

Health Priority: Access to Primary and Preventive Health Services
Objective 1: Increase the Percentage of the Population with Health Insurance
(Template)

Long-Term (2010) Subcommittee Outcome Objective:

By 2010, increase to 92 percent the proportion of the population with health insurance for all of the year.

Long-term outcome objective updated as of: Sept 2004

Wisconsin Baseline	Wisconsin Sources and Year
88 percent in 2000	Wisconsin Health Insurance Coverage, 2000 (Bureau of Health Information)

Federal/National Baseline	Federal/National Sources and Year
86 percent in 2000	Current Population Survey, 2000 (U.S. Census Bureau)

Related USDHHS Healthy People 2010 Objectives			
Chapter	Goal	Objective Number	Objective Statement
1 – Access to Quality Health Services	Improve access to comprehensive, high quality health care services.	1-1	Increase to 100 percent, the proportion of the population with health insurance.

Definitions	
Term	Definition
Access	According to the Institute of Medicine, “The timely use of personal health services to achieve the best possible health outcomes.” This definition includes both the use and effectiveness of health services. The concept of access also encompasses physical accessibility of facilities. IOM. <i>Medicare: A Strategy for Quality Assurance</i> . Vol. 1. Lohr, K.N., ed. Washington, DC: National Academy Press, 1998.

Rationale:

- Health insurance is linked to access to primary and preventive care. Health insurance is an important indicator for access to health services (U.S. Department of Health and Human Services, 2000), and persons with health insurance are more likely to use primary and preventive services than those without (Hoffman, 2000). Uninsured individuals are less likely to have a primary care provider and to receive appropriate preventive care such as a recent Pap test, immunizations, or early prenatal care than insured persons (USDHHS, 2000). Although preventive health services help reduce morbidity and mortality, uninsured persons are more likely than the insured to put off needed health care because of cost. (National Center for Health Statistics, 2003).
- Those who are uninsured rely on more high-cost services. The uninsured are more likely to be poor, more likely to seek out institutions willing to provide care regardless of ability to

pay (such as hospitals), and more likely to be admitted for preventable or avoidable conditions (National Center for Health Statistics, 2003 and Kovner & Jonas, 1999). Costs at these institutions are often higher, increasing total costs for the health care delivery system (Kovner & Jonas, 1999)

- Uninsured persons receive less overall care and have poorer health outcomes. Lack of insurance over an extended period significantly increases the risk of premature death, and death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance (USDHHS, 2000). For example, uninsured pregnant women tend to begin prenatal care later and have fewer total visits than privately insured mothers, and uninsured newborns are more likely than those covered by insurance to have adverse outcomes (Kovner & Jonas, 1999). In addition, uninsured persons admitted to the hospitals receive fewer resources and procedures than insured patients (Kovner & Jonas, 1999).
- Basic health plans should include a defined set of primary and preventive physical, mental, and oral healthcare services. These are essential to “promoting and protecting the health of all.”
- It is desirable to use state funds to leverage other funding sources where possible (e.g., Federal Medicaid funding).
- It is desirable to educate businesses regarding the advantages of providing health insurance to their employees.
- Public policy should aim to cover target populations since insurance coverage is essential to reducing or eliminating health disparities.
- Data and information are lacking on health insurance coverage for particular populations of interest (e.g., low-income workers, workers in small firms, students and graduates transitioning to work, adults without minor children, homeless, migrants, and undocumented residents).
- There are very limited state and federal data on the depth and breadth of services covered by various types of health insurance (e.g., Medicare, private insurance, and employer self-insured).
- In order to successfully achieve this objective, a governance structure must be in place to ensure the creation of key aspects of the 10-year long term outcome objective, including the creation of a benchmark definition for basic services for health insurance coverage.

Outcomes:

Benchmarking

Short-term Outcome Objective (2002-2004)

- By 2004, define a benchmark plan that identifies the basic services to be covered by health insurance and the preferred options to finance the additional coverage.

Medium-term Outcome Objective (2005-2007)

- By 2007, propose an implementation plan and budget to fill gaps identified in development of the benchmark plan.

Inputs: (What we invest – staff, volunteers, time, money, technology, equipment, etc.)

- Use a consensus generating process in the workgroup that is informed by available research to define the appropriate benchmarks.

- Resources to support meetings of the workgroup to include existing and new relevant materials.

Outputs: (*What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.*)

Activities:

- Create a standing workgroup within the Wisconsin Department of Health and Family Services. This workgroup should be comprised of diverse partners to include:
 1. Key staff and Divisions from the Wisconsin Department of Health and Family Services whose programs and services relate to access to primary and preventive health services (e.g., Wisconsin Well Woman Program; BadgerCare; Wisconsin Diabetes Program, Tobacco Control Program, Wisconsin Cardiovascular Program).
 2. Office of the Commissioner of Insurance; state elected officials; representatives of payers, providers, and consumers.
 3. Local health departments; community health centers; Wisconsin Primary Health Care Association; professionals (e.g., physicians, nurses, dentists, social workers, nutritionists, health educators).
- Identify the best place to house this workgroup (e.g., Division of Public Health, Division of Health Care Financing).
- Assure linkages to the Public Health Advisory Committee and the State Health Plan and Public Health Policy Officer in the Division of Public Health.
- The aforementioned workgroup will generate a benchmark plan based on the following steps:
 1. Partners will review a variety of existent plans and policies including those suggested by professional associations (e.g., American Academy of Family Practice); other states (e.g., Oregon); existing programs (e.g., Medicaid and BadgerCare); and consumer advocacy groups (e.g., ABC for Health, Wisconsin Council on Children and Families).
 2. Partners will review reports of existing coverage by the type of plan and will determine current and emerging gaps.
 3. Partners will define “basic health care coverage.”
 4. Partners will recommend priority actions to close gaps.

Participation/Reach:

- Department of Health and Family Services, Division of Public Health and Division of Health Care Financing staff and existing programs
- Office of the Commissioner of Insurance
- State elected officials
- Representatives of payers
- Providers
- Consumers
- Local health departments
- Community health centers
- Wisconsin Primary Health Care Association

- Health care professionals
- Public Health Advisory Committee
- Professional organizations
- Other states
- Consumer advocacy groups

Set Specific Magnitudes

Short-term Outcome Objective (2002-2004)

- By 2004, establish specific magnitudes or percentage targets for insurance coverage for the following specific populations based on aforementioned benchmark plan.
 - Low income workers
 - Workers in small firms
 - Students and those in transition
 - Adults without a minor child/children
 - Workers in medium and large firms
 - Specific racial/ethnic groups
 - Homeless persons
 - Migrants and undocumented workers

Medium-term Outcome Objective (2005-2007)

- By 2007, increase by 25 percent the targets for insurance coverage identified in the short-term objective for Component II.

Long-term Outcome Objective (2008-2010)

- By 2010, increase by 50 percent the targets for insurance coverage identified in the short-term objective for Component II.

Inputs: (*What we invest – staff, volunteers, time, money, technology, equipment, etc.*)

- Staff time and resources for public health system Partners will be required.

Outputs: (*What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.*)

Activities:

- Partners will identify aforementioned target populations as well as others not identified in the above list. Additional questions will be added to the Department of Health and Family Services Wisconsin Family Health Survey. Partners will develop policies to expand existing health plan coverage to incorporate eligible enrollees in appropriate health plans.
- Partners will develop and implement outreach programs to incorporate eligible enrollees in appropriate health plans.
- Partners will continue to implement outreach programs to incorporate eligible enrollees in appropriate health plans.

Participation/Reach:

- Public health system partners

Determine Baselines and Set Specific Targets for Magnitudes of Change

Short-term Outcome Objective (2002-2004)

- By 2004, establish baselines and specific magnitudes or percentage change targets for insurance coverage for the following specific populations based on aforementioned benchmark plan.
 1. Low income workers
 2. Workers in small firms
 3. Students and those in transition
 4. Adults without a minor child/children
 5. Workers in medium and large firms
 6. Specific racial/ethnic groups
- Investigate ways to assess insurance coverage in mobile, difficult-to-reach population groups such as homeless persons, migrants and undocumented workers.

Medium-term Outcome Objective (2005-2007)

- By 2007, increase by 25 percent over the baseline insurance coverage identified in the short-term objective for Component II.

Long-term Outcome Objective (2008-2010)

- By 2010, increase by 50 percent over the baseline insurance coverage identified in the short-term objective for Component II.

Inputs: (*What we invest – staff, volunteers, time, money, technology, equipment, etc.*)

- Staff time and resources for public health system partners will be required.

Outputs: (*What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.*)

Activities:

- Partners will identify aforementioned target populations as well as others not identified in the above list. Questions will be added to the Department of Health and Family Services Wisconsin Family Health Survey to the extent feasible and other measurement tools will be investigated. Partners will develop policies to expand existing health plan coverage and to incorporate eligible enrollees in appropriate health plans.
- Partners will develop and implement outreach programs to incorporate eligible enrollees in appropriate health plans.
- Partners will continue to implement outreach programs to incorporate eligible enrollees in appropriate health plans.

Participation/Reach:

- Public health system partners

Wisconsin Private Employer Health Care Coverage Program

Short-term Outcome Objective (2002-2004)

- By 2004, initiate the Wisconsin Private Employer Health Care Coverage Program and determine a baseline for the percentage of companies with fewer than 50 employees that have joined this private purchasing cooperative.

Medium-term Outcome Objective (2005-2007)

- By 2007 there will be a 35 percent increase in the number of companies that have joined the purchasing cooperative.

Long-term Outcome Objective (2008-2010)

- By 2010, increase by 50 percent over the 2004 baseline, the number of companies that participate in the private purchasing cooperative program.

Inputs: *(What we invest – staff, volunteers, time, money, technology, equipment, etc.)*

- State designated administrators and chambers of Commerce will seek additional participation in the private purchasing cooperative program.
- The Governor, along with the state Legislature, will identify funding for the implementation and administration of this private purchasing cooperative. Initial program administrators will be designated.

Outputs: *(What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.)*

Activities

- The private purchasing cooperative legislation will be revised and funded so as to encourage employer participation and active participation by chambers of commerce and the State Employee Trust Fund in increasing participation.
- Opportunities for small businesses to join the program will be expanded.

Participants/Reach

- State designated administrators
- Chamber of Commerce
- State Employee Trust Fund
- Governor and state legislature

Enrollment Percentage Targets

Short-term Outcome Objective (2002-2004)

- By 2004, determine the enrollment percentage targets for BadgerCare based on benchmark plan priorities (Refer to short-term objective under Benchmarking.)

Medium-term Outcome Objectives (2005-2007)

- By 2007, increase by 25 percent the target percentages of enrollment in BadgerCare indicated in the above short-term objective.

Long-term Outcome Objective (2008-2010)

- By 2010, increase by 50 percent the target percentages of enrollment in BadgerCare indicated in the above short-term objective.

Inputs: *(What we invest – staff, volunteers, time, money, technology, equipment, etc.)*

- The state legislature, along with the Governor, based on input from consumers advocacy groups, professional organizations, social service/human service departments, local health departments, Department of Health and Family Services, and others will seek appropriate legislative changes and funding.

Outputs: *(What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.)*

Activities

- Based on the benchmark plan for covered services and gaps in coverage that receive priority, the legislature will establish and fund an appropriate set of vouchers for qualified residents.
- BadgerCare participation will be expanded through a multifaceted marketing initiative under the direction of the Department of Health and Family Services.

Participation/Reach

- Governor and state legislature
- Advocacy groups
- Professional organizations
- Social service/human service departments
- Local health departments
- Department of Health and Family Services
- Others seeking appropriate legislative changes and funding

Identify Successful Outreach Strategies

Short-term Outcome Objective (2002-2004)

- By 2004, identify successful outreach strategies to increase participation of eligible enrollees in the Temporary Assistance to Needy Families and Medicaid programs.

Medium-term Outcome Objective (2005-2007)

- By 2007, the percentage of eligible enrollees should reach 50 percent of the targeted level.

Long-term Outcome Objective (2008-2010)

- The percentage of eligible enrollees should reach 75 percent of the targeted level.

Inputs: *(What we invest – staff, volunteers, time, money, technology, equipment, etc.)*

- The Department of Health and Family Services will devote staff time and resources to such identification.

- The Department of Health and Family Services will devote staff time and resources to outreach programs.

Outputs: (*What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.*)

Activities

- Staff will identify those eligible enrollees who presently do not participate in Temporary Assistance to Needy Families and Medicaid programs and set a target percentage for participation.
- Staff will use various outreach programs to enroll eligible residents in the Temporary Assistance to Needy Families and Medicaid programs.
- Staff will continue outreach efforts made during the medium term.

Participation/Reach

- Department of Health and Family Services staff
- New eligible enrollees in Temporary Assistance to Needy Families and Medicaid programs.

State Planning Grant

Short-term Outcome Objective (2002-2004)

- By 2004, apply and incorporate the results of the Division of Health Care Financing’s State Planning Grant to improve measurement of the uninsured and outreach strategies designed to enroll groups with low insurance coverage rates.

Medium-term Outcome Objective (2005-2007)

- By 2007, the Division of Health Care Financing will continue to build upon State Planning Grant efforts to improve measurement and policy to address the uninsured.

Inputs: (*What we invest – staff, volunteers, time, money, technology, equipment, etc.*)

- Division of Health Care Financing will use the results of the September 2001 “Conference on the Uninsured” to identify potential for improved measurement and outreach.
- Division of Health Care Financing will continue identification and outreach efforts.

Outputs: (*What we do – workshops, meetings, product development, training. Who do we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.*)

Activities

- Division of Health Care Financing’s State Planning Grant will implement improved reporting characteristics and outreach strategies.
- Enrollments in insurance will increase.

Participation/Reach

- Division of Health Care Financing

Evaluation and Measurement:

The public health system partners, through the Division of Health Care Financing, will track and evaluate the gaps in insurance coverage as indicated in the various outcomes discussed above. Much of the relevant information can be obtained from an annual report entitled *Wisconsin Health Insurance Coverage* issued by the Department of Health and Family Services, Bureau of Health Information.

For those outcomes that do not relate to percentage of targeted population covered, the partners will each year issue a report detailing their activities and the resulting outcomes. Such reports will include but not be limited to (1) a report and implementation budget concerning benchmarking, (2) a report of outcomes and results of legislative actions in public documents, (3) annual reports from the Division of Health Care Financing concerning outreach programs and success in meeting objectives, and (4) an annual report from the Bureau of Health Information concerning changes in its annual survey and reported outcomes.

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Social and Economic Factors that Influence Health: Income and community characteristics affect the availability of and likely enrollment in health insurance programs. Social and cultural factors affect the ability of outreach programs to successfully enroll eligible individuals in various health insurance programs.

Integrated Electronic Data and Information Systems: Measurement and monitoring is essential to determining existing gaps in insurance and progress in narrowing these gaps. Timely data will be critical to fine-tuning the programs designed to reduce the number of uninsured overall and for specific populations. The annual report entitled *Wisconsin Health Insurance Coverage* should be made a part of an integrated data system.

Community Health Improvement Processes and Plans: In order to leverage programs and funding sources, Partners need to take advantage of existing health plans and partnerships in each community. Community health planning is central to identification of opportunities to take advantage of both state and Federal programs.

Coordination of State and Local Public Health System Partnerships: To make efficient use of available resources, both revenue and staff time, state government should work with each local set of community partners to determine the appropriate mix of resources best achieves the desired outcomes.

Equitable, Adequate, and Stable Financing: In order to enroll those without insurance in a health insurance plan, additional financing (or reallocation of existing financing) must be obtained. The selection of sources of funding should attempt to share burdens in a fair manner, be sufficient to accomplish the desired objectives, and be stable over time. To achieve this outcomes, new programs should not encourage employers to reduce or eliminate existing insurance coverage.

Significant Linkages to Wisconsin's 12 Essential Public Health Services

Educate the public about current and emerging health issues: Education plays a critical role in achieving outcomes. Community-based advocates need accurate information in order to assure

that case management and advocacy can maximize use of existing resource to improve access to health care.

Promote community partnerships to identify and solve health problems: Access to care requires that diverse and inclusive partners be “at the table” working together to assess the scope of issues affecting access to care and advancing policy recommendations and strategies to assure a “medical home” for all persons. This includes community stakeholders (e.g., African American; Hispanic/Latino; Asian/Hmong; American Indian; Lesbian, Gay, Bisexual, and Transgendered Persons; elderly; mental health; alcohol and substance abuse treatment programs). Key partners also include but are not limited to: local health departments, social service and human service providers, professionals, community advocates, outreach and case management providers, community health centers, hospitals, rural/urban perspectives.

Create policies and plans that support individual and community health efforts: This includes review of existing policies, perceived and actual barriers to care, new public policy (e.g., state-based purchasing cooperatives, BadgerCare expansion, and identification of target populations).

Link people to needed health services: Financing is a central ingredient in improving people’s access to primary and preventive health services.

Evaluate effectiveness, accessibility, and quality of personal and population-based health services: Defining benchmark basic services coverage and the study of new potential targets will incorporate such evaluations.

Conduct research to seek new insights and innovative solutions to health problems: This essential service is related to all six major categories of this objective: (1) benchmarking, (2) Wisconsin Private Employer Health Care Coverage Program, (3) enrollment percentage targets, (4) setting specific magnitudes, (5) identifying successful outreach strategies, and (6) Wisconsin’s State Planning Grant.

Assure access to primary health care for all: Since all four 10-year, long-term outcome objectives for the access to primary care subcommittee are centrally focused on this service, all outcomes are directly or indirectly related to improved access.

Foster the understanding and promotion of social and economic conditions that support good health: Benchmarking basic services coverage and state-based purchasing cooperative directly relate to social and economic conditions.

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010

- *Protect and Promote Health for All*
- *Eliminate Health Disparities*
- *Transform Wisconsin’s Public Health System*

This objective seeks to increase access to health insurance for all and to ensure financial support for those people who presently lack it. Satisfaction of the goal will yield “reduced health disparities” and “increased health promotion” since those with insurance coverage have better

access to services and better health than those without such coverage. The activities envisioned in this plan to reduce the percentage of the population without health insurance engage a “variety of partners” – governmental, public, private, nonprofit – to expand health insurance coverage and health promotion. These efforts will assist in making public health more than just a governmental function and, thus, in transforming the public health system to one based on the health of the population.

Key Interventions and/or Strategies Planned:

- Develop a benchmark plan to identify basic services to be covered and propose an implementation plan and budget to fill identified gaps. This should include the identification of specific magnitudes or percentage targets for insurance coverage for specific target population groups.
- Provide incentives for group purchasing. Initiate the Wisconsin Private Employer Health Care Coverage Program and increase, over time, the number of companies that participate in this program so that by 2010 there is at least a 50 percent increase in participation.
- Provide vouchers to qualified employees to purchase coverage from a qualified set of options under BadgerCare. Increase the target percentages of BadgerCare enrollment so that by 2010 there is a 50 percent increase over what was “actual” in the year 2004.
- Compile data on sub-populations that are uninsured (e.g., low-income workers, workers in small firms, migrants) and develop options for expanding public and/or private insurance coverage (e.g., Medicaid, BadgerCare, purchasing cooperatives, private insurance).
- Identify and expand successful outreach strategies to increase the participation of eligible populations in existing health insurance programs.
- Build upon State Planning Grant currently administered by the Wisconsin Division of Health Care Financing. Use the results from the September 2001 “Conference on the Uninsured” to identify potential for improved measurement and outreach.

References:

Coverage Matters: Insurance and Healthcare; Institute of Medicine of the National Academies; September, 2001. <http://www.iom.edu/reports.asp?year=2001#Year2001>

Health, United States. Early release of selected estimates based on data from the January-June 2003 National Health Interview Survey. National Center for Health Statistics. Hyattsville, MD, 2003. <http://www.cdc.gov/nchs/about/major/nhis/released200312.htm>

Healthy People 2010 (Second edition.). U.S. Department of Health and Human Services. U.S. Government Printing Office, Washington D.C. November, 2000.

Hoffman, Catherine and Schlobohm, Alan, editors. *Uninsured in America: A Chartbook prepared for the Kaiser Commission on Medicaid and the Uninsured* (Second edition). May, 2000. <http://www.kff.org/uninsured/1407-index.cfm>

Institute of Medicine (IOM). *Medicare: A Strategy for Quality Assurance*. Vol. 1. Lohr, K.N., ed. Washington, DC: National Academy Press, 1998.

Kahn, Charles N, III and Pollack, Ronald F. Building a Consensus for Expanding Health Coverage, *Health Affairs*, Volume 20, Number 1, January/February, 2001.

Kovner, A.R. and Jones, S. Health Care Delivery in the United States (Sixth edition). Springer Publishing. New York, 1999.

Mills, Robert J. Health Insurance Coverage: 2000. *Current Population Reports*. U.S. Census Bureau. Washington D.C. September, 2001. <http://www.census.gov/prod/2001pubs/p60-215.pdf>

Private Employer Health Care Purchasing Cooperative: Progress Report. Wisconsin Office of Private Health Care Coverage. July, 2001.

Who are the Uninsured in Wisconsin? A health policy, research, and information sharing conference on the issues of the uninsured. Wisconsin Department of Health and Family Services. September, 2001. <http://www.dhfs.state.wi.us/medicaid8/state-grant/>

Wisconsin Health Insurance Coverage 2000; Bureau of Health Information, Division of Health Care Financing, Wisconsin Department of Health and Family Services; September, 2001. <http://dhfs.wisconsin.gov/stats/pdf/fhs00ins.pdf>