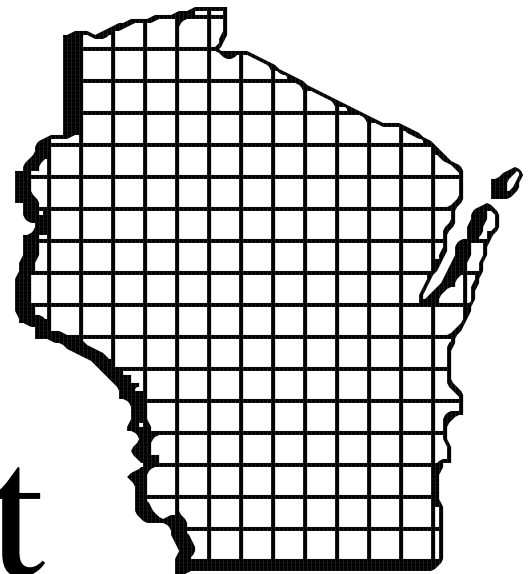


Wisconsin

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Institute

Report



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**THE
MEDICALLY
UNINSURED IN
MILWAUKEE**

*Current Problem and
Future Crisis*

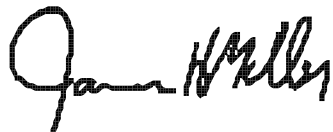
REPORT FROM THE PRESIDENT:

Over the last decade no state has had more changes in public policy than Wisconsin. In welfare, education and criminal justice, Wisconsin's reforms are well ahead of the other forty nine states and are constantly used as a model. Still there are issues which must be addressed over the next decade. The uninsured in health care may be the number one problem.

We contracted with Professor Sammis White of the University of Wisconsin-Milwaukee to examine this complex problem. His findings in this report will certainly stir debate on what we do about this health care. Today there are over 100,000 uninsured people in Milwaukee County. While there are several programs including the new BadgerCare that will cover some of them, there will still be approximately 80,000 individuals who will not have any type of medical insurance. These people get sick. More importantly, their children also become ill. The question is what do we do when this inevitability happens. That is the reason that we believe this topic must be addressed while Wisconsin's economy is doing well and we have the ability to prevent this current problem from turning into a major crisis.

Health care costs today affect every institution in Milwaukee — businesses, government agencies, social service providers, and possibly most importantly taxpayers. The current system still works, but it is clearly under economic pressure. It is in everyone's best interest to have the uninsured use the current clinics which are now set up in their neighborhoods. Potentially the biggest social disaster which could happen in Milwaukee would be to have these clinics close and force the poor into hospital emergency rooms. The costs would be staggering.

With the governor and the legislature currently developing BadgerCare, a new healthcare plan for the state, it is the ideal time to address what we do about the medically indigent. It is also clear that no one agency can solve this problem. Hospitals and health care systems will have to join together with government, social service providers, businesses and taxpayers to form a rational plan that can deal with the future projections for health care and not force any of our existing institutions into bankruptcy. We are certainly not suggesting that big government or big anything solve this problem. We are talking about a policy that rationally deals with the uninsured and continues Wisconsin's remarkable reputation as the most innovative state in the nation when it comes to solutions to public policy problems.



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THE MEDICALLY UNINSURED IN MILWAUKEE *Current Problem and Future Crisis*

SAMMIS B. WHITE, PH. D.

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EXECUTIVE SUMMARY

Despite Wisconsin's having the second highest percentage of its population covered by health insurance of the 50 states, the medically uninsured are still a problem in Milwaukee County. Statewide 91.4% of the population has health insurance. In Milwaukee County the percentage of uninsured is estimated to be in the neighborhood of 14%. Given the range around the estimate, there are said to be between 113,000 and 144,000 medically uninsured individuals in Milwaukee.

The bulk (82%) of these individuals live in the city of Milwaukee. But unlike the common image of the indigent, the medically uninsured population is not largely the poor. In fact, 46% of the uninsured have incomes equal to or above two times the Federal Poverty Level (FPL) or at least \$26,660 for a family of three. An additional 34% have incomes equal to the FPL or up to 200% of the FPL (between \$13,330 and \$26,659). And at least 41% are white.

The medically uninsured in Milwaukee have historically been treated by a combination of providers. Among them have been Milwaukee County through its hospital, the private hospitals, private doctors, non-profit clinics, and a host of smaller actors. This shared approach worked reasonably, if not ideally, to bring at least minimal health care coverage to the uninsured. But a number of changes have made the historic approach untenable. Among the changes are the following: 1) Milwaukee County closed its public hospital and reduced its level of financial commitment to indigent health care; 2) the cost of providing health care has risen dramatically over the last two decades; 3) the ability of private hospitals to cross-subsidize the treatment of the indigent with earnings from the treatment of private patients has been greatly reduced by the demands of price reduction by the new managed care and HMO approaches to health care and by the federal government demanding discounts for treatment of those patients whose treatment is being paid for by federal dollars; and 4) the number of medically uninsured has been increasing despite the booming economy. The result is a large and growing problem for the County and its health care providers.

The County and others have not been sitting by idly. They are attempting to address this issue. Milwaukee County, with state support, has created a program called the General Assistance Medical Program, GAMP for short, that is designed to provide health care to the truly indigent, defined, for example, as those with less than a monthly income of \$840 for a single individual or \$1,240 for a family of three. This program serves the sick and initially serves them through primary care neighborhood clinics. The program began April 1, 1998. It is expected to serve some 18,000 individuals during its first year.

The State has also been active. It created a health program (W-2 Health Plan) for those participating in W-2. The state created another new program, BadgerCare, to serve the next lowest income population. BadgerCare was designed to serve the "working poor," those with incomes below 185% of FPL who are not otherwise participating in a health insurance program. BadgerCare will begin July 1, 1999, so its impact is unknown. But it is expected to assist approximately 7,000 children and 5,800 parents in Milwaukee County and some 50,000 persons statewide.

Simple math shows that even the low estimate of 113,000 minus both 18,000 (GAMP) and 12,800 (BadgerCare) leaves at least 82,200 individuals in Milwaukee County who are without medical insurance. In 1998 the five largest hospitals in Milwaukee County provided some \$35 million in charity care (unbilled service) to this population, an increase from \$30 million in 1997. They expect this figure to continue to rise. Other health care providers failed to collect millions of dollars more for services rendered. Even with the initiatives undertaken to date, the medically uninsured remain a very large problem in Milwaukee.

With these large numbers, is a health care crisis developing in Milwaukee? A crisis does not appear to be on the doorstep, except at a few neighborhood clinics that are being financially strained attempting to serve the indigent and medically uninsured populations. But that does not mean that a health care crisis is not looming; it is. The implementation of BadgerCare may postpone it because of the additional dollars it injects into the system. But BadgerCare is not encompassing enough to ensure elimination of a potential crisis. The scale of need of the medically uninsured is too large, and too many other events may trigger a downfall in the health care delivery system.

For example, local political support for property tax dollars to be used for health care in Milwaukee County has been eroding. Should the County decide to back out of its current \$23 million dollar commitment, which is possible after the year 2000 election, the loss of funds and organization could be devastating for the entire system. Or if the neighborhood clinics cannot survive on their current patient mix, more, possibly many more, of the uninsured will of necessity go to the hospital emergency rooms and demand expensive treatment. At the moment a new, sick, adult patient who goes to a neighborhood clinic can be treated at a cost to the County of between \$36 and \$44 compared to the average ER (emergency room) visit that cost \$1,265 in 1996. Expanded use of the ERs will threaten the hospitals' financial health, a condition that does not exist today. The clinics are financially threatened by the very

modest cost reimbursement they receive today for their services to GAMP patients and by the decline in Medicaid patients. Several have cut back on their services to the uninsured. If the GAMP payment is not increased, fewer uninsured will be served by these clinics, and the uninsured will be deflected to the hospitals. It is very possible to paint a scenario of a tumbling house of cards of medical care provision unless any of several steps are taken to provide some stability to the providers.

To avoid the crisis conditions of chaos in health care provision, all health care providers should be actively involved in contingency planning. These providers should be meeting regularly with one another and deciding who among them will take particular actions under specific conditions in order to avoid a crisis. The County has established a Health Care Policy Task Force (HCPTF) that is already meeting and already discussing some of these issues. This Task Force should assume the initiative and become even more active in gaining insight and commitment. It should more assertively seek additional funding to address the medically uninsured. It should actively lobby for some of the tobacco settlement money and explore a number of options that could yield additional resources for the uninsured, such as a level of commitment for charity care from the health care systems. Moreover, it should explore ways to increase the health of the uninsured, thereby reducing the need for future health care. And most immediately, Milwaukee County should increase its rate of reimbursement for the treatment of GAMP patients to assure continued treatment for them.

The ability to address the problem of the uninsured is at hand. The current providers all have reasons to be involved in the solution. But the exact composition of the answer to the question must still be determined. Now is the time to formulate the response that best meets the needs of the uninsured, the health care providers, and the potential payers. Rather than wait for the crisis and some hastily formulated response, the providers should now negotiate a rational, acceptable approach that not only meets the needs of the uninsured and continues the viability of the health care providers, but that also reduces the number of uninsured and the degree of their need. The impetus for this agreement is the potential for failure that threatens many providers, if the size of the uninsured population remains too large and the scale of health care service provision is reduced through attrition.

INTRODUCTION

It is no wonder that the national debate in the early 1990s over universal health insurance was so acrimonious and contentious. The debate covers virtually all of the human condition. The debate is not just about access to health care; it is about the broadest of social issues, who is responsible for whom, to what degree, and in what ways. The debate happened to focus on health care.

Health is a fundamental requisite for a good life. Much of one's health comes from doing what is known to keep one healthy: eat right, drink right, sleep enough, and avoid dangerous situations. That largely works. But some individuals have genetic predispositions toward certain conditions; others live in conditions such as poverty that makes doing the right thing for one's health more difficult; and accidents do happen. For other individuals, however, health issues commonly derive from poor judgment. We rely on health care to help steer us to better health decisions and to fix what ails us, regardless of the cause.

Often times health care can heal us, but occasionally only at great expense. Because of the possible extraordinary expense, we have created a health care insurance system that protects most of us by sharing the financial responsibility for health care expenditures. The vast majority (84.5%) of Americans participate in that system, usually through their employer.¹ But not everyone has a connection to work, and some employers either do not offer health insurance or offer insurance that requires a large financial commitment by the employee. Certain individuals elect not to make that financial commitment, choosing instead to take a chance that they will not need medical assistance. Still others are served by government programs.

In Wisconsin the percentage covered by medical insurance (91.4% in 1996) is even higher than nationally.² But there still remains a segment of the population that has no insurance. That uninsured population makes tremendous financial demands on the health care system when its members do seek treatment. And this medically uninsured population can, and periodically does, make problems for the population at large, either because of the diseases they spread or because of the additions to health insurance premiums they require insurers to charge to compensate for serving the uninsured. If the size of this medically uninsured population could be further minimized, it would benefit not only the uninsured individuals but also the many health care providers in the health care system and our collective health. The issue is how to best reduce the number and negative impacts of the medically uninsured.

Health care is very expensive. It can absorb virtually any resources that may be aimed at it. There is no set limit that is enough. The debate then must focus on what is the minimal amount of health care our society should provide to all of its members. The US has spent many resources targeting specific groups whom it has felt deserve health care. For example, it serves poor children and poor mothers through Medicaid. It serves the elderly through Medicare. It serves Veterans through the Veterans Administration hospital system. It serves the disabled through Social Security Insurance (SSI). These populations have been deemed deserving. But these populations, plus those who pay for health insurance for themselves or have it paid for by their employers, are not inclusive. There are millions of Americans who do not have health insurance either by choice or because they are not offered it. These are the populations in the national debate. These are largely the individuals who locally are putting stress on the health care system. These are the individuals whose presence and demands on the health care system have precipitated this and numerous other studies.

The basic question before us is how can we best deal with the medically uninsured. Some of these individuals are clearly deserving of assistance by most standards. One example is those individuals who are working and are offered medical insurance through their employers but who do not participate because their incomes are not high enough to cover the basics of life and the insurance premiums. But what of others? What of those who are offered health insurance at work but who decline, choosing instead to spend the money that could go to premiums on a boat or a better car? Do they deserve assistance? What of those who abuse their bodies with alcohol, tobacco or drugs or who just eat badly and never exercise, even though they have been told numerous times that these habits need to be changed? These are tough questions.

There are more. Should we decide that health care providers should bear the responsibility for serving the uninsured? We could argue that there is so much money being spent on health care that providers can easily handle the modest demands this uninsured population can put on them at any point in time. But is this fair? Will it work in the long run? Probably not. Health care organizations need to at least balance costs and revenues; paying out more than they take in will only mean the erosion of health care for others.

If we cannot put the health care burden on the health care providers, that then suggests the burden should be on the individual, so that each individual is responsible for making him- or herself healthy and pay a portion of the cost of any medical treatment received. This is the ideal model in our market economy. It includes incentives for

keeping oneself healthy. But many lower income individuals simply do not have the resources to pay for insurance premiums, much less all of the health care costs. And others elect not to pay, forcing the rest of us to pay more. What incentives, if any, might be created to increase the percentage of the population that has a monetary as well as a personal incentive to lead a healthy life and to contribute to whatever costs may be associated with their own health care? That remains to be determined.

The issue of the medically uninsured in previous decades was not as large as it is today. Health care has traditionally been provided to those who needed it, regardless of ability to pay. Health care institutions provided care in part because of mission, in part because of ethics, and in part because the scale of giving was not unreasonable (medical care was less costly). Money from paying customers provided sufficient income to keep the institutions healthy, despite their largess for the uninsured.

But the evolution of the health care has changed this. The ability to cross-subsidize the provision of health care to the uninsured has been shrinking as HMOs and the federal health programs have forced care providers to reduce their costs and accept even lower payments for services provided. Many public hospitals that used to serve the indigent have closed. And with consolidation in the industry and changes in health care delivery, many private hospitals have also closed. The result is that the remaining providers have less ability to give away services and face greater demands to do so. Most still do give them away, but the trend is one that threatens some providers with the inability to continue for much longer to provide health care to the enlarging, medically uninsured population.

As we begin to examine the many different components of this issue of serving the medically uninsured, it becomes increasingly clear that this is a very complex issue, one that can stimulate many varied, yet perhaps valid, solutions. Our intention in this report is to organize the issue in a fashion that others might better address it, as well as examine a number of alternatives that have been or could be proposed. The end state is not to make a case for one particular approach, since a final solution can only be one that is negotiated by many involved actors. But it should help to steer discussion to alternatives that stand a chance of contributing to a solution. We do not pretend to think that we have the answer: many others have approached this issue and failed. But we hope that our systematic examination will draw us closer to some answers to this very critical question for our community, its institutions, especially its health care institutions, and its residents.

CONTEXT

The issues surrounding the medically uninsured are knotty. The whole system for providing health care is in flux. HMOs and managed care are still evolving. Health care systems (the combination of hospitals, clinics, and related services) are expanding. The federal role in health insurance is changing modestly. The State of Wisconsin is changing its role with the institution of BadgerCare (see more below) and its support of local initiatives. The Milwaukee County role has changed from direct service provision to one of managed care for the indigent. The initial site of care for the medically indigent has shifted from hospitals to neighborhood clinics. Furthermore, the forces creating more or fewer medically uninsured, such as W-2 and the economy are, are in flux. Trying to then create a solution to the problem of serving the medically uninsured is very difficult. Many components are dependent upon specific conditions existing. If the conditions change, then certain solutions are not as appropriate. Therefore, it is essential to first understand the context of the current condition of the uninsured before one attempts to judge the appeal of alternative ways of addressing the problem.

The focus of this study is local, basically Milwaukee County. The national attempt to address the issue of the uninsured stalled several years ago and is not likely to resurface for several more years. Therefore, if the issue is to be addressed in the short or intermediate run, it must be done at the local and state levels. That is an underlying assumption of this effort. The federal government and its policies will play a role. Medicaid and Medicare are still important actors. But some rule changes at the federal level are making it more, not less, difficult to serve the uninsured. One example is the federal government's decreased willingness to pay 100% of cost for Medicaid patients in Federally Qualified Health Centers (FQHCs), basically non-profit, neighborhood clinics located in low-income neighborhoods. Such policy changes put even greater financial pressure on these health care providers to not serve the Medicaid population, much less the uninsured. With this type of federal help, it is clear that the solutions to help the health-care providers survive and the uninsured to have access to health care must be developed locally over the next several years: the federal government will not be the major actor.

In Milwaukee County alone there are somewhere between 113,000 and 144,000 medically uninsured individuals.³ In the state there are in excess of 430,000. The number of uninsured is said by some to have increased with the advent of W-2 and the rather large decline in both cash assistance and Medicaid enrollments. Since September of

1997, when AFDC officially ended, the number of individuals given income assistance in the state had dropped 20,373 persons to 11,102, at the end of June 1998. The number of persons enrolled in Medicaid had dropped from 228,914 to 219,507. Relative declines have not been as large in Milwaukee County. Cash assistance dropped 56% compared to the state's 65% decline. Medicaid enrollments in Milwaukee have supposedly dropped at the same 4% rate as in the state as a whole since September 1997. But local health care providers think the decline is much larger here.⁴

One presumption is that a portion of the decline in Medicaid enrollments is accounted for by individuals who are still theoretically eligible for, but not enrolled in, Medicaid. The result is an even larger number of persons who are not covered by medical insurance than was true in 1997.⁵ That then parlays into even greater non-paying demands on the health care system.

These demands are then likely to be magnified by the common pattern of care seeking. The uninsured usually seek health care only when they are very ill. At this point they usually enter the health care system at the most expensive portal, the ER (Emergency Room) at local hospitals. The costs of care are then compounded because the uninsured are so ill they often require the most expensive service at the most expensive service-delivery point. Even if the uninsured have nothing more than a cold, it remains the most expensive service, one that should be reserved for true emergencies.

The Changing Public Approach

There are several reasons why the medically uninsured are an increasingly important issue in Milwaukee County. For one, Milwaukee County has changed its form of involvement in the issue. The County, after decades of direct health care provision, no longer has its own hospital to provide care to the indigent. Doyne Hospital was not the sole answer for all medical care for the indigent, but it did serve a large portion of that population until the hospital closed at the end of 1995. The closing meant that the uninsured population either had to be served by others in greater number or not be served at all. The underlying reason for the closing was the increasing cost of providing the services and the decreasing ability and desire of the Milwaukee County taxpayers to support health care for the indigent at the level they had been doing, given other increasing demands for those same property-tax dollars.

The County did create an interim approach to serving the uninsured. It contracted with the neighbor to Doyne, Froedtert Hospital, to serve the population that used to utilize Doyne. To make it attractive, Froedtert was offered some \$60 million per year for two years to handle the patient load. The arrangement was criticized by other health care providers because they thought that Froedtert accepted the money but still steered uninsured patients to other health care providers that did not receive any share of the County funding. Furthermore, these other providers were being visited by more uninsured because of other dynamics in the community. The result was a big jump in the uninsured being served by Froedtert but also large increases at several other hospitals.

In the third year after the closing of Doyne, the County further changed its role and the approach within the County to serving the medically uninsured. The service model in the county changed from one relying on hospitals, often through the emergency rooms, to one that employs the primary care model. Patients are being steered to local health clinics before going to hospitals. This model makes sense for preventive care, especially if the system can serve the entire population. These clinics can theoretically serve the population for much less money per patient than can emergency rooms. Furthermore, if the patients can establish contact with one doctor with whom they can establish rapport, then more preventive care can be accomplished. If successful, this would mean fewer health problems and lower medical costs. And the health problems that did appear should be less severe because they would be caught long before they become acute. Unfortunately, the postponement of treatment until the need becomes acute is common in today's world of the uninsured.

The new County approach is known as GAMP, General Assistance Medical Program. The program name is actually many years old, but the program has been revamped for the new conditions. It has been set up as managed care for the truly indigent. To be eligible for free medical care, individuals must be poor (monthly incomes less than

Froedtert was offered some \$60 million per year for two years to handle patient load.

\$840 for a single person, \$1040 for a family of two, \$1210 for three, etc.), a resident of Milwaukee County for at least 60 days, sick, and they must not be eligible for or receiving health care coverage through any public or private source. The medically indigent are initially supposed to report to a local clinic, unless their need is truly of an emergency nature. The clinics address the medical problems that they can. They refer more difficult medical problems to a series of pre-established specialists or to pre-contracted hospitals. The intention is that those with more modest health problems will be treated at much lower cost than if they present ("present" is the term used by providers to depict the act of showing-up for health care services) themselves at the hospitals directly. Furthermore, once they have a clinic contact, they may make regular visits to the clinic for up to six months with the expense being paid by GAMP. The six-month period is intended to help get these individuals well and keep them well for an extended period. Both health care and health advice are dispensed over the six months, usually from the same doctor.

The full-fledged GAMP plan had a budget for 1998 of \$39.4 million. Of that \$16.9 million was state/federal funding, and \$22.5 million was County tax levy. The budget for 1999 is just slightly larger. GAMP has contracts with 32 different vendors. Twelve clinics are the primary service providers. But GAMP also has contracts with 20 other vendors that provide such services as pharmacy, rehabilitation, home care, and ambulance service. The majority of the funds is allocated to the clinics, pharmacies, and the like related to primary care and to the specialists referred from the clinics. A large sum is also allocated to the need for emergency services, inpatient services, and a reserve to help cover unknown demands made on various providers in the system. The actual move to the primary care model began April 1, 1998 and is in full force today.

Just how well this model will work remains to be seen. The initial question of whether these individuals who were very used to traveling out to Doyne and then to Froedtert to receive medical treatment would utilize the neighborhood clinics has been answered. The answer is yes. Enrollments at the 12 clinics are largely as predicted. At the end of the first seven months of the revised GAMP, the clinics averaged 46% of their expected GAMP load for the entire first year. Six clinics had seen more than half their expected load already. Almost all of the clinics were fulfilling their role as first contact for the medically indigent. While Froedtert is contracting as a clinic and is among those with more than the expected patient load (56% by the seventh month), the basic effort to steer patients to primary care clinics seems to be working. The budgetary expenditures appear to be right on target overall for the initial months of operation.

The effort, however, is not without its problems. These may not be major, but they could become so. An issue is that clinics are paid only a limited portion of the costs of serving GAMP patients. A second is that a portion of those who do present themselves at the clinics are very sick individuals whom the clinics either can serve only at

TABLE 1 GAMP Clinics and Patient Loads: April 1 - October 28, 1998

Clinics	Patient Allotment	% of Allotment Served
Rainbow Health	2,200	56
Mil. Health Services	3,500	56
Johnston Comm. HC	2,000	44
Mary Mahoney	300	89
16th Street Health	2,000	46
Sethi Medical Services	1,500	39
Shafi Med. Center	1,500	4
Medical College OW	2,500	56
HCFT Homeless	300	41
Parker & Pruitt	1,000	18
Silver Spring	50	192
K&R Medical, Inc.	<u>50</u>	<u>60</u>
Total Clinics	16,900	46

Source: GAMP Office, December 1998.

great expense to themselves or are patients whom the clinics cannot serve because the patients are too ill. The latter patients must be immediately passed on to specialists or to hospitals.

These conditions create some difficulties. Entry into the GAMP program requires that low income and sick individuals be in need of medical treatment. Yet GAMP is designed as a preventive care model. Obviously, there is a contradiction here: once one gets treated, GAMP can treat patients for up to six months to try to get that person healthy. But then the care stops for six months. If the preventive part is successful, that is enough. If not, the person will be asking for uninsured medical treatment or waiting for the six months to qualify for GAMP treatment again. If the latter is the case, then at the time of presentation, it is likely that more expensive health care will be needed than if that care could have been continuously provided. GAMP is making trade-offs between helping more individuals and serving one population well. It is a difficult call as to which is best. In either approach, someone must pay.

Another related problem that is endemic to the GAMP rule that one must be sick to qualify for medical attention from GAMP is that the very sick among the GAMP patients can receive little treatment at the primary care clinics. The patients who present are often sick enough that they need to go to the specialists or to the hospitals. At least the costs are covered for the individuals; it is just that the GAMP program does not kick in until they are sick, thwarting attempts to reduce costs and severity of illness through the preventive-care model. If the true preventive care model were being employed, a portion of that sickness would be prevented or at least addressed earlier when it would be less expensive to treat.

A third problem that is being created by the current GAMP approach is the limited reimbursement that clinics receive for GAMP patients: \$.39 on each dollar of service cost billed. A new patient to a clinic with problems of moderate to high severity, warranting a 60 minute visit, earns a clinic a primary rate of \$35.77.⁶ Obviously, this payment at the \$.39 per dollar is better than nothing, but clinics are still losing money on the service delivery. The clinics are grateful for some cost reimbursement. But if the clinics must keep treating patients and losing money on each, the equation does not work. The clinics must stop serving such patients, receive more money for each GAMP patient served, or receive more money for other patients to subsidize the service delivery to the indigent on GAMP.

Unfortunately, the other payers seem to be headed in the same direction as GAMP: they want to pay less for the services provided. Medicaid has been changed by the federal government. Instead of paying full cost to the FQHCs, five of Milwaukee's larger neighborhood clinics, medical payment is on a sliding downward scale which pays a lower and lower percentage each year until 2003. Thus, even though Medicaid coverage remains, the reimbursement formula for providers is less and less related to the costs of service provision. This change in reimbursement means that some service providers will soon, if not already, lose money on each patient served. If that is combined with the modest payment for GAMP patients, service providers will not be able to continue with a patient mix that is a combination of the two programs, unless some other funding mechanism is inserted. Five of the inner-city clinics do receive some federal funds because the clinics serve an indigent population. But the dollars transferred are limited and insufficient to cover the decreases in revenue caused by the smaller proportion of service costs paid by GAMP and Medicaid.

The Growing Number of Medically Uninsured

Also contributing to the overall scale of the problem is the fact that the number of medically uninsured has been increasing for several reasons. One reason is the increasing size of the poverty population in the city of Milwaukee. The poverty population almost doubled between 1980 and 1990, and the number of persons living in poverty in Milwaukee County is estimated to have risen from 14.3% in 1989 to 19.4% in 1993.⁶ Among workers the picture is not much brighter. Health insurance is often not available for lower wage employees. With an increase in this type of employment, especially part-time employment, more workers exist who are not covered by health insurance. Some additional number of workers are offered health insurance, but they elect not to pay for it because they do not have sufficient income to meet both health insurance costs and other primary needs. And there are still others who make a conscious choice not to spend their income on increasingly expensive health insurance. With health insurance premiums in the state rising, on average, 6% in 1998 and projected to rise 9% in 1999, it is no wonder that while more individuals are being offered insurance, participation is actually shrinking. Non-participating individuals hope that they do not get sick; but if they do, they rely on the rest of us who have insurance to pay their medical expenses.

The state of Wisconsin has the lowest percentage of its population of any state that is medically uninsured. The problem is smaller here than elsewhere in the US. But while the state figure looks very good at 8.6%, that is a statewide average.⁷ The situation in Milwaukee County is quite different. The percentage is estimated at 13-15%.

That makes the issue more pressing, especially since many of those who do present for services have health conditions which are expensive to treat. For example, in 1996 the average cost of treating a person at the emergency room was over \$1,265 per person (compared to \$35.77 for the initial visit at a neighborhood clinic). It does not take too many unpaid emergency room visits before the hospital's resources are taxed. If a higher proportion of such cases were addressed with preventive care (a study in Washington, DC estimated that at least one third of cases presenting at emergency rooms could have been avoided with preventive care - primary treatment),⁸ the cost to the hospitals would be considerably reduced.

Another piece of the changing context for the medically uninsured is the money available for their care from Milwaukee County. Milwaukee County not only changed its form of involvement, it changed the dollars committed to health care. Instead of \$60 million a year, they are now down to under \$40 million (combined state and local), of which \$23 million is property tax dollars and the other \$17 million is state money. The push is to reduce the local contribution, and thus the total spent, even further.

The Changing Political Context

The composition of the Milwaukee County Board is changing. An increasing portion of the Board has no experience with the County's long term commitment to health care provision. The new members increasingly see this area as an expensive service that would best be removed from the property tax. The County Executive and the chairperson of the Board of Supervisors have committed the County to continued County support of health care for only a short period. This commitment may disappear if more pressure is put on the County to provide other services (such as corrections) that require more of the limited property tax dollars. If the pressure to remove County support for health care is successful, other payers must make up the difference.

Not only is the local commitment to health care for the indigent waning, the same can be said is true for the federal government. With the initiation of W-2 and the demise of AFDC, the number of persons covered by federal health care programs is shrinking. As noted above, the proportion of citizens supported by cash grants in the state and in Milwaukee County has dropped by more than half over the last year. What has also declined is the number of individuals appearing on the Medicaid rolls. The decline among those on Medicaid is not nearly as great as those on cash assistance. Still there is a decline.

Some portion of the decline is due to persons working and qualifying for health insurance. But another portion of the decline, especially in counties such as Milwaukee, derives from the lack of knowledge among those eligible that they are, in fact, still eligible. Information on continuing eligibility has not been well spread, according to health care providers who see many patients appear who are eligible but who are not enrolled in Medicaid. Furthermore, the state has elected to have a cumbersome procedure for Medicaid enrollment that discourages participation: it requires re-registration quarterly, using a 20 page application. Some individuals do not know of their continued eligibility, but other potential enrollees are unwilling to spend the time qualifying. The result is that health care providers must spend extra resources trying to qualify these individuals when they present for care. And, furthermore, many individuals do not seek the preventive health care for which they are eligible under Medicaid. This results in greater demands on the health care providers when the sick do present for services.

Drug and Alcohol Abuse

Another element in the changing context is the large increase in the use of illegal drugs over the last decade. This alone has decreased incomes available for health care. But perhaps more importantly, it has led to a number of unhealthy conditions: lack of interest in maintaining one's health; lack of interest in preventive care; lack of dollars for nutrition; loss of sense of time and plan for the future; risk taking that greatly threatens health, be it robberies for cash, sex for drugs, or a number of related activities. When drug use is combined with alcohol use and abuse, both of which rob individuals of initiative and open the door to numerous maladies, the result is more expensive health care demands. If drug and alcohol abuse (and tobacco use) could be curbed, then the scale of the health care delivery problem would be much reduced. Ironically, health care involves the curbing of these abuses. The system that might be able to help is being overwhelmed by abuse, so much so that it has few resources available to try to reduce the abuse. Additional resources need to be directed to this area of health care, if overall demands for health care treatment are to be reduced.

Implementation of BadgerCare

A very recently approved component of the context is BadgerCare. The Thompson administration, in its attempt to create an environment that is more supportive of work for lower-wage earners, proposed a health insurance program that has come to be known as BadgerCare. More formally, it is known as part of S-CHIP (State Child Health Insurance Program). The program is in addition to the W-2 Health Plan and the state's MA (Medical Assistance) program. The W-2 Health Plan was created and implemented to serve those who are participating in the W-2 program, the program which replaced AFDC (Aid to Families with Dependent Children). The W-2 Health Plan has some very specific statements as to who is eligible, but generally it serves participants in W-2 and their relatives. Those eligible include the individual who is a custodial parent, her or his dependents, and her or his dependent's dependents, with income under 165% of Federal Poverty Level (FPL). The program also serves pregnant women with no children and income up to 165% of FPL, the spouse of the custodial parent, if the spouse lives with the W-2 group, and a number of other situations.⁹

BadgerCare will serve those children and adults in uninsured families with incomes below 185% of FPL. Once enrolled, these families could remain in BadgerCare until their family income exceeds 200% of FPL. Families with incomes of over 150% of FPL will pay a monthly premium of 3.5% of family income. Milwaukee County estimated that this plan will offer health insurance to approximately 7,000 children and 5,800 parents in Milwaukee County who are currently uninsured.¹⁰ Statewide the plan is said to cover 23,000 children and some 27,000 adults.¹¹

In order to implement this plan the federal government had to approve a series of waivers from existing regulations. Many of these were granted in mid-1998. But one stumbling block remained: Wisconsin wanted this to be a fixed-budget plan that would serve all eligibles up to one set budgetary figure. The federal government insisted that it be an entitlement that would serve all who applied and qualified, even if the cost to the state exceeded the budget figure the state had established. In mid-January 1999, a compromise was reached. The federal government allowed the state to modify eligibility requirements to moderately diminish the number of eligible persons. That allows the program to cost less, thereby staying within the budget limit set by the Governor. It is a creative solution that will inject an additional \$71 million into the health care system the first year and give paid access to health care to an additional 50,000 persons.

The additional dollars will allow health care providers to not only serve those with BadgerCare support but also serve a larger portion of the remaining uninsured because of the additional revenue flow.

The health care system would be bolstered by even more money flowing into it. Whether the dollars come from the "Big Tobacco" settlement or other sources, the more complete the answer to the question of who pays, the more complete the access to health care and the less the threat to the lives of the health care providers and the uninsured.

Wisconsin wanted this to be a fixed-budget plan that would serve all eligibles up to one budgetary figure.

THE PROBLEM

As the reader has just seen, many elements in the health care system are changing. Perhaps the most dramatic include the increasing number of uninsured because of the advent of W-2, the switch from Doyne Hospital to local clinics as the intended entry into the health care system, the reliance on the clinics to serve a significantly greater number of the indigent, the decrease in the number of dollars Milwaukee County is putting into health care for the indigent, and the decreased ability of health care institutions to cross-subsidize indigent patients. Given these and other less dramatic changes, the question that arises is whether these changes are creating any specific problems for the actors involved. Are, for example, hospitals or neighborhood health clinics experiencing greater financial strain or are the medically uninsured receiving less or lower quality medical care? Are the county and the city facing the possibility of public health breakdowns? Additionally, if these or other problems are intensifying, what might be done to reduce them?

Details of the Uninsured

As was noted above, Wisconsin is in an enviable position in terms of the percentage of its residents who are covered by health insurance. Only 8.6% are not enrolled in some type of health insurance program. That means the percentage uninsured is almost half the national average of 16.1%. Such a figure for the state implies that the strain on the health care system of serving the uninsured should not be as great as it is in many other parts of the country. This appears to be the case. For example, the percentage of gross non-governmental hospital revenues that was eaten by uncompensated care (the combination of unbilled and unpaid service to the poor and unpaid, billed service to all patients) in Wisconsin was 2.3% in 1995, much below the national average.¹²

The story on the scale of the medically indigent in Milwaukee County is a bit different. The Milwaukee County Audit Department estimates put the likely number of medically uninsured in Milwaukee County in 1997 at

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between 113,000 and 118,000 persons or 12%. Estimates actually vary depending on what data set one uses to construct the estimate. The number could be as low as 73,000 or as high as 144,315.¹³ The 113,000 to 118,000 is taken as the most reliable estimate since it is based on two estimates, one derived from a state survey of health and another estimate derived by subtracting from the total population in the county the number of individuals who did not participate in any of the health care insurance programs (employer or government-based). The 15% is twice the state rate and illustrates the concentration of this problem in one county, Milwaukee. In fact, Milwaukee County is the one county of the 72 in the state that operates a health program for the indigent.

The other estimated 310,000 medically uninsured in Wisconsin are dispersed across the state, with approximately 30% living in rural areas. The fact that a significant portion of

the medically uninsured are concentrated in but one county means that there is not a lot of political pressure to address this issue at the state level. The state is involved in health care and is becoming more involved with the introduction of BadgerCare. But the State has not been pressed from several geographic quarters to become more involved. It is Milwaukee County alone of the local jurisdictions that is under mounting pressure to address the costs of the medically uninsured.

Since we do not have a precise count of the uninsured in Milwaukee County, we cannot say with certainty who is uninsured. We must rely on estimates of the composition of the uninsured population in Milwaukee County based on estimates from the state health survey. If Milwaukee matches the nation, the bulk (65%) of the uninsured is white. But if we use the state survey, the number of blacks and whites without insurance is about the same (41% each); Spanish-speakers and others make up the rest. The average age of the uninsured person is 42 years old, and 57% are between the ages of 18 and 44. The uninsured are geographically concentrated: 82% live in the City of Milwaukee. In terms of income, it is not the lowest income that constitutes the majority of the uninsured. Only 20% of those without insurance have incomes of less than the poverty level. The largest group, 46%, actually have incomes at least equal to if not above 200% of poverty (\$26,660 for a family of three in 1997), and 34% have incomes between 100% and 199% of poverty (between \$13,330 and \$26,659 in 1997). Thus, it is clear that the various programs to aid the least able to pay are providing some coverage. Those individuals with incomes directly above the most impoverished appear to be the ones most in jeopardy.¹⁴

The numbers just examined are the 1996 and 1997 estimates. The 1998 estimates may be larger because of the switch from AFDC to W-2. As AFDC ended and women were told they had to either go immediately to work or be on limited-term, W-2 funding, their Medicaid was suspended. If they wanted to continue to receive Medicaid, each woman had to reapply every three months for Medicaid. If they qualify, they can receive it. Unfortunately, many of the former recipients did not receive, or perhaps did not understand, the message that they could continue to receive Medicaid even if they were no longer receiving cash grants from the state. The number of Medicaid registrants has dropped, but not as fast as the number receiving cash awards. Yet it has dropped. Some say that the number of enrollees in the state has dropped below what it should be at this juncture. If true, then the number of uninsured in the state and especially in Milwaukee County, which now is home to over 85% of those in the state receiving cash

grants, has grown. The county figure is alleged to be as high as 155,000 medically uninsured persons.¹⁵ Again, this is only an estimate; an accurate count is not yet possible. If true, though, it means increasing pressure is likely being placed on the health care providers. There is evidence of this new pressure.

The Impact on Health Care Systems

The value of medical care provided by the area's hospitals that is not expected to be paid at the time of care delivery, known in the trade as "charity care," has been rising in recent years (Table 2). Among the six hospitals with larger charity care burdens, the charity care total has grown from \$22.7 million in 1995 (prior to the closing of Doyne) to \$32.4 million in 1997 (expressed in current dollars). These hospitals project that it will rise to \$38.1 million in 1998. In 1997, Froedtert and St. Luke's had charity care burdens of just over \$8.9 million each, accounting for almost 60% of the total. And it is these two hospitals that project the bulk of the increase in charity care for 1998. Sinai's burden is less than half of either of these two hospitals, despite its inner-city location, and its projected increase for 1998 is a modest one-half million dollars. Sinai's 1997 burden or even its 1998 burden are both below what it had in 1995. Such changes imply better control over patient mix and access to funding for the patients served. Admittedly, the hospital has some large, bad-debt problems, but these cannot be attributed to the medically uninsured.

TABLE 2 Absolute Dollars of Charity Care (in thousands),
Select Milwaukee Hospitals, 1995-97

<u>Hospital</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998 est.</u>
Froedtert	\$1,683	\$8,250	\$8,904	\$10,570
St. Joseph's	2,170	2,832	4,931	4,799
St. Luke's	6,613	9,841	8,947	12,074
St. Michael's	2,738	2,598	2,537	2,905
Sinai	6,901	3,096	4,440	5,000
Waukesha Mem.	<u>2,559</u>	<u>2,382</u>	<u>2,654</u>	<u>2,787</u>
TOTAL	22,664	28,999	32,413	38,135

Source: Wisconsin Office of Health Care Information, Special runs, December 1998

The absolute increases in charity care for these hospitals suggest that they might be increasingly suffering from this unpaid demand being made on their services. Undoubtedly, it is a painful demand that they wish were not there. But if one examines the charity care burden in relative terms, that is charity care as a percentage of gross patient revenues (a commonly accepted measure of impact) in Table 3, it is clear that the burden collectively and individually is not very high. In 1994 it was 1.4%, on average, rising to 1.6% in 1997, far below the national average (6%) just noted.¹⁶ That is a far cry from the Milwaukee average and from that experienced by any individual hospital in the Milwaukee area. The highest ratios of charity care to gross-patient revenues in 1997 were experienced by Sinai and Froedtert, a modest 1.8%. (The highest over the three years was 2.8% at Doyne in 1995.) These relatively low incidences suggest that while charity care is a concern, it is not threatening the hospitals' existence in Milwaukee at this time. In fact, no hospital in Milwaukee publicly claims to be financially threatened by charity care at this time. The hospitals are, however, concerned.

Even if one examines the ratios of all "uncompensated" care — a combination of (1) bad debt, revenues billed with the expectation of being paid but thereafter not paid, and (2) charity care — to gross patient revenues (Table 4), it is evident that the percentages of this overall computation are below the national average for just the charity care component for all of the hospitals. Furthermore, one of the largest, Froedtert, is becoming less, not more, of a problem. After the shock of the closing of Doyne at the end of 1995, this hospital has seemingly taken better charge of its costs and revenues. Sinai's 1997 uncompensated care rate of 5.1% is the highest, but its management claims that it now has the sources of the problems under control and that they claim that the hospital might actually break even by the end of 1999.¹⁷ The number of admissions in the first half of 1998 does not reinforce the claim

TABLE 3 Ratio of Charity Care to Gross Patient Revenues, Select Milwaukee Hospitals, 1995-1997

Hospital	1995	1996	1997	1997 GPR (\$ mil)
Doyne	2.8%	NA	NA	NA
Froedtert	0.7	1.7%	1.8%	508
St. Joseph's	0.8	1.0	1.7	297
St. Luke's	1.3	1.6	1.4	659
St. Michael's	1.8	1.6	1.5	170
Sinai	2.4	1.1	1.8	253
Waukesha Mem.	1.3	1.2	1.2	221

Source: Wisconsin Office of Health Care Information, Special runs, December 1998

(admissions as of 6/30/98 were down 6.5% for the first six months of the year at Sinai). But the patients may have more expensive and longer stays that help to counterbalance the decline in the number of patients.

Froedtert, on the other hand, experienced a 1.9% increase in admissions for the first six months of 1998,¹⁸ and it experienced a 7% increase in gross-patient revenues between 1996 and 1997, implying it is moving in the right direction. Sinai, as mentioned, lost two managed-care contracts and experienced an 11% decline in gross patient revenues between 1996 and 1997. More current figures are not yet available. The point is that for most of the Milwaukee hospitals the issue of uncompensated care is a small and very modestly growing problem. No business likes to experience such losses, but the scale currently is not such that overall viability of these hospitals is threatened.

TABLE 4 Ratio of Total Uncompensated Care to Gross Patient Revenue, Select Hospitals in the Milwaukee Area, 1995-1997

Hospital	1995	1996	1997
Doyne	15.2%	NA	NA
Froedtert	4.2	7.2%	5.0%
St. Joseph's	1.4	1.8	2.6
St. Luke's	2.2	2.4	2.6
St. Michael's	2.5	2.4	2.6
Sinai Samaritan	3.0	2.5	5.1
Waukesha Mem.	1.8	1.7	1.9

Source: Wisconsin Office of Health Care Information, Special runs, December 1998

Indeed, since almost all of the area hospitals are now part of larger health care systems, the losses can be more easily absorbed. Sinai Samaritan, for example, is part of Aurora Health Care. The Milwaukee-area member hospitals of Aurora had combined net income of \$17.3 million in 1997. Aurora overall earned enough in 1997 to reinvest over \$200 million in its many facilities in Eastern Wisconsin, even though Sinai itself lost \$21.6 million. During the same year Horizon's five Milwaukee-area hospitals earned a net income of \$46 million. (Covenant's area hospitals earned a more modest \$9.9 million in net income.) The scale of the reinvestment at Aurora and the net income figures at all care systems indicate both the enormous number of dollars that flow through these entities and the overall health of the larger organizations. No organization likes to see blood flowing from its members. But if the blood

supply is large enough, then the losses can be carried without the need for an amputation. At this point the relationship between the overall fiscal health of the organization and the charity demands being made on it are such that no major operations are being requested.

If we look at the overall net earnings for area hospitals, this point is reinforced. The 22 Milwaukee area hospitals reported net earnings of \$146 million in 1996 and \$125 million in 1997. The difference between the two years is attributable to the \$21.6 million loss Sinai Samaritan took in 1997. These net income figures reflect their financial status after subtracting the investments these hospitals made in their own operations, any paying down of outstanding debt, and any investments they may have made. The figure above from Aurora, noting some \$200 million invested in its system, strongly reinforces the point that these hospitals are not seriously threatened by charity care and the demands the uninsured are currently making on them. That situation can change as the economy changes, as W-2 is more fully implemented, as Milwaukee County further withdraws its commitment to indigent health care, and the like. But at this juncture, these are not the institutions that are suffering greatly from the impact of the medically uninsured. They may like further relief from the costs, such as the one they were able to win from Governor Thompson — a \$1.2 million Medicaid supplement payment to begin in the year 2000 to Milwaukee County hospitals that provide more unpaid care because of welfare reform. But the hospitals will easily survive under present conditions.

Steps Taken to Reduce the Pain

Hospitals have not had to make major changes in how they operate because of demands from the uninsured. But this should not imply that the system and the hospitals are not taking steps to try to reduce the unpaid demands being made on them. Aurora is very much involved, as are the other health systems. Aurora, however, has been the most aggressive in its attempts to find ways in which it can intervene in health care provision to reduce the non-paying demands on its hospitals. It has established a very proactive nursing program in the inner city where nurses actually go door-to-door searching for pregnant women in an attempt to ensure that they receive pre-natal care. Aurora also provides nurses to the congregations of several inner-city churches. It also has established clinics for students at four Milwaukee public high schools. In each setting the idea is to do preventive care in order to reduce the chances that more expensive demands will subsequently be made on the area's hospitals and doctors.

Covenant Health Systems, as another example, has taken an active role in the Sexually Transmitted Diseases clinic. Again this is an area that can be alarmingly expensive unless the diseases are caught early. It is in the best interest of both the health care providers and the individual patients that early intervention be achieved. Horizon, through St. Mary's, has several innovative programs aimed at schools and the elderly. The Medical College of Wisconsin has a residency in family practice that allows it to keep clinics open that serve the medically indigent. The model for all of these organizations is that of preventive care or at least early treatment. To the degree that the uninsured can be reached before major health problems develop, the less expensive it will be to the health care institutions individually and collectively.

The reasons for the outreach activity by each hospital system, however, may differ. Each institution has historic roots. Aurora, for example, has a history of service and a mission of service. Although it may gain financially from its outreach activities (it does search for outside funding for its outreach activities), it is being motivated, at least in part, by its desire to insure that the medically needy are served. Aurora envisions itself as there “to work with the community to be more healthy.”¹⁹ Yes, they are concerned with the bottom line, but Aurora also has a vision of helping the citizenry become healthier. If Aurora's initiatives also allow it to get reimbursed for its actions, that is fine, but it keeps trying to think of ways in which it might intervene to improve health. Other care providers may not have quite the same philosophy, but all seem to be taking some steps to help reduce the potentially negative impact of the uninsured.

There is talk among providers that they all serve those who present at their doorstep, that it is the ethical thing to do, that they have the resources to serve, and so forth. But it was also a recurring theme in a number of interviews that one hospital in particular, Froedtert, turned away uninsured patients if there was an opportunity to do so. The hospital was said to refuse to serve patients who presented and were deemed not sick enough to need immedi-

Hospitals have not had to make major changes in how they operate because of demands from the uninsured.

ate care (and the patients were steered to a neighborhood clinic), patients who were at other institutions that were thought to need the skills available from the Medical College staff but who were not accepted by Froedtert because they did not have proof of insurance, or patients who had been treated at Froedtert and sought follow-up treatment but who were allegedly, prematurely steered to clinics that were not as capable of providing the care required. Besides being an undesirable practice from most perspectives, this steering away of patients serves to illustrate that some institutions are very actively trying to reduce their exposure to charity-care expenses. While they will not publicly claim that they are in great financial pain, their actions suggest that hospital staff has been instructed to limit its exposure to such clients. The practice strongly suggests that serving the uninsured is a very real concern to at least some of the larger health care providers.

One of the services that Froedtert and other hospitals are trying to preserve is that of emergency medicine. Milwaukee area residents should also be concerned with the continued availability of emergency care. If the clinics cannot handle the uninsured patient volume and more of the uninsured present themselves at the hospital ERs, the cost to the hospitals could be so high that they close their ERs. This has happened in other cities and is a disaster scenario. Emergency care is especially needed in an urban environment.

One way such a scenario might play out is that a hospital like Sinai may be inundated with charity care cases at the emergency room. Rather than continue to lose money on the ER or try to make extemporaneous decisions on whom they will or will not serve (opening themselves to the lawsuits if they refuse to serve certain types of individuals or refusing to serve someone who dies shortly thereafter), it would close the ER completely. This patient pool would then move to the remaining ERs, placing even greater burden on them. The ERs could fall like a house of cards. The one ER that will likely remain open the longest is Froedtert's, because it is a regional trauma center that also attracts a number of well-paying, dramatic cases. The paying cases could well outweigh the non-payers, at least for a while.

Impact on Private Physicians

The negative impact of non-paying clients affects not only the institutions. Private physicians are affected. They too provide services for no pay and must absorb the expenses. How large a problem is this? We have no way of knowing, but it grows as the number of uninsured are served. Many doctors think that this is part of their practice and ethical responsibility. But since there are so many physicians who operate independently, there is no easy way to capture the extent of the non-paying patients. The dollar volume lost probably is not as large as the hospital charity-care figures, since the hospital charges are usually so much higher. But the costs are substantial. They are counted when the doctors are organized, such as in an inner-city clinic. But for the many other doctors, it just remains a point to be noted. Our efforts to document the true impacts of serving the uninsured are really incomplete due to the unavailability of dollar figures on the foregone payments attributable to the indigent care provided by the doctors.

Impacts on Neighborhood Clinics

Neighborhood health clinics are the newly anointed primary place of entry to health care for the uninsured as well as GAMP patients. Many of these clinics have been around for years while others have recently opened their doors. The larger ones commonly receive some federal funding because they are targeted to serve the indigent population. Five of these are referred to as FQHCs, Federally Qualified Health Centers. Others clinics are non-profits. A few are operated by the City. And still others are private, profit-seeking businesses. Together they are the current line of defense among health care institutions. The clinics are where the indigent seeking medical attention are steered. They are also where primary medical care can be delivered at a much lower cost than at the traditional fail-safe, the emergency rooms of hospitals.

The model of offering primary care in the neighborhood near the clients has intuitive appeal. If the health services can be delivered at lower cost there than elsewhere, it is also a good idea. Furthermore, if the clinics can succeed at preventive care as well as primary care, then the cumulative costs will be even lower. The question that remains is whether the series of clinics currently available in Milwaukee is financially strong enough to handle the enormous population that has been laid at its doorstep. If the clinics can, then the hospitals and other larger health institutions will be financially better off. If, however, the neighborhood-based clinic approach fails, then the hospitals will be more concerned than they currently are about the financial impact of the uninsured. Bottom lines are currently looking good for most of the hospitals, as the clinics have begun to handle the indigent burden. But it is very possible to foresee the time when the clinics, with their \$7-12 million annual budgets, will be unable to handle the demands being placed upon them. In fact, it is already happening in some of the clinics.

One organization, Rainbow Community Health Centers, that operates three inner-city clinics, is really struggling and is close to bankruptcy. Their loans have not been called, so they have not formally been foreclosed upon. But their organization is bleeding badly and is unable to serve as many patients as it had been. Other clinics are also feeling pain from the current arrangements. For example, Milwaukee Health Services is still very successful. But they have recently made a decision to serve fewer indigent patients; they simply cannot afford to serve as many as they had. The Sixteenth Street Health Clinic is seriously contemplating the same option: cutting back on the number of indigents served. If these and others follow the same path, there will be an increase in the number of medically indigent that presents at the area hospitals. The hospitals will have to serve them, taxing their currently healthy bottom lines. What is now seen as a reasonable approach, dispersed primary care, could well become unreasonable, as it disintegrates under the financial pressure of serving the uninsured.

The clinics see the current approach of using clinics as the primary medical source as reasonable, theoretically. But the approach suffers in practice because insufficient dollars are available to fund it. And the pressure that makes it less than viable is building. The clinics lose money on every GAMP patient they serve, since they are reimbursed only \$.39 for every dollar of service provided. Furthermore, the GAMP patients that present must of necessity be sick. This then requires more time (often two to three times more minutes of medical attention is required for a moderately to severely distressed new patient than one who has low to moderate severity). Clinics are paid only 50% more for the more distressed patients despite spending two to three times more time with them.²⁰ The clinics lose money on the low reimbursement rate, the additional, unreimbursed time required, and the opportunity-cost loss of not being able to use the time to serve and bill higher-paying patients.

The FQHC clinics have also begun to lose money on each Medicaid patient served, as the federal government reduces the percentage of the cost of services it will pay. The FQHCs have traditionally received 100%, cost-based reimbursement for Medicaid patients to insure that the clinics do not have to subsidize losses in the Medicaid program with other federal grants. A sliding scale of an increasingly smaller percentage of costs has been instituted by the federal government for the next five years, but at the moment it is still close to 100% of billed cost. This year it is 95%, but it drops to 0% by the year 2003.²¹ The effect is that clinics receive less money for each Medicaid patient seen. And they are seeing fewer Medicaid patients because of the decline in those enrolled in the program due either to the transition to W-2 or to the onerous application that must be completed every three months. (One clinic estimated the decline in Medicaid patients to be on the order of 12-15% over the last year. Another said the decline was 8%. A third just reported the decline as “large”.) The result is that the clinics like their role as primary care providers and entree to the medical care system, but the funding is clearly inadequate to serve the demand that exists in the community. And the unpaid or only partially paid demand is increasing. It appears to be a recipe for disaster. But the disaster has yet to arrive, except at an occasional clinic door.

Some clinics are able to survive because they see a higher percentage of Medicare patients. The reimbursement for these patients is 100%. But other clinics are not as fortunate. They depend on a patient mix that includes a high proportion of Medicaid patients. The greater the proportion of GAMP or uninsured patients, the closer the clinic is to financial disaster. For the five FQHCs, the more Medicaid patients they see over the next several years, other payers remaining equal, the less able they will be to serve the uninsured or GAMP patients. **Someone must pay** for the services or those services will no longer be available.

As the responsibility for paying is passed on from one institution to another, each afflicted institution affected absorbs the losses that it can. Then, each has three options: continue to serve at the same level, which is unlikely unless they have very deep financial pockets; cut back on their services to the medically indigent; or fail financially and completely stop services to the indigent. The County elected the last option for Doyno Hospital. Individual clinics are now implementing the second option. Hospitals are largely utilizing the first because they have not yet been overwhelmed by the scale of the indigent case load. But as more clinics elect the second or third options, the pressure to serve many more indigent will fall to the hospitals. These hospitals will then have to decide if they accept the burden and continue with the first option of continued service or whether they too will have to elect the second option. Given possible public health risks, societal ethics, and community sensibilities, political pressure will build

The greater the proportion of GAMP or uninsured patients, the closer the clinic is to financial disaster.

to find an option that does not leave an ever increasing number of citizens without access to health care. We are not at this juncture yet, but each month we appear to be moving closer as more of the current providers of health care services restrict access to that care.

Issue of the Quality of Care

There are two components to the medically uninsured issue. The first is simply access to medical care. The second is whether that access is to quality care, the same quality of care that the rest of the population receives. Since much of the rest of this report addresses the access issue, it is appropriate to spend at least a paragraph or two exploring the issue of the quality of the care the medically indigent receive.

The basic charge made by critics of the current system is that the medically uninsured do not receive the same quality of health care as provided to paying customers. But whenever this charge was made to the hospitals during the interview process, it was vehemently denied. Each hospital representative made it clear that the health care staff did not know, nor did they care, about the financial status of any patient. The professional health care providers did whatever was necessary to treat their patients' conditions. The hospitals claimed repeatedly that they served everyone similarly. The provision of similar care to all income groups is not found in many large American cities.

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But based on their experience in Milwaukee and elsewhere, those administrators interviewed concluded that the quality of care across income lines in Milwaukee is "pretty even." Even physicians interviewed said they treated patients the same initially; they admitted, however, that they might not be as aggressive about following-up on patients who were unable to pay. But initial treatment was comparable across income levels.

But one set of administrators did go on to say that it is well documented nationally that there is a difference by outcomes and ability to pay: the greater the ability to pay, the better the outcomes. They gave many reasons for the discrepancy in outcomes across income groups. One is that very few doctors come from low income backgrounds. Thus, few of the physicians are well attuned to their patients. Second, lower income patients are often not able to articulate their health problems well, so oftentimes their conditions are misdiagnosed. Third, the lower income population is poorly educated as to how to

live healthily. This creates more problems that require medical attention. Fourth, drug and alcohol abuse are commonplace, creating additional health and health maintenance problems. Fifth, private health providers, thinking of the bottom line, may provide equal care for what they know of the conditions, but they may know less because they may not send such patients for the full list of tests. Sixth, low income patients are more likely to be unable to read and follow doctors' directions, thereby negating what was initially comparable health care treatment. Seventh, a portion of the uninsured have very limited ability to converse, much less read, English. This complicates access to care and the following of health care instructions, be they written or oral. Eighth, by the time members of this population present for health care, they are often very sick. It is difficult to address all of their ailments at the same time, especially when the patients are not as likely to articulate all of their problems nor comply with the medical regimen specified. The outcomes, thus, often appear to be the result of uneven medical treatment.²² But the cause of the differential outcomes is far more complex.

This list of reasons suggests some of the complications of creating a healthier, medically-indigent population. What complicates the assignment even further is the need for a much greater investment in "behavioral health." This is health care provision that helps to change lifestyles and reduce the need for expensive and recurring treatment for a variety of ills. The medically indigent population has a great need for such health care. But no one, especially not the federal government at this point in time, will fund such care. The result is that members of this population present themselves for medical care more commonly in greater need of extended treatment than should otherwise be the case. This raises the cost of treatment to the institutions and further taxes the entire health care system.

Impact on Public Health

The presence of a large uninsured population also creates more public health problems that could be prevented. Low-wage workers, for example, are disproportionately found in food services. It is very common for such

individuals, living in poor conditions, to contract diseases, such as tuberculosis or hepatitis. If these diseases are not identified early, they can be spread, infecting large numbers of those partaking of the food services. Soon the city can have a major health crisis, one that could be prevented if the community had the resources to provide preventive and early disease detection to this uninsured population. It is clearly in the public interest to serve this population and prevent the crises. But at this point in time, with well over 100,000 uninsured in the County and most of these living in the City, it is also clear that the resources are not currently available to do so. Milwaukee is, therefore, susceptible to the development of a public health crisis.

The Impacts Today

Are these impacts problems that need to be addressed? It depends greatly on one's perspective. Will they be greater problems in the near future? It is less likely, now that BadgerCare has been approved. The influx of the additional dollars relieves a little of the pressure. But when one looks at the number of uninsured in Milwaukee county and the small proportion served by BadgerCare — 12,800 of approximately 100,000, it is clear that while BadgerCare will help, there are still many individuals who remain medically uninsured and potentially a financial drain on health care providers and all others who pay for health care services.

We really do not know the impact of BadgerCare. Will it be enough to keep clinics like the Rainbow Health Centers solvent? Will it be enough to allow clinics to expand rather than contract their provision of services to the uninsured? We do not yet know, nor will we until BadgerCare begins to operate. But the scale of the remaining uninsured is so large, it strongly suggests that while BadgerCare will be helpful, it is a far cry from preventing the many negative impacts noted above.

Furthermore, the W-2 program has not been instituted long enough to know what its true impact on health care will be. But the impression it has created to date, with the declining number of those who are enrolled in Medicaid and clinics and hospitals discovering eligibles among those who present for services, W-2 impact is in flux but likely adding to the uninsured numbers in Milwaukee County. Is this a problem? Yes, it is for the individuals involved because they are uninsured. Yes, it is for the clinics that are feeling overwhelmed by the number of uninsured seeking their services. Yes, it will be at the hospitals that are just beginning to experience a rising tide of uninsured presenting for services. This tide is largely being deferred to clinics at the present, but as more of the clinics limit their response, the burden will increasingly fall to the hospitals. As the wave of need sweeps through the system, it is likely to leave carnage in its wake: clinics will downsize or fold completely, creating an even larger, more needy population to be served by the remaining institutions. The primary care treatment model that makes such sense will be phased out by the inability to fund its operation. Such is the likely scenario, unless the system changes. **Someone must pay.** The question is who. Can resources be organized in such a manner that this scenario does not come to pass?

Are these health care problems? Or are they income problems? Or are they employment problems? Depending upon how one defines the issue, the solutions can be quite different. One can easily make the case that the problems are income problems. If these individuals and families had higher incomes, they could procure their own health care with their own resources. That may be true at some level, but it still is unlikely to be universal. Some would still elect to use their higher incomes on other items than health insurance.²³ We, therefore, need to explore a variety of possible solutions, if we are to find answers to reducing the negative impacts of the medically uninsured in Milwaukee County.

POSSIBLE SOLUTIONS

Is there a current crisis involving the medically uninsured in Milwaukee County? We see no major public health problems, no segments of the population dying in the streets from lack of access to medical care. We do not hear public complaints about the financial pain the various health care systems might be experiencing. The larger health care systems may be wincing from the pain, but they are not crying out in pain.

The clinics, however, are another matter. The neighborhood clinics just cannot handle the burden coming their way. Unfortunately, the clinics are not visible enough nor politically powerful enough to cause major change in how the medically indigent are handled. The clinics do seem to have gotten the attention of Milwaukee County officials who are speaking publicly of raising the GAMP fee paid for patient care. This is a recognition of the clinics' fragile financial state. But the amount the GAMP program may be willing to pay is unlikely to be sufficient to keep the clinics operating at even their current levels. The reduction in Medicaid patients for all clinics and the reduction

in payment for treating Medicaid patients for the five clinics that are FQHCs will continue to erode their financial positions. The most likely outcome is continued downsizing in the number of patients, especially uninsured patients, that these clinics can see. That means that the uninsured will, of necessity, present themselves for treatment in increasing numbers at the hospitals.

The pace at which this will occur is difficult to estimate, since it depends on a number of factors. Among these are: 1) whether the state will increase its payments to health care systems to help offset the loss of Medicaid patients; 2) whether and to what degree the County pays more for GAMP patient treatment; 3) the relief that implementation of BadgerCare brings; 4) whether the federal government spends any more money on the medically indigent (as Clinton is proposing); and 5) the timing of these decisions. If the past is any indicator, the uninsured and providers serving them will all feel much more pressure before any new steps are taken by non-local actors. This strongly suggests that to keep the current system afloat and whole, the local actors must get together and negotiate changes that help everyone to continue to provide access to medical care, however fleeting, to the vast majority of residents while keeping health care institutions operating at least at the current levels. That is a major assignment, but one that, if resolved, will benefit everyone.

But somehow getting many actors to accept a greater burden when all really want a lesser burden is a very demanding challenge. The one force that will push them to agree is the fear that if they do not act, virtually all will pay even more. The cost will not only be higher than what an agreement might bring but also more than they can afford to leave to chance. There is no question that those with resources will be asked to contribute more while those with few resources (for example, some of the neighborhood clinics) will be able to do less without additional money from others.

The situation of today is not a crisis for the hospitals and the health care systems. Perhaps it will never be, given that the health care systems can cross-subsidize the city hospitals which are losing money serving the uninsured with surplus revenues from suburban hospitals and clinics that are making money. Even a cursory look at the financials (Table 5) indicates that these health systems, even with their different accounting methods, have some room before they are financially strapped.

TABLE 5 **Net Hospital Income for Southeastern Wisconsin Hospital Systems, 1996+1997**

<u>Health Care System</u>	<u>1996+1997 Net Income (\$ million)</u>
Aurora	32.9
Covenant	25.4
Horizon	84.1

That is not to say that the health systems and the individual hospitals will not start screaming, should serving the uninsured become much more expensive for them than they are today. Health care providers are businesses. They may be termed “non-profits,” but they operate on business principles. They can only bleed so long before they must take action. The most obvious actions are to reduce the costs of treating the uninsured or to increase the revenues received for treating them. A third option is to make more money on their paying patients and subsidize the treatment of the uninsured. Health systems are looking in these directions at this moment. And the answer for the systems in the last couple of years has been to make more money on paying customers, using any surplus to help offset the increased costs of serving the uninsured. The net incomes of all three systems have increased. The same cannot be said for all of the individual hospitals, but the larger systems have become healthier. For the most part, the health care systems have been successful with the tactic of finding more paying customers. They have also been aided by the redirection of the uninsured to clinics for the delivery of health care.

Can these health care systems continue to find more paying patients? Perhaps. But the trend in health is to promote outpatient treatment, not hospital utilization. If paying patients do use the hospitals, they do so for shorter and shorter stays. Furthermore, the HMOs and managed care organizations that steer patients to hospitals and clin-

ics are making every effort to reduce the prices they pay to the health care providers. Sinai Hospital lost money in 1997 because it lost two large managed care contracts. It lost those paying patients. The loss may have been due to service, but it also involved charge rates: other hospitals were willing to serve the patients for lower rates. With less “profit” per patient served, given the price pressures on providers, it is likely the financial solution of serving more and more paying patients is not a very viable strategy for increasing net revenues. It may succeed to some degree, but the pricing pressure will limit the rewards.

What can we do to make the health care system work better for a greater percentage of the population? It is to that question we now turn.

The Status Quo or Do Nothing Option

One obvious option is to leave things as they are and see what happens. We do not yet know enough about W-2 and the emphasis on work to really know what number of additional individuals are truly without medical insurance. Perhaps the number of unserved is overstated, and even more persons will be covered with the implementation of BadgerCare. Besides there are a number of individuals who remain basically healthy without visits to doctors or hospitals. Furthermore, hospitals are not publicly writhing in pain, although some signs of pain do appear on the balance sheets. Most of the clinics are still functioning reasonably and serving most of the population that presents itself for health care. There is not a public, health-care crisis, except for a clinic or two. The system may need some readjustment, but not a big fix. Making very minimal changes is one option that is open.

But if one looks at the messages that are coming from the clinics, this option is not likely to work for very long. If one clinic closes due to financial exigencies, then that burden will fall on the others. Since few of the clinics have the resources to serve additional indigent patients, such patients will likely be refused. That is beginning to happen today, as clinics are making explicit decisions to limit the number of non-paying clients they are willing to see. These patients will then seek care elsewhere, either at the remaining clinics or the hospitals, putting greater strain on all of them. Or they will not receive medical attention, possibly leading to various public health crises. Neither scenario is particularly attractive. Cut-backs at clinics have little appeal. Closing of emergency rooms has little appeal. Public health crises have no appeal. These potential conditions suggest that alternatives to the status quo need to be explored. We may have a little time to work out a solution. But if we do not find an acceptable alternative to the present, we can be pretty sure that an access crisis will develop, and that several health care institutions will either close or greatly reduce the scale of their operations. The true losers will be the uninsured. But the whole community will suffer, and some health care workers will lose their jobs.

This scenario then suggests that other options for the health care systems must be explored further, if major problems are to be avoided. These options include: 1) reducing the level of health care service provided to the uninsured, 2) reducing the number of uninsured, 3) increasing the health of the uninsured, thereby decreasing their health-care needs, or 4) generating new revenues to serve the uninsured. Each requires further exploration.

Reducing Services

This is an option on paper only, unless there are alternative means to provide health care services for the uninsured. If the clinics are underfunded, as they are, they are not an option for serving more of the uninsured. The result, unless someone else steps up to share the burden, is that either the hospitals accept the burden or they push the uninsured to the street, an option that will not long be viable. Our society will not accept people dying on the street. Our current approach, while perhaps not ideal, at least provides some access for virtually all individuals to health care. If the minimum access of today is eroded any further, the outcry and health results will create pressure for society and its health care providers to do more. Thus, the reduced services approach will not work for very long. Dismissed though the uninsured may be today, it is very unlikely that they will be allowed to die without some medical attention.

Decrease the Number of Uninsured

This is an option with many components. One component that is being used today is to spend money on persons who can help to qualify low-income individuals for Medicaid and any other health insurance programs for which they may be qualified. This is a no brainer. We know that there are thousands of individuals who used to be on Medicaid but who are not currently. Some of them, perhaps most of them, are still eligible.

Another way to decrease the number of uninsured is to require more employers to provide health insurance, especially fully or nearly fully, employer-paid, health insurance. This will place a competitive burden on employers in the state. But a healthier work force is a more productive work force. An alternative that is not as effective at getting

Some portion of the decline in the number of Medicaid recipients in Wisconsin is likely due to the out migration of former AFDC recipients.

individuals insured is to raise the state's minimum wage rate. To the degree that workers have higher incomes, they will be more able to afford health insurance. But since they might not be required to pay for such insurance, the additional earnings may be spent elsewhere, doing little to reduce the number of uninsured. To solve this quandary, the state could require participation in health insurance programs at work whenever they are offered. Any requirements for insurance provision or participation will, however, not be well received. Employers and employees will both object to the cost. The opposition to such requirements, especially in light of the continuing escalation in the cost of health insurance, suggests that this option is not likely to prove acceptable.

Still other ways to decrease the number of uninsured exist. One is to maintain strict rules for participation in W-2. If these appear onerous, more onerous than those found in other states, then the pool of uninsured is likely to be decreased by

out migration. This approach may be having an effect already. Some portion of the decline in the number of Medicaid recipients in Wisconsin is likely due to the out migration of former AFDC recipients. (Anecdotal information from the City of Milwaukee's garbage collectors indicates a higher than usual number of move-outs, empty apartments, and one-time piles of trash in 1998, following the full commitment to W-2). The scale of the out migration is not easy to estimate. A report to soon be issued by Maximus, a W-2 provider in Milwaukee, is supposed to reveal just how important this factor has been in affecting the number of participants in W-2 and Medicaid. Even if out migration is a factor, its net effect is not likely to be very large.

A related option is to work with Congress to further expand federal dollars flowing to the state to serve the medically indigent. Tom Hefty, CEO of United Wisconsin Services, the Blue Cross-Blue Shield of Wisconsin company, has urged the state and county to seek federal money.²⁴ The current pots available may not be very large. But any money received will help to reduce the expected burden that other health organizations will have to bear.

Increase General Health

An alternative way to diminish the impact of the uninsured on the health care providers is to improve the general health of the uninsured. If this can be done, then the uninsured will make both fewer and less expensive demands on health care providers. Health care systems know this and are already involved. The door-to-door program for expectant mothers, the MPS clinics, the parish nurse program, all operated by Aurora, are good examples of steps that can be taken to reduce the need for expensive health care. The City of Milwaukee's three health centers, its TB and STD clinics, its mobile mammography, and its lead poisoning follow-up are also good examples.²⁵ The expansion of these programs makes a great deal of sense, as does the creation of other early intervention programs that reach the higher risk populations in the community. Just how these would be funded would have to be worked out. But the cost to fund these efforts is far less than the cost of providing the needed health care to those who were not helped early.

As far as Wisconsin is concerned, the best source of funding is the federal government because less of each dollar comes directly from Wisconsin. Prevention and early intervention are the keys to lower cost health care. If federal dollars could be received for such expenditures, the state would benefit. But the federal government must be persuaded that it should spend additional dollars in these areas. Clinton's new proposal for the year 2000 and beyond is a step in this direction in that it is promoting early and continued intervention. But the dollar sum is small, and the focus is on those with health problems, not the prevention of health problems. To the degree that promoting healthier living can become part of a funded effort, the greater the reduction in need for health care. The federal government to date has, however, elected not to fund efforts that aim explicitly at changing unhealthy lifestyles.

Workplace wellness programs are another longer term approach that could greatly reduce the uninsured's medical needs. The five leading causes of death in the United States — heart disease, cancer, stroke, accidents, and

lung disease — are all related to negative lifestyles. If Americans could be convinced to live the life we know through research to lead to much better health, the nation's \$250 billion health bill for these five killers could be reduced by 70%. That would markedly lower the pressure on health care providers, be it for the insured or uninsured.²⁶ The question is how to reach the public to convince them that they should live their lives differently. It is clear just by looking at our own co-workers that the message on healthy living has not gotten through to a large number of individuals. But it is through work that the message is most likely to be learned.

Employees spend about one third of their waking lives at work. Furthermore, there are financial incentives to live more healthy lifestyles available for both the employers and the employees. Employers can realize lower health, disability, and workman's compensation insurance premiums from a healthier staff. Employees are likely to be more productive, more often present, and have higher morale, thus helping the bottom line in several ways. "A healthy work force is a competitive advantage for employers. People who have health concerns are not going to perform well on the job, just as equipment will not function well if it is not maintained."²⁷ Employees are likely to feel better, more energized, and more positive. And they too may realize lower insurance premiums and co-payment requirements. With such incentives it is little wonder that wellness programs at the workplace are proliferating. But the pace of adoption of these programs by employers is much too slow to have any but a minimal effect on the uninsured unless a dramatic effort is made to expand these efforts.

Furthermore, the uninsured are probably the least likely population to be employed by business that have the foresight to create wellness programs. The uninsured are likely to be working for lower-wage operations that are trying to cut corners. They do not provide insurance or provide only the most minimal at high cost. The challenge is then to provide a mechanism of getting such employers to be involved in health issues, either through better and more encompassing health insurance for the employees or through wellness programs for these same employees. The wellness programs are less expensive, require more time for benefits to occur, are voluntary, and do not guarantee success. But even they would be a welcomed addition to the mix of efforts required to reduce the costs and burdens of providing health care to the currently uninsured.

Generating New Revenues to Serve the Uninsured

To health care providers the most appealing option is to be paid to serve a larger population. The greater their revenue stream, the more the health systems are able to earn, the more they can pay staff, the more they can invest in equipment and technology, the better the service they can provide, and so forth. Generating additional revenue has more appeal, especially if it is greater than the costs of serving the uninsured. But the big question is what is the source of those payments. That is where the discussion of alternative revenue sources arises. If the answer is that the health care systems must generate the money within, accepting some level of charity care, say 3% of Gross Patient Revenues, they will likely be limited as well as extremely unenthusiastic. If it is outside, then it likely involves some form of taxation. The question, as noted above, is which is most acceptable. This cannot be answered at this time, but it is a question that must be answered soon, if the uninsured are to be provided greater access to health care.

A related question is how are these dollars to be distributed to the providers? The reconstructed GAMP program designers decided that they could not provide true health insurance for the low-income uninsured; they substituted limited-access managed care. Health insurance was deemed to be too expensive. The GAMP approach may be too cheap, but it can and is likely to be modified to increase payments to providers. The GAMP approach also attempts to steer the uninsured away from the health care systems. This technique also has appeal because the clinics provide less expensive treatment and primary care treatment, both of which can reduce costs to the health systems. The GAMP approach appears to be a good model for an expanded effort to serve the uninsured. The GAMP program is still in its infancy, however, and more must be learned before greater commitment is made to it. But the promise is there.

ASSESSMENT OF OPTIONS

If we reject as options maintaining the status quo and doing even less for the medically uninsured because such options are unacceptable, something else must be done to better serve the medically uninsured, to avoid scandal, and to meet what are thought to be basic human needs. That leaves us with two general options: either we decrease the needs of the uninsured or we increase the resources committed to the uninsured. Actually, most ways of decreasing the needs of the uninsured also require additional resources. One option that does not is that of scaring

the medically uninsured away from Wisconsin. If we ignore that option, then the question is from whom do the additional resources come to address the needs of the uninsured? Should they come from employers in terms of health insurance availability and cost or from other sources?

Expanded Employer Insurance Provision

The trend in the US is toward less health insurance coverage and less complete coverage provided by employer health insurance. The number of uninsured nationally has grown in recent years to about 43 million persons.²⁸ The characteristics of today's insurance plans have changed as well to make the coverage more expensive and less complete. Health insurance costs rose 6% in 1998 and are projected to rise another 9% in 1999, far faster than worker earnings. Because of the added cost of health insurance to both employers and employees, some of the employers and employees are refusing to make the financial commitment. Some employers are marginal and lack the financial resources to provide the employer portion of health insurance. Many of the employees of these marginal

The more complete and more likely answer involves more resources from other sources being spent on health care.

employers would not elect health insurance were it to be offered because their earnings are not sufficient to meet other basic needs, much less pay for health insurance premiums. Both of these are reasons why attempting to ask employers to do more for their employees in terms of health insurance is not likely to get very far. Another reason is that if a state law were to demand that these employers provide health insurance, a portion of them would fold because they would not be able to pass on the costs in their competitive markets. The result would then be fewer employees being covered than might be expected.

Thus, a legislative requirement for more encompassing employer health insurance may, at least, be able to cover a small portion of the uninsured. But it might eliminate coverage for others. And it would still miss many persons. Some would be missed because they do not work. Some work for such short time periods that they would not qualify for any plan. Others would work for such marginal employers that despite legisla-

tion, health insurance would not be provided. And certainly for some, the cost and co-payment requirements would be prohibitively high for the employees. The requiring of health insurance from more employers would likely go part of the way to reducing the health care burden on others, but it would likely be a small part. And employers would scream loudly against it, suggesting it might have limited political appeal.

This option may, if costs can be controlled and political support generated, be able to serve a limited portion of the uninsured. But it is not the complete answer, and it is not a very likely answer. The more complete and more likely answer involves more resources from other sources being spent on health care.

Generate Additional Resources

The cost of funding a true health insurance program for all of the uninsured in Milwaukee County is a sizable figure. It is estimated to be \$225 million, assuming each patient can be served for \$1,500 per year.²⁹ That is an unrealistic sum to think it can all be raised locally, much less in the state. But it may be possible to create a health care program, one that relies on primary care, most likely through existing and yet-to-be established clinics, that might be affordable. Since there is some proof that GAMP is working to serve the truly indigent who do not otherwise qualify for health care programs, it may be possible to expand on this model. The most likely way would be to raise the income limits of those persons to be served, if additional funding could be found for the program.

There are theoretically a large number of options for paying for the services to the medically uninsured. Several of these are theoretical only: there is no practical way to implement them. But all should at least be mentioned, if not explored, to give the reader a more thorough understanding of the rationale for choosing any of the options mentioned. Listed below are some of the more prominent options that might be chosen, were more resources to go to serving the medically uninsured. These approaches can be used separately or in combination with others. It is unlikely that any one will be sufficient by itself. In fact, it is unlikely that any combination will truly solve all of the problem. But utilizing one or more of these to a greater degree than today may well not only better meet the needs of the uninsured, that utilization is likely to keep the health care system functioning.

The list that follows is not inclusive. But it does contain the major options at this time for attempting to answer the question of who should pay for expanded health care coverage for the medically uninsured.

1. Requiring fully- or partially-paid medical insurance from all employers.
2. Local property tax increases.
3. Local sales tax add-on to pay for medical-care access.
4. Universal medical insurance, paid for by income tax revenue, federal or state.
5. Increased liquor or cigarette tax, with the additional revenue being funneled to health care.
6. Use of “Big Tobacco” settlement funds.
7. Tax (fair-share burden) assessed to all health care providers or a subset (e.g., large health systems).
8. Combination of sources, none too large, but all relying on a form of increased financial commitment.

It is often hard to separate how we pay from how we deliver health care services. If we say we are asking for a “fair share” from the health care systems, we are assuming care provision by these organizations. If we are talking medical insurance from employers, we are implying that there will be a range of providers, chosen by those seeking care. If we are talking sales tax revenue, we are probably implying a GAMP-like program, a managed-care program with a primary-care, clinic-based approach or some other minimal care option that is organized to provide the basics. The focus here is on who pays, not on who delivers. Who delivers may be answered in part by the choice of who pays and in part by how many additional dollars are steered to health care for the uninsured.

The first two options on the list above have already been discussed. They could contribute modestly, at best, if implemented. And they do not garner much political support at this point in time. What follows below are elaborations on the other alternatives.

Sales Tax

One suggested option is to address the revenue needs by expanding the local sales tax, just as was done to pay for the baseball stadium. To most persons, the stadium tax is not noticeable. Some may object on principle, but it does not often affect their purchase decisions. In 1997, the .1% sales tax increment, applied in five counties, raised \$17.9 million. It is unrealistic to expect Racine County to contribute to the Milwaukee medical insurance problem. If we count just the four county Milwaukee metropolitan area, then the tax generated some \$16.2 million. Given that minimal regional cooperation exists on any issue, sharing revenue from four counties for Milwaukee’s indigent will be a very difficult negotiation. If it comes down to just Milwaukee County, the .1% sales tax generated \$9.7 million in 1997.

To replace Milwaukee County’s current property tax contribution would require more than twice that or a .24% sales tax increment. If the intention were to expand the coverage of the uninsured, this would have to be increased even further. If it increased to .4%, applied to only Milwaukee County, it would generate \$39 million annually, assuming current purchase patterns (Table 6). (That assumption is probably not a good one, since purchase patterns would likely shift modestly away from Milwaukee county.)

The sales tax increase could help reduce the scale of the revenue problem, but it is unlikely to solve it by itself. If GAMP can serve approximately 18,000 individuals annually with a budget of about \$36 million and if service providers are complaining they cannot continue to serve GAMP patients when clinics are paid only \$.39 for every dollar billed for services provided, it is clear that even a .4% increase in the sales tax will not solve the problem. It would certainly help, but without a state match, the dollars generated would only serve some 15,156 persons, even fewer than today. The key to expanded coverage is the role the state would play in matching the local contribution, regardless of whether the local contribution is sales or property tax revenue.

If the state government matched the sales tax revenue increase and we assume the County continues to provide \$23 million in property tax revenues for GAMP, the moneys could go further. But even then, the number served, assuming the same average cost of \$2,000 to serve each person, the total of an additional \$78 million would serve another 39,000 individuals, bringing the total to 57,000 persons served. This is a large improvement. But with at least 115,000 uninsured individuals in Milwaukee County, taking away the 18,000 served by GAMP currently and an additional 12,800 served by BadgerCare, still leaves us with at least 55,200 persons uninsured. And that assumes that the additional tax could be legislatively accepted and the property tax increment maintained.

TABLE 6 **Number of Persons Served by GAMP Under Varying Sales Tax/Match Assumptions for Milwaukee County**

<u>Sales Tax Increment</u>	<u>.2%</u>	<u>.4%</u>	<u>.2%</u>	<u>.4%</u>
Sales Tax Revenue (\$ mil)	19.4	38.8	19.4	38.8
GAMP Payment Level	<u>\$.39 per \$1 billed</u>		<u>\$.50 per \$1 billed*</u>	
Persons served without state matching funds	9,700	19,400	7,578	15,156
Persons served with state matching funds	19,400	38,800	15,156	30,312

**Assumed new payment rate; none has been chosen as of yet.*

If Milwaukee County elects to stop spending property tax revenue on health care and rely instead on just sales tax revenues, these dollars do not go nearly as far. The 18,000 served by GAMP today would have to be covered before any expansion in service occurred. That could mean that the number remaining uninsured could be between 73,200 and 92,600 persons, depending on the sales tax revenues generated.

One point these calculations make is that the cost to address the medically uninsured is substantial. We are talking \$114 million annually to serve 57,000 of the uninsured, at the current GAMP payment levels. But the current payment levels are not working well. The health clinics are complaining that they cannot survive on current payment levels. The GAMP approach to pay but \$.39 on each dollar of medical service billed is starving the system and must be changed. Providers must be paid a higher percentage of cost or they will not be able to provide services. Thus, the crude estimates of the number of individuals who might be served by an expansion of the system needs to be reduced. If the payments must rise to say \$.50 on the dollar, that would decrease the number of individuals who might be served by 22%. Thus, instead of serving 57,000, for example, the program could only serve 44,500 persons. If a greater proportion of the uninsured is to be served, the dollar cost will be even higher.

It is certainly possible that the marginal cost of serving additional patients under an expanded GAMP program could be lower than the current costs. It is likely that the patients most in need of medical attention are presenting themselves for service at this time. Those who come later are likely to not be in need of as many or as expensive health services. But for purposes of estimation, the assumption is reasonable, especially since providers lose money on every patient they serve at \$.50 on a dollar billed.

Another point that must be made is that the size of the dollar commitment needed to further address the medically uninsured will make any solution politically challenging. Within Milwaukee County the support for even the current level of commitment to health care, \$23 million, is eroding. If a non-property-tax source of funds is found, the property-tax commitment may be maintained, but it is certainly not likely to increase.

The state level is harder to predict at this juncture. The issue of the medically uninsured is commonly seen in the legislature as a "Milwaukee issue," one that the rest of the state is not excited about collectively solving. Thus, the options for additional funding may well be limited. The state currently has a revenue surplus; it is committed to helping W-2 work, an ingredient of which is viable health care access; and it has matched Milwaukee County to date on the GAMP expenditures and is increasing its health expenditures statewide because of BadgerCare. If the County were to increase its dollar commitment because of a new revenue source, would the state match it? That is not easily answered, especially in the abstract. Should the County get past step one, the increased funding, then an answer to step two, the match, could be more easily predicted. It is likely that both steps would be negotiated together. But neither is especially likely at this juncture, given the absence of outcries of system failure or widespread public health problems.

Third, even with a large increase in funds available, were the sales tax increment to be approved and were the state to increase its matching contribution to medical care, the dollar amount will fall short of meeting the total

need. Thus, additional steps would have to be taken to fully address the problem. One element would be continued reliance on the current health care providers to provide charity care. It could involve requiring greater health insurance coverage by employers, be it more employees covered, part-time workers, for example, or it could mean lower co-pays and contributions by employees, making insurance less expensive to employees. It could require employees to elect medical insurance and to have to contribute some money toward it. These are options, all of which have some limitations and liabilities that would have to be weighed before they were adopted. The issue is the degree to which there is a political will to more fully address the problem. If the will is not there, the pressure from the health care system to address the burden of the uninsured will force the medical system actors to attempt to address it by themselves. In fact, some of the actors recommend this themselves, but with an assumption that the County and state will continue to fund the GAMP program at least at its current level.

Income Tax

If a sales tax could not be made politically acceptable or if what is acceptable is not sufficient to cover the costs of providing access to health care for the medically uninsured, another option is to use alternative forms of taxation. The largest single source is the income tax. This is currently collected at both the state and federal levels. Both sources are now used to some degree to address the problems of the medically indigent. The federal government provides assistance through Medicaid, Medicare, SSI, the Veterans Administration, moneys for inner city clinics, and so forth. The State of Wisconsin provides assistance to the county, matching the county money for GAMP. It subsidizes medical education. It supports a significant portion of BadgerCare costs. This financial support is largely achieved through income tax revenues.

Could more come from these sources? Possibly, it could. President Clinton is making one of his priorities for this year the expansion of the federal role in providing health care coverage to the medically uninsured. His proposal, just announced, is to work with existing providers to attempt to provide continuity to the coverage of the uninsured. He is proposing the expenditure of one billion additional tax dollars on grants to 100 communities in which community clinics and hospitals would collaborate to track patients and see that they receive the treatment they need.³⁰ It is not health insurance, and it only attempts to strengthen the health care system. But if it works as intended, it would help to get people treated before they let health problems get too expensive. But even this initiative is not the answer. It would help reduce the unpaid demands placed on health care providers, but the scale is much too small.

Alcohol and Cigarette Tax and "Big Tobacco" Settlement

If sufficient additional revenues cannot be raised from the income tax or a sales tax, then what other sources are possible? The common response is the "sin" tax, increased taxation on both cigarettes and alcohol. It is appropriate that these two primary contributors to health care needs be asked to pay a greater share of the burden, since they are a major source of health problems. But these commodities are already heavily taxed. Can the taxes be raised further? If so, how much money can be raised? And would the tax have any additional benefits that might come from forcing a reduction in consumption?

There is evidence from Canada that cigarette consumption dropped dramatically when a large increase in the cigarette tax was instituted. Over time that should contribute to a healthier population. The same is likely to happen to alcohol, should a significant increase in price occur. But it is extremely difficult to obtain political approval for the same scale of increase in alcohol taxes. More and more medical studies are showing that alcohol used in moderation has medical benefits. It is at least as clear, though, that alcohol used immoderately is very costly in terms of health. But the message on the latter is not as favorably accepted as that of the potential benefits. Furthermore, in a state that has had a long tradition of brewing, distributing, and consuming alcoholic beverages, the political will to make this product more expensive is not strong.

If active negotiations were to occur in search of additional funds for medical care, sin taxes would be put on the table. It is impossible at this juncture to estimate just how much additional tax money could be raised. But without a concerted effort to paint alcohol as a major contributor to the medical problems, it would be very unlikely that this would be a source for more than very limited funds. Cigarettes are likely to be less resistant to additional tax increases, especially if Philip Morris sells Miller Brewing. But vendors will complain that additional taxes will make them less competitive, etc. and revenue gains from additional taxation will, therefore, be limited.

A strong case can be made, however, that some of the tobacco settlement money should be allocated to indigent health care. Such support would certainly help. But with the settlement so recent, allocation of those dollars has yet to be made. Those who think that the state should contribute more to indigent health care can make a compelling argument that this money is truly health care money and that its use in preventive and early care will help to reduce future state expenditure on Medicare as well as uninsured patients. In other states, such as New York, that will receive Big Tobacco settlement money, a new bi-partisan coalition is building to use a portion of the settlement annually to assist the medically uninsured.³¹ Furthermore, some of the settlement dollars will replace dollars the state previously had to spend on the health care for the elderly under Medicare and could now go into expanded indigent health care. It could even help support BadgerCare. This is politically more likely than using new tax revenue, but the scale of support is difficult to estimate. No doubt there is additional pressure to return the tax moneys to the tax payers.

Tax on Health Care Systems

This option does not necessarily mean that new resources are brought into the health care system, as is implied in the preceding proposals. It means that the largest providers today would have to donate more services to the medically indigent. This option involves creating a standard accounting procedure and definition of charity care for all health care systems and then assessing each some minimal level of service to the medically uninsured. Since the rate of uninsured in Wisconsin is lower than elsewhere and since the percentage of Gross Patient Revenues (GPRs) that goes to charity care is much lower here than the 6% average nationally, a lower commitment is defensible. If a target of 3% were to be established, this would mean that 3% or just under \$57 million of charity care (using 1997 revenue figures) would have to be provided by the largest five hospitals alone in Milwaukee. That is about \$28 million more than they contributed in 1997 and \$22 million higher than they contributed in 1998. If system-wide GPRs were to be used, the contribution would be even higher.

Painful though the health care systems may find this heightened level of charity care, the increase in dollars contributed is not much greater than the proportionate increase in dollars (\$18.2 million) that will be injected into the county with the implementation of BadgerCare in its first year. Furthermore, a 3% contribution is not out of line with uncollectables in other consumer businesses. Ideally, new funds could be brought into the system. But with GPRs increasing and more investment in the health systems occurring, a base commitment to charity care seems manageable internally and helpful externally to procure greater resource commitment from others. The alternative may be eating all of the increased costs of charity care, should the current approach to the uninsured fail. That option should have little appeal to the health care systems.

The Fall Back Position

If no additional outside resources are made available to address the medically uninsured, changes will have to be made or numerous health-care institutions will be forced to cut back on their service to all patients, not just the uninsured. The challenge will then be to organize the major health care providers to get them to see through the individual pain and institute a communal system that forces each to contribute certain resources to the system on some proportional basis. The details of such a system would take a concerted effort to work out, much less get accepted. But the medically uninsured problem will not go away. Someone must pay. It is in everyone's best interest to create a method of addressing the issue that will not stress and kill health-care providers. The big question is how this might be done.

Several, long-time health care officials suggested in interviews that the county government must play an organizing role. But to succeed, most, if not every, health care provider must be committed. If the burden falls increasingly to a few, it will crush them; the financial impact is just too large. The question, then, is how can an agreement be reached as to the relative role of the many actors? How can each be made to see the wisdom in acting collectively to share the burden?

The house of cards or the domino theory both come to mind. If the neighborhood clinics diminish in size or number, more of the uninsured and a sicker population of the uninsured will present at the hospitals. Those geographically closest to the population will suffer first. But if the institutions start to refuse service or close the emergency rooms, the burden will shift to those less affected to date by calls for charity care. This will challenge even their fatter bottom lines. The hospitals will, in turn, attempt to pass the costs on to their paying customers, the insured patients. They and their insurers will certainly object. The employers who are contributing to the health insurance of

their employees will object. The search will go on, attempting to answer the question of who will pay. Someone must. If it is to be answered with rational analysis and decisions, then it must be approached that way. The actors cannot afford to just let the pain fall where it may. Many will lose, perhaps even their institutional lives, with a reactive, as opposed to a proactive, approach.

At this juncture Milwaukee County health staff has been moving in the direction of some shared, communal action on the uninsured. The initial step was the establishment of the GAMP program. Along with GAMP has come an effort to address the larger issues of serving the uninsured and payment for such services. A committee of individuals representing many parts of the health care community (the Health Care Policy Task Force) meets regularly to discuss new developments in GAMP and possible future directions that might be taken.

This committee seems to be a natural for additional responsibility. Committee members have had vigorous debates on possible funding sources and coverage issues. They are aware of each others' concerns. They could, if charged, work to develop an expanded program of coverage along with possibly-acceptable means of paying for the expanded coverage. The debate would be animated. But the more each committee member felt threatened by the possible outcomes that might occur without a negotiated agreement, the more likely each would be willing to give a little to get a little from an expanded agreement. The Health Care Policy Task Force must assume the larger role, if outside sources of funding are not secured. The hope is that the federal and state governments can be tapped to a greater degree, so as not to unnecessarily burden the community. But if this cannot happen, then the local actors must get together and reach a mutually acceptable agreement as to the extent of coverage and the sources of payment within the local community.

The Hooks

Finding an acceptable, proactive means of addressing this issue is a large challenge. If a simple, inclusive approach can be found, such as a large enough revenue source, then it would be a relatively simple assignment. The subsequent challenge would be to spend the money wisely. If the simple revenue source cannot be found, then the negotiated settlement appears to be the next best approach. Someone will have to step forward and generate enough reasons to get the many actors to come to the table and truly commit to an approach that will serve the indigent population without unduly burdening any providers or others involved in the system. There may be models of this elsewhere, but they have not been unearthed as of yet.

Neighborhood Clinics

The neighborhood clinics will likely be the first at the negotiating table because they are feeling the most pain at this juncture. There is little more they can do without additional resources or without additional relief from serving those who cannot pay. The clinics would like to continue to serve their neighbors, but they must have additional resources to do so. Their preventive care approach makes sense. They just need the resources to practice this on a larger population.

Health Care Systems

These systems should step to the table for a number of reasons. For one, they are experiencing a growing dollar amount committed to charity care. If there is some way to stem this, they would be delighted. Second, they realize that if the clinics become less able to serve the uninsured and partially covered, these client groups will increasingly appear on their doorsteps, making even greater financial demands on the health care systems. Third, if they do not participate in finding a solution, an even more unacceptable solution, such as a "fair share plan" among only the health care systems, might be developed by the other actors. Fourth, the health care systems are already involved in some of the programs that are aimed at prevention and early intervention in the community and know that it would be wise to build on that experience. Fifth, a look at their bottom lines reveals an ability to absorb some additional expenditures without threatening their survival. Others see the health systems earnings and wonder why they are not doing more for the uninsured. The public relations image alone demands that they be at the table and likely that they do more than they currently are. Sixth, they have power collectively to force solutions that are more acceptable to themselves.

Milwaukee County

The County will come to the table for a number of reasons. One is that they have a long history of involvement in health care for the indigent. There are several individuals who work for the County who do not want to see this tradition extinguished. Second, they are leading the one large local government effort to serve the most disadvantaged (GAMP). They are learning valuable lessons as they go and want to continue to apply them. Third, the County does not want to be saddled with additional health expenditures, if it can avoid them. There is a good deal of pressure within the Board of Supervisors to reduce the property tax commitment to health care. If the County is to be involved, it must be involved on its own terms, that means it must be involved in the discussions on what is to be done next. Fourth, the County must be involved if higher levels of government are to be involved. The County is the largest conduit for the state and federal health-care dollars that come into the county. Fifth, county supervisors will hear an increasing number of screams from constituents if the health system becomes less responsive to their needs. And sixth, if the County withdraws completely from medical assistance, it is hard to imagine how private providers could justify investments in low-income neighborhoods. The County is leveraging its funds, paying almost enough to keep clinics alive. Aurora and others are involved, in part, because they have faith that others will be there. If the County withdraws, the health care systems would also have justification to withdraw: they would be overwhelmed. The proverbial house of cards could fall and with it health care for the indigent.

City of Milwaukee

The City will become involved in negotiations for several reasons. The largest is that it wants to avoid any expectation that it will commit any more resources to health care. The Mayor is on a nine-year crusade to continuously reduce the City's property tax rate. He has been successful to date, using a variety of techniques. But if demands are made for more public involvement, especially City involvement, the City must be there to refuse, unless it involves outside dollars. The City has health staff who have been serving the uninsured and indigent in many capacities. These could be strengthened, but not with internal funds. The City may be eligible for additional state and federal dollars, and it should be at the table to be ready to act to qualify for those funds. Furthermore, the City would like to be in a position to avoid negative publicity, should more uninsured appear.

The State of Wisconsin

On first blush one might assume the state is not interested in being involved in health care. The basic tenor of the state is that it is pushing for less government involvement in its residents' lives. But that first impression is not an accurate one with regard to health care for lower income individuals. The Governor has a great deal invested in welfare reform. The state has created and implemented two health care programs aimed at the W-2 participants and has just had a third approved (BadgerCare) for those individuals with earned incomes just above the W-2 levels. The Governor realizes that health care is an important element in allowing individuals to become self-sufficient. He wants very much to create a system that will work to end dependency.

State officials are also likely to be involved because they know the state is a conduit for available federal dollars. They need to be ready and able to respond to the availability of these dollars. That is more likely to happen if the state is already involved in efforts to deliver health services to the uninsured. The state is also on the ready to force others to pay for any initiatives that may come forward. The state recently was involved with the suit against Big Tobacco. It has been involved in the 1990s in health insurance reform for small businesses. It has regulated health insurance offerings. For all of these reasons it will want to continue to be involved in discussions of services to the medically uninsured.

Employers

To the degree to which they can get involved, employers will want a say if solutions to the problems created by the uninsured involve greater insurance commitments by employers. Whether the proposals are for more employers to offer insurance, employers to have to pay more for lower insurance costs for employees, or for employers to have to offer insurance to those who work fewer than 30 hours a week for half of the business weeks a firm operates in a year, the current requirement. Employer organizations will certainly step to the fore, if such proposals begin to surface as partial answers to the issue of reducing the problems of the uninsured.

RECOMMENDATIONS

There are many reasons for most of the actors mentioned above to step to the table and become actively involved in negotiating an improved way of serving the uninsured. The level of their interest will vary with the seriousness of the discussions. At this point in time, there does not appear to be sufficient pain being experienced by the medical care providers nor by the uninsured to move anyone but the clinics to serious discussions. But if the trend in reduced clinic ability to serve the uninsured (and even GAMP patients) continues to grow, as it seems to be doing, more providers, especially the health care systems, will become actively involved.

The smartest thing for the community to do, however, is to begin those discussions today, rather than waiting for disaster to strike. The GAMP advisory committee, formally known as the Health Care Policy Task Force (HCPTF), is the most logical vehicle, since it is already meeting, is representative of most providers, and is involved in broader health care delivery discussions beyond the existing GAMP program. This committee should assume it has a more comprehensive charge. It should call the providers together, develop alternative scenarios, and develop agreement as to who should and will take what steps if various scenarios develop. Planning at this time will mean that conditions should not deteriorate as far nor be as expensive to remedy if solutions are agreed upon for earlier interventions. Proactive, rather than reactive, actions will better serve the uninsured and the institutions involved.

As the county-initiated HCPTF meets, it and other providers should move forward in a number of directions. Among the most compelling are the following:

1. Increase the amount of money flowing into the health care system to serve the uninsured. The very recent approval of BadgerCare will bring some much needed funds into the system. It will also reduce the number of uninsured that will present for free health care services. But it is unlikely to have completely solved the resource issue. It is a welcome step, but the additional \$71 million to be spent statewide is still far short of the estimated \$225 million needed to serve all of the uninsured in Milwaukee County.

A number of other options for funding should be pursued in order to generate money to pay for: 1) the increased scale of GAMP payments, 2) an expanded number of persons to be covered by BadgerCare or GAMP, 3) the growing number of uninsured; and 4) the provision of additional support to the neighborhood clinics and the health care systems for additional outreach efforts in health care prevention and early intervention. The funding options include:

- Deriving an understanding of what is a useable definition of “charity care” for health care systems and procuring an agreement as to what are acceptable levels of charity care for the providers. A commitment of 3% of GPR is a reasonable start. If health care systems commit, then others can be expected to commit.
- Procuring a portion of the “Big Tobacco” settlement that the state is to receive.
- Instituting the sales tax increment of .1 - .4% in Milwaukee County to create an on-going revenue source for indigent health care.
- Modestly changing the minimum requirements for health care coverage offered by employers, so that it becomes more affordable, and therefore, more commonly elected by employees.
- Increasing the number of paying patients at the clinics who are supported by private insurance, Medicaid, Medicare, or any source of funds.
- Convincing the federal government to withdraw its declining reimbursement schedule for Medicaid patients at the Federally Qualified Health Centers and continue to reimburse them for 100% of cost for Medicaid patients served.
- Convincing the State of Wisconsin to reduce its Medicaid application to the 3 pages used in several other states from 20 pages used in Wisconsin to more easily qualify those who are eligible for Medicaid, utilizing federal and state rather than local health care dollars.

2. Increase the reimbursement rate to health care providers for serving GAMP patients, so that the clinics can continue to provide the initial contact for indigents seeking medical treatment.
3. Strive to make sure that BadgerCare works and serves at least as many individuals as initially intended.
4. Longer term, the HCPTF must work to develop additional interventions that will reduce the need for health care by increasing the scale of health care prevention programs and responses. Keeping people well is much less costly than repairing them once they become ill. One of the biggest areas for additional intervention is drug, alcohol, and tobacco use and abuse. More resources should be allocated to these areas.
5. Adjust the financial pain among health care providers so that it does not threaten the lives of any viable providers.
6. Continue to explore mechanisms to induce individuals with resources to use a portion of those resources toward health care.

This list is not specific as to the best mix of these steps. The recommendation does not spell out the detailed, individual steps that need to be taken. Those must be developed. But the list does give several alternatives that might be implemented to solve the question of who pays. If a number of sources of funds are used, then no one source should be overtaxed.

The ability to address the problem of the uninsured is at hand. The providers all have reasons to be involved in the solution. But the exact composition of the answer to the question must still be determined. Now is the time to formulate the response that best meets the needs of the uninsured, the health care providers, and the potential payers. Rather than wait for the crisis and some hastily formulated response, the providers should now negotiate a rational, acceptable approach that not only meets the needs of the uninsured and continues the viability of the health care providers but it should also reduce the number of uninsured and the degree of their need. The impetus for this agreement is the potential for failure that threatens many providers, if the size of the uninsured population remains too large.

Two questions are raised as we look at the issue of options; the first is how we pay. That has just been addressed. The second is how the necessary health care services should be delivered. The options include expanded health insurance coverage, clinics for specific income groups, expansion of current providers, and the addition of new providers, such as more neighborhood clinics or more public clinics.

Forms of health care delivery:

Traditional service providers: current mix
 Expanded neighborhood clinics
 More publicly operated clinics: City and County
 Private health insurance and client choices
 Options yet to be devised

How health care gets delivered is an important question to answer. But the question can not be answered without answering the one about how we will pay for it. If we have a larger sum of money, however generated, the delivery system could be organized in one fashion, most likely similar to the system that today serves those with full insurance. All clients would have choices as to when and where they would go for medical attention. The system would involve primary care for all, and trips to the ER only for true emergencies.

But if the funds are more limited, those with less money for medical treatment would face increasingly more limited options. What the mix of neighborhood clinics, public clinics, and hospital access would be would have to be determined. The answer would, no doubt, be in part based on the current experience of the efforts in Milwaukee. If GAMP proves to be successful for the 18,000 persons to which it is targeted, then it is likely to be expanded if additional resources are provided. If it is failing to meet certain needs, it would be altered to try to improve its track record. If a case can be made for additional capacity at public clinics, then they may be expanded. If more should be done through primary treatment programs, such as those the health systems are operating for target populations, then

these may well be expanded. If hospitals are willing and able to handle an increased uninsured population or are told to do so, then they will do so.

It is very difficult at this juncture to write a prescription for the best mix of health care providers under an expanded system for serving the uninsured without knowing the scale of resources to be available, the sources of those resources, and the success of the current experiments with serving the uninsured. Although all three questions require answers, the questions that need the most attention at the moment are those of the scale of resources to become available to assist the medically uninsured and the sources of those funds. If no more resources are available, the other questions are largely moot.

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