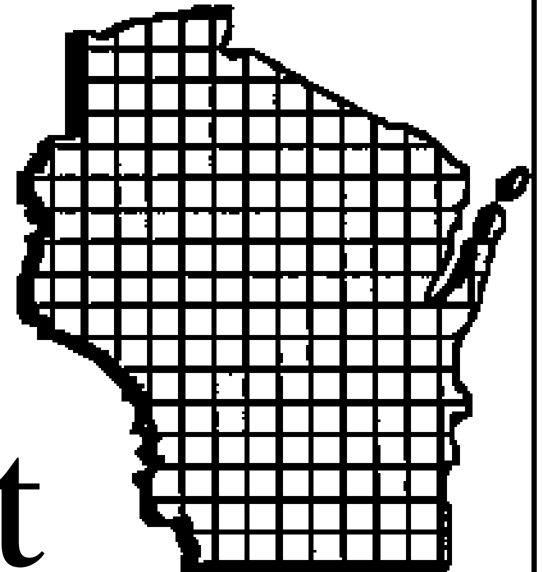
Wisconsin Policy Research Institute Report



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HEALTH INSURANCE IN WISCONSIN

A Survey of Public Opinion

REPORT FROM THE PRESIDENT:

As health care is being researched and debated across the country, we commissioned a study to examine issues involving health care and health care insurance in Wisconsin. Harris Interactive surveyed 1,000 Wisconsin residents to identify the types and origins of their health care insurance. Professor Sammis White, and other researchers familiar with the issues, analyzed the data at the University of Wisconsin-Milwaukee. The results are informative.

Over 51% of the adults in Wisconsin with health insurance receive their primary coverage through a government agency. To our knowledge this is the first time this kind of data has been examined in any state by any institution. There are enormous amounts of data in this in-depth study. Instead of just reporting the survey results, the author has tried to place them in the context of major issues facing Wisconsin, especially the rising health care costs, which are some of the highest in the country. People who receive government health care benefits usually have better coverage and spend less money than those in the private sector. While some of the results may be intuitive, this is the first time there has been hard data to clarify these issues.

One of the difficulties with the results is that there are no other states to compare our data with because no other state has tried to identify health care coverage as we have in Wisconsin. Later this year state government officials in Madison will debate the problem of health care costs. The data in this report will be extremely important because it demonstrates that Wisconsin residents with private health care insurance pay twice for health care coverage. First through their taxes they pay the insurance costs for public employees. Secondly they pay much higher premiums for their own insurance to cover the cost-shifting associated with low reimbursements to providers for government health care coverage.

The amount of data in this study may overwhelm some, but it is an academic study, not rhetoric from lobbyists, which actually gives hard data about health care in Wisconsin based on information obtained directly from the citizens of our state. It is a document that needs to be replicated not only in Wisconsin but also in other states across the country. It seems almost ludicrous to talk about reforming health care insurance at any level in this country without having a basic knowledge of the kinds of coverage that now exist.

Finally we would like to express our gratitude to The JM Foundation whose financial support for this project made this research possible.

James H. Miller

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SAMMIS WHITE, PH.D

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EXECUTIVE SUMMARY

Over 51% of the adults in Wisconsin with health insurance have their primary health insurance provided by the public sector either through various subsidy programs or through public employers. Furthermore, those with publicly provided insurance tend to have more complete coverage and less expensive coverage than those with privately provided insurance. These are important facts to know because these conditions contribute to the high health care costs in Wisconsin.

This study reports on a unique, new survey, conducted by Harris Interactive, of a random sample of 1,000 adults in Wisconsin undertaken to learn the sources and characteristics of their health insurance. What was learned for the first time was that the concentration of publicly provided insurance creates several reasons why health costs are higher in Wisconsin. These reasons include a heightened demand for health care services, a low incentive to curtail health care use, and easier access and lower costs to health care for those with publicly provided health insurance.

This groundbreaking survey sheds new light on the role of publicly provided health insurance in Wisconsin. Some of the highlights appear below.

- Wisconsin (88.3%) has greater health insurance coverage than the nation (84.5%), on average.
- About 28% of Wisconsin adults receive health insurance from one or more of the federally subsidized health insurance programs, such as Medicare, Medicaid, BadgerCare, and CHAMPUS (VA).
- Another 11% of Wisconsin adults receive health insurance only from a public employer or a related union, as a public employee, former employee, or family member. None of the 11% receives any federally subsidized insurance or private insurance concurrently.
- The remaining 6% of those publicly insured receive insurance from a public employer but also from a private employer or through private purchase insurance programs.
- Altogether 45% of Wisconsin adults receives some kind of publicly provided health insurance. These adults constitute more than 51% of the adults with insurance.
- Almost half (49%) of Wisconsin adults with health insurance are covered by more than one health insurance program.

These percentages have several implications for health care costs in Wisconsin.

- The high percentage insured means that more health care services will be demanded, raising their price.
- The 28% of adults with federal subsidies means that more than one quarter of the persons using health care services will yield their health care providers less than market rate reimbursement for services. The federal government pays less than $.80 for every $1 of medical expense billed under Medicaid and Medicare in Wisconsin. The large shortfall in payments to health care providers (well over $1 billion annually) is recaptured in part by higher charges to other users of the health care system.
- With just over 70% of the population not receiving these subsidies, the 70% not subsidized must share the burden of the unreimbursed costs. Therefore, the burden is greater for each and results in higher health care costs and higher health care insurance rates for all who must pay.
- Publicly provided insurance tends to be more generous in its coverage, and it contains fewer cost-sharing elements for users than the privately provided counterpart. To the degree to which this is true, it results in greater use of health care services and fewer incentives to live healthy lifestyles.

This last point on more generous coverage and lower cost was examined in detail. Respondents were asked numerous questions as to exactly how much they had to pay for insurance overall, how many ways they had to cost share to access health care services, and how expensive that cost sharing was for them. To undertake this analysis, the population was divided into two groups, those who only had some form of privately provided insurance (49%) and those who had any form of publicly provided insurance (51%).

- In terms of what the individuals had to pay in annual premiums for their insurance, the differences were not great. For example, 71% of those with privately provided insurance and 71% of those with publicly provided insurance reported paying $3,000 or less for health insurance premiums. However, among a smaller sub-group consisting of those with only public employer provided insurance, 79% claimed to be paying $3,000 or less. (The small difference between public and private has likely changed in the few months since the survey, as private employers have increasingly passed on more health insurance costs to employees.)

- What did differ was that fewer individuals with publicly provided coverage were subject to common methods designed to control utilization. These include out-of-pocket payments for co-pays and deductibles for drugs and doctor visits. Overall, those with publicly provided insurance tended to pay less. For example, 58% of those with any publicly provided insurance paid $500 or less out-of-pocket annually compared to just 41% of those with privately provided insurance. Furthermore, 81% of those with only public employer provided insurance paid $1,000 or less annually compared to 75% of all with publicly provided insurance and 63% of those with just private insurance.
- Additional costs were charged through annual deductibles for prescriptions, cost-sharing payments for each prescription, co-payments for visits to doctors, and the like. Those with publicly provided insurance paid these fees less often, and when they did pay, the fees were lower. Visits to doctors, for example, were fully covered for 52% of those with publicly provided insurance and by only 24% of those with privately provided insurance. Prescription costs were completely covered for 22% of those with publicly provided insurance but only 12% of those with privately provided insurance.
- Another aspect of coverage is ease of access to health care. Again, on average, 26% more respondents with privately provided than publicly provided insurance experienced any of five restrictions on access to health care. Thus, for example, 63% of those with private insurance versus 45% of those with public must use a doctor from a preset list.

The implications of these findings for health care costs are the following:

- Those with publicly provided insurance are less likely to modify their health-related behavior because they have fewer health care cost disincentives. Thus, those with publicly provided insurance are more likely to use health care services, since access is less costly and easier to arrange for them than it is for those with private insurance.
- Since those (51%) with publicly provided insurance are more likely to make demands on health care services, the costs of those services are likely to be driven up by the increased demand.
- This higher demand for health care services is further enlarged in Wisconsin because of the characteristics of the population here. It is both older and more obese than the rest of the U.S. These two conditions are strongly related to higher health care expenditures.

Respondents were asked to assess a commonly mentioned alternative means of providing health care, the Canadian approach. Under this plan, the government pays for all of the costs of health care out of taxes and negotiates directly with doctors and hospitals to set fees and the type of care they offer.

- This approach had appeal to 57% of those with privately provided insurance and 61% of those with publicly provided insurance.
- But when those who favored the plan were asked whether they would still support its use if they have to pay for the new program with their state taxes, many fewer favored its implementation: 41% of all adults with privately provided insurance and 44% with publicly provided insurance favored the Canadian plan.

Wisconsin health care cost increases are driven by four factors related to the high level of public provision of health insurance: 1) a substantial portion of the adult population with publicly provided insurance that provides limited incentives for policy holders to be wise consumers of health services or to live healthy lifestyles; 2) very low federal reimbursement rates to health care providers; 3) sizeable absolute underpayments from the federal government because of the over 28% of the adults with subsidized health care; and 4) a need to spread these underpayment costs among a reduced percentage of the adult population. This combination leads to increased health care costs in Wisconsin.

If Wisconsin is to begin to address these causes of higher health care costs, the state should make a concerted effort to gain a larger reimbursement from the federal government on Medicare and Medicaid services. Employers should be encouraged to choose health care insurance that includes proper incentives for individuals to live healthier lifestyles and use health care services more judiciously. Public employers should strive to bring publicly provided health insurance into better balance with that provided by private employers. And the state and its citizens should address the issue of obesity, an epidemic that is said will consume at least 20% of health care dollars for those persons 50 to 69 years of age by 2020 unless the extent of obesity is reduced (Rand 2004).

INTRODUCTION

Health insurance coverage, health insurance costs, and health care costs are at the top of the list of issues that currently concern Wisconsin employers (Economic Summit IV 2003). All three are intertwined. Since health care costs have been rising rapidly in Wisconsin in recent years, health insurance costs have been rising at least commensurately in an attempt to compensate, and health insurance coverage overall and the proportion of costs covered by insurance have been in decline. Changes in any one affects the other two. What sets Wisconsin apart from some other parts of the country have been the rates of increase in health care costs and the concurrent increases in health care insurance costs. "This [2004] marks the fourth year in a row that businesses are experiencing 20%-plus premium increases" (Manning 2004b). One result of these increases is that in 2003 health care insurance costs per employee in Wisconsin among large employers were said to be 20% higher than the U.S. average (Mercer 2003). The key question is why have these costs been rising so rapidly and becoming so much higher here than elsewhere?

Health care expenditures across the U.S. have been rising for decades. In recent years the growth has been pronounced. Per capita expenditures on health care for the U.S. were $4,675 in 2000 and $5,775 by 2003, a jump of nearly 24% (DHHS 2004). Several factors have contributed, including a sharp increase in the number of prescriptions per person, an increase in the cost of each prescription, an increase in the number of procedures performed per doctor visit, increases in doctor fees, especially in certain specialties, an increase in hospital utilization rates, and so forth. But these types of changes are found in many markets; they are not unique to Wisconsin. While contributing they do not explain why Wisconsin's health care costs have risen faster than the nation's.

Numerous explanations have been given as to why Wisconsin health care costs are higher than elsewhere. Among the many proposed are the following:

- Low federal reimbursements to health care providers serving Medicare and Medicaid clients
- An older Wisconsin population
- A Wisconsin population that is not as healthy as that found in other states
- A more highly paid set of doctors
- An overbuilt supply of health care facilities
- A high rate of health insurance provision by the public sector, be it from publicly subsidized programs or the federal, state, and local government employers

This study will concentrate on the sixth explanation: that government health insurance coverage in its many possible forms is high in Wisconsin. But before exploring that in depth, the other five explanations need some examination, because they help to set the stage for the sixth.

One very plausible (and largely proven) reason for higher health care costs and higher insurance costs in Wisconsin is that Wisconsin health care providers are reimbursed by the federal government at a significantly lower rate than health care providers in many other states. One big element is federal reimbursement for serving Medicare patients. In fact, Wisconsin ranks 45th in the rate per patient that Medicare pays health care providers (Manning 2004a). As an example, a subset of the Medicare program is one that uses local health maintenance organizations (HMOs). A Medicare HMO in Milwaukee County will receive $613.98 per month in 2004 for each client who enrolls. In Dade County, Florida, a similar HMO will receive $869.60 per month (Manning 2004a). Governor Doyle spoke to this issue when he was Attorney General: he sued the federal government for higher reimbursement. He made the case to Washington that Wisconsin is paid about $1 billion less annually than it should be because of the current reimbursement rate structure. He and Wisconsin lost. Wisconsin continues to lose, because a change in payment structure is a political issue.

The underpayment of $1 billion annually is important to the state's health care providers. They are not receiving dollars that they need to cover their costs. The result is hardship for the health care providers. One solution for them to recoup some of these lost dollars is to charge more for their services. A similar procedure is found in real estate: landlords charge higher rents on units that are leased to tenants who they think will not pay all of the rent due. The hope is that when the rent is paid it will help to compensate for the rents lost to non-payment. The impact of this practice in health care is higher costs for everyone else, including insurance companies. The underpayment calculation using these higher rates may, in turn, lead to an overstatement on the scale of underpayment by the federal government, but the condition of underpayment does exist.

Medicaid causes similar problems for health care providers. In cost cutting moves over the years, the federal government has cut the rate of reimbursement for these services. Doctors have been known to refuse to service Medicaid patients because the reimbursement does not cover basic costs. Others limit their acceptance of Medicaid patients so as not to suffer large losses of income. They also increase the rates for private-pay patients in an attempt to cover lost revenues.

Hospitals are challenged in a similar fashion. According to the Wisconsin Hospital Association, Wisconsin ranks 44th in the nation in Medicaid reimbursement to hospitals, covering only 72% of costs (WHA 2003). The WHA says that public underpayment forces hospitals to cost-shift to the private sector and in turn to private commercial insurers, thus increasing health insurance premiums. The greater this shortfall becomes, the greater the need to compensate with higher rates.

The second explanation that Wisconsin's citizens are older has some truth to it also. The question, though, is whether the differences are sufficient to contribute substantially to overall health costs. The answer is not clear. To begin with, Wisconsin's population is a bit older than that of the U.S. as a whole. In 2000 some 13.1% of the Wisconsin population was 65 years of age or older. The U.S. rate was 12.4% (Census 2000). That modest concentration of elderly does imply the likelihood of greater health care utilization in Wisconsin and subsequently higher expenditures on health care. But the difference between the U.S. and Wisconsin rates is not large enough to fully account for the scale of difference found in health care costs. Admittedly, the small concentration and the faster growth of those age 65 and over does contribute.

What may have modestly exaggerated this second factor is a faster growth of the elderly in Wisconsin than the nation as a whole. In 1990, some 11.9% of the U.S. population was 65 or over compared to Wisconsin's 12.4%. Thus, the 65 and over population grew 4.2% over the decade of the 1990s in the U.S. as a whole, and it grew 5.6% in Wisconsin (Census 2000). This somewhat faster growth tended to exaggerate the health cost increases because of the greater health care demands of this older population.

A different factor that may reinforce the Wisconsin trend toward greater health care utilization and higher health care costs is an unhealthier population. One measure of healthiness, because of its association with higher risks of developing chronic diseases associated with excess fat, is the proportion of the population that is obese. Wisconsin is on the high side. In 2001 some 21.9% of the Wisconsin population was termed "obese" by the U.S. Center for Disease Control (2003). This is higher than the U.S. average (20.1%) and higher than all but 13 other states. Given those facts, we could expect greater use of health care, more health problems per person, and possibly more costly problems to be addressed, driving up health care costs. Thus, higher levels of obesity and an older population combine to contribute somewhat to higher health care costs in Wisconsin.

The fourth explanation of overbuilt health care infrastructure is harder to assess. If building and the equipment upgrading are done to increase the quality of the care, it is more difficult to contend that this is an inflated cost. If, however, the expansion and upgrading do result in underutilized services being available, then cost increases could be partially attributable to over-investment by health care providers. One piece of evidence offered by the Wisconsin Hospital Association reveals that hospital costs, while rising in the neighborhood of 2.7% per year in recent years, are growing more slowly than either physician costs (6.4% per year) or pharmacy costs (12% per year) (WHA 2002). Inpatient days decreased between 1995 and 2001 and then began slowly increasing (WHA 2002). If there was a surplus in beds and services, those are less an issue today and are not likely to be contributing in a substantial way to higher costs.

The fifth explanation that doctors earn more in Wisconsin than elsewhere and that their incomes have risen faster than elsewhere does not appear to be valid. Median incomes among doctors in Wisconsin are about 4% lower than similar types of doctors in Chicago and equal to those in Minnesota (Fast Company 2004). As such, it is not a very compelling reason for higher health care costs in Wisconsin.

The sixth explanation — that having a high proportion of individuals who are covered by publicly provided health care insurance raises everyone's costs — has merit. That is explored in the rest of this report. The most obvious component, that the low rate of federal reimbursement on Medicare and Medicaid raises the costs of health care and health insurance to others, appears well supported. Low federal reimbursement is one element that does contribute, especially since Wisconsin is among the lowest-ranked states in rates of reimbursement and among the highest in health care costs. That clearly differentiates Wisconsin from the U.S. average.

A second link between higher rates of publicly provided health insurance and higher health care costs is that the smaller the percentage of private sector coverage, the greater the burden on that privately insured population, since

health care payments must come from somewhere. This means that those with private insurance pay more than they might otherwise to generate sufficient incomes for health care providers who feel shortchanged by the payment levels of various publicly supported health insurance programs.

A third link to higher costs is that many of the publicly provided policies, especially those provided through public employers, are less likely to have cost-sharing requirements, have smaller cost-sharing requirements, or lack other elements that help to make good health care consumers. Publicly provided insurance is likely to cover all costs or a greater proportion of the costs of service, so there is less reason for consumers to restrain health care use or to live lives that require less health care intervention. If Wisconsin is dominated by individuals covered by publicly provided insurance, then we can expect higher health care utilization and subsequently higher costs for everyone.

The first and sixth explanations on the expanded role of publicly provided health insurance deserve further exploration. That is what follows. The method of analysis is that of empiricism. We examine the use of alternative forms of health insurance among the adults in Wisconsin and develop the implications of that information.

The Data

Data Source

This study is of adults only. It does not examine health insurance for children. The data in this report come from a survey of a randomly selected sample of 1,000 Wisconsin residents who were 18 years of age and older. The survey was undertaken in October of 2003 by Harris Interactive, the nationally renowned survey research firm. The sample was drawn from a list of telephone numbers generated by a computer. This method includes both unlisted numbers and new listings in proportion to their representation in the population. Nearly every number was called at least three times before the number was discarded. This process, and the sampling itself, is controlled by a Computer Aided Sampling (CAS) System that monitors the entire process to insure that callbacks are made at appropriate times and that numbers are sampled correctly.

The methodology is the same process that Harris Interactive employs in its telephone election surveys. The demographic profile of the sample of residents surveyed was compared to the 2000 Census results for the state. The sample was constructed to compensate for two harder-to-reach populations: younger respondents and black respondents. The number of male and female respondents was also controlled to insure an approximately equal division.

A survey of 1,000 randomly selected residents has a margin of error of plus or minus 3 percent for percentages based on the entire sample. That is an important figure to remember. For an underlying percentage of 60%, for example, this means that repeated samples would produce results between 57% and 63%, 95 times out of 100. The margin of error for sub-samples, such as women, blacks, young people, or those with a particular form of insurance, will be significantly greater.

One note that will be expanded upon below is that respondents did not always know exactly what health insurance they had. This led to claims of several forms of insurance concurrently. While possible in most cases, a few were not. The cases where the combinations reported were not possible (for example, a respondent with several different forms of insurance including income-based federal insurance at the same time as private employer insurance, with income well above eligibility levels for subsidy) were deleted before analysis. This case-by-case screening of all respondents was undertaken to improve the quality of the data.

Identifying Health Insurance Carriers

Ask ten persons on a street corner to tell you whether it is Medicare or Medicaid that provides government health insurance for persons 65 years of age and older, and you might hear 3 or 4 correct responses. Several of the responses will be guesses; others will be an admission that the person does not know. Even those of us who write of the programs will occasionally misstate to which program we are referring. It is no wonder that when persons are cold called for a survey, they have a little difficulty correctly identifying what form(s) of health insurance they have. What further complicates the picture is that about half of U.S. adults have more than one kind of health insurance, and there are many possible combinations of insurance.

Most U.S. citizens who have some understanding of our health care insurance system would say that Medicare is for persons 65 and older. That is largely true. Most of us qualify for it at age 65. But a number of others qualify for it before age 65 because of special conditions they meet (e.g., certain disabilities or have end-state renal disease). Medicaid is thought to serve low-income women and children. That is the main target, but it also serves those receiving Social Security Insurance (aged, blind, disabled), certain Medicare groups, and special protected groups. There are examples of persons on both Medicaid and Medicare, just as there are individuals who have both Medicare and private insurance. Some adults have three or more kinds of health insurance. One example is someone who receives private insurance from a current or former employer, but who also is covered by Medicare and a private Medicare supplemental policy. That is straight–forward. Some of these individuals may also qualify for health coverage from the Veterans Administration. Other combinations of public and private are possible because of disabilities. The possible combinations are mind-boggling.

We would like to be able to say that all respondents correctly identified their own health insurance in Wisconsin. That was our goal. Unfortunately, we cannot make that claim. We have relied on individuals to report what form(s) of health insurance they have. Despite our best efforts individuals were sometimes not sure as to exactly what insurance they have. At times they were even not sure as to the characteristics of their insurance. The result is that a few of the details of what follows are not as precise as we had intended.

This problem is not unique to our efforts. Even the U.S. Census Bureau admits, for example, that respondents to their surveys "may not realize they are enrolled in Medicaid" (Census 2004). The result is that certain claims of participation in specific governmental programs or even private direct purchase of health insurance may be over-estimated in our results. This occurred because respondents could say yes to any or every health insurance plan that was read to them. In their responses they likely said yes to participation in more programs than they should have because more than one sounded familiar. Despite somewhat exaggerated claims of participation in one specific government insurance program (Medicare, likely because it was the first program read to respondents), what is on target are the estimates of the relative roles of publicly and privately provided insurance. The case for that assertion follows.

Comparison with Other Estimates

Before going into the specifics of the survey results, one may ask why undertake such a study, especially when sources such as the Census Bureau already release their annual estimates of health insurance coverage. One reason is to check on the veracity of those estimates. A second is to gain insights into multiple-source health insurance coverage in ways that the Census does not. And a third is to get detailed insights into the characteristics of the insurance provided by different sources. It is likely that privately provided insurance differs in important ways from publicly provided insurance. Those differences may have an impact beyond what individuals must do to take advantage of their insurance. We turn first to the issue of other estimates of coverage.

The U.S. Census Bureau, through its Current Population Survey (CPS), for a number of years has undertaken a survey in March each year that covers social and economic issues. Included in the many topics is that of health insurance. The CPS develops estimates of health insurance coverage for the population at large. CPS also estimates the proportion of the population of each state covered by specific forms of health insurance. Thus, annual estimates are created of the percent of each state's and the nation's population that has any form of health insurance, has private sector health insurance, or has each of several publicly subsidized forms of health insurance, such as Medicare, Medicaid, and that provided by the military. The annual report gives participation rates and absolute numbers of the total population, the under 18 population, and the 65 and over population. The CPS is the usual place to go to learn the details of health insurance coverage.

In comparing our survey results with those from the CPS, we found that our individual federal program participation rates were higher. But upon further research on actual program enrollments (specifically Medicare and Medicaid) and the discovery that the CPS has a high margin of error, we came to understand that our numbers agree with the CPS overall on such measures as the percent of the adult population that has health insurance and the percentage that receive publicly subsidized insurance, and that our estimates of program enrollments are more accurate than those from the CPS. The details of these comparisons can be found in Appendix A. The conclusion reached is that our survey data are better and more accurate and that we should proceed with the analysis. Thus, we now confidently explore insights into multiple-source health insurance coverage, details of insurance coverage, and the implications of these findings.

The Strong Role of Publicly Paid Insurance

Respondents were asked a long series of detailed health insurance coverage questions, once it was determined that they had health insurance. The first question after determining that they were covered was what the source(s) of their insurance was. Respondents were asked to indicate whether they received insurance from each of nine different possible sources plus an "other" category that they could define. The choices ranged from simply private employer provided health insurance, to union provided, to privately purchased, to a series of publicly subsidized forms of insurance that included six such programs as: Medicare, Medicaid, Badger Care, CHAMPUS, GAMP (Milwaukee County only), and Indian Health Service.

In terms of sources of insurance, employers were the primary providers. Almost 68% of adults receive their health insurance through their employer. The many forms of government-assisted insurance just noted were the next most common source. Some 28% of respondents received at least one form of assisted health insurance. About 26% of the respondents purchased insurance directly, and 17% received insurance through their union. It becomes clear that this totals far more than 100%.

Respondents could and did indicate that they often had more than one form of coverage. Just over half (51%) of those with health insurance had one form of coverage. Some 30% had two forms. Some 16% had three or four forms of insurance. And the remaining two percent had even more forms of insurance. That is the introduction to the complexity of health insurance coverage.

What complicates the picture further is that there is overlap between publicly and privately provided insurance. Thus, someone who works for a private employer may also have Medicare, a publicly assisted insurance. That same person may also have purchased a Medicare supplemental policy that extends the coverage of Medicare. Moreover, an individual who works for a public employer may have privately purchased insurance. And a retiree on Medicare may have private supplemental insurance. The combinations multiply.

Health Insurance Sources Wisconsin Adult Population October 2003

Source of Insurance	Recipients (%)
No insurance	11
Employer	68
Union	17
Direct Purchase	26
Medicare	24
Medicaid	7
Badger Care	4
GAMP	0
CHAMPUS	4
Indian Health Service	1
Total	138

Number of Health Insurance Policies Held October 2003

Number	Respondents (%)	Insurees(%)
0	12	
1	45	51
2	27	30
3	10	11
4	4	5
5	1	2

To simplify the analysis of the various combinations and permutations, we have decided to focus on two basic categories, public and private. The latter consists of all adults who have said no to any and all forms of publicly provided insurance. Thus, this group receives its health insurance only from a private employer, a private-sector union, or the individuals buy health insurance directly from a private company. The second group receives health insurance from a public employer, through a public-sector union, or from some government-assisted insurance program. The second group also contains individuals who work for and receive insurance from private employers or purchase it privately themselves. But since they also receive publicly provided insurance, they are placed in that single public category. Some 16% of the respondents fall into this mixed source group.

One of the most critical questions to be explored with this study is that of the relative roles of publicly and privately provided health insurance. The answer to the question is complex. That is because there are many variations in terms of coverage. Some persons simply have only private health insurance. The respondents work for private sector firms, and the insurance is provided by private sector employers. The workers are not eligible for and do not participate in any form of public sector insurance. That is a neat segment of the population. In our sample, some 43% of Wisconsin adults are covered by insurance in this manner. An additional 12% are not insured, according to our sample. The remaining 45% are covered by some form of governmentally provided insurance, be it provided for government employees or those who qualify for some form of subsidized insurance. The latter may be working for a public sector employer, a private sector employer, or not be working at all.

Sources of Health Insurance Among Wisconsin Adults, October 2003

Source	%
Private sources only (employer, union, private purchase)	**43.0%**
Any Public source (publicly assisted, public employer or union)	**45.3**
Any publicly assisted insurance, regardless of other insurance	28.2
Public union or public employer only; no public assistance	10.9
Any publicly assisted insurance and private employer insurance	8.3
Any public source but no form of private insurance	20.1

If we re-compute the relative roles of public and private providers for the insured population, we come to realize that 48.7% of those adults with health insurance in Wisconsin have only privately provided insurance. That means that **over half (51.3%)** of the adults with health insurance **receive some form of publicly provided insurance**, even if not exclusively publicly provided. That seems to be a high percentage and one with several important implications for health insurance costs and coverage in Wisconsin.

The details needed to make the links between higher public utilization and higher health care costs are developed in the rest of this report. But it is very possible that one strong factor contributing to Wisconsin's high health insurance costs is the extent of public sector coverage of the population. According to the CPS data, data that we think underreport but are probably consistent in doing so across states, there are not great differences across Midwest states in terms of coverage by government subsidized health insurance. Therefore, the difference may be attributable to the proportion of persons covered by public employer provided health insurance or public union provided insurance or perhaps it is the completeness of that coverage. We do not have the data to answer all of that speculation. But we do gain some insights as to the differences between publicly and privately provided insurance in Wisconsin.

Demographic Differences

One would expect there to be some differences between those who have private sector health insurance and those with public insurance, especially those with publicly subsidized insurance. One of the most obvious differences is likely to be age distribution. Those receiving private insurance are likely to almost all be less than 65 years of age, since that is the age at which Medicare coverage largely begins. We would also expect quite different rates of employment, somewhat different income distributions, and perhaps even different education levels between those with public and private insurance. These and many similar characteristics are what are explored here. The thinking is that demographic differences may help to explain some of the differences in health insurance coverage as well as some of the differences in attitudes toward various public problems and policies.

Age Distribution by Source of Health of Insurance

Age Range	Private (%)	Public (%)
18-24	9	13
25-34	19	11
35-44	30	13
45-54	26	15
55-64	15	12
65+	1	35

The first difference to explore is that of age distribution. Does the publicly insured population contain a higher proportion of those 65 years of age or older? The answer is clearly yes. Only 1% of those with only private insurance are over 65 whereas 35% of those with public insurance are 65 or older. Some 17% of the population at large in Wisconsin is 65 and over, so private insurance serves a quite different population by age. That means that there is also a much higher rate of private insurance coverage among those 35-54 years of age.

Education levels are quite different, especially among those not graduating from high school and having attended college or technical school. Those with private health insurance are more likely to have gone further in school than those with public insurance. In fact, only 38% of those with private insurance have graduated from high school or less whereas a majority (51%) of those with public insurance have not entered high school, completed high school, or only completed high school. This difference might suggest one of the reasons for use of public insurance. The difference between the two groups is then largely accounted for among those having attended college or technical school but who did not complete a four-year degree.

Education Levels by Source of Health Insurance

Education	Private (%)	Public (%)
No High School	2	5
Less than High School	3	11
High School Degree	33	35
Attend College/Tech	34	24
Graduate 4 year	27	23

What the reader should not infer, however, is that the public workers among the public pool are not as well educated as the private sector workers. In fact, 45% of the public workers who receive no form of publicly subsidized insurance have college degrees compared to only 27% of the private sector workers. The large difference comes among those with publicly subsidized insurance: 23% of the population that receives publicly subsidized insurance has not graduated from high school and another 42% has only graduated from high school. These figures suggest that the subsidized population is quite different from the population covered by insurance from an employer. This is not unexpected.

Employment status is another characteristic on which there are large differences between those served by public and private insurance. Some 63% of those with only private insurance worked full time, and another 9% worked part time. This is in sharp contrast to those with public insurance where only 38% were working full time and another 7% were working part time. The large difference is mostly attributable to the 31% of the publicly supported population that is retired (remember the 35% who are 65 years of age and older). Within the publicly insured group again there is a distinct difference between those who have insurance through their public sector employer and those who rely on publicly assisted insurance only. Some 77% of those with public employer provided insurance were working full time.

Employment Status by Source of Health Insurance

Employment Status	Private(%)	Public (%)	Public Employer (%)*
Employed Full Time	63	38	77
Employed Part Time	9	7	4
Self-employed	7	5	7
Not Employed but looking	2	4	1
Not looking	1	1	0
Retired	2	31	4
Student	4	4	3
Homemaker	10	9	5
Total	**98**	**99**	**101**

* Public employer with no forms of publicly subsidized insurance

Marital status is also different but not as pronounced. About 72% of those with private insurance are currently married compared with 60% of those with any form of public insurance. A major contributor is the higher incidence of widows in the public population (12% versus 3% for the privately insured). Again the different age distributions contribute. This difference is exaggerated within the publicly provided insurance pool. Among those publicly employed with no assistance 73% are married compared to 50% among those receiving some form of publicly assisted insurance. As expected, widows form an even larger portion (19%) of those with assistance.

MARITAL STATUS BY SOURCE OF HEALTH INSURANCE

Marital Status	Private (%)	Public (%)
Single, never married	17	19
Married	72	60
Divorced/Separated	7	7
Widowed	3	12
Total	**99**	**98**

Given different age, education, employment, and marital status distributions between the publicly and privately insured groups, one would expect differences in such characteristics as income and housing tenure (rent or own). Those differences do exist, but they are not as pronounced as might be expected. As can be seen below, there are categories of income in which there is little difference between the two groups (for example, those with incomes of $30,000-$49,999). There are as well, however, some sharp contrasts. Only 10% of those on private insurance have incomes below $30,000 while one quarter (26%) of those with publicly provided insurance do. In fact, among those with only publicly assisted insurance some 42% of respondents have incomes below $30,000. That is expected, since many federal subsidy programs are aimed at lower income recipients.

INCOME DISTRIBUTION BY SOURCE OF HEALTH INSURANCE

Income ($)	Private (%)	Public (%)	Public Employer* (%)
< 15,000	2	9	4
15,000-29,999	8	17	6
30,000-49,999	19	21	19
50,000-74,999	27	15	23
75,000 and up	34	28	45
Missing	9	11	3
Total	**99**	**101**	**100**

*Those with public employer linked insurance and no publicly subsidized insurance.

At the upper end of the distribution, there is not a huge difference: 34% of those with private insurance and 28% of those with public insurance have incomes over $75,000. A large difference does exist in the next highest category. Many more respondents with private (27%) than with public (15%) insurance have incomes between $50,000 and $75,000. This is expected. What is not expected is that those with public employer insurance only have a skewed income distribution that has 45% of respondents in the category over $75,000. That pool of respondents is not large enough to greatly influence the larger public pool, but it does indicate that the mix of individuals with various forms of public insurance is quite varied.

HOUSING TENURE BY SOURCE OF HEALTH INSURANCE

Tenure	Private (%)	Public (%)
Own	86	72
Rent	12	23
Live w/family	0	2
Other	0	1

With the income differences just noted, one would expect different rates of home ownership as well. That is what was found, although not to the same degree. Some 86% of those with private insurance were homeowners while 72% of those with public insurance were. What explains the more modest difference is that some of those who are publicly employed and those who are retired and receiving publicly provided insurance still have the resources to be homeowners.

To complete the description, we should examine race and gender. There is little difference on either count in the state. Minorities are just a bit more likely to be found in the publicly provided insurance pool, but the differences are very small. Whites constitute 90% of those with private insurance and 85% of those with public insurance. Those with only subsidized insurance are 84% white, and those with insurance from a public employer look like the private employer roles, 91% white. These differences are not large enough to have much of any influence.

Gender overall is also very similar across the two large groups of public and private health insurance participants. Males constitute 50% of those with private insurance and 49% of those with public. Given the larger number of widows in the public pool, one would not expect this match. But the public employer pool is 61% male while the publicly assisted pool is only 45% male. These balance out. So gender is not an issue overall between public and private.

Race and Gender by Source of Health Insurance

Race	Private (%)	Public (%)
White	90	85
Black	2	5
Asian	1	1
Hispanic	3	2
Other	2	3
NA	2	3
Gender		
Male	50	49
Female	50	51

Health Insurance Coverage

One of the first questions one might ask is whether publicly and privately provided insurance is different in some basic ways in terms of whom the policies cover. That is what is examined next.

Before proceeding we should learn of the sources of insurance for the private and public insurance recipients. For those with only private insurance, some 88% receive it from their current or former employer, 9% get their insurance through their union, and 21% claim to make a direct purchase of it. This last seems overstated, but the picture of multiple sources is an accurate one.

Among those with some form of publicly provided insurance, some 66% claim to receive some or all of their insurance from their current or past public sector employer. About 28% claim that the insurance comes through their union. An even higher percentage (38%) reported that they had direct purchase insurance. This may be an overstatement. But we would expect a higher percentage such as this, since those on Medicare often do purchase a private supplemental policy, some of those on Badger Care may view their payments as private purchase, and some may just know that they pay someone. The 38% rate of direct purchase appears to be high, as does the 21% among those with private insurance. But there should be a markedly higher rate, whatever it is, among those with public insurance.

Reported Sources of Insurance for the Private and Public Groups

Source	Private (%)	Public (%)
Current or former employer	88	66
Union	9	28
Direct Purchase	21	38

All respondents were asked to identify which of nine types of insurance they had. As has been noted, they could and often did report more than one source. Respondents were also given an additional chance to note if they had other health insurance policies or programs beyond those specified. Interestingly, among those with only private insurance about 11% claim to have yet more insurance; 15% of those with some form of public made the same claim. We did not pursue exactly what these were.

A related issue is the extent of the insurance coverage for other members of the household. The question asked was whether the coverage was limited to the respondent (him or herself), covered the respondent and a significant other, or covered the entire family. There are differences. Among those privately insured, almost 60% had their entire family covered compared to but 41% of those with publicly provided insurance. This difference is partially expected because some of the public plans, such as Medicare, are reserved for specific populations – those individuals 65 years of age or older (largely). Furthermore, those with public insurance (especially Medicare) were more likely to be single compared to those with private insurance. Thus, when we see that among public sources policies cover only the respondent in 33% of the cases, we are not surprised. Similarly, among those with private insurance only 19% of the cases are exclusively for the respondent, a figure that nearly matches the 17% of this population who claim to be single.

Inclusion of others in Coverage by Source of Health Insurance

Persons Covered	Private (%)	Public (%)
Respondent only	19	33
Respondent and significant other	20	27
Entire Family	59	41

Another aspect of coverage beyond the individual is the degree to which children are covered when the respondent is. In both the public (93%) and private (99%) sectors almost all children less than 18 years of age were covered, regardless of the source of insurance. Also 5% of the respondents in each pool claimed to have other insurance for the children, either in lieu of or in addition to their own policy. Children appear to be pretty well covered, but this was not an issue that we pursued in detail.

Health Insurance Restrictions

One of the requirements of certain health insurance policies that tends to bother some recipients are rules that limit access to health care services outside a pre-selected group of health care providers. All respondents with insurance were asked a series of five questions regarding the to degree to which they must initially select a doctor or medical group for services and then what other restrictions there may be for access beyond the initial doctor or group. As can be seen below, many respondents do have specific procedures they must follow to access care. But there are large differences between those with only private insurance and those with various forms of public insurance.

Presence of Restrictions on Health Care Access by Source of Health Insurance

Restrictions	Private (%)	Public (%)
Choose Dr. from list	63	45
Pay more if Dr. not on list	69	41
Required to select Dr./med group	63	50
Must obtain referral from primary Dr.	59	53
Obtain referral before use outside Dr.	46	43
None of these restrictions	10	19

On the first question of whether individuals must choose a doctor from a list of doctors, there is a considerable difference between the two groups of respondents. Almost two-thirds (63%) of those with private insurance have to make such a choice while only 45% of those with publicly provided insurance must do so. There is less of a difference on a similar question of whether their insurance requires them to select a primary care doctor or a medical group as their initial health care contact. In this case 63% of the respondents with private insurance must choose such an arrangement whereas 50% of those with public sector insurance must do so.

Some health insurance policies have rules that say if you go outside the list, you must pay extra to see a doctor who is not on the official list. About 69% of the private sector respondents and only 41% of the public experience this condition. The implication is that if there is an additional cost for visiting an unlisted doctor, it is more often covered by the public health insurance plan.

A related question asked if the respondents had to obtain permission from a primary care doctor before seeing a specialist. On this question, the requirements are fairly comparable. Some 59% of those with private insurance and some 53% of those with public claimed that they had this requirement. Again, though, there is less restricted access among those with publicly provided insurance. Nevertheless, in both instances, the policies of the public providers are more expensive for the provider and are more likely to result in greater health care utilization, driving up costs.

The fifth question in this series asked if respondents had to obtain a referral from their doctor to see a doctor outside their plan. The responses were almost exactly the same: 46% for private and 43% for public. On the whole, however, fewer respondents had none of these requirements in the private sector (9%) compared to those with publicly provided insurance (19%). What this suggests is that somewhat fewer of those with private insurance have more flexibility in terms of health care choices. The majority of both groups, however, are quite regulated in terms of access to particular doctors. The modest difference on this aspect is not likely to greatly affect health care costs.

Speaking of costs, both groups were asked a series of questions related to various costs of accessing health care insurance. The most critical is that of the out-of-pocket cost of health insurance. Each respondent was asked to note how much he/she paid annually for health insurance. The detailed results appear below. What may be surprising is the parallel distributions: the same proportion of each population fell into each cost category. Thus, 71% of those with only private insurance paid $3,000 or less annually. A comparable 71% of those with publicly provided insurance made the same claim. Among those with only public employer insurance, the figure is comparable (79%). What must be noted, however, is that 7-10% of the respondents did not know what they paid annually. This is another sign of the lack of clarity that surrounds health care insurance.

Distribution of Annual Health Insurance Costs by Source of Insurance

Annual Cost ($)	Private (%)	Public (%)	Public Employ*
Nothing	4	6	9
≤ 1,000	30	34	47
≤ 2,000	23	21	16
≤ 3,000	14	10	7
≤ 4,000	6	6	4
≤ 5,000	5	6	4
≤ 10,000	5	7	5
>10,000	3	3	5
Not Sure	10	7	3

*Refers to those (109 respondents) with public employment and no publicly subsidized insurance.

In the quest to try to limit the rate of increase of health care insurance, an increasing number of employers are changing the rules regarding the completeness of the coverage of health care insurance. Policyholders have to pay more of the costs of health care provision. The means to make this happen involve cost sharing and deductibles for services and medications. Respondents were asked how much they paid in terms of out-of-pocket expenses in the last 12 months for services and drugs not covered by their health care plan. The results appear on the next page.

A quick glance at the table does reveal some differences. Those with publicly provided insurance are more commonly found in the smaller expense categories. For example, 58% of those with publicly provided insurance paid $500 or less out-of-pocket. This compares favorably with 41% of those with private insurance. For $1,000 or less the figures are 75% and 63% respectively. If we look at the subset of public that includes only those with insurance from a public employer, 81% pay $1,000 or less out-of-pocket. Clearly, those with public insurance have fewer additional health related costs.

A subset line of inquiry is the degree to which health insurance covers the costs of prescription drugs. Again the benefits of public sector provided insurance are evident. Some 22% of publicly insured respondents say that all pre-

OUT-OF-POCKET EXPENSES FOR HEALTH CARE SERVICES AND MEDICATIONS LAST 12 MONTHS

Annual Cost ($)	Private (%)	Public (%)
≤ 250	23	34
≤ 500	18	24
≤ 1,000	22	17
≤ 1,500	9	6
≤ 2,500	13	8
≤ 5,000	8	4
>5,000	2	2
Not Sure	4	5

scription drug costs are covered compared to only 12% of those with private insurance. On the other hand, some forms of insurance have provided no coverage of prescriptions. This is true for 15% of the publicly insured overall, .5% of those with public employer-provided insurance, and 6% of those privately insured. The picture here is not clear: those with publicly provided insurance, especially subsidized insurance, are more likely to either have no cost sharing on prescriptions or no coverage of prescriptions.

COMPLETENESS OF PRESCRIPTION COST COVERAGE BY SOURCE OF HEALTH INSURANCE

Cost Coverage	Private (%)	Public (%)
All	12	22
Some	81	62
None	6	15
Not sure	1	1

Those who do have to pay something for prescriptions were asked the size of the increase over the last year in their out-of-pocket expense each time they filled a prescription. There were not large differences between the two sets of respondents. Almost equal percentages of both groups experienced large increases and little increases. The fact that about 15% of both groups experienced large increases indicates that this is an important issue for both such populations. It was an especially important issue to those with just public employer insurance: 27% claimed a large increase. Dramatic cost increases are not limited to those with private insurance.

OUT-OF-POCKET COST INCREASES OVER THE LAST YEAR BY SOURCE OF HEALTH INSURANCE

Scale of Increase	Private (%)	Public (%)
A Lot	16	14
A Little	29	28
Same as last year	45	38
Decreased	1	1
Not sure	4	3
NA (not pay at all)	7	16

Another way to address the potential differences in prescription drug costs to respondents was to ask detailed questions about formats and sizes of ways to insure some out-of-pocket payment by insured respondents. The first question in this series asked whether the respondent had an annual deductible that they must pay for prescriptions. Both groups are relatively similar in the proportion that has a deductible: 23% of those with private insurance and 20% of those with public. This is not an issue that differentiates between the two. One difference, though, is that 7% of those with private insurance did not know whether they had a deductible whereas 3% of those with public insurance were not sure.

When those with deductibles were asked the size of their annual deductible, there were virtually no differences between them. The responses ranged from $5 or less to $50 or more dollars. The only category to have close to 10% of all respondents was that of greater than $50. About 46% of all those with deductibles and private insurance and

45% of those with deductibles and public insurance had deductibles of this scale.

Deductibles are not the only way those with insurance are required to help share the costs of prescriptions. Another question asked respondents to best describe the payment they make when they fill a prescription, once they have paid any annual deductible. Their two basic choices were "a flat fee, also called a co-payment" and a "percentage of the price of the prescription, also called coinsurance." In some cases they might have to pay both.

Presence of Annual Deductible for Prescriptions by Source of Health Insurance

	Private (%)	Public (%)
Yes, deductible	23	20
No deductible	74	61
Not sure	4	3
Not apply	0	16

As is evident, those with publicly provided insurance were less frequently (51%) called upon to pay the flat fee and a little less frequently (21%) called upon to make a coinsurance payment than were those with private insurance. The comparable private insurance numbers were 60% and 24% respectively. The differences are not large, so the chances of encountering either of these charges are only slightly lower with publicly provided insurance.

Size of Annual Deductible for Drugs for Those w/Deductibles by Source of Health Insurance

Annual Deductible ($)	Private (%)*	Public (%)*
≤ 10	15	15
≤ 20	18	18
≤ 30	4	11
≤ 50	16	11
>50	47	45
N =	**86**	**82**

*Percentages are calculated on the basis of just those with a deductible

When queried as to the size of the flat fee per prescription for non-generic, preferred drugs, those with publicly provided insurance were more likely to have a smaller flat fee payment. Some 54% of those with such fees and public insurance paid $10 or less, and only 32% of those with private insurance did so. The public insurance provides somewhat better coverage in this regard than the private. So, not only did fewer of those with public insurance have to pay a flat fee, the payments that have to be made are more often smaller, thus encouraging greater use of preferred drugs.

Incidence of Co-payments and Coinsurance for Prescription Drugs, Once An Annual Deductible Has Been Paid by Source of Insurance

Payment Type	Private (%)	Public (%)
Flat Fee	60	51
% of price	24	21
Neither	4	8
Not sure	5	4
NA	7	16

Distribution of Flat Fee/Co-pay for Non-generic, Preferred Drugs by Source of Health Insurance

Size of Fee	Private (%)*	Public (%)*
≤ 5	7	28
≤ 10	25	26
≤ 15	24	12
≤ 20	24	25
>20	20	9
Total	**101**	**100**
N =	248	226

*Percentages calculated on the basis of just those who pay a flat fee.

To determine if there is any difference between generic and preferred drugs, a similar question was asked with regard to how much respondents had to pay. Again those with public coverage were less likely to pay a flat fee, and they were likely to pay less than those with private coverage. Some 76% of those with public insurance and 62% of those with private insurance paid $10 or less for each prescription. Again, publicly provided insurance is less costly to those insured.

Distribution of Flat Fee/Co-Pay for Generic Drugs, by Source of Health Insurance

Size of Fee	Private (%)*	Public (%)*
≤ 5	20	41
≤ 10	42	35
≤ 15	18	10
≤ 20	13	11
>20	6	4
Total	**99**	**101**

*Percentages calculated on the basis of just those who pay a flat fee

The last questions in this series that tried to get at the dimensions of shared costs of prescriptions was a question on the size of the coinsurance fee, when a respondent filled a prescription for a preferred drug and a generic drug. Respondents were asked to answer to the best of their abilities. Less than one quarter of each pool (24% of the privately insured and 21% of the publicly insured) had a coinsurance payment. That limits the scale of difference to begin with. Then when asked for specific dollar amounts in five dollar increments between equal to or less than five dollars up to more than $20, some 26% of those with private insurance versus 38% of those with public insurance paid $10 or less for preferred drugs. A similar difference existed with regard to generics: 54% of those with private versus 64% of those with private paid $10 or less per prescription.

Once again, those with publicly provided insurance tended to pay less.

Prescription Decisions Dictated by Health Plan Coverage

Respondents with health insurance were asked if, in the past 12 months, he/she had been told by their doctor that the medication being prescribed for the respondent was determined by the coverage rules of their health insurance plan. In most instances this had not occurred. But 15% of those with private insurance and 21% with public insurance had had that experience. This is an instance where those with publicly provided insurance did not fare quite as well.

Respondents were asked an ancillary question: In the past 12 months have you asked a pharmacist about a less expensive alternative for a prescribed drug? This was an indirect way to get at the question of how expensive it is to fill some prescriptions. Again, there was very little difference in the responses. Some 32% of those with private insurance said they had asked such a question whereas 34% of those with public insurance do so. This is not an issue that helps to differentiate between the two groups.

In yet another variation on the theme, respondents were asked if in the last 12 months they had had to change medications because their plan no longer covered the medication they were taking. One would expect a smaller percentage saying yes, because it requires individuals to be on particular drugs for the longer term. The responses for the two groups were exactly the same, 14%. It is an issue for some, but it does not vary by source of insurance.

Additional Costs Borne

Another measure of health insurance coverage is that of the need to supplement what the insurance basically provides. For example, respondents were asked if in the past 12 months they had paid more out of their own pocket to get a better drug. The source of insurance did not matter: 23% of those with private and 21% of those with public insurance did pay more out of pocket to gain access to a better drug. That is a very small difference between the two. But the fact that over 1/5th felt they had to go beyond what the insurance would cover suggests that this is a failing for a notable proportion of the health policies in effect.

Respondents were also asked whether they had paid out of pocket in the last 12 months to get a higher standard of care. Not many respondents had done so. In fact only 15% of those with private insurance had done so, as had 10% of those with publicly provided insurance. Again those with public insurance were less likely to pay the extra amount, but that may well be due to lack of resources, the very reason many receive public insurance in the first place.

Situations in Which Respondents Paid Additional Costs for Health Care by Source of Health Insurance

Possible Situation	Private (%)	Public (%)
Paid more out-of-pocket to get a better drug	23	21
Spent own money to get a higher standard of care	15	10
Paid extra to see a doctor outside your plan	17	10

Respondents were also asked whether in the last 12 months they had paid extra to see a doctor outside their plan. Again, this was not a common occurrence: some 17% of those with private coverage did so while only 10% of those with publicly provided insurance paid extra. The smaller public insurance number is more likely to reflect fewer resources to use for such a doctor than any comment on the adequacy of the doctors provided by the health insurance.

Office Visit Costs

One of the most common issues with regard to health insurance coverage is whether the user's health plan pays all, some, or none of the cost of an office visit to their doctor. This question reveals a very different degree of expense coverage between those privately and the publicly insured. Only 24% of those with private insurance are fully covered for a doctor's office visit. By contrast over 52% of those with public insurance are fully covered. Very few members of either group must pay fully.

Degree of Insurance Cost Coverage for an Office Visit by Source of Insurance

	Private (%)	Public(%)
All Covered	24	52
Some Covered	69	42
None Covered	4	3

A related question on the cost of office visits was whether the participant has an annual deductible that they must pay for office visits to their doctor. Again those with publicly provided insurance are less likely to have such an expense, but the differences between the two groups is not large. Some 41% of those with private insurance and 34% of those with public insurance have an annual deductible. Between 4% and 5% of the respondents were not sure whether they had this requirement.

Presence of An Annual Deductible for Office Visit by Source of Insurance

Deductible?	Private (%)	Public (%)
Yes	41	34
No	48	55
Not sure	4	5
NA	8	6

Those respondents with an annual deductible were asked the size of that deductible. There was virtually no difference in the distribution of the requirement. Virtually the same proportion of those with private and public insurance (61%) had to pay more than a $50 annual deductible. For those with this greater than $50 annual deductible, 90% of those with private insurance and 70% of those with public must pay more than $100 per year. Again the publicly provided insurance tends to require less expenditure by its participants.

Adequacy of Medical Insurance in Specific Situations

Respondents were asked a series of questions on whether they felt that the insurance they have is adequate in a number of different situations. The specific situations are listed with the responses.

Respondents with either source of insurance were quite positive in their assessment of their insurance in most situations. Those with publicly provided insurance were slightly more positive in their assessment in all six situations, but the differences are not large (half were within the survey's margin of error). For whatever reason, though, those with public insurance were consistently more generous in their assessment: more of them are convinced that their coverage is adequate.

Assessment of Adequacy of Insurance Coverage by Source of Insurance

Medical Procedure	Yes, Adequate (%)		Not Sure (%)	
	Private	Public	Private	Public
Annual Check-ups	84	89	2	5
Treat Minor Illnesses	82	85	3	5
Treat Injuries like broken leg	86	91	7	7
Hospitalization for serious illness	84	87	8	9
Surgery	84	87	9	8
Long Term Care	25	31	38	33

What must be noted, however, is another sign of the lack of complete knowledge with regard to the respondents' health insurance coverage. When asked of the adequacy of their long-term care coverage for a nursing home or similar facility, one-third or more of both sets of respondents did not know. Those that did know knew that such coverage was unusual; only 25% to 31% said it was adequate. That may speak to yet another need.

Satisfaction with Health Insurance

Satisfaction with Current Health Insurance Plan by Source of Health Insurance

Reaction	Private (%)	Public (%)
Satisfied	78	88
Not Satisfied	20	11
Not Sure	2	0

Respondents were queried on their overall satisfaction with their health insurance. If they were not satisfied, they were asked a series of questions as to just why they were not satisfied. The results shed light on some of the difference between the two groups.

Those with publicly provided health insurance were more likely to be satisfied (88%) than those who had only private insurance (78%). The scale of that difference is enough to think that the coverage is different, as previous questions have shown.

Reasons for Dissatisfaction with Health Insurance by Source of Health Insurance

Reason for Dissatisfaction	Private (%)	Public (%)
Quality of Care	4	5
Cost of Care	17	8
Number of physicians to chose from	6	5
Other Reason	6	4

Those who were dissatisfied were then asked to specify why they were dissatisfied. There were differences of opinion among those who were dissatisfied as to what characteristics of the insurance they disliked. Of those who were dissatisfied, the one large group of complaints came on the cost of care. Those with private insurance were twice as likely to mention this facet. Otherwise, the two groups largely agreed on the cause of the problem.

Health Insurance Influence on Personal Behavior

Respondents were asked a series of three questions to attempt to determine just what role having health insurance played in some personal decisions. The first question in this series asked if the respondent or any one in their household had postponed going to the doctor in the past year because they could not afford to go. Somewhat surprisingly, respondents in both pools said that that had been the case. Some 17% of those with private insurance had postponed going while some 13% in the public did so. This figure pales when placed against the over 60% without any insurance who indicated that they had postponed such a visit. But again, among those with insurance there is a

Respondent or Family Member Postponed Going to the Doctor in the Last Year Because Could Not Afford To Go by Source of Health Insurance

Response	Private (%)	Public (%)
Yes	17	13
No	83	86

slightly better utilization of doctors among those with the publicly provided insurance. As we saw above, there were likely to be fewer and smaller co-pay requirements among those with publicly provided insurance.

A larger question was asked: "Have you ever taken one rather than another job mainly because it had better health coverage?" Having better insurance was influential in 17% of the privately insured respondents and 14% of the publicly insured respondents. These are hard numbers to interpret, other than to say that health insurance is obviously a concern for at least one-sixth of the population.

Respondent Taken One Job Over Another Mainly Because It Had Better Health Insurance by Source of Health Insurance

Response	Private (%)	Public (%)
Yes	17	14
No	83	86

The third question asked whether the respondent ever decided to stay in a job when he/she wanted to quit mainly because he/she did not want to lose health insurance? This occurred relatively often (30%) among those with private insurance and not so often (20%) among those with public insurance. Together it indicates some stickiness in the labor market, as one fourth of the adult population in Wisconsin has made decisions to stay with a job because of the benefit of health insurance. This is understandable in terms of the expense of health care and even of health care insurance. But it may not be the most efficient way to organize a labor market. The rates of being influenced by insurance while different between the two groups may also just reveal that some portion of those on public insurance have not had jobs, thus leading to the lower response.

Decided to Stay in a Job You Wanted To Quit Mainly Because You Didn't Want to Lose Health Insurance by Source of Health Insurance

Reaction	Private (%)	Public (%)
Yes	30	20
No	68	78

Reactions to an Alternative Plan

One might hypothesize that those with higher levels of dissatisfaction with their current plan might be more likely to endorse an alternative. All respondents were asked first if they would favor the implementation in Wisconsin of a health plan similar to that in Canada, where the government pays for all of the costs of health care out of taxes and negotiates directly with doctors and hospitals to set fees and the type of care they offer. Then those who would favor such an approach were asked whether they would still favor it if their state taxes had to increase it to pay for it.

Response to Proposed Use of the Canadian Health Plan in Wisconsin by Source of Health Insurance

Reaction	Private (%)	Public (%)
Favor	57	61
Oppose	32	27
Not Sure	10	12

Response to Canadian Plan if State Taxes Had to be Increased to Pay For It by Source of Health Insurance

Reaction	Private (%)	Public (%)
Favor	41	44
Oppose	12	13
Not Sure	4	4
NA	43	39

The responses were a bit predictable. On the first question, among those currently with insurance, fairly similar majorities of both populations favored its use. Some 57% of those with private insurance favored the use of the Canadian approach while a slightly higher percentage (61%) of those with public insurance favored this alternative. In other words, there was not much difference between the two populations in terms of their level of support for the Canadian plan: both had a similar majority

When crunch time came and they might have to pay for the new program with their state taxes, the proportion favoring the Canadian plan dropped by relatively similar proportions. If they would have to pay more taxes, 41% with private insurance favored the Canadian system while 44% of those with public insurance did so. The difference is modest, but it appears that there is slightly more commitment to the current system among those with publicly supported insurance.

Political Attitude Difference

One might suspect that there would be differences in attitudes between recipients associated with their source of health insurance. To determine if this is the case, the respondents were asked several questions related to political affiliation, philosophy, and opinion on a series of public policy issues. A key issue was already discussed: their assessment of the Canadian health system. But several other topics merit examination as well.

Political Party Affiliation by Source of Health Insurance

Affiliation	Private (%)	Public (%)
Democrat	25	31
Republican	33	29
Independent	33	28

A fundamental question is whether there are differences in political party affiliation. There are, but they are not pronounced. About 33% of those with private insurance identified themselves as Republicans, 25% as Democrats, and 33% Independents. Among those with public insurance the respective numbers were 29%, 31% and 28%. Those differences are barely larger than the sample's margin of error (+/- 3%). Within the public insurance pool there are much larger differences. Some 35% of those with some form of publicly assisted insurance identified themselves as Republicans whereas 21% of those with government employers indicated this. Obviously, the two groups offset one another in the total tally.

Assessment of Place on Political Spectrum by Source of Health Insurance

Assessment	Private (%)	Public (%)
Conservative	26	31
Middle-of-the-road	55	45
Liberal	16	14

A related question is where on the political spectrum individuals identified themselves, regardless of what party affiliation they claimed. There are differences, but these are not huge. About the same proportion of those with private insurance (16%) and public insurance (14%) identified themselves as liberals. Those with private insurance were also more likely to identify themselves as "middle-of-the-roaders" (55%) compared to those with public insurance (45%). What this indicates is that overall those with public insurance are more likely to be conservative than those with private insurance. The question is whether this is reflected in the responses to a series of policy questions.

All respondents were asked to listen to a list of twelve different public issues and then to identify from among them the single most important problem facing Wisconsin that the government should be addressing. The top responses varied for those with and without health insurance. Those without insurance indicated, quite naturally, that "Unemployment/jobs/wages" was the category that most deserved (25%) the state's attention. That held second place (14%) among those with insurance. Those that had insurance thought that taxes were far and away (23%) the most pressing issue.

All respondents were then asked a follow-up question: "Which one of the following six issues do you think needs the most attention from the Wisconsin state government at the present time?" Respondents did focus their attention on four of the six, and there were differences of opinion as to which is the top priority. The single issue that received

the most votes, not surprisingly, is that of containing health care costs. It was at the top of the list for both privately insured (32%) and publicly insured (34%). The issue was of concern to substantially more members of each population than their second choices. Current source of insurance does not influence the level of this concern. As the reader may recall, similar percentages of both populations realized substantial increases in health insurance costs this past year.

In second place among those with private insurance are about an equal number of respondents who were concerned with tax reform (23%) and improving the state's economy (22%). Taxes were not an issue for those with public insurance. But improving the state's economy was (23%) as was improving public education (20%). The latter was aided by 28% of those with public employer insurance, a group that contains a remarkable 44% who are, or who have a member of their immediate family who is, employed in education.

When the respondents were asked a series of questions about local government,

Distribution of Votes for the Single Most Important Problem Facing Wisconsin that the government should be doing something about by Source of Health Insurance

Problems	Private (%)	Public (%)
Taxes	28	20
Government issues	14	14
Unemployment/jobs/wages	12	14
Health Care issues	10	10
Schools/education	7	6
Loss of business/economy	6	6
Welfare/poverty/social issues	4	5
Criminal justice system/law	4	5
Environmental issues	1	1
Farming	1	0
Gasoline/ home heating oil prices	1	1
Other	5	6
Nothing	1	1
Don't Know	7	10
Total	**101**	**99**

Which one of the following six issues do you think needs the most attention from the Wisconsin state government at the present time? By Source of Health Insurance

Problem	Private (%)	Public (%)
Controlling health care and prescription drug costs	32	34
Reforming the tax system	23	13
Improving the state's economy	22	23
Improving public education	14	20
Ethics of WI's state and local officials	4	3
Security from terrorist attacks	2	3
None of these	1	1
Declined to answer	2	2
Total	**100**	**99**

some differences of opinion between those with public and those with private insurance were revealed. When asked if they think their local government spends too much, too little, or the right amount of tax dollars, the responses did vary. Those with private sector insurance, the vast majority of which comes through private employers, had 59% of the vote that local governments spend too much and only 5% about right. Among those who are benefiting from publicly provided insurance, some 48% thought that local governments spend too much. Nine percent thought that they spent too little. Among public employees, the percentage thinking that local governments spent too much was a modest 36%, reflecting a rather different perspective.

ATTITUDE TOWARD LOCAL GOVERNMENT EXPENDITURES BY SOURCE OF HEALTH INSURANCE

Attitude	Private (%)	Public (%)
Spend too much	59	48
Spend too little	5	9
Spend about right	29	34
Not sure	6	8

When asked if their local property taxes were too high, too low, or just about right, the respondents were largely in agreement. Some 70% of those with private and 65% of those with public insurance indicated that taxes were too high. Almost no one said that they were too low. So there is at least one point on which these populations largely agree.

When asked to identify which of several reasons was the primary reason for increases in local property taxes, there was again general agreement. Both populations thought that the lack of adequate state funding was the primary reason, followed by increased spending at the local level. A majority (53%), not surprisingly, of those with only public-employer provided insurance blamed the inadequacy of state funding. They agreed with the others, but more so.

PRIMARY REASON FOR WHY PROPERTY TAXES INCREASE BY SOURCE OF HEALTH INSURANCE

Reason	Private (%)	Public (%)
Increased Spending	45	39
Lack of state aid	46	45
Neither	5	3
Both	2	3
NA	3	10

The last question in the series was whether they favored a freeze on their local property tax rates. That seems like a pretty easy policy with which to agree. The majority of both the publicly and privately insured indicated they liked the idea, but it was by no means universal. About 64% of those with private insurance favored a freeze, as did 58% of those with public insurance. That is not a large difference. The group that did not agree to the same degree was that of public workers. Only 49% of that sub-population thought a freeze was a good idea.

ATTITUDE TOWARD A TAX FREEZE ON LOCAL PROPERTY TAX RATES BY SOURCE OF HEALTH INSURANCE

Attitude	Private (%)	Public (%)	Public Employee (%)
Favor freeze	64	58	49
Oppose freeze	26	32	48
Not sure/ NA	9	9	3

EVALUATION OF HYPOTHESIS SIX: PUBLICLY PROVIDED INSURANCE DRIVES HEALTH CARE COSTS

It is clear that Wisconsin does have a large portion (45%) of its adults covered by at least one form of publicly provided health insurance. That seems like a high percentage. But it is not possible at this time to compare this with other states to determine the degree to which this is a significant factor in the higher health care and insurance costs in Wisconsin. We need similar data from other states for the analysis. It appears, though, that it does contribute, given the absolute scale, if nothing else.

If 28% of the adult population receives subsidized care, care that is reimbursed at a less-than-full rate, it does force other health service users to pay more. One publicly available estimate related to Medicare is $1 billion shortfall annually across the state. Wisconsin hospitals additionally claim to lose $146 million every year treating Medicaid patients (WHA 2003). Doctors and clinics "lose" still additional dollars. These figures may overstate the case, as health service fees are inflated to compensate for federal underpayment. Nevertheless, the net result is that others (private payers, be they private or public) have to pay more. Costs do get shifted, as health care providers claim, to health insurance payers. Since Wisconsin is near the bottom of the list of states with low rates of federal reimbursement, this is certainly one reason for higher health care costs in Wisconsin.

That might not be so hard to swallow if those costs are distributed over a large population. But when the private market covers only half of the insured population and the public employer market carries another fifth, then the relatively small pool must share the large burden, further driving up their costs. The costs appear both in the rates for health care providers and in their insurance.

Another factor that contributes to higher health care costs is the completeness of insurance coverage of public sector employees and those with publicly assisted health insurance. Given the many responses to detailed questions about just what their health insurance covers and how much they must cost share in some fashion, the publicly provided insurance is usually more complete and less costly to recipients. Those with publicly provided insurance tend to more often have full cost coverage, to have lower co-pays and deductibles, fewer restrictions on access to health care providers, and are less often forced to make difficult treatment decisions by the nature of their health insurance. The differences between those with publicly and privately provided insurance are not huge, but they are large enough to suggest that participants in each will act differently

On the one hand, the more complete coverage can be said to be a positive for those with publicly provided insurance. They should have better health care treatment and, hopefully, health. On the other hand, the link to better health may, in fact, be quite the opposite. Those who do not need to worry about health insurance coverage and who pay less for access to health care may well lead lifestyles that create more need for health care. With few external incentives for maintaining one's health and limiting one's need for health care, the more complete and less expensive (to the individual) coverage may create a greater demand for health care services. To the degree to which this occurs, that is likely to raise costs for others who are not as well covered.

Since publicly provided insurance covers more of the costs of health care provision, its extensive use means that fewer consumers are driven by incentives to make better decisions about health care utilization and lifestyle decisions that may lead to costly health services. Thus, Wisconsin suffers from a quadruple clubbing: very low federal reimbursement rates, sizeable absolute underpayments from the federal government, a need to spread federal underpayment costs among a relatively small percentage of the adult population, and a sizeable portion of the adult population whose insurance provides few incentives for policy holders to be wise consumers of health services or to live healthy lifestyles. That combination of forces helps to increase health care costs in Wisconsin. Add to these factors the many forces that are working nationally, exaggerated by the high obesity and the higher concentration of elderly found in Wisconsin, and the result is high and rapidly climbing health care and health insurance costs in Wisconsin.

Policy Options

The issues that Wisconsin can and should most immediately address are the federal underpayment, the lack of incentives in health insurance policies, and the explosion of obesity. Wisconsin can also work with other states and the federal government to address the many other factors that are contributing to rapidly growing health care costs nationally.

An easy recommendation to make is that Wisconsin should convince the federal government that it should reimburse health care providers in Wisconsin at much higher rates than currently for Medicare and Medicaid patients. The goal should be full reimbursement, but even the national average of 95% would be a huge step forward. But as we all know, saying this and making it happen are two very different things. Nevertheless, fuller federal reimbursement should remain at the top of the state's agenda because it is such a large and obvious step.

A second element that is needed, though, is a greater incentive for individuals to exercise good judgment in their own lifestyles. If high proportions of all health care costs are covered by health insurance, then there is no monetary incentive to exercise discretion in one's behavior. If, however, one who uses a doctor or prescriptions less because of better judgment is asked to pay less, then behavior is more likely to be modified. If "sticks" of additional costs are employed rather than incentives (carrots) to live healthier lives, there are many individuals on publicly subsidized insurance who do not have the resources to meet additional cost-sharing requirements. That makes a simple rise in some cost-sharing requirement unwise. More thought must be given to this dilemma; the changes should focus on those who might be able to respond to incentives to change lifestyle and health care access decisions.

One element that contributes and might be addressed is the lower incidence of cost contribution among those receiving unsubsidized, publicly provided insurance, in other words those who work for the public sector. This insur-

ance currently has fewer costs for the participants, so they have less reason to think and act smartly with regard to their own health and health insurance utilization. Despite being one of those benefiting from such a policy, I think that there should be greater inducements built into our policies to stress wellness and healthy lifestyles. Inducements that are carrots rather than sticks are likely to be more effective here as well. If incentives were more universal, we would see lower health care costs for all develop over time, since health care utilization rates would be lower. That would benefit others as well as us.

A third initiative is that Wisconsin's public employers should strive to bring publicly provided health insurance into better balance with that provided by private employers. This should not mean that public employers merely shift more costs to their employees. All employers should become more creative in the use of incentives, rather than disincentives, to promote better health while lowering everyone's health care costs. An example would be to pay progressively higher percentages of health insurance premiums for those who prove through annual checkups that they are healthier and therefore have lower risks of needing expensive health services. Participation in various wellness programs can also be used to reduce employee health care contributions.

The fourth initiative must be one that addresses obesity. The proportion of those overweight and obese in Wisconsin (21.9% obese in 2001) has been growing about as rapidly (72%, 1991-2001) as it has nationally (74%, 1991-2001) (CDC 2003). And the obese population in Wisconsin is larger than in all but 13 states. This is a condition that has exploded in recent years. It can and must be reversed. But it will take a focused initiative at all age levels. It will require some dollars of investment, but a reduction in obesity will also save many dollars in health care expenditures, since it currently consumes 7% of all health care dollars nationally (proportionately more in Wisconsin), and it is projected to consume 20% of all health care dollars among those 50-69 years of age by 2030, if it is not sufficiently addressed (Rand 2004). We need to expand access to and incentives for actively participating in wellness activities. This will be a challenge, but the wellness program alternative is much less expensive than the health care treatment alternative.

These recommendations are not sufficient in themselves. But they do involve steps that the state and local governments can initiate that are not overly costly and that would be effective at addressing some of the forces that are responsible for rapidly rising health care costs in Wisconsin.

Appendix A

The Detailed Case for the Harris Survey Results

According to the 2003 report on the 2002 distribution of health insurance, the Current Population Survey (CPS) estimates that 90.2% of the Wisconsin population (all ages) had health insurance some time in 2002 (US Census 2003a). This rate of coverage was far better than the 84.8% of the U.S. population that had health insurance some time in 2002. CPS also reveals that according to its well-regarded survey, undertaken in March 2002, that 78.5% of all Wisconsin residents were recipients of health insurance provided through private sources (U.S. Census 2003a). Some 23.2% of all citizens were covered by some form of publicly subsidized insurance. Among adults 18 years of age and older the respective figures were 78.3% private and 23.5% public. And yes, given the two figures add to more than 100%, you can have both public and private insurance simultaneously. Examples include Medicare participants who may still be working or those who have Medicare and buy a private insurance supplement.

The survey we undertook in October of 2003 contains some quite different estimates of specific health insurance coverage. Because of the specific differences, these differences need to be discussed up front. It is this author's contention that the survey undertaken in October 2003 is actually more accurate in terms of the proportion of the population covered by publicly subsidized insurance than the CPS survey of March 2002. Part of the difference may be attributable to the passage of time and the increased number of persons relying on publicly subsidized insurance, given the deterioration of the Wisconsin economy. But the differences are much more attributable to what appear to be underreporting of the use of public insurance programs on the CPS.

At the aggregate level our survey yielded an uninsured rate among Wisconsin adults of 11.7%. This is very comparable to the CPS estimate of 11.5% (CPS 2003a). That difference is miniscule, is well within the survey margin of error, does not affect any other estimates of specific coverage, and may be partially attributable to the loss of jobs in Wisconsin between March 2002 (CPS) and October 2003 (our survey). There is also relatively modest difference between the two sources on the proportion receiving insurance that is tied to their employment: 65.6% (CPS) and 67.7% (ours). That is not a large difference and affirms the basic accuracy of our survey.

What are quite different are the estimates on the percentage of adults covered by private insurance and the percentage covered by publicly subsidized insurance. The key difference is the public estimate. CPS estimates that 23.5% of the adult population in Wisconsin is covered by some form of publicly subsidized insurance. Our estimate is 28.2%. That is a sizable difference, is larger than the sample margin of error (+/- 3%), and requires an explanation.

The most likely explanation beyond a possible skewed sample for our survey is some errors by the CPS. First, however, we must address whether we employed a potentially skewed sample. This appears unlikely, since the sample of respondents to our survey is an almost perfect match with the known characteristics of the population. Because it does, it should also reflect other characteristics of the population, such as use of health insurance. The fact that the overall rates of insurance coverage are almost exactly the same as that of the CPS indicates that on the most fundamental question (coverage), the two samples match.

What does not match are some of the details of coverage, especially the proportion covered by public insurance. There is no question but that individual respondents are a bit overwhelmed by the multitude of possible ways to be covered by health insurance. Individuals may have just one form of insurance, but almost half (49%) have more than one form. That may lead to confusion as to the specific types of coverage respondents have.

CPS claims they have a very refined procedure for helping people differentiate say between Medicaid and Medicare. That may be. We did not use their procedure. But the one we did employ asked each respondent if they were covered by each of six forms of publicly assisted health insurance. If there was some confusion (and there was), the respondents were still able to cover themselves by identifying their participation in more than one government program. Respondents were asked first if they were covered by Medicare. That appeared to sound familiar to more respondents than it should have. We have cases where the respondent is less than 65 years of age and claims to have the nearly impossible complete family coverage by Medicare. Other similar combinations appeared. Several are legally possible but improbable to the degree reported. Given their characteristics, they are likely eligible for some form of government assisted insurance, but it may not be the kind they initially identified.

We did receive reports of many combinations, as does the CPS (they admit that there are many individuals with multiple kinds of insurance). In the end we counted respondents' coverage by the public sector on the basis of their having said yes to any one of the public programs. Thus, if a respondent thought they were covered by Medicare and

then, when asked about Medicaid, also said yes, they may have been accurate or they may have wanted to be sure to somehow indicate the correct program. Both are likely to sound very familiar. If they covered themselves by reporting participation in more programs than they should have, the result would overstate individual program participation but not overstate the rate of participation in government programs overall. That is what seems to have occurred, especially with Medicare, the first option read to respondents.

According to U.S. Department of Health and Human Service records, July 2002 adult participation in Medicare in Wisconsin included 794,178 persons (DHHS 2002b). The March CPS estimate was 693,000, a difference of over 100,000 persons. Some 545,000 persons of all ages were estimated by the CPS to participate in Medicaid. DHHS reports that 676,395 were enrolled in Wisconsin at the end of 2002 (DHHS 2002a). When adult participation is calculated, the difference is about 100,000 again: 254,000 (CPS) versus 353,971 (DHHS). These are large discrepancies, but they are not unique to Wisconsin.

It should be noted that similar discrepancies exist in other states that were examined. CPS estimates were often considerably below reported DHHS enrollments. In Illinois Medicaid enrollment, as reported by CPS, was more than 500,000 below the DHSS count. The Minnesota CPS figure was 67,000 below the DHHS enrollment figure; in Maryland the CPS count was over 307,000 lower than the DHHS enrollment. An e-mail from a researcher at the Census states: "Because our state estimates are based on relatively small sample sizes, there can be a lot of variation in our one-year estimates. . . . Also, the CPS may understate Medicaid coverage because respondents may not admit to being covered due to the stigma associated with public programs, or because they are not currently receiving medical services. . . ." (Census email 2004). The result is often an underestimate of the publicly insured by the CPS.

2002 Medicare and Medicaid Adult Participation, Wisconsin

Program	CPS Estimate	DHHS Enrollment	DHHS/Adults
Medicare	693,000	794,181	19.6%
Medicaid	254,000	353,971	8.8%

The CPS also uses a larger denominator for the state's population than either the Census Bureau itself or the State of Wisconsin uses. The latter two estimate that the state's population grew 2% between April 2000 and 2002; CPS uses a 3% figure. If 2% is the case, then the number of adults in Wisconsin in 2002 was 4,043,020, not the 4,117,000 that the CPS uses. The result is that Medicare and Medicaid use in Wisconsin, using DHHS figures and a slower growth rate, was 19.6% of adults and 8.8% of adults, respectively, in 2002. This compares to the CPS estimates of 16.8% and 6.2%, respectively. So the DHHS figures are larger than the CPS figures. The DHHS figures are actual enrollment and should be considered superior to that from what is likely to have been an insufficient sample.

The revised numbers are still smaller than both of ours (23.5% for Medicare and 11.2% for Medicaid and related insurance programs). The 11.2% is a combination of both Medicaid and Badger Care utilization, an addition the national Medicaid figures (e.g., 8.8%) claim to make. However, we cannot just combine these figures, since there is overlap: individuals often participate in at least two insurance programs simultaneously. Our overall government participation rate of 28.2% is not out of line with the DHHS figures, when the DHHS rates are combined with the other subsidized insurance programs, such as those aimed at military veterans. A small portion of individuals receive insurance from the military (CHAMPUS, Medical Plan for Uniformed Services/Tricare, and CHAMPVA). Thus, Medicare (19.6%) plus Medicaid (8.8%) minus the overlap (1.3% estimated overlap between the two, according to CPS) plus Military (2.7% CPS estimate for Wisconsin) yields an estimate of 29.9% of the adult population covered by publicly subsidized health insurance.

There may still be unaccounted overlap as well between military and the other subsidized insurance programs that would reduce this a bit further. If we modify the estimate of government program participation, counting those who use more than one government insurance program as just one user, the figure we derive from public records of participation is in the neighborhood of 29%. Our survey data report it to be 28.2%, using the same method of counting those with more than one government source as just one recipient.

Thus, what at first blush may appear to be an over-count of those receiving government assisted health insurance appears not to be. Admittedly, our numbers do overstate participation in Medicare, and the combined figure for Medicaid and Badger Care may be a little bit higher than the 3% sampling error. But the overall participation rate in government-assisted health insurance appears to be relatively accurate when compared to one created using DHHS and VA actual enrollment numbers as opposed to the CPS estimates.

Because of the apparent lack of clarity as to exactly in which subsidy programs individuals participate, we will not use the individual program participation rates in our detailed analysis. Instead, all of the discussion combines the recipients of any and all subsidy programs into the one category of subsidized insurance.

But the combination does not stop there. In most cases these individuals with publicly subsidized health insurance will also be combined with other respondents who receive unsubsidized insurance through some employment tie to the government sector. The tie may be directly as an employee of a government or as an employee who receives insurance from a union that serves public workers (or as a spouse or family member of a government employee).

This combination of those with publicly subsidized insurance and those with public employment is a unique attempt to measure just how important the public provision of health insurance is. We know that the government sector is currently responsible for 14.4% of employment in Wisconsin. We also know that some government retirees continue to receive health insurance benefits from their former employers. According to our survey, 17% of the adult population receives health insurance in some way from a public employer. That is right in line with expectations. Thus, we would further expect the role of government provision of insurance to be considerably higher than just the figure associated with subsidized insurance. By combining the two, we are able to better understand just how important the public sector is in this field. We can then speculate as to what the impacts are of that larger role.

The bottom line on the proportion of adults served by some form of publicly subsidized insurance in Wisconsin is that it is in the 28-29% range of all adults. When those who receive health insurance paid for by the public sector are combined with those with publicly subsidized insurance, our estimate is that it is over 45% of all adults and 51.3% of all adults with insurance. That is a significant role.

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About the Institute

The **Wisconsin Policy Research Institute** is a not-for-profit institute established to study public-policy issues affecting the state of Wisconsin.

Under the new federalism, government policy increasingly is made at the state and local levels. These public-policy decisions affect the life of every citizen in the state. Our goal is to provide nonpartisan research on key issues affecting Wisconsinites, so that their elected representatives can make informed decisions to improve the quality of life and future of the state.

Our major priority is to increase the accountability of Wisconsin's government. State and local governments must be responsive to the citizenry, both in terms of the programs they devise and the tax money they spend. Accountability should apply in every area to which the state devotes the public's funds.

The Institute's agenda encompasses the following issues: education, welfare and social services, criminal justice, taxes and spending, and economic development.

We believe that the views of the citizens of Wisconsin should guide the decisions of government officials. To help accomplish this, we also conduct regular public-opinion polls that are designed to inform public officials about how the citizenry views major statewide issues. These polls are disseminated through the media and are made available to the general public and the legislative and executive branches of state government. It is essential that elected officials remember that all of the programs they create and all of the money they spend comes from the citizens of Wisconsin and is made available through their taxes. Public policy should reflect the real needs and concerns of all of the citizens of the state and not those of specific special-interest groups.