasing property taxes, downsizing or getting out of the nursing home business altogether.

The proposed changes in the Intergovernmental Transfer Program will help preserve county nursing homes by capturing additional federal Medicaid matching funds. This mechanism, which is used by about two dozen other states, could increase Medicaid nursing home funds by $115 million in the first year of the budget and $157 million in the second year, provided the federal government approves these changes. About $40 million of these funds would be allocated to county nursing homes, which are truly the safety net for our most vulnerable citizens.

I urge this committee to support these changes in the I-G-T Program when you forward your budget recommendations to the Joint Finance Committee. With no new state dollars allocated to nursing homes in this budget, the state should make every effort to capitalize on any other available funding source to ensure adequate care for our most vulnerable residents.

Please support increasing Medicaid reimbursement funding through the proposed changes in the I-G-T program. Thank you.

April 4, 2001

WISCONSIN
PRIMARY HEALTH CARE
ASSOCIATION

My name is Mari Freiberg. I am the Policy and Public Affairs Director of the Wisconsin Primary Health Care Association. Our organization's mission is to promote access to comprehensive community oriented primary health care services for medically underserved Wisconsin communities. Our testimony will provide comments on several budget items – the State Community Health Center Grant Program, Breast and Cervical Cancer Treatment, the Tobacco Control Board, Prescription Drug Benefits and the BadgerCare program.

**Support $6 million for State Community Health Center Grant Program**

Wisconsin's federally funded Community, Migrant and Homeless Health Centers provide primary health care services (medical, dental, and mental health care) to almost 100,000 men, women and children in our state. Health Centers provide care to all who live in our service areas, regardless of insurance status or ability to pay. Wisconsin's Health Centers make up the core of health care providers who serve populations in need, whether they are geographically, linguistically, culturally or financially isolated from traditional health care services.

During the last biennium, the Health Centers received an unprecedented $5.5 million to increase access to health care services for thousands of state residents. Governor McCallum's budget proposal includes $6 million in Department of Health and Family Services base funding for the State Community Health Center Grant Program.

- Community Health Centers have comprehensive primary and preventive care services at one location and offer on-site enrollment opportunities for Medicaid and BadgerCare. State funding supports a one-stop shopping model for health services and benefits.

- Community Health Centers eliminate barriers to health care services for thousands of people. They provide primary care access points in 36 counties – reducing geographic barriers; they have bilingual health care providers – reducing cultural and linguistic barriers; and they have a published sliding fee scale – reducing financial barriers.

With the previous years' funding, Community Health Centers were able to expand health care services, facilities and staff, support health education programs, expand dental facilities, support mental health and substance abuse programs, and offer linguistic and cultural training opportunities for staff. State funding in this budget will allow for the expansion of direct health care services and improved patient care in the coming years.

Please support Governor McCallum's budget request for $6 million for the State Community Health Center Grant Program.

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**Support Breast and Cervical Cancer Treatment Program and Include Presumptive Eligibility**

The Association supports the Governor's plan expanding Medicaid to provide treatment services for uninsured women under age 65 who have been screened and found to be in need of treatment for breast or cervical cancer.

Further, we request that the State adopt Presumptive Eligibility. Presumptive Eligibility is a Medicaid option that allows Medicaid applicants with a high probability of eligibility to get immediate health care services while their applications are filed and processed. This will allow women diagnosed with breast or cervical cancer in need of immediate care and treatment to receive it without waiting, sometimes weeks, for formal acceptance into the Medicaid program. In this program, Presumptive Eligibility can mean the difference between life and death.

**Support Tobacco Control Board Funding**

The Association is pleased that Governor McCallum has maintained funding for the Wisconsin Tobacco Control Board and recognizes the need for a long-term commitment to tobacco control. The proposed $33.2 million for the biennium to tobacco prevention recognizes the need to invest in efforts to reduce the death and disease caused by tobacco use. However, significant benefits will only be realized when such efforts are funded within the levels recommended by the U.S. Centers for Disease Control and Prevention ($31 to $82 million per year). We support increasing funding to at least the CDC minimum level.

**Include Prescription Drug Assistance Program**

The Association supports plans to create a Medicare prescription drug benefit and urge that it be accessible and affordable for as many people as possible, and at a minimum, for low-income Medicare beneficiaries. We ask that any state plan recognize and support the continuation of existing programs that make medication affordable to low-income individuals, especially those programs offered at Federally Qualified Health Centers through federal drug purchasing programs.

The Governor's budget also requires the Department of Health and Family Services to collect and disseminate information on areas of Wisconsin that might be eligible for Federally Qualified Health Center status. We support this provision and ask that the information be shared with communities and others interested in expanding access to a wide range of primary care services, including reduced cost prescription drug benefits. We look forward to working with the State to expand the network of primary care providers who serve all regardless of insurance status or ability to pay.

**Support and Maintain BadgerCare Program**

We support the Governor's funding recommendations for the BadgerCare program. However, we ask the Legislature to delete his proposal to extend, from three months to six months, the BadgerCare eligibility waiting period for a family that has lost access to employer-subsidized health care coverage. Please maintain the three-month waiting period contained in current law.

Wisconsin Counties Association

MEMORANDUM

TO: Honorable Members of the Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Craig Thompson, Legislative Director

DATE: April 4, 2001

SUBJECT: Budget Items Relating to Health, Utilities, Veterans and Military Affairs

The Wisconsin Counties Association (WCA) thanks you for this opportunity to comment on the 2001-2003 state biennial budget bill. Last biennium, this committee had a significant impact on actions taken by the Joint Committee on Finance, especially on the topic of Family Care. We appreciate the committee once again taking the time to listen to our concerns regarding portions of the state budget.

**Intergovernmental Transfer Program**

On February 2, 2001, an agreement was signed by the Department of Administration, the Department of Health and Family Services, the Wisconsin Counties Association, the Wisconsin Association of Homes and Services for the Aging and the Wisconsin Health Care Association outlining the provisions for securing additional federal funding for the state of Wisconsin through an expanded / revised intergovernmental transfer program, from which additional funding for the state's nursing home industry could be achieved. Governor McCallum's budget codifies portions of that agreement. Attached please find a copy of the agreement.

In general, if Wisconsin's state MA plan amendment is approved by the federal Health Care Financing Administration, additional IGT funds totaling $258.7 million would be claimed in 2000-01, $189.6 million in 2002-03 and $155.7 million in 2002-03. The Governor's budget creates an MA Trust Fund into which all IGT dollars received by the state of Wisconsin would be deposited. Additionally, the Governor's budget outlines how Trust Fund dollars would be spent.

If, by May 9, 2001, Wisconsin's state MA plan amendment is approved, the budget provides an additional $40 million to county nursing homes and provides rate increases for all nursing homes. The budget, at this time, expends no GPR dollars on the nursing home industry.

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Mark M. Rogacki, Executive Director

Mark D. O'Connell, Chief of Staff
Craig M. Thompson, Legislative Director
Darla M. Hium, Deputy Director
Lynda L. Bradstreet, Administrative Director

Wisconsin's current IGT program operates as a certification program, not a true intergovernmental transfer program, whereby the state certifies county nursing home losses and utilizes those losses as state match for federal dollars. Under Wisconsin's revised intergovernmental transfer program, three Wisconsin counties (Rock, Walworth and Sheboygan) borrowed over $600 million in funds, transferred those funds to the state, the state then made payments to those three counties for medicaid purposes, resulting in federal matching funds (if the plan amendment is approved).

As a result of new federal MA rules, Wisconsin's ability to capture additional IGT funds is limited. Beginning in 2003-04, the amount of IGT dollars Wisconsin can claim will begin to decrease significantly. However, because all IGT dollars will be placed in the MA trust fund, increased payments to the nursing home industry can be made beyond 2004.

The Wisconsin Counties Association respectfully requests your support for the creation and maintenance of the MA Trust Fund as outlined in the Governor's budget bill. As stated previously, three counties undertook great effort to secure additional IGT dollars for the state of Wisconsin. These same three counties are adamant that the trust fund not be tapped into for other MA-related programs. If the trust fund is utilized for other purposes, it will be difficult, if not impossible, to ensure that the three counties will once again participate in the new IGT program.

Proposed new regulations regarding the IGT program were recently introduced at the federal level. WCA, as well as the state, are in the process of determining what effect, if any, the proposed regulations will have on Wisconsin's IGT program. We will update committee members as additional information becomes available.

**Family Care/COP/Community Aids**

Governor McCallum's budget makes several changes to the Family Care program. WCA would like to comment briefly regarding the Family Care program, as well as other long term care programs.

The Department of Health and Family Services, in its budget request, requested funding for the expansion of the Family Care program to Kenosha County, as well as recommended inflationary increases for Resource Centers, additional COP slots, etc. The Governor's budget does not include the expansion of CMO status to Kenosha County, eliminates the Long Term Care and Family Care External Advocacy, and includes no new COP slots over the course of the biennium.

Several years of planning, meeting and negotiations went into the formulation of the Family Care Pilot Program. This pilot was undertaken in an effort to address the tremendous increase in the demographic population that will be in need of long term care as well as addressing the current waiting list for services. By putting a halt to the expansion of Family Care pilots, the questions becomes: What direction are we heading in for long term care in Wisconsin and is there still a commitment to Family Care?

County governments are committed to the success of the Family Care program and support the additional funding in the Governor's budget for the pilot counties. However, only five counties are involved in the Family Care program to date. The other 67 counties will receive no additional funding in this budget to reduce their waiting lists. It is disappointing to see no additional COP slots created in the budget. It is equally disappointing that counties will receive a decrease in the community aids appropriation in each year of the biennium. WCA believes it is time for the administration to map out its plan for long term care programs in the future, be it Family Care, additional funding for COP, community aids, etc.

Thank you for considering our comments.

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MADISON WI 53701-03
Telephone: 608-266-60
FAX: 608-266-10
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Scott McCallum
GOVERNOR

State of Wisconsin
Department of Health and Family Services

# WCA/WAHSA/WHCA IGT Agreement with DOA/DHFS

- Continue current level of Intergovernmental Transfer (IGT) funds (i.e., $40.1 million and $78.1 million in FY 01 and $37.1 million and $78.1 million in FY 02 and FY 03 in nursing home base).
- Devote all new IGT funds to the Medicaid Program. The vast majority of IGT funds will be used to address nursing home funding needs.
- IGT funds received by the State will not be utilized to reduce or replace current GPR funding (as adjusted in the Medicaid base reestimate) for the nursing home payment system.
- Propose statutory language to establish an interest-bearing IGT Medicaid Trust Account that will be effective upon passage of enabling legislation. An amount equal to all IGT funds received by the State of Wisconsin during or after FY 2001 will be deposited into the trust account. The vast majority of the trust account balances will be utilized to fund current and future expenditures contemplated under this agreement.
- Counties will be identified to participate in an IGT through a wire transfer. Development and transaction costs will be paid from Trust funds (counties will be fully reimbursed for these costs).
- Increase Medicaid nursing home funding by $115 million in 2001-02 and by an additional 4% in 2002-03. The 2001-02 funds would be split $40 million to counties and $75 million for the reimbursement formula. To facilitate a reasonable determination of how the $40 million allocated to the counties will be distributed, the Wisconsin Counties Association (WCA), the Wisconsin Association of Homes and Services for the Aging (WAHSA) and the Wisconsin Health Care Association (WHCA) agrees DHFS should model the following formula parameters for distribution of the $75 million:

  1. Direct Care targets at 104% of the median.
  2. Property/Capital T2 set at 9.5%.
  3. Support Care targets at 95% of the median.
  4. Administration targets at 95% of the median.

  These percentages will be adjusted proportionally as necessary to distribute no more than $75 million. Final formula parameters regarding how the $75 million will be distributed under the 2001-02 nursing home reimbursement formula will be developed by DHFS and the Associations at a later date.
- The Associations' support of a 4% increase in 2002-03 is committed with the expectation that this level is sufficient to maintain the 2001-02 formula. In the event that this level is insufficient, the Associations reserve the right to seek additional funding from the Legislature.
- The Associations and DOA/DHFS have agreed to distribute the $40 million IGT county allocation to cover certain operating deficits of certain facilities operated by counties and other local units of government, in the priority order set forth below. (The attached provides the Associations' projected 2001-02 distribution based on this methodology.) If after covering all deficits within a higher priority category remaining funds are insufficient to cover all deficits within the next lower category, remaining funds shall be divided among

facilities within the next lower category in proportion to the amount of their respective deficits.

*For 2001-02:*

1. Direct care operating deficits of all such facilities.
2. Total (i.e., direct care plus non-direct care) operating deficits of such facilities operated by Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties, during the period such facilities are downsizing.
3. Non-direct care operating deficits of all such facilities.

*For 2002-03:*

The priority order noted for 2001-02 shall be modified so that categories #2. #1 and #3 become the revised priority order for 2002-03.

- Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties will agree to continue pursuing their downsizing plans.
- The Associations will work with DOA/DHFS to eliminate the Ourada Amendment, assuming the agreement holds and the expanded IGT program is achieved (approved by HCFA). If the parties are not successful in eliminating the Ourada Amendment, all parties agree to renegotiate the terms of this agreement.
- The Administration and Associations will work in a unified manner to secure legislative and federal approval of this agreement.

***The above represents the entirety of the agreement between the Associations and DOA/DHFS and assumes that additional IGT federal payments secured by the State of Wisconsin will net approximately $260 million for SFY 01, $190 million for SFY 02 and $155 million for SFY 03. Should actual net IGT federal payments result in funding increases significantly higher or lower than projected, all parties pledge to bargain in good faith to renegotiate a revised IGT funding agreement.***

Dated this 2nd day of February, 2001:

Secretary, Department of Administration

Secretary, Department of Health and Family Services

Wisconsin Counties Association

Wisconsin Association of Homes and Services for the Aging

Wisconsin Health Care Association

Managed
Health
Services

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April 10, 2001

Senator Rodney Moen
8 South State Capitol
Madison, WI 53708

Dear Senator Moen:

As you know, Managed Health Services is a 16 year-old Medicaid HMO that serves more than 95,000 residents in 18 counties from Green Bay to Kenosha. We consider it a privilege to participate with the State of Wisconsin to provide managed care services for children and adults, many of whom are working, low income, taxpaying citizens, without health insurance for their children or themselves.

From my experience, the Medicaid/BadgerCare program has proven to be a blessing to the poor and uninsured families who had been living in fear that a serious injury or illness could destroy their often fragile financial stability. Managed Health Services has been able to provide quality care to both our Medicaid and BadgerCare members because we are fortunate to have over 3,6000 caring physicians in our network, in addition to hospital systems like Aurora, Children's Hospital and Covenant in the Milwaukee area and Affinity in the Green Bay area.

The continued success of this program is the reason I am writing to you today. I ask that you support the Budget as submitted by Governor McCallum; however, there are four issues that I would like to bring to your attention:

- Continued funding for the Medicaid and BadgerCare Managed Care Program. The current budget provides for increases of 3.5% for 2002 and 3.9% for 2003. These are the minimum increases that would enable these programs to remain viable.

- Increases in hospital rates need to be tied to increases in premiums for Managed Care companies. As currently outlined in the budget, there are increases in the Medicaid rates for the hospitals. To remain competitive, the HMO Program needs similar increases.

- Make up reductions in State support of HIRSP by increasing "tax" on insurance/HMO entities. The current budget would tax the Medicaid Managed Care Program.

- Contract restrictions on HMOs may make them non-competitive. The proposed elimination of the HMO exemption would increase costs to the State by increasing administrative and management costs.

These issues are of great concern to us as continued resources and funding are needed to keep the Medicaid/BadgerCare program alive and operating as a model program for America's working poor. Thank you in advance for your support.

Sincerely,

Kathleen Crampton

Kathleen Crampton
President & CEO

**BlueCross & BlueShield United of Wisconsin**

An independent licensee of the Blue Cross and Blue Shield Association

401 West Michigan Street
P.O. Box 2025
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**Testimony Presented to the**
**SENATE COMMITTEE ON HEALTH, UTILITIES, VETERANS AND MILITARY AFFAIRS**

**April 11, 2001**

**By Thomas R. Hefty**
**Chairman, President and Chief Executive Officer**
**Blue Cross & Blue Shield United of Wisconsin**

Good afternoon Chairman Moen and members of the Committee. My name is Tom Hefty and I am CEO of Blue Cross & Blue Shield United of Wisconsin. Thank you for providing this opportunity to testify on health related issues in the 2001-2003 biennial budget.

Clearly, the budget in front of the Legislature's Joint Committee on Finance is one of the leanest budgets in recent years. The slowing economy has forced the Governor to look at other funding to meet the state's obligations. There are three points that I would like to summarize for you today:

- first, the Legislature should fully fund the HIRSP and Medicaid and BadgerCare program;
- second, the State should do everything possible to tap available federal funds and segregate tobacco settlement monies; and
- lastly, the Legislature should tighten HMO regulations, which will reduce pressure on state programs and also raise needed tax revenue.

## I. Background

At a time when the economy is slowing down, Wisconsin is seeing a rise in enrollment in many of its public health programs, which subsequently leads to higher program costs. In only eight months, BadgerCare enrollment has gone up by nearly ten thousand people and HIRSP enrollment has gone up over two thousand individuals since March of 2000. Not since 1994 has the HIRSP population exceeded 10,000 and it appears that the program enrollment is on course for exceeding its highest year ever, 12,707 in 1992. A rash of HMO cancellations in the Metro-Milwaukee and Madison regions have more than likely contributed to the rise in enrollment in these state health programs.

Following the success of the mid-1990s when Wisconsin had the lowest uninsured rate in the U.S., in year 2000 for a second straight year, Wisconsin has a double digit uninsured rate (11%). Unfortunately, in this difficult economic environment where health care costs are rising, the budget includes cuts for some of the key health programs intended to address these

public needs. In 1998, the state became a partner in the HIRSP funding mechanism by providing $12 million in GPR each year for HIRSP program costs. Now, the budget reneges on the state's commitment by reducing the state's GPR subsidy for HIRSP by $3.8 million over the biennium. With HIRSP enrollment climbing, there has never been a worse time for a cut in funding. The brunt of this cut would affect HIRSP policyholders, who would pay over $2.2 million in higher premiums. This affects all small business health plan costs. It is a hidden sales tax on health private care plans.

The budget also fails to fully fund Medicaid administration and program costs, nor does it address the growing budget needs for General Assistance Medical Program (GAMP) in Milwaukee County. The Legislature can play a key role in ensuring that the health of Wisconsin's citizens does not fall by the wayside during these unpredictable economic times.

## II. How can these programs be fully funded?

First, all available opportunities to draw down federal dollars must be fulfilled. The IGT for nursing homes and the S-CHIP funding for children's and now adult health care are useful vehicles for states to get federal health care dollars that Wisconsin taxpayers help fund. Although the budget taps federal funds for nursing home costs, it fails to do so for other health costs. The GAMP in Milwaukee County is a worthy recipient of these funds. Lessons in funding worthy programs while reducing local tax burdens can be learned from other states that have developed innovative methods for attracting federal dollars.

Second, the Legislature must be mindful of the way that the tobacco monies are spent. Clearly, the settlement dollars have intent in mind: to improve the health of citizens in our country. The job for the Legislature is to preserve a portion of the funding for intended health purposes. Helping to fund insurance costs for high risk individuals or paying for programs to encourage Medicaid or BadgerCare recipients to engage in healthier living is an appropriate and legitimate use of the tobacco monies.

## III. Tighter HMO Regulation

Another budget item of interest constitutes one way that the Legislature can reform HMO regulation in this state. First, I would ask that you support the ban on management contracts for HMOs. This ban already applies to all other lines of insurance. In her early years as a partner with LaFollette, Sinykin, Anderson, Davis and Abrahamson and as a professor, Chief Justice Shirley Abrahamson co-authored a study of management contracts in the insurance industry per the request of the Governor. Chief Justice Abrahamson made the best case for the ban on management contracts when she said:

"As a business, with a public interest, the insurance industry is subject to extensive regulation. Yet, by use of the management contract, business entities, which are not

themselves regulated, control the internal management and management decisions of insurance companies Management contracts can be used to siphon profits out of insurance companies, they create problems of conflict of interest and subsequent violations of the fiduciary

responsibility of corporate officers and directors; they can jeopardize the security of policyholders." (1969 Wis. Law Review 698)

"The authors conclude that because of the great dangers of abuse the most realistic and constructive alternative is to prohibit completely management contracts with insurance companies." (1969 Wis. Law Review.698)

Abrahamson's words were prophetic, given the Family Health Plan (FHP) bankruptcy last year. FHP's for-profit management company, Family Health Systems managed the health plan into bankruptcy—the largest in the state's history. Last year, 70,000 individuals covered by FHP were in limbo when their insurer went out of business. Because management companies are not subject to the same executive compensation and conflict of interest disclosure requirements as other HMOs, the Office of the Commissioner of Insurance (OCI) could not foresee or prevent this insolvency.

Medica HMO, which operates in Wisconsin, but is owned by a Minnesota based management company, has recently come under scrutiny from the Minnesota Attorney General. Copies of the Minnesota new coverage are available for the Committee from the Chairman.

All insurers must play on a level playing field. Management contracts are currently banned for all other insurers in Wisconsin except HMOs. The sunshine laws requiring full disclosure have not hurt those industries. In fact, it has produced a better, more informed market.

Tighter HMO regulation saves tax dollars in two ways. HMOs should be prohibited from selectively canceling coverage, thereby keeping individuals in the private market rather than HIRSP or Medicaid. This was the intent of legislation passed in 1991 under the "Small Employers Health Insurance Act," and if there is any question about that law's interpretation, it is time to address it. In recent months, UnitedHealthcare—another Minnesota firm with management contracts for a Wisconsin health plan—announced that they were moving over 150 jobs outside Wisconsin. The result is a loss of tax revenue to support needed programs.

In summary, tighter HMO regulation saves tax dollars in two ways. Keeping individuals with private coverage and maintaining the tax base in Wisconsin. Management contracts transfer revenue, jobs and taxable income out of state.

Thank you for your time today Chairman Moen and members of the Committee. I welcome the opportunity for any questions.

## HIRSP ENROLLMENT MAR 00- MAR 01

| | |
|---|---|
| MAR 00 | 8,567 |
| APR 00 | 8,716 |
| MAY 00 | 8,943 |
| JUN 00 | 9,129 |
| JUL 00 | 9,226 |
| AUG 00 | 9,436 |
| SEP 00 | 9,512 |
| OCT 00 | 9,658 |
| NOV 00 | 9,949 |
| DEC 00 | 10,042 |
| JAN 01 | 10,412 |
| FEB 01 | 10,471 |
| MAR 01 | 10,805 |

## HIRSP APPLICATIONS 4 YEAR AVERAGE

| | |
|---|---|
| 1997- | 119.5 a month |
| 1998- | 182.75 a month |
| 1999- | 248.75 a month |
| 2000-- | 407.5 a month |

**APPLICATIONS IN THE LAST SIX MONTHS:**

| | |
|---|---|
| Oct. 00- | 426 |
| Nov. 00- | 472 |
| Dec.00- | 559 |
| Jan. 01- | 431 |
| Feb. 01- | 487 |
| Mar.01- | 493 |

*(Source: HIRSP Monthly Reports)*

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## BADGERCARE ENROLLMENT:

| | |
|---|---|
| **AUG. 00-** | **72,057** |
| **SEP. 00-** | **74,747** |
| **OCT. 00-** | **76,515** |
| **NOV. 00-** | **77,046** |
| **DEC. 00-** | **78,063** |
| **JAN. 01-** | **78,659** |
| **FEB. 01-** | **78,831** |
| **MAR. 01-** | **81,003** |

*(Source: Department of Health and Family Services Website)*

# Measuring Success

Benchmarks for a Competitive Wisconsin
**2000**

**Competitive Wisconsin, Inc.**
A nonpartisan consortium of Wisconsin leaders in agriculture, business, education and labor

**December 2000**

Prepared by Wisconsin Taxpayers Alliance
335 W. Wilson St. • Madison, WI 53703

## Health Insurance Coverage

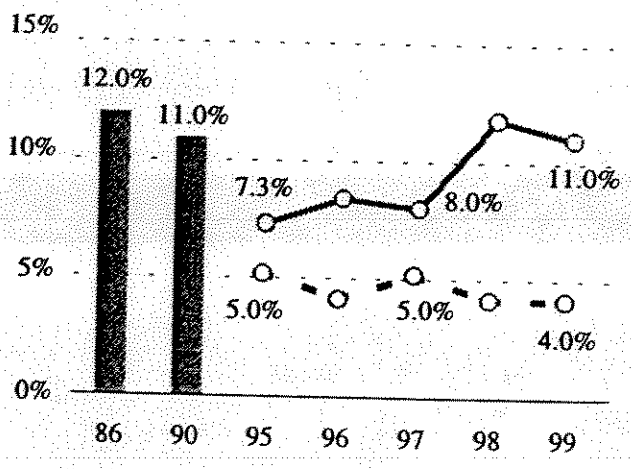
### Significance

States with higher rates of insurance coverage and lower uninsured rates generally have healthier populations and more productive workforces.

### Performance

On the basis of an in-state survey, Wisconsin estimates its 1999 uninsured at 4.0%, the same as 1998. However, the U.S. Census Bureau estimate is 11.0%, 3.7 points above 1995. According to the U.S. Census Bureau, Wisconsin's uninsured rate is well below the national average.

***State's Uninsured Rate Falls***




***And Remains Below Average***
Current Level and 5-Year Change

| Wisconsin, 1999 | 11.0% | +2.1 pts. |
|---|---|---|
| U.S. | 15.5% | +0.3 pts. |
| Illinois | 14.1 | +2.7 |
| Iowa | 8.3 | -1.4 |
| Michigan | 11.3 | +0.4 |
| Minnesota | 8.0 | -1.5 |

Source: U.S. Bureau of the Census.

December 2000

# Sources of Health Insurance and Characteristics of the Uninsured:

## Analysis of the March 2000 Current Population Survey

by Paul Fronstin, EBRI

EBRI
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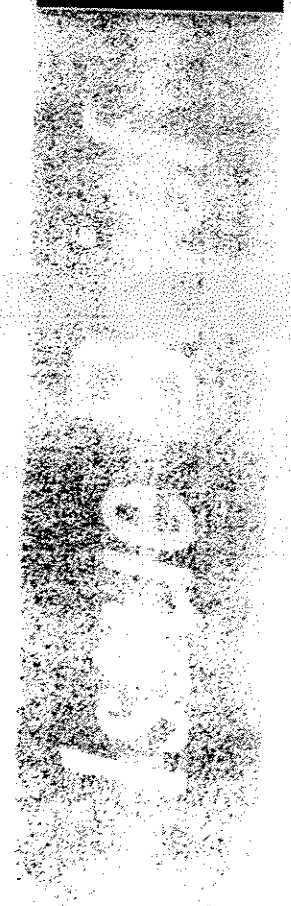


- This *Issue Brief* provides summary data on the insured and uninsured populations in the nation and in each state. It discusses the characteristics most closely related to an individual's health insurance status. Based on EBRI estimates from the March 2000 Current Population Survey (CPS), it represents 1999 data—the most recent available.

- In 1999, for the first time since at least 1987, the percentage of Americans with health insurance increased: 82.5 percent of nonelderly Americans (under age 65) were covered by some form of health insurance, up from 81.6 percent in 1998. The percentage of nonelderly Americans without health insurance coverage declined from 18.4 percent in 1998 to 17.5 percent in 1999.

- The main reason for the decline in the number of uninsured Americans is the strong economy and low unemployment. Between 1998 and 1999, the percentage of nonelderly Americans covered by employment-based health insurance increased from 64.9 percent to 65.8 percent, continuing a longer-term trend that started between 1993 and 1994.

- In 1999, 34.1 million Americans received health insurance from public programs, and an additional 15.8 million purchased it directly from an insurer. Twenty-five million Americans participated in the Medicaid program, and 6.5 million received their health insurance through the Tricare and CHAMPVA programs and other government programs designed to provide coverage for retired military members and their families.

- Despite expansions in the State Children's Health Insurance Program (S-CHIP), public health insurance coverage did not increase overall between 1998 and 1999. The percentage of nonelderly Americans covered by Medicaid and other government-sponsored health insurance coverage did not change between 1998 and 1999, though some children benefited from expansions in government-funded programs. The percentage of children in families just above the poverty level without health insurance coverage declined dramatically, from 27.2 percent uninsured in 1998 to 19.7 percent uninsured in 1999. Some of the decline can be attributed to expansions in Medicaid and S-CHIP, but it appears that expansions in employment-based health insurance and individually purchased coverage had an even larger effect than expansion of S-CHIP.

- Even though the number and percentage of uninsured declined substantially between 1998 and 1999, more than 42 million Americans remain uninsured. As long as the economy is strong and unemployment is low, employment-based health insurance coverage will expand and the uninsured will decline gradually. If the economy continues to soften or comes close to a recession, the number of uninsured would easily and quickly start to increase again as unemployment rises. Should a severe downturn in the economy occur, causing the uninsured to represent 25 percent of the nonelderly population, 63 million Americans would be uninsured.


In 1999, for the first time since at least 1987, the percentage of Americans with health insurance increased:[1] 82.5 percent of nonelderly Americans were covered by some form of health insurance, up from 81.6 percent in 1998 (calculated from table 1). As a result, 198.6 million nonelderly Americans (under age 65) had health insurance coverage in 1999, while 42.1 million were uninsured. The percentage of nonelderly Americans without health insurance coverage declined from 18.4 percent in 1998 to 17.5 percent in 1999 (table 1). Not only is this the first significant decline in the *percentage* of uninsured since at least 1987, but it is also the first time that the *number* of uninsured Americans has declined.[2]

The main reason for the decline in the number of uninsured Americans is the strong economy and low unemployment. More workers and their dependents are being covered by employment-based health insurance, already the most common form of health insurance coverage in the United States. Between 1998 and 1999, the percentage of nonelderly Americans covered by employment-based health insurance increased from 64.9 percent to 65.8 percent, continuing a longer-term trend that started between 1993 and 1994 (table 1).

While the majority of nonelderly Americans with health insurance in 1999 received coverage through an employment-based health plan, 34.1 million Americans received health insurance from public programs, and an additional 15.8 million purchased it directly from an insurer. Twenty-five million Americans participated in the Medicaid program,[3] and 6.5 million received their health insurance through the Tricare and CHAMPVA[4] programs and other government programs designed to provide coverage for retired military members and their families.

Prior to 1999, the uninsured were increasing for a number of reasons. For instance, between 1987 and 1993, the increase in the uninsured can be attributed to the erosion of *employment-based* health benefits.[5] While public programs were covering an increasing percentage of Americans prior to 1993, the growth in these programs was not enough to offset the erosion in employment-based health insurance, so the uninsured increased. By contrast, between 1993 and 1998, the portion of Americans covered by employment-based health insurance increased, but the percentage of Americans without health insurance coverage continued to increase. During this period, the decline in *public* sources of health insurance would mostly explain the increase in the uninsured population.

For example, the percentage of nonelderly Americans covered by Tricare or CHAMPVA declined from 3.8 percent to 2.9 percent between 1994 and 1998, and continued down to 2.7 percent in 1999, in large part due to downsizing in the military. Similarly, between 1993 and 1998, the percentage of nonelderly Americans covered by Medicaid (the federal-state insurance program for the poor) declined from 12.7 percent to

[1] *The number of Americans both with and without health insurance coverage can grow every year because of population growth.*

[2] *The number of uninsured Americans can grow when the percentage is declining because of population growth.*

[3] *The estimate for Medicaid likely also includes children enrolled in the S-CHIP program. It is currently impossible to obtain separate estimates of Medicaid and S-CHIP from the CPS. Medicaid (and Medicare) estimates are underreported in the CPS, according to comparisons of these data with enrollment and participation data provided by the Health Care Financing Administration (HCFA). See Robert L. Bennefield, "Health Insurance Coverage: 1997,"* Current Population Reports, *P60-202 (Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, September 1998).*

[4] *Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.*

[5] *See Fronstin and Snider (1996/97) for an analysis of the decline in employment-based health insurance between 1988 and 1993.*

Table 1

**Nonelderly Americans With Selected Sources of Health Insurance Coverage, 1987–1999**

| | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | (millions) | | | | | | | |
| Total Population | 214.4 | 216.6 | 218.5 | 220.6 | 222.9 | 225.5 | 228.0 | 229.9 | 231.9 | 234.0 | 236.2 | 238.6 | 240.7 |
| Employment-Based Coverage | 148.5 | 149.4 | 149.8 | 147.7 | 147.7 | 145.9 | 144.9 | 146.3 | 147.9 | 149.8 | 151.7 | 154.8 | 158.4 |
| Own name | 72.5 | 73.5 | 74.0 | 73.1 | 73.1 | 71.7 | 74.9 | 75.2 | 75.9 | 76.9 | 77.4 | 79.1 | 80.3 |
| Dependent coverage | 75.9 | 75.9 | 75.8 | 74.7 | 74.6 | 74.3 | 69.9 | 71.1 | 72.1 | 72.9 | 74.3 | 75.7 | 78.1 |
| Individually Purchased | 14.3 | 13.5 | 14.5 | 14.3 | 13.6 | 14.6 | 16.6 | 16.4 | 16.0 | 16.0 | 15.8 | 15.5 | 15.8 |
| Public | 28.5 | 28.8 | 28.7 | 31.9 | 34.4 | 36.0 | 38.1 | 38.9 | 38.4 | 37.4 | 34.9 | 34.2 | 34.1 |
| Medicare | 3.1 | 3.2 | 3.2 | 3.4 | 3.5 | 3.9 | 3.7 | 3.7 | 4.1 | 4.6 | 4.7 | 4.8 | 4.8 |
| Medicaid | 18.4 | 18.9 | 19.2 | 22.4 | 24.8 | 26.5 | 29.0 | 28.7 | 29.0 | 28.2 | 26.0 | 24.9 | 25.0 |
| Tricare/CHAMPVA[a] | 8.5 | 8.2 | 7.9 | 7.9 | 7.9 | 7.5 | 7.4 | 8.7 | 7.4 | 6.8 | 6.6 | 6.8 | 6.5 |
| No Health Insurance | 31.8 | 33.6 | 34.3 | 35.6 | 36.3 | 38.3 | 39.3 | 39.4 | 40.3 | 41.4 | 43.1 | 43.9 | 42.1 |
| | | | | | | (percentage) | | | | | | | |
| Total Population | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Employment-Based Coverage | 69.2 | 69.0 | 68.6 | 67.0 | 66.3 | 64.7 | 63.5 | 63.6 | 63.8 | 64.0 | 64.2 | 64.9 | 65.8 |
| Own name | 33.8 | 33.9 | 33.9 | 33.1 | 32.8 | 31.8 | 32.9 | 32.7 | 32.7 | 32.9 | 32.8 | 33.1 | 33.4 |
| Dependent coverage | 35.4 | 35.0 | 34.7 | 33.8 | 33.5 | 32.9 | 30.7 | 30.9 | 31.1 | 31.2 | 31.5 | 31.7 | 32.4 |
| Individually Purchased | 6.7 | 6.3 | 6.6 | 6.5 | 6.1 | 6.5 | 7.3 | 7.1 | 6.9 | 6.8 | 6.7 | 6.5 | 6.6 |
| Public | 13.3 | 13.3 | 13.2 | 14.5 | 15.5 | 16.0 | 16.7 | 16.9 | 16.6 | 16.0 | 14.8 | 14.3 | 14.2 |
| Medicare | 1.4 | 1.5 | 1.5 | 1.6 | 1.6 | 1.7 | 1.6 | 1.6 | 1.8 | 2.0 | 2.0 | 2.0 | 2.0 |
| Medicaid | 8.6 | 8.7 | 8.8 | 10.2 | 11.1 | 11.8 | 12.7 | 12.5 | 12.5 | 12.1 | 11.0 | 10.4 | 10.4 |
| Tricare/CHAMPVA[a] | 4.0 | 3.8 | 3.6 | 3.6 | 3.5 | 3.3 | 3.3 | 3.8 | 3.2 | 2.9 | 2.8 | 2.9 | 2.7 |
| No Health Insurance | 14.8 | 15.5 | 15.7 | 16.1 | 16.3 | 17.0 | 17.3 | 17.1 | 17.4 | 17.7 | 18.3 | 18.4 | 17.5 |

Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

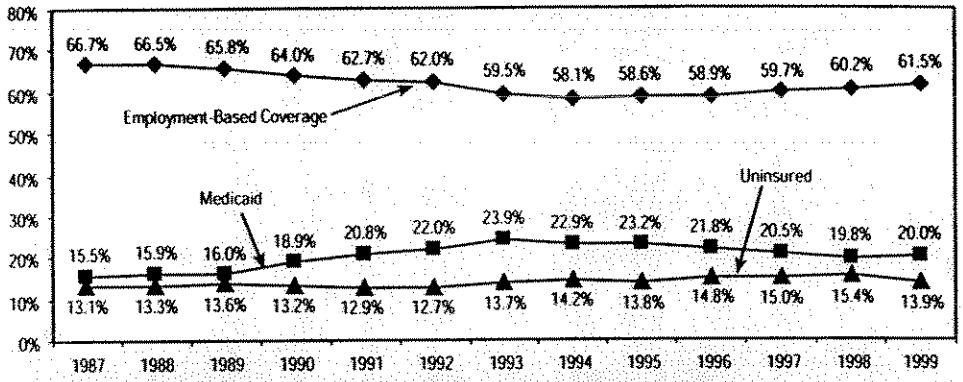
10.4 percent as welfare reform, coupled with the strong economy, resulted in fewer people in the welfare ranks and more former welfare recipients moving into private- and public-sector employment.

Despite expansions in the State Children's Health Insurance Program (S-CHIP), public health insurance coverage did not increase overall between 1998 and 1999. The percentage of nonelderly Americans covered by Medicaid and other government-sponsored health insurance coverage did not change between 1998 and 1999—remaining at 10.4 percent in 1999. While the data used in this paper currently do not allow researchers to count the number of children enrolled in S-CHIP, it appears that some children benefited from expansions in government-funded programs. Findings from the U.S. Census Bureau's Current Population Survey (CPS) indicate that the percentage of children in families just above the poverty level without health insurance coverage declined dramatically, from 27.2 percent uninsured in 1998 to 19.7 percent uninsured in 1999. Some of the decline can be attributed to expansions in Medicaid and S-CHIP. Between 1998 and 1999, the percentage of near-poor children covered by these programs increased from 39.3 percent to 40.5 percent. However, it appears that expansions in employment-based health insurance and individually purchased coverage had an even larger effect than expansion of S-CHIP. Specifically, the percentage of near-poor children covered by an employment-based health insurance plan increased from 30.5 percent to 34.5 percent between 1998 and 1999, while the percentage of near-poor children covered by individually purchased plans increased from 7.8 percent to 10.3 percent.

The purpose of this *Issue Brief* is to examine the status of health insurance coverage in the United States. The data are based primarily on the March 2000 Current Population Survey (CPS), with some analysis based on earlier CPS years. The report focuses on the nonelderly population (under age 65) because this group receives health insurance coverage from a number of different sources, depending, for example, on income, employment status, and location. Medicare covers 96 percent of the elderly population, the least likely group to be employed. The next section discusses recent trends in health insurance coverage and some of the underlying factors affecting these trends. The following section discusses the determinants of having employment-based health insurance coverage and other sources of coverage. The

Chart 1

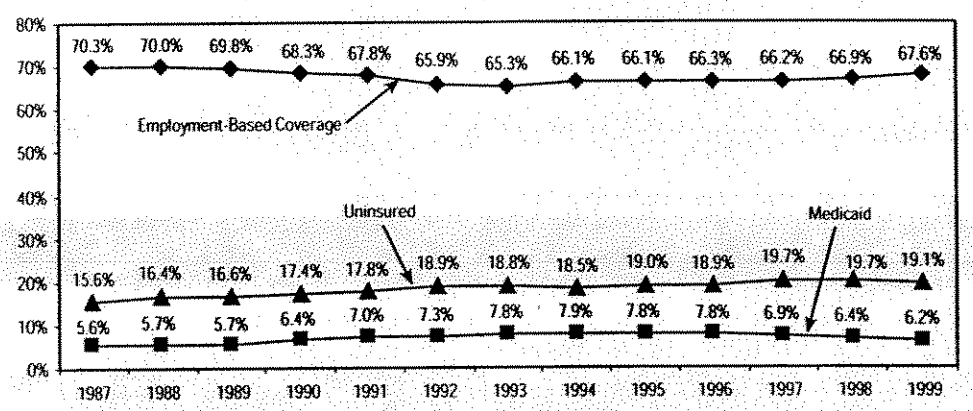
**Percentage of American Children, Ages 0–17, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987–1999**




Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Surveys.

Chart 2

**Percentage of American Adults, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987–1999**




Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Surveys.

section after that discusses the uninsured population and the factors associated with being uninsured, and is followed by a section examining policy implications. The final section presents conclusions. Data sources are discussed in the appendix.

## Recent Trends

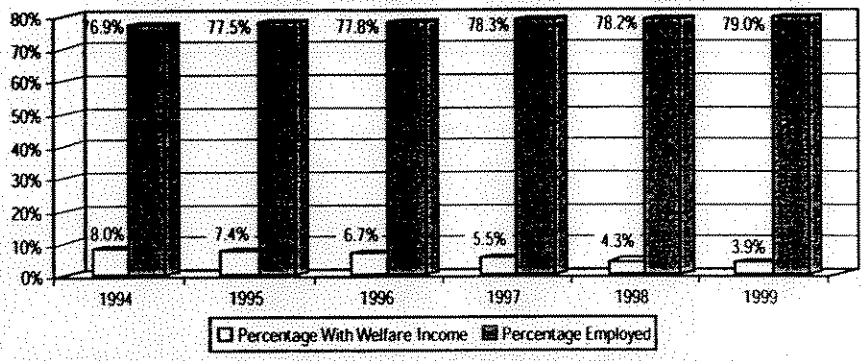
Since 1994, the percentage of nonelderly Americans covered by an employment-based health insurance plan has been increasing[6] (table 1). Overall, the increase in coverage was due mainly to a higher likelihood that children were covered by an employment-based health plan. Between 1994 and 1999, the percentage of children covered by an employment-based health plan increased from 58.1 percent to 61.5 percent (chart 1). For adults, it increased from 66.1 percent to 67.6 percent, with the increase mainly occurring between 1997 and 1999 (chart 2).

Fronstin (1999b) has shown that the likelihood of a child being covered by an employment-based health plan increased for a number of reasons. The study found

[6] *The analysis presented in this section does not include data from prior to the March 1995 CPS. Starting with the March 1995 CPS, the questionnaire was revised. The revision is discussed in more detail in the appendix.*

Chart 3

**Percentage of Women Ages 18–45 Who Are in Families With Welfare Income or Who Are Employed, 1994–1999**




Source: Employee Benefit Research Institute estimates from the March 1995–2000 Current Population Surveys.

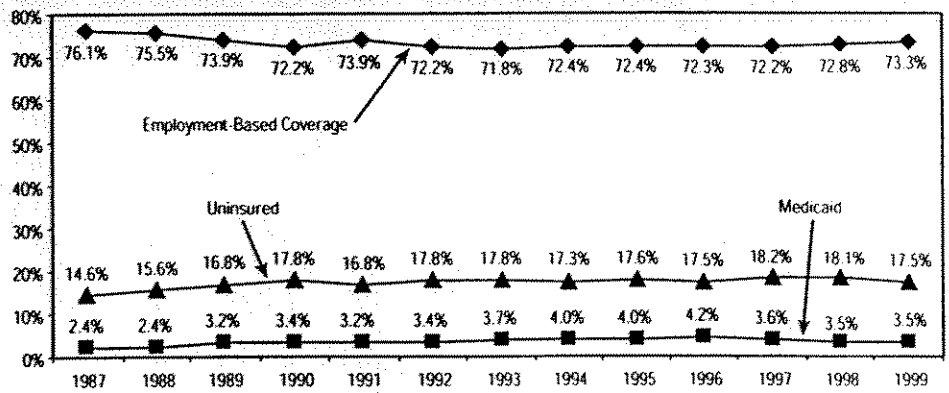
that the percentage of children with a working parent increased, the percentage of children in families with incomes below the poverty level decreased, and more children had a working parent employed in a large firm. The increase in employment-based coverage among children can in part be attributed to a combination of welfare reform and the strong economy, both of which resulted in fewer adult women on welfare and more adult women working. Chart 3 shows how the percentage of women ages 18–45 in families receiving public assistance or welfare income declined, while the employment rate increased.

Between 1994 and 1997, the percentage of working adults with employment-based health insurance coverage held steady at roughly 72.3 percent (chart 4). During this period, health care cost inflation was essentially nonexistent. Between 1997 and 1999, the percentage of working adults with employment-based health insurance increased from 72.2 percent to 73.3 per-cent, despite the apparent return of health care cost inflation in 1998 and 1999. It is likely that the changing composition of the labor force accounted for some of the increase in employment-based coverage. For example, the percentage of workers who were self-employed declined between 1997 and 1999, and the percentage of workers employed on a part-time basis decreased (chart 5).

The increase in employment-based coverage between 1997 and 1999 is both surprising and not surprising. It is not surprising because the strong economy and low unemployment rates have caused more employers to provide health benefits in order to attract

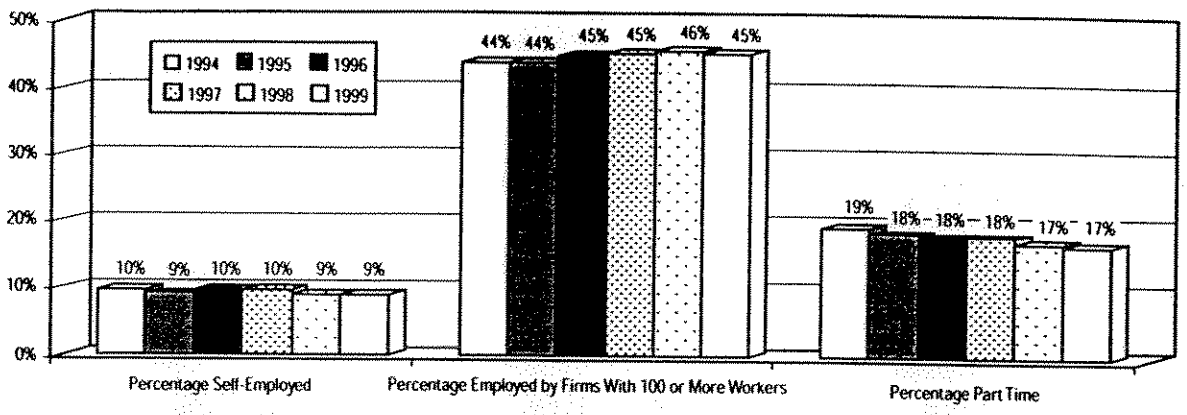
Chart 4

**Percentage of Workers, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987–1999**




Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Surveys.

Chart 5
**Percentage of Workers Who Are Self-Employed or Part-Time, 1994-1999**




Source: Employee Benefit Research Institute estimates from the March 1995–2000 Current Population Surveys.

and retain workers, and also may have resulted in more workers being able to afford health insurance. It is surprising because 1998 saw the return of health care cost inflation, and this inflationary trend accelerated in 1999. In the late 1980s and early 1990s, the percentage of Americans covered by an employment-based health plan declined in large part because of health care cost inflation. In the late 1980s, health care costs increased an average of between 15 percent and 20 percent. However, between 1994 and 1997, health care costs barely changed. In 1998, they started to increase again, but the increase does not appear to have affected the percentage of Americans with employment-based health benefits.

## Determinants of Coverage

Full-time workers, public-sector employees, workers employed in manufacturing, and individuals living in families with high levels of income are most likely to be covered by employment-based health insurance. Persons in families with income below the poverty level, especially children and single-parent families, are most likely to be covered by public health insurance such as Medicaid.

Employment status is the most important determinant of health insurance coverage. Almost two-thirds of the nonelderly population have employment-based coverage. This coverage can be obtained either directly through one's employer/union or previous employer or indirectly through an employed person in one's family. In this report, individuals who receive coverage directly through their employer/union or a previous employer are categorized as having coverage in their *own name*. Individuals who receive employment-based coverage indirectly are categorized as having *dependent* coverage.

Large employers that provide access to group health insurance often are able to provide health benefits at lower cost than small employers, because they are subject to less adverse selection and their average administrative costs and marketing costs are lower. However, examination of health benefit costs across firms usually shows that per-person costs are higher in larger firms than in smaller firms. This occurs because large firms typically offer more extensive health benefits than small firms. Furthermore, the nature of employment, the industry, and the firm's size often determine the cost and extent of coverage. Workers in large firms are more likely to be covered by health insurance than those in small firms.

In 1999, 65.8 percent of the nonelderly were covered by employment-based health insurance (table 1). Workers were much more likely to be covered by employment-based health insurance than nonworkers (table 2). Seventy-three percent of workers were covered by an employment-based plan, compared with 41.4 percent of nonworkers (chart 6). In addition, 76.1 percent of individuals in families headed by full-year, full-time workers were covered by employment-based health insurance, compared with 39.1 percent of those in families headed by other workers, and 21.6 percent of individuals in families headed by nonworkers (table 2).

With respect to industry, workers employed in

Table 2

**Nonelderly Population With Selected Sources of Health Insurance, by Age and Own Work Status, and Work Status of Family Head, 1999**

| Own Work Status and Work Status of Family Head | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (millions) | | | | |
| Total | 240.7 | 158.4 | 80.3 | 78.1 | 15.8 | 34.1 | 25.0 | 42.1 |
| Own Work Status | | | | | | | | |
| Child | 72.3 | 44.5 | 0.2 | 44.3 | 5.3 | 16.6 | 14.5 | 10.0 |
| Adult | | | | | | | | |
| worker | 138.5 | 101.5 | 77.0 | 24.6 | 7.9 | 8.3 | 4.8 | 24.2 |
| nonworker | 29.9 | 12.4 | 3.1 | 9.3 | 2.6 | 9.2 | 5.7 | 7.9 |
| Work Status of Family Head | | | | | | | | |
| Full-year, full-time worker | 184.4 | 140.3 | 69.4 | 70.9 | 9.5 | 15.2 | 9.5 | 25.8 |
| Other worker | 33.8 | 13.2 | 7.5 | 5.7 | 3.9 | 9.0 | 7.8 | 9.6 |
| Nonworker | 22.5 | 4.8 | 3.3 | 1.5 | 2.4 | 9.9 | 7.7 | 6.7 |
| | | | | (percentage within coverage category) | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Own Work Status | | | | | | | | |
| Child | 30.0 | 28.1 | 0.3 | 56.7 | 33.8 | 48.6 | 58.0 | 23.8 |
| Adult | | | | | | | | |
| worker | 57.5 | 64.1 | 95.9 | 31.4 | 49.9 | 24.5 | 19.2 | 57.4 |
| nonworker | 12.4 | 7.8 | 3.9 | 11.9 | 16.2 | 26.9 | 22.8 | 18.8 |
| Work Status of Family Head | | | | | | | | |
| Full-year, full-time worker | 76.6 | 88.6 | 86.4 | 90.8 | 60.3 | 44.6 | 38.0 | 61.1 |
| Other worker | 14.0 | 8.3 | 9.4 | 7.3 | 24.4 | 26.4 | 31.2 | 22.9 |
| Nonworker | 9.3 | 3.1 | 4.2 | 1.9 | 15.3 | 29.0 | 30.8 | 16.0 |
| | | | | (percentage within work status categories) | | | | |
| Total | 100.0% | 65.8% | 33.4% | 32.4% | 6.6% | 14.2% | 10.4% | 17.5% |
| Own Work Status | | | | | | | | |
| Child | 100.0 | 61.5 | 0.3 | 61.2 | 7.4 | 22.9 | 20.0 | 13.9 |
| Adult | | | | | | | | |
| worker | 100.0 | 73.3 | 55.6 | 17.7 | 5.7 | 6.0 | 3.5 | 17.5 |
| nonworker | 100.0 | 41.4 | 10.3 | 31.0 | 8.6 | 30.7 | 19.1 | 26.5 |
| Work Status of Family Head | | | | | | | | |
| Full-year, full-time worker | 100.0 | 76.1 | 37.6 | 38.5 | 5.2 | 8.2 | 5.1 | 14.0 |
| Other worker | 100.0 | 39.1 | 22.3 | 16.8 | 11.4 | 26.7 | 23.1 | 28.5 |
| Nonworker | 100.0 | 21.6 | 14.9 | 6.7 | 10.7 | 43.9 | 34.2 | 30.0 |

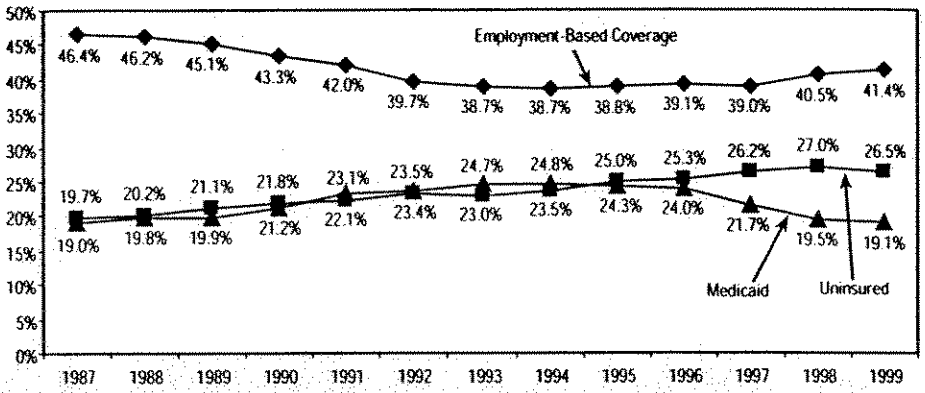
Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

the public sector and in manufacturing were more likely to have employment-based coverage in their own name than other workers (table 3). In addition, the larger the firm the more likely workers were to have employment-based coverage in their own name. Fewer than 26 percent of self-employed workers and 27.5 percent of private-sector workers in firms with fewer than 10 employees were covered through a group health plan sponsored by their own employer/union or former employer in 1999, compared with 66.9 percent of private-sector workers in firms with 1,000 or more employees (table 4).

Health insurance coverage is also related to income. In general, individuals with higher levels of income are more likely to be covered by private health insurance, while those with lower levels of income are more likely to be covered by a publicly sponsored plan. In 1999, 11.5 percent of individuals in families with annual income below $5,000 were covered by employment-based health insurance, compared with 84.6 percent of those in

Chart 6

**Percentage of Nonworkers, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1987–1999**




Source: Employee Benefit Research Institute estimates from the March 1988–2000 Current Population Surveys.

Table 3

**Workers Ages 18–64 With Selected Sources of Health Insurance, by Industry of Primary Employment, 1999**

| Industry | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (millions) | | | | |
| Total | 138.5 | 101.5 | 77.0 | 24.6 | 7.9 | 8.3 | 4.8 | 24.2 |
| Agriculture, forestry, fishing, mining, and construction | 12.8 | 7.1 | 5.0 | 2.1 | 1.2 | 0.6 | 0.4 | 4.1 |
| Manufacturing | 29.4 | 24.2 | 21.1 | 3.1 | 0.8 | 1.2 | 0.6 | 3.9 |
| Wholesale and retail trade | 46.3 | 30.9 | 21.6 | 9.3 | 3.3 | 3.3 | 2.1 | 10.0 |
| Personal services | 29.9 | 22.1 | 14.9 | 7.2 | 2.0 | 1.9 | 1.2 | 4.7 |
| Public sector | 20.0 | 17.4 | 14.5 | 2.9 | 0.6 | 1.3 | 0.5 | 1.5 |
| | | | | (percentage within coverage category) | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Agriculture, forestry, fishing, mining, and construction | 9.3 | 7.0 | 6.4 | 8.5 | 15.4 | 7.7 | 8.4 | 17.1 |
| Manufacturing | 21.2 | 23.8 | 27.4 | 12.7 | 9.7 | 14.1 | 13.3 | 16.1 |
| Wholesale and retail trade | 33.5 | 30.4 | 28.0 | 37.9 | 41.9 | 39.8 | 44.5 | 41.4 |
| Personal services | 21.6 | 21.8 | 19.4 | 29.3 | 26.0 | 22.5 | 24.4 | 19.3 |
| Public sector | 14.4 | 17.1 | 18.8 | 11.7 | 7.0 | 15.9 | 9.4 | 6.1 |
| | | | | (percentage within industry categories) | | | | |
| Total | 100.0% | 73.3% | 55.6% | 17.7% | 5.7% | 6.0% | 3.5% | 17.5% |
| Agriculture, forestry, fishing, mining, and construction | 100.0 | 55.0 | 38.7 | 16.3 | 9.4 | 5.0 | 3.2 | 32.2 |
| Manufacturing | 100.0 | 82.3 | 71.7 | 10.6 | 2.6 | 4.0 | 2.2 | 13.3 |
| Wholesale and retail trade | 100.0 | 66.6 | 46.5 | 20.1 | 7.1 | 7.2 | 4.6 | 21.6 |
| Personal services | 100.0 | 73.8 | 49.8 | 24.0 | 6.8 | 6.3 | 3.9 | 15.6 |
| Public sector | 100.0 | 86.8 | 72.5 | 14.3 | 2.8 | 6.7 | 2.3 | 7.4 |

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey

Note: Details may not add to totals because individuals may receive coverage from more than one source

Table 4

**Workers Ages 18–64 With Selected Sources of Health Insurance, by Firm Size, 1999**

| Firm Size | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (millions) | | | | |
| Total | 138.5 | 101.5 | 77.0 | 24.6 | 7.9 | 8.3 | 4.8 | 24.2 |
| Self-Employed | 12.5 | 6.6 | 3.2 | 3.3 | 2.5 | 0.6 | 0.3 | 3.1 |
| Total Wage and Salary Workers | 126.0 | 94.9 | 73.7 | 21.2 | 5.4 | 7.7 | 4.5 | 21.1 |
| Public sector | 20.0 | 17.4 | 14.5 | 2.9 | 0.6 | 1.3 | 0.5 | 1.5 |
| Private sector | 106.0 | 77.6 | 59.2 | 18.3 | 4.9 | 6.4 | 4.0 | 19.6 |
| fewer than 10 | 15.3 | 8.0 | 4.2 | 3.8 | 1.5 | 1.1 | 0.8 | 5.0 |
| 10–24 | 11.4 | 7.2 | 4.6 | 2.6 | 0.7 | 0.7 | 0.4 | 3.0 |
| 25–99 | 16.4 | 11.7 | 8.8 | 3.0 | 0.7 | 1.0 | 0.6 | 3.4 |
| 100–499 | 16.7 | 13.0 | 10.6 | 2.4 | 0.5 | 0.9 | 0.6 | 2.6 |
| 500–999 | 6.2 | 5.1 | 4.2 | 0.9 | 0.2 | 0.3 | 0.2 | 0.8 |
| 1,000 or more | 40.1 | 32.6 | 26.8 | 5.8 | 1.2 | 2.4 | 1.4 | 4.9 |
| | | | | (percentage within coverage category) | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Self-Employed | 9.0 | 6.5 | 4.2 | 13.6 | 31.2 | 7.2 | 6.4 | 12.6 |
| Total Wage and Salary Workers | 91.0 | 93.5 | 95.8 | 86.4 | 68.8 | 92.8 | 93.6 | 87.4 |
| Public sector | 14.4 | 17.1 | 18.8 | 11.7 | 7.0 | 15.9 | 9.4 | 6.1 |
| Private sector | 76.6 | 76.4 | 77.0 | 74.7 | 61.8 | 76.8 | 84.2 | 81.2 |
| fewer than 10 | 11.0 | 7.8 | 5.5 | 15.3 | 19.5 | 13.0 | 15.8 | 20.7 |
| 10–24 | 8.2 | 7.1 | 6.0 | 10.5 | 8.8 | 8.5 | 9.4 | 12.3 |
| 25–99 | 11.9 | 11.6 | 11.4 | 12.1 | 8.9 | 11.8 | 13.5 | 14.1 |
| 100–499 | 12.0 | 12.9 | 13.8 | 9.9 | 6.7 | 10.9 | 11.7 | 10.6 |
| 500–999 | 4.5 | 5.0 | 5.5 | 3.5 | 2.0 | 3.3 | 3.6 | 3.3 |
| 1,000 or more | 29.0 | 32.1 | 34.8 | 23.4 | 15.8 | 29.3 | 30.1 | 20.2 |
| | | | | (percentage within firm size categories) | | | | |
| Total | 100.0% | 73.3% | 55.6% | 17.7% | 5.7% | 6.0% | 3.5% | 17.5% |
| Self-Employed | 100.0 | 52.7 | 25.9 | 26.8 | 19.7 | 4.8 | 2.5 | 24.5 |
| Total Wage and Salary Workers | 100.0 | 75.4 | 58.5 | 16.8 | 4.3 | 6.1 | 3.6 | 16.8 |
| Public sector | 100.0 | 86.8 | 72.5 | 14.3 | 2.8 | 6.7 | 2.3 | 7.4 |
| Private sector | 100.0 | 73.2 | 55.9 | 17.3 | 4.6 | 6.0 | 3.8 | 18.5 |
| fewer than 10 | 100.0 | 52.1 | 27.5 | 24.6 | 10.0 | 7.1 | 5.0 | 32.8 |
| 10–24 | 100.0 | 63.4 | 40.7 | 22.7 | 6.1 | 6.2 | 4.0 | 26.2 |
| 25–99 | 100.0 | 71.4 | 53.3 | 18.1 | 4.3 | 6.0 | 3.9 | 20.7 |
| 100–499 | 100.0 | 78.3 | 63.7 | 14.6 | 3.2 | 5.4 | 3.4 | 15.4 |
| 500–999 | 100.0 | 82.5 | 68.5 | 14.0 | 2.5 | 4.5 | 2.8 | 12.9 |
| 1,000 or more | 100.0 | 81.2 | 66.9 | 14.3 | 3.1 | 6.1 | 3.6 | 12.2 |

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.

Table 5
**Nonelderly Population With Selected Sources of Health Insurance, by Family Income, 1999**

| Family Income | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (millions) | | | | |
| Total | 240.7 | 158.4 | 80.3 | 78.1 | 15.8 | 34.1 | 25.0 | 42.1 |
| Under $5,000 | 10.8 | 1.2 | 0.6 | 0.6 | 1.3 | 3.8 | 3.6 | 4.8 |
| $5,000–$9,999 | 10.6 | 1.5 | 0.9 | 0.5 | 1.0 | 5.5 | 4.9 | 3.3 |
| $10,000–$14,999 | 13.0 | 3.1 | 2.0 | 1.1 | 1.4 | 4.7 | 4.1 | 4.5 |
| $15,000–$19,999 | 14.1 | 5.4 | 3.4 | 2.0 | 1.2 | 3.7 | 3.1 | 4.5 |
| $20,000–$29,999 | 27.6 | 14.7 | 8.7 | 6.0 | 2.4 | 5.1 | 3.9 | 6.8 |
| $30,000–$39,999 | 27.2 | 18.2 | 10.0 | 8.2 | 1.7 | 3.0 | 1.9 | 5.3 |
| $40,000–$49,999 | 24.1 | 18.2 | 9.3 | 8.9 | 1.4 | 2.2 | 1.2 | 3.3 |
| $50,000 and Over | 113.3 | 95.9 | 45.3 | 50.6 | 5.4 | 6.1 | 2.3 | 9.7 |
| | | | | (percentage within coverage category) | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Under $5,000 | 4.5 | 0.8 | 0.8 | 0.8 | 8.3 | 11.2 | 14.3 | 11.4 |
| $5,000–$9,999 | 4.4 | 0.9 | 1.2 | 0.7 | 6.0 | 16.0 | 19.8 | 7.8 |
| $10,000–$14,999 | 5.4 | 1.9 | 2.4 | 1.4 | 8.6 | 13.8 | 16.4 | 10.6 |
| $15,000–$19,999 | 5.8 | 3.4 | 4.3 | 2.6 | 7.7 | 10.9 | 12.5 | 10.7 |
| $20,000–$29,999 | 11.5 | 9.3 | 10.9 | 7.7 | 15.1 | 15.1 | 15.5 | 16.1 |
| $30,000–$39,999 | 11.3 | 11.5 | 12.5 | 10.5 | 11.0 | 8.7 | 7.7 | 12.5 |
| $40,000–$49,999 | 10.0 | 11.5 | 11.6 | 11.4 | 8.9 | 6.4 | 4.7 | 7.9 |
| $50,000 and Over | 47.1 | 60.6 | 56.4 | 64.9 | 34.3 | 17.9 | 9.1 | 22.9 |
| | | | | (percentage within family income categories) | | | | |
| Total | 100.0% | 65.8% | 33.4% | 32.4% | 6.6% | 14.2% | 10.4% | 17.5% |
| Under $5,000 | 100.0 | 11.5 | 5.7 | 5.8 | 12.0 | 35.3 | 33.1 | 44.3 |
| $5,000–$9,999 | 100.0 | 13.9 | 8.8 | 5.1 | 8.9 | 51.2 | 46.5 | 31.0 |
| $10,000–$14,999 | 100.0 | 23.8 | 15.1 | 8.6 | 10.5 | 36.3 | 31.6 | 34.6 |
| $15,000–$19,999 | 100.0 | 38.6 | 24.3 | 14.3 | 8.6 | 26.4 | 22.1 | 32.0 |
| $20,000–$29,999 | 100.0 | 53.4 | 31.7 | 21.7 | 8.6 | 18.6 | 14.0 | 24.6 |
| $30,000–$39,999 | 100.0 | 67.1 | 36.8 | 30.3 | 6.4 | 10.9 | 7.1 | 19.4 |
| $40,000–$49,999 | 100.0 | 75.6 | 38.6 | 37.0 | 5.8 | 9.1 | 4.9 | 13.9 |
| $50,000 and Over | 100.0 | 84.6 | 40.0 | 44.7 | 4.8 | 5.4 | 2.0 | 8.5 |

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.

families with annual income of $50,000 or more (table 5).

Although many individuals in poor families are covered by public health plans, that coverage is far from universal. In 1999, 43.8 percent of the nonelderly with family incomes below the poverty line were covered by a public plan—40.9 percent by Medicaid (table 6)—although many low-income individuals may be eligible for Medicaid coverage even though they do not report coverage. Other sources of public health insurance include Medicare (which primarily covers the elderly but also covers qualified nonelderly disabled persons), Tricare, CHAMPVA, and Veterans Administration (VA) health insurance.

Table 6

## Nonelderly Population With Selected Sources of Health Insurance, by Race and Poverty Status, 1999

| Race and Percentage of Poverty Level | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (millions) | | | | |
| Total | 240.7 | 158.4 | 80.3 | 78.1 | 15.8 | 34.1 | 25.0 | 42.1 |
| 0–99% | 29.7 | 4.7 | 2.1 | 2.6 | 2.7 | 13.0 | 12.1 | 10.6 |
| 100%–149% | 20.7 | 7.5 | 3.2 | 4.3 | 2.0 | 6.0 | 5.0 | 6.4 |
| 150%–199% | 20.6 | 10.6 | 4.6 | 6.0 | 1.7 | 3.9 | 2.8 | 5.6 |
| 200% or more | 169.7 | 135.5 | 70.4 | 65.2 | 9.4 | 11.2 | 5.0 | 19.5 |
| White | 165.9 | 120.7 | 61.3 | 59.4 | 12.4 | 17.9 | 11.4 | 21.1 |
| 0–99% | 13.1 | 2.6 | 1.3 | 1.3 | 1.9 | 5.1 | 4.6 | 4.2 |
| 100%–149% | 10.5 | 4.1 | 1.8 | 2.3 | 1.3 | 3.0 | 2.4 | 2.7 |
| 150%–199% | 11.8 | 6.6 | 2.9 | 3.7 | 1.3 | 2.1 | 1.3 | 2.5 |
| 200% or more | 130.5 | 107.4 | 55.3 | 52.1 | 7.9 | 7.7 | 3.1 | 11.8 |
| Black | 31.6 | 16.8 | 9.1 | 7.6 | 1.3 | 8.1 | 6.7 | 7.2 |
| 0–99% | 7.6 | 1.0 | 0.4 | 0.6 | 0.4 | 4.2 | 4.0 | 2.3 |
| 100%–149% | 3.9 | 1.5 | 0.7 | 0.8 | 0.3 | 1.3 | 1.1 | 1.1 |
| 150%–199% | 3.4 | 1.7 | 0.8 | 0.9 | 0.2 | 0.8 | 0.6 | 1.0 |
| 200% or more | 16.7 | 12.6 | 7.3 | 5.3 | 0.5 | 1.8 | 1.0 | 2.8 |
| Hispanic | 31.0 | 13.6 | 6.3 | 7.3 | 1.3 | 6.2 | 5.5 | 10.9 |
| 0–99% | 7.2 | 0.9 | 0.3 | 0.6 | 0.2 | 3.0 | 2.9 | 3.3 |
| 100%–149% | 5.1 | 1.6 | 0.6 | 1.0 | 0.2 | 1.3 | 1.2 | 2.2 |
| 150%–199% | 4.4 | 1.8 | 0.7 | 1.1 | 0.2 | 0.7 | 0.6 | 1.8 |
| 200% or more | 14.3 | 9.3 | 4.7 | 4.6 | 0.6 | 1.1 | 0.7 | 3.6 |
| Other | 12.2 | 7.2 | 3.5 | 3.7 | 0.7 | 1.8 | 1.4 | 2.9 |
| 0–99% | 1.8 | 0.3 | 0.1 | 0.1 | 0.2 | 0.7 | 0.6 | 0.8 |
| 100%–149% | 1.2 | 0.3 | 0.1 | 0.2 | 0.1 | 0.4 | 0.3 | 0.5 |
| 150%–199% | 1.0 | 0.4 | 0.2 | 0.3 | 0.1 | 0.2 | 0.2 | 0.3 |
| 200% or more | 8.3 | 6.2 | 3.1 | 3.1 | 0.4 | 0.6 | 0.2 | 1.4 |
| | | | | (percentage within race and poverty level category) | | | | |
| Total | 100.0% | 65.8% | 33.4% | 32.4% | 6.6% | 14.2% | 10.4% | 17.5% |
| 0–99% | 100.0 | 15.9 | 7.1 | 8.8 | 9.1 | 43.8 | 40.9 | 35.6 |
| 100%–149% | 100.0 | 36.3 | 15.5 | 20.9 | 9.4 | 29.0 | 24.2 | 31.1 |
| 150%–199% | 100.0 | 51.3 | 22.3 | 29.0 | 8.2 | 18.7 | 13.5 | 27.3 |
| 200% or more | 100.0 | 79.9 | 41.5 | 38.4 | 5.6 | 6.6 | 3.0 | 11.5 |
| White | 100.0 | 72.8 | 37.0 | 35.8 | 7.5 | 10.8 | 6.9 | 12.7 |
| 0–99% | 100.0 | 19.5 | 9.8 | 9.7 | 14.4 | 39.0 | 35.3 | 32.1 |
| 100%–149% | 100.0 | 39.2 | 17.2 | 22.0 | 12.8 | 28.6 | 22.5 | 25.7 |
| 150%–199% | 100.0 | 56.2 | 24.8 | 31.4 | 10.8 | 17.6 | 11.4 | 20.9 |
| 200% or more | 100.0 | 82.3 | 42.4 | 40.0 | 6.1 | 5.9 | 2.3 | 9.0 |
| Black | 100.0 | 53.1 | 28.9 | 24.2 | 4.2 | 25.7 | 21.3 | 22.8 |
| 0–99% | 100.0 | 13.8 | 5.6 | 8.2 | 5.3 | 55.6 | 52.7 | 30.5 |
| 100%–149% | 100.0 | 38.5 | 16.9 | 21.6 | 7.8 | 33.6 | 28.5 | 27.6 |
| 150%–199% | 100.0 | 48.5 | 22.6 | 25.9 | 4.8 | 23.2 | 18.7 | 29.9 |
| 200% or more | 100.0 | 75.3 | 43.6 | 31.7 | 2.7 | 10.8 | 5.8 | 16.7 |
| Hispanic | 100.0 | 44.0 | 20.5 | 23.5 | 4.2 | 20.0 | 17.8 | 35.0 |
| 0–99% | 100.0 | 12.2 | 4.2 | 8.0 | 3.4 | 41.5 | 40.2 | 45.4 |
| 100%–149% | 100.0 | 31.0 | 11.7 | 19.2 | 4.5 | 25.9 | 23.6 | 43.1 |
| 150%–199% | 100.0 | 42.2 | 16.6 | 25.5 | 4.2 | 17.1 | 14.7 | 40.9 |
| 200% or more | 100.0 | 65.4 | 33.0 | 32.3 | 4.5 | 7.9 | 5.2 | 25.0 |
| Other | 100.0 | 59.1 | 28.6 | 30.5 | 6.0 | 15.0 | 11.1 | 24.0 |
| 0–99% | 100.0 | 14.3 | 6.4 | 7.9 | 10.4 | 37.9 | 34.7 | 43.6 |
| 100%–149% | 100.0 | 27.5 | 11.3 | 16.2 | 6.7 | 31.1 | 28.2 | 37.7 |
| 150%–199% | 100.0 | 42.4 | 16.9 | 25.5 | 6.2 | 22.8 | 16.2 | 35.0 |
| 200% or more | 100.0 | 75.2 | 37.2 | 38.0 | 4.9 | 6.9 | 3.0 | 16.6 |

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source


Many factors influence whether or not an individual has any type of health insurance coverage. This section presents data on the characteristics of the uninsured population.

## Location

The proportion of the nonelderly population with and without health insurance varies by location. In 13 states, 20 percent or more of the population was uninsured in 1999 (table 7). These states are in large part concentrated in the south central and southwestern parts of the United States (chart 7). In many of these states a smaller proportion of the population was eligible for employment-based insurance and/or a larger proportion was eligible for publicly financed health programs than the national average. Lower average income and higher unemployment rates both may contribute to this difference. In addition, many of these states have a higher concentration of racial and ethnic groups that are less likely to be covered by health insurance.[7] In contrast, states with a low percentage of uninsured individuals include Rhode Island, Minnesota, Iowa, and Missouri.

The percentage of the population without any form of health insurance coverage also varies by metropolitan region. For example, 18.1 percent of the population residing in Consolidated Metropolitan Statistical Areas (CMSAs) was uninsured in 1999 (table 8). The Houston-Galveston-Brazoria, TX, CMSA had the highest percentage uninsured among CMSAs, at 29.5 percent, followed by Miami-Fort Lauderdale, FL, at 29.4 percent, Los Angeles-Riverside-Orange County, CA, at 27.2 percent and Dallas-Fort Worth, TX, at 22.3 percent. This compares with 11.7 percent in Boston-Worcester-Lawrence, MA-NH-ME-CT, and 11.8 percent uninsured in both the Cincinnati-Hamilton, OH-KY-IN, CMSA, and the Detroit-Ann Arbor, MI, CMSA.

## Citizenship

Citizenship is a primary factor in the likelihood of an individual having coverage and in the source of that coverage (table 9). In California, for example, 17.4 percent of nonelderly individuals reported that they were noncitizens, compared with 6.5 percent of the nation as a whole. More than 45 percent of nonelderly respondents indicating they were noncitizens were uninsured in 1999, compared with 16.5 percent of citizens. In Arizona, 57.4 percent of the noncitizen population was uninsured, while in Texas, 56.9 percent was uninsured, and in California, 46.7 percent was uninsured. High uninsured rates may be due in part to the fact that a higher proportion of noncitizens than citizens were in low-income families, were likely to be nonworkers, or were likely to work in small firms.

## Employment

Eighty-four percent of the uninsured lived in families headed by workers in 1999, primarily because most people (90.7 percent) live in families headed by workers, including one-person families (table 2). Sixteen percent of the uninsured were in families in which the family head did not work.

## Industry

Uninsured workers were most likely to be employed in the wholesale and retail trade industry (table 3). This is not surprising, as workers in general are most likely to be employed in the wholesale and trade industry. About one-third of all workers are employed in the wholesale and retail trade industry, while 41.4 percent of uninsured workers are in this industry. This indicates that

[7] *See Fronstin (2000b).*

Table 7

## Nonelderly Population With Selected Sources of Health Insurance, by Region and State, 1999

| Region and State | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (millions) | | | | |
| Total | 240.7 | 158.4 | 80.3 | 78.1 | 15.8 | 34.1 | 25.0 | 42.1 |
| New England | 11.9 | 8.6 | 4.2 | 4.4 | 0.7 | 1.8 | 1.4 | 1.4 |
| Maine | 1.1 | 0.8 | 0.4 | 0.4 | 0.1 | 0.2 | 0.1 | 0.1 |
| New Hampshire | 1.1 | 0.8 | 0.4 | 0.5 | 0.1 | 0.1 | 0.1 | 0.1 |
| Vermont | 0.5 | 0.3 | 0.2 | 0.2 | 0.0 | 0.1 | 0.1 | 0.1 |
| Massachusetts | 5.4 | 3.8 | 1.9 | 1.8 | 0.3 | 1.0 | 0.8 | 0.6 |
| Rhode Island | 0.8 | 0.6 | 0.3 | 0.3 | 0.1 | 0.1 | 0.1 | 0.1 |
| Connecticut | 2.9 | 2.2 | 1.0 | 1.2 | 0.2 | 0.3 | 0.2 | 0.3 |
| Middle Atlantic | 33.3 | 22.5 | 11.2 | 11.2 | 2.1 | 4.7 | 4.0 | 5.2 |
| New York | 16.2 | 10.1 | 5.1 | 5.0 | 0.9 | 2.8 | 2.4 | 3.0 |
| New Jersey | 7.1 | 5.1 | 2.6 | 2.5 | 0.4 | 0.6 | 0.5 | 1.1 |
| Pennsylvania | 10.0 | 7.3 | 3.6 | 3.7 | 0.8 | 1.2 | 1.0 | 1.1 |
| East North Central | 39.7 | 28.7 | 13.9 | 14.8 | 2.3 | 4.7 | 3.7 | 5.3 |
| Ohio | 9.9 | 7.2 | 3.5 | 3.7 | 0.5 | 1.3 | 1.0 | 1.2 |
| Indiana | 5.2 | 3.8 | 1.9 | 1.9 | 0.4 | 0.6 | 0.5 | 0.6 |
| Illinois | 10.9 | 7.7 | 3.9 | 3.9 | 0.5 | 1.2 | 0.9 | 1.7 |
| Michigan | 9.0 | 6.5 | 3.0 | 3.5 | 0.5 | 1.1 | 1.0 | 1.1 |
| Wisconsin | 4.8 | 3.4 | 1.6 | 1.8 | 0.4 | 0.5 | 0.4 | 0.6 |
| West North Central | 16.4 | 11.8 | 5.9 | 5.9 | 1.5 | 2.1 | 1.5 | 1.7 |
| Minnesota | 4.3 | 3.2 | 1.5 | 1.7 | 0.4 | 0.4 | 0.4 | 0.4 |
| Iowa | 2.4 | 1.8 | 0.9 | 0.9 | 0.2 | 0.3 | 0.2 | 0.2 |
| Missouri | 4.9 | 3.5 | 1.9 | 1.6 | 0.4 | 0.7 | 0.5 | 0.5 |
| North Dakota | 0.5 | 0.3 | 0.2 | 0.2 | 0.1 | 0.1 | 0.0 | 0.1 |
| South Dakota | 0.6 | 0.4 | 0.2 | 0.2 | 0.1 | 0.1 | 0.0 | 0.1 |
| Nebraska | 1.4 | 1.0 | 0.4 | 0.5 | 0.2 | 0.2 | 0.1 | 0.2 |
| Kansas | 2.3 | 1.5 | 0.8 | 0.8 | 0.2 | 0.3 | 0.2 | 0.3 |
| South Atlantic | 42.2 | 27.5 | 14.6 | 12.9 | 2.7 | 5.9 | 3.7 | 7.9 |
| Delaware | 0.7 | 0.5 | 0.3 | 0.2 | 0.0 | 0.1 | 0.1 | 0.1 |
| Maryland | 4.3 | 3.3 | 1.7 | 1.6 | 0.2 | 0.4 | 0.2 | 0.6 |
| District of Columbia | 0.4 | 0.3 | 0.2 | 0.1 | 0.0 | 0.1 | 0.1 | 0.1 |
| Virginia | 6.0 | 4.1 | 2.2 | 2.0 | 0.4 | 0.8 | 0.3 | 1.0 |
| West Virginia | 1.5 | 0.9 | 0.4 | 0.4 | 0.0 | 0.3 | 0.2 | 0.3 |
| North Carolina | 6.6 | 4.4 | 2.4 | 2.0 | 0.4 | 0.9 | 0.5 | 1.1 |
| South Carolina | 3.3 | 2.1 | 1.2 | 1.0 | 0.2 | 0.5 | 0.3 | 0.7 |
| Georgia | 7.0 | 4.5 | 2.4 | 2.1 | 0.5 | 1.1 | 0.8 | 1.3 |
| Florida | 12.4 | 7.5 | 3.9 | 3.5 | 0.9 | 1.6 | 1.1 | 2.8 |
| East South Central | 14.6 | 9.5 | 4.8 | 4.7 | 1.0 | 2.6 | 1.9 | 2.3 |
| Kentucky | 3.4 | 2.3 | 1.1 | 1.1 | 0.2 | 0.6 | 0.3 | 0.6 |
| Tennessee | 5.0 | 3.2 | 1.6 | 1.6 | 0.4 | 0.9 | 0.8 | 0.6 |
| Alabama | 3.9 | 2.5 | 1.3 | 1.2 | 0.3 | 0.6 | 0.5 | 0.6 |
| Mississippi | 2.4 | 1.5 | 0.7 | 0.7 | 0.2 | 0.4 | 0.3 | 0.5 |
| West South Central | 26.8 | 15.8 | 8.2 | 7.6 | 1.6 | 3.8 | 2.6 | 6.5 |
| Arkansas | 2.2 | 1.4 | 0.7 | 0.7 | 0.2 | 0.4 | 0.2 | 0.4 |
| Louisiana | 3.8 | 2.2 | 1.1 | 1.1 | 0.2 | 0.7 | 0.5 | 1.0 |
| Oklahoma | 2.8 | 1.7 | 0.9 | 0.8 | 0.2 | 0.4 | 0.2 | 0.6 |
| Texas | 18.0 | 10.6 | 5.6 | 5.0 | 1.0 | 2.3 | 1.7 | 4.6 |
| Mountain | 15.7 | 9.9 | 4.9 | 5.0 | 1.1 | 2.1 | 1.2 | 3.4 |
| Montana | 0.8 | 0.4 | 0.2 | 0.2 | 0.1 | 0.1 | 0.1 | 0.2 |
| Idaho | 1.1 | 0.7 | 0.4 | 0.4 | 0.1 | 0.1 | 0.1 | 0.2 |
| Wyoming | 0.4 | 0.3 | 0.1 | 0.1 | 0.0 | 0.1 | 0.0 | 0.1 |
| Colorado | 3.8 | 2.6 | 1.3 | 1.2 | 0.2 | 0.5 | 0.2 | 0.7 |
| New Mexico | 1.6 | 0.8 | 0.4 | 0.4 | 0.1 | 0.3 | 0.2 | 0.5 |
| Arizona | 4.3 | 2.5 | 1.2 | 1.2 | 0.3 | 0.7 | 0.4 | 1.0 |
| Utah | 2.0 | 1.5 | 0.6 | 0.9 | 0.1 | 0.2 | 0.1 | 0.3 |
| Nevada | 1.7 | 1.1 | 0.6 | 0.5 | 0.1 | 0.2 | 0.1 | 0.4 |
| Pacific | 40.2 | 24.1 | 12.6 | 11.6 | 2.8 | 6.4 | 5.1 | 8.5 |
| Washington | 5.1 | 3.3 | 1.8 | 1.5 | 0.4 | 0.8 | 0.5 | 0.9 |
| Oregon | 3.0 | 2.0 | 1.1 | 0.9 | 0.2 | 0.4 | 0.4 | 0.5 |
| California | 30.4 | 17.7 | 9.1 | 8.6 | 2.1 | 4.9 | 4.0 | 6.8 |
| Alaska | 0.6 | 0.4 | 0.2 | 0.2 | 0.0 | 0.1 | 0.1 | 0.1 |
| Hawaii | 1.1 | 0.8 | 0.4 | 0.4 | 0.0 | 0.2 | 0.1 | 0.1 |

(continued)

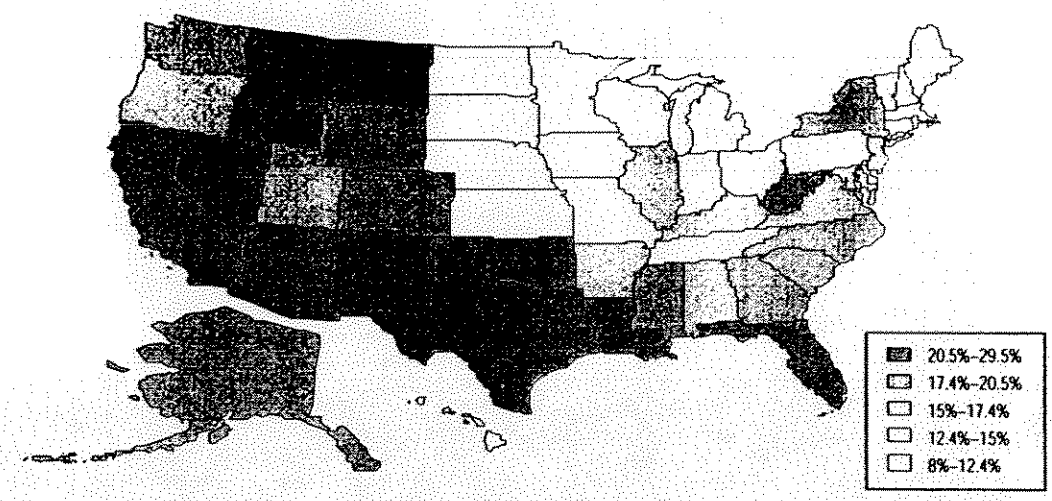
Table 7 (continued)

| Region and State | Total | Employment-Based Coverage | | | Individually Purchased | Public | | Uninsured |
|---|---|---|---|---|---|---|---|---|
| | | Total | Own name | Dependent | | Total | Medicaid | |
| | | | | (percentage) | | | | |
| Total | 100.0% | 65.8% | 33.4% | 32.4% | 6.6% | 14.2% | 10.4% | 17.5% |
| New England | 100.0 | 72.0 | 35.0 | 37.0 | 5.8 | 15.1 | 11.5 | 11.6 |
| Maine | 100.0 | 67.7 | 32.7 | 34.9 | 8.4 | 15.6 | 9.8 | 13.3 |
| New Hampshire | 100.0 | 75.6 | 33.3 | 42.3 | 6.0 | 10.6 | 7.8 | 11.3 |
| Vermont | 100.0 | 63.7 | 32.5 | 31.2 | 7.2 | 22.2 | 18.6 | 13.6 |
| Massachusetts | 100.0 | 69.6 | 35.4 | 34.2 | 5.0 | 18.3 | 14.9 | 11.8 |
| Rhode Island | 100.0 | 74.6 | 34.4 | 40.1 | 7.5 | 12.6 | 10.7 | 8.1 |
| Connecticut | 100.0 | 77.4 | 36.3 | 41.2 | 5.5 | 10.1 | 6.2 | 11.3 |
| Middle Atlantic | 100.0 | 67.6 | 33.8 | 33.7 | 6.2 | 14.2 | 11.9 | 15.5 |
| New York | 100.0 | 62.1 | 31.4 | 30.7 | 5.3 | 17.6 | 14.9 | 18.5 |
| New Jersey | 100.0 | 72.8 | 36.6 | 36.2 | 5.8 | 9.0 | 7.3 | 15.0 |
| Pennsylvania | 100.0 | 72.7 | 35.7 | 37.0 | 7.9 | 12.4 | 10.3 | 11.0 |
| East North Central | 100.0 | 72.3 | 35.1 | 37.2 | 5.9 | 11.9 | 9.4 | 13.3 |
| Ohio | 100.0 | 73.2 | 35.6 | 37.6 | 5.3 | 12.7 | 9.7 | 12.5 |
| Indiana | 100.0 | 73.3 | 37.1 | 36.1 | 7.1 | 12.3 | 8.8 | 12.3 |
| Illinois | 100.0 | 71.3 | 35.6 | 35.7 | 4.6 | 10.7 | 8.4 | 15.7 |
| Michigan | 100.0 | 72.5 | 33.5 | 39.0 | 5.6 | 12.7 | 10.9 | 12.4 |
| Wisconsin | 100.0 | 71.2 | 33.6 | 37.7 | 8.9 | 10.8 | 8.6 | 12.2 |
| West North Central | 100.0 | 72.0 | 35.9 | 36.1 | 9.3 | 12.6 | 8.9 | 10.6 |
| Minnesota | 100.0 | 76.0 | 36.1 | 39.9 | 8.3 | 10.4 | 8.7 | 8.9 |
| Iowa | 100.0 | 74.5 | 35.9 | 38.6 | 9.0 | 10.6 | 7.7 | 9.5 |
| Missouri | 100.0 | 72.5 | 38.7 | 33.8 | 8.1 | 13.9 | 11.2 | 9.6 |
| North Dakota | 100.0 | 64.4 | 32.9 | 31.4 | 12.8 | 14.8 | 7.7 | 14.0 |
| South Dakota | 100.0 | 63.7 | 33.0 | 30.7 | 14.9 | 12.0 | 7.1 | 13.6 |
| Nebraska | 100.0 | 66.5 | 31.0 | 35.4 | 13.1 | 14.2 | 8.0 | 12.3 |
| Kansas | 100.0 | 68.2 | 34.1 | 34.1 | 9.2 | 14.9 | 7.2 | 14.0 |
| South Atlantic | 100.0 | 65.2 | 34.7 | 30.5 | 6.4 | 13.9 | 8.7 | 18.8 |
| Delaware | 100.0 | 69.6 | 37.0 | 32.6 | 4.9 | 18.4 | 14.1 | 12.9 |
| Maryland | 100.0 | 76.2 | 38.5 | 37.7 | 5.6 | 9.6 | 5.4 | 13.6 |
| District of Columbia | 100.0 | 58.4 | 41.0 | 17.4 | 6.8 | 21.3 | 19.5 | 17.6 |
| Virginia | 100.0 | 69.3 | 36.4 | 32.8 | 6.6 | 13.8 | 4.8 | 16.0 |
| West Virginia | 100.0 | 60.8 | 30.1 | 30.7 | 3.3 | 18.6 | 14.8 | 20.5 |
| North Carolina | 100.0 | 66.8 | 36.6 | 30.2 | 6.4 | 13.9 | 8.3 | 17.4 |
| South Carolina | 100.0 | 65.1 | 35.4 | 29.7 | 5.7 | 14.1 | 8.7 | 20.1 |
| Georgia | 100.0 | 63.4 | 34.1 | 29.3 | 6.7 | 16.0 | 11.1 | 17.9 |
| Florida | 100.0 | 60.1 | 31.7 | 28.3 | 7.0 | 13.2 | 9.1 | 22.9 |
| East South Central | 100.0 | 64.7 | 32.7 | 32.0 | 6.6 | 17.8 | 13.0 | 15.6 |
| Kentucky | 100.0 | 66.5 | 33.1 | 33.4 | 4.8 | 18.2 | 10.1 | 16.5 |
| Tennessee | 100.0 | 64.5 | 33.1 | 31.4 | 7.3 | 19.0 | 16.5 | 12.7 |
| Alabama | 100.0 | 65.0 | 32.8 | 32.3 | 7.2 | 15.4 | 11.7 | 16.2 |
| Mississippi | 100.0 | 62.1 | 31.2 | 30.8 | 6.4 | 18.2 | 12.2 | 19.0 |
| West South Central | 100.0 | 59.2 | 30.7 | 28.5 | 6.1 | 14.2 | 9.7 | 24.4 |
| Arkansas | 100.0 | 62.4 | 30.9 | 31.5 | 8.2 | 19.4 | 10.7 | 17.1 |
| Louisiana | 100.0 | 57.2 | 28.5 | 28.6 | 5.9 | 17.8 | 12.3 | 25.1 |
| Oklahoma | 100.0 | 62.1 | 31.7 | 30.3 | 7.3 | 14.2 | 7.7 | 20.6 |
| Texas | 100.0 | 58.8 | 31.0 | 27.8 | 5.8 | 12.7 | 9.3 | 25.8 |
| Mountain | 100.0 | 63.0 | 31.0 | 32.0 | 6.8 | 13.4 | 7.8 | 21.5 |
| Montana | 100.0 | 57.0 | 28.8 | 28.2 | 11.3 | 15.6 | 10.5 | 21.1 |
| Idaho | 100.0 | 64.7 | 31.9 | 32.7 | 7.3 | 10.7 | 7.7 | 21.7 |
| Wyoming | 100.0 | 65.3 | 31.2 | 34.1 | 7.6 | 13.9 | 8.1 | 18.1 |
| Colorado | 100.0 | 67.7 | 35.1 | 32.6 | 5.6 | 12.5 | 5.5 | 18.4 |
| New Mexico | 100.0 | 52.2 | 26.9 | 25.3 | 5.2 | 18.4 | 13.8 | 29.4 |
| Arizona | 100.0 | 57.7 | 29.1 | 28.6 | 7.5 | 15.8 | 9.5 | 24.3 |
| Utah | 100.0 | 73.7 | 28.5 | 45.2 | 6.2 | 9.1 | 4.7 | 15.3 |
| Nevada | 100.0 | 64.1 | 33.5 | 30.5 | 7.0 | 10.6 | 6.0 | 22.8 |
| Pacific | 100.0 | 60.1 | 31.3 | 28.8 | 7.0 | 16.0 | 12.6 | 21.1 |
| Washington | 100.0 | 64.4 | 34.9 | 29.4 | 7.2 | 15.0 | 9.6 | 17.6 |
| Oregon | 100.0 | 66.1 | 35.3 | 30.8 | 7.8 | 13.8 | 11.8 | 16.4 |
| California | 100.0 | 58.3 | 30.0 | 28.3 | 7.0 | 16.2 | 13.3 | 22.4 |
| Alaska | 100.0 | 62.1 | 29.6 | 32.5 | 5.9 | 22.0 | 11.7 | 20.4 |
| Hawaii | 100.0 | 72.0 | 38.1 | 34.0 | 4.6 | 16.7 | 10.8 | 12.5 |

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Chart 7
**Percentage Uninsured, by State, 1999**




Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.

workers employed in the wholesale and retail trade industry are more likely to be uninsured than most other workers. (These data are shown in the bottom part of table 3.) Workers employed in agriculture, forestry, fishing, mining, and construction were also disproportionately more likely to be uninsured, accounting for 17.1 percent of the uninsured population, while representing 9.3 percent of the working population.

## Firm Size

Nearly 60 percent of all uninsured workers were either self-employed or working in private-sector firms with fewer than 100 employees in 1999 (table 4). Almost 25 percent of self-employed workers were uninsured, compared with 17.5 percent of all workers. Nearly 33 percent of workers in private-sector firms with fewer than 10 employees were uninsured, compared with 12.2 percent of workers in private-sector firms with 1,000 or more employees.

## Income

The uninsured are concentrated disproportionately in low-income families. In 1999, 40.5 percent of the uninsured were in families with annual incomes of less than $20,000 (table 5). More than 44 percent of individuals in families with incomes less than $5,000 were uninsured, compared with 8.5 percent of those in families with annual incomes of $50,000 or more. Generally, as income increases, the percentage of the population without health insurance decreases, the percentage covered by private health insurance increases, and the percentage covered by publicly financed health insurance programs decreases.

Workers with low earnings are more likely to be uninsured than those with high earnings. Thirty percent of workers with earnings less than $10,000 were uninsured, compared with 5.1 percent of workers with earnings of $50,000 or more (chart 8). Low-income workers are employed generally in industries less likely to offer health insurance, may have a weaker (or temporary) attachment to the work force, and have less disposable income to allocate to the purchase of health insurance.

## Race and Origin

While 69 percent of the nonelderly population is white, whites comprised 50 percent of the uninsured 1999. Individuals of Hispanic origin were more likely to be uninsured than other groups (35 percent) (table 6). This may be due in part to the fact that 54 percent of the Hispanic population reported income of less than 200 percent of the federal poverty level. However, even at higher income levels, Hispanics generally were more likely to be uninsured than other racial groups and were less likely to be covered by employment-based health insurance.