

July 2002

Evaluation of the BadgerCare Medicaid Demonstration

Case Study Report

Prepared for

Paul Boben, PhD

Centers for Medicare and Medicaid Services
OA/OSP/REG/DBR, MS C3-19-07
7500 Security Boulevard
Baltimore, MD 21244-1850

Prepared by

Deborah A. Gibbs, MSPH

Norma I. Gavin, PhD

Kristin R. Siebenaler, MPA

Nancy L. Fan, MHA

RTI

Health, Social, and Economics Research
3040 Cornwallis Road
Research Triangle Park, NC 27709
and

Kristianna Pettibone

MayaTech Corporation

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Executive Summary

BACKGROUND

Following more than 10 years of experience with welfare reform initiatives, Wisconsin implemented an innovative new health care program. The new program, called BadgerCare, complements the State's welfare initiatives by bridging the gap between Medicaid and private insurance for the working poor. Key features of the program include expansion of coverage to uninsured children in families up to 185 percent¹ of the federal poverty level (FPL), their parents, and spouses of parents; enhanced outreach activities to encourage qualified families to apply; premium payments for some families and other measures to limit crowd-out of private insurance; and integration of employer-sponsored insurance (ESI).

To document Wisconsin's experience with these innovations, the Centers for Medicare and Medicaid Services (CMS) contracted with RTI and its subcontractor, the MayaTech Corporation, to evaluate key features of the BadgerCare program. Evaluation activities include a case study; surveys of BadgerCare participants, nonparticipants, and disenrollees; and analysis of secondary data, including BadgerCare enrollment files and extant survey data. This report presents findings from the case study component, which documents the program's development and current operation and provides an analytic context for the surveys and secondary data analyses.

¹ Once enrolled, families can remain covered until income exceeds 200 percent of the FPL.

BadgerCare's success is linked to engagement of diverse stakeholders and use of existing Medicaid infrastructure.

The State created a distinct image for the program, conducted an array of outreach activities, and simplified enrollment.

BadgerCare enrollment exceeded expectations and reduced Wisconsin's already low rate of uninsurance.

FINDINGS

Because State planners believed that a commitment from all stakeholders was key to getting BadgerCare approved, they engaged in a collaborative planning process from the outset. Compromises on crowd-out provisions, such as premium payments for the higher income eligibles, were key to gaining stakeholder support. Collaboration and compromise were extended to the State's interaction with CMS in obtaining approval for the program. Another key factor in the success of the BadgerCare program is the State's decision to use the existing Medicaid eligibility and health care delivery system for the BadgerCare program and to fine-tune the systems later as needed. As a result, implementation was quick and effective once approval was received.

To encourage qualifying families to apply for BadgerCare, the State created a distinct image for the program, conducted an array of outreach activities to disassociate it from welfare, and adopted several enrollment simplification measures. Statewide outreach activities for the BadgerCare program included a media campaign and placement of outreach workers at health care and community establishments. With support from the *Covering Kids* initiative, the State also engaged in training of outreach workers, capacity building among community agencies, and information dissemination, and made changes to the enrollment process. Targeted outreach activities have been implemented through schools, health care providers, and tribal clinics. The program's enrollment success suggests that these activities were highly effective.

From the start, BadgerCare enrollment has exceeded expectations, reversing the downward trend in Medicaid family coverage resulting from the declining welfare rolls. At the end of 2001, approximately 91,500 individuals were enrolled in BadgerCare and an additional 53,300 children had been added to the Medicaid/Healthy Start rolls. BadgerCare participants were geographically dispersed throughout the State rather than concentrated in urban areas. Virtually all Wisconsin Works (W-2) participants are currently covered by Medicaid or BadgerCare. The increase in Medicaid and BadgerCare enrollment was accompanied by a significant drop in the uninsurance rate in Wisconsin to 7 percent in 2000, down from a

Focus group participants identify several possible deterrents to participation but agree that premiums reduce the stigma of public assistance.

high of 13 percent prior to BadgerCare implementation (U.S. Census Bureau, 2001).

While largely favorable toward the program, focus group participants noted a variety of potential deterrents to participation in BadgerCare, including difficulties with the enrollment process and county eligibility workers. The State has been addressing these problems with enrollment simplification measures and training. Although many researchers and policymakers believe that family coverage encourages parents to enroll their children in BadgerCare, focus group participants report that they would have enrolled their children even if they themselves would not gain coverage. Focus group participants also did not view premium payments as a deterrent to enrollment; they felt that premium levels were reasonable and made them feel like they were not “leeching” off the system. No evidence that crowd-out provisions have prevented many otherwise eligible families from enrolling in BadgerCare was found.

Most BadgerCare participants receive coverage through Medicaid managed care; the State’s buy-in to employer-sponsored insurance is not yet well used.

Wisconsin’s Medicaid managed care delivery system for the Aid to Families with Dependent Children (AFDC)-related/Healthy Start population is the primary health care delivery system under BadgerCare. In 2000, three-fourths of BadgerCare enrollees were enrolled in a health maintenance organization (HMO) plan for at least part of the year. Wisconsin’s premium assistance plan for ESI has so far enrolled only a handful of program eligibles, due to stringent eligibility rules, low familiarity and understanding of the program, and a general opposition to expanded government involvement in health care among Wisconsin employers and their representatives. The State has recently lowered the required employer contribution amount and allowed self-funded employer plans to be considered as qualifying Health Insurance Premium Payment (HIPP) plans and is considering other measures to increase enrollment in the program.

BadgerCare is viewed as a success by its varied stakeholders, who remain attentive to specific concerns.

Stakeholders in State government, health care delivery, insurance, and advocacy organizations clearly consider the program an achievement that resonates with the State’s long-standing commitment to increase access to health care and its more recent crusade to reduce welfare dependency. However, even the program’s most ardent supporters readily identify areas in need of improvement. The most commonly cited concerns include barriers

The Title XXI waiver was critical to BadgerCare's viability. Premium payments play a financially small but politically significant role.

to enrollment and retention created by both program procedures and agency culture, which the State is addressing. Additional concerns within specific sectors include advocates' desire to facilitate financial access to the program and concern in the business sector over program crowd-out of private insurance.

BadgerCare's early successes threatened to overwhelm program resources, as rapid enrollment growth, particularly among adults, fueled higher than anticipated costs. The eventual approval of the federal waiver, allowing a higher match rate for family coverage, provided an urgently needed boost in program revenue. Premiums represent a small portion of total program revenue, approximately 2 percent, and add to the administrative burden. Nevertheless, they serve a beneficial role in reducing any stigma attached to BadgerCare and increasing the program's political appeal.

CONCLUSION

High enrollment figures and low uninsurance in Wisconsin attest to the success of the BadgerCare program. While further study is needed, the early experience of the Wisconsin BadgerCare program suggests that family-based coverage and premium payments for low-income families can work in a publicly funded program. However, the State has had little success in integrating public and employer-based coverage through its premium assistance program.

Much of BadgerCare's success is attributable to factors that are reproducible in other states such as the engagement of all stakeholders in the planning process, the use of the existing Medicaid infrastructure, and the creation of a distinct image for the program. Other factors contributing to the program's success, such as the State's long tradition of innovation and the efforts of key political leaders, may be unique to Wisconsin.

Furthermore, BadgerCare was developed during a period of robust economic conditions in Wisconsin, characterized by high rates of employment and employer-sponsored insurance (ESI) coverage. Since the program's implementation, economic conditions have shifted substantially, and employers now struggle with rising health insurance costs. As its policy and economic context evolve, BadgerCare will need to evolve as well.

1

Introduction

1.1 BACKGROUND AND KEY FEATURES OF BADGERCARE

Following more than 10 years of experience with welfare reform initiatives, the Wisconsin Department of Health and Family Services (DHFS) implemented an innovative health care program. The new program, called BadgerCare, complements the State's welfare initiatives by bridging the gap between Medicaid and private insurance for the working poor (Bartels and Boroniec, 1998). The program uses a combination of federal and State matching funds under Title XIX, through a Section 1115 Medicaid demonstration waiver and Title XXI, the State Children's Health Insurance Program (SCHIP), to cover uninsured low-income children and parents.

1.1.1 Support for Welfare to Work Transition

As a result of W-2, which is the State's Temporary Assistance for Needy Families (TANF) program, and its predecessor demonstration programs, welfare caseloads in Wisconsin dropped 87 percent from January 1993 to September 1998—more than any other state in the nation (*New York Times*, January 25, 1999). However, along with this decline in the welfare caseload came a dramatic reduction in Medicaid enrollment. Medicaid enrollment of nonaged, nondisabled cash assistance recipients dropped more than 57 percent and, although Medicaid enrollment in other noncash categories increased, a net decline in total nonaged, nondisabled Medicaid enrollment of almost 26 percent occurred during this time (HCFA, 2000). Such a large drop in the Medicaid caseload alarmed policy makers because families leaving welfare are eligible for

transitional Medicaid coverage and many children should remain insured through the poverty-related criteria (Ellwood and Ku, 1998). Furthermore, some growth in noncash Medicaid enrollment would have occurred from the phased-in expansion of poverty-related child coverage.

Health care coverage is an important element of support for families making the transition from welfare to work. TANF legislation “de-linked” Medicaid eligibility from eligibility for cash assistance and established a new family coverage category, Section 1931 of Title XIX (Mann, 1999). Prior to BadgerCare, Wisconsin’s financial eligibility requirements for this category were set at the State’s AFDC program standards. These standards are less generous than eligibility standards for W-2. Wisconsin’s Medicaid program also covers pregnant women and children up to age 6 with incomes at or below 185 percent of the FPL, children born after September 31, 1983, with incomes up to 100 percent of the FPL, and the medically needy. Nevertheless, a large number of families participating in W-2 were no longer eligible for Medicaid. Because many of the adults leaving welfare would be working at low-wage jobs with no health benefits, it was feared that the number of low-income uninsured in the State would increase. To prevent or reverse this possibility, BadgerCare expanded Medicaid coverage in Wisconsin to all uninsured children in families with incomes up to 185 percent of the FPL, their parents, and spouses of parents. Once enrolled, families can remain in the program until income exceeds 200 percent of the FPL.

1.1.2 Family Coverage

However, low take-up rates under SCHIP suggest that eligibility expansion is not enough to reduce the number of uninsured. Policy makers in Wisconsin believe that family-based coverage will be more effective than child-only coverage in providing health insurance to the uninsured by making it more attractive and less complex for all family members to be enrolled in a single plan (Bartels and Boroniec, 1998). In a study of the Medicaid expansions of the late 1980s and early to mid 1990s, Thorpe and Florence (1998) found Medicaid child-only expansions enrolled about 45 percent of potentially eligible children, whereas family-based expansions brought in 75 percent of potential eligibles. The authors concluded that although funds authorized for SCHIP would be

adequate to insure four out of five eligible uninsured children, states would need considerable effort and creativity to reach and enroll them. They argued that allowing parents of these children to enroll would enhance child participation. Using different methods and data sources, other studies have also found higher child enrollment in states that offered family coverage than in those that did not, although the differences were not as large (Ku and Broaddus, 2000; Dubay and Kenney, 2001).

1.1.3 Enrollment Simplification

Other efforts are also needed to increase the enrollment of eligible children. A recent survey found that complex and burdensome enrollment processes, coupled with a general lack of knowledge of Medicaid eligibility rules, pose the greatest barriers to Medicaid enrollment for eligible children (Perry et al., 2000). With the implementation of BadgerCare, Wisconsin increased outreach efforts designed to inform providers, community-based organizations, and public health and social services agency workers about the program and to encourage qualified families to participate.

1.1.4 Crowd-Out Provisions

Policy makers desired to increase health insurance coverage of the uninsured, but they were also concerned that the program would attract families who were already covered—enticing them to substitute BadgerCare coverage for their costly private coverage. Although this “crowd-out” effect may be minimal at lower income levels, studies have found that more substitution of public program benefits for private insurance coverage occurs as eligibility is extended to the higher income categories (Dubay and Kenney, 1997). Therefore, Wisconsin policy makers incorporated several features in BadgerCare designed to keep crowd-out at a minimum. These features include premium payments for higher income families, waiting periods, the exclusion from eligibility of families with access to ESI for which the employer pays 80 percent or more of the premium payment, and a buy-in option for qualifying ESI plans.

Premiums

In keeping with the State’s emphasis on promoting personal responsibility and reducing potential crowd-out, premium payment

provisions were instituted with BadgerCare. Families with incomes over 150 percent of the FPL must pay monthly premiums of approximately 3 percent of their income. Premium payments make BadgerCare more like private insurance and therefore may reduce the political and social stigma sometimes associated with public programs. However, premiums are known to reduce participation and can lead to adverse selection. Research with low-income populations has demonstrated that as premiums increase, participation rates decrease (Ku and Coughlin, 1997; Lewin-VHI, Inc., 1994). Furthermore, a report issued by Families USA (1998) asserts that State choices on premiums and cost sharing directly affect families' decisions to enroll in new programs and use services, despite provisions for maximum out-of-pocket expenses.

In addition to discouraging participation, premiums complicate program administration: payments must be collected and tracked, late payment notices must be sent, and penalties for nonpayment must be imposed. Failure to pay a premium by the end of the following month for which they apply could result in some or all family members being dropped from BadgerCare. The dropped family members would not be able to reenroll for 6 months. Thus, premium payments could result in increased enrollment "churning."

Waiting Periods

Waiting periods are also used to discourage substitution of BadgerCare for existing insurance, or crowd-out. Applicants are not allowed to enroll in BadgerCare for 3 months following any coverage with private health insurance or within 18 months of having access to ESI. Exceptions are made in circumstances where the discontinuation of private insurance is outside the applicant's control.

ESI Integration

Another innovative feature of BadgerCare is the integration of ESI with Medicaid. Family members who could have been covered by an ESI plan in which the employer pays at least 80 percent of the premium during the past 18 months are excluded from BadgerCare. If a family's employer pays between 40 percent and 80 percent of the premium cost of a health plan and the payment of such premiums and wrap-around services for certain noncovered services is deemed to be cost effective relative to coverage under the State

Medicaid plan, the State pays the premium for the family under its HIPP program.² Services covered by the State Medicaid plan but not by the ESI plan are provided through Medicaid fee-for-service (FFS) reimbursement. Determination of access to eligible ESI plans and their cost effectiveness relative to the State Medicaid plan adds to the program's administrative burden. However, these provisions are considered important to State policy makers as a means to prevent crowd-out and to strengthen the ties already forged in Wisconsin between welfare and work.

In summary, Wisconsin has implemented several innovative features in its BadgerCare program that are designed to support families in achieving self-sufficiency while maintaining high insurance rates but that have possible negative effects as well. Some of these features, including family coverage and integration with ESI, are being adopted by other states for their Medicaid and SCHIP programs. Wisconsin's experience with these innovations must be documented and assessed to derive lessons learned for future program development in Wisconsin and other states. To do so, CMS³ contracted with RTI and its subcontractor, the MayaTech Corporation, to evaluate key features of the BadgerCare program. This is the first in a series of reports on findings resulting from this contract.

1.2 THE BADGERCARE EVALUATION

As outlined in our design report submitted in March 2001, the RTI/MayaTech evaluation of Wisconsin's BadgerCare program investigates five key features of the program: (1) eligibility expansion, (2) outreach and enrollment simplification, (3) family-based coverage, (4) premium payments, and (5) integration with ESI. Evaluation activities include a case study; surveys of BadgerCare participants, nonparticipants, and disenrollees; and analysis of secondary data, including BadgerCare enrollment files and extant survey data. This report presents findings from the case study component, which documents the program's development and

² Prior to November 1, 2001, the lower limit of the required employer contribution was 60 percent.

³ CMS was still known as the Health Care Financing Administration (HCFA) in the early stages of this contract.

current operation and provides an analytic context for the surveys and secondary data analyses.

The case study was designed to provide information to address several of the questions posed by CMS on the BadgerCare program (see **Exhibit 1**). The first set of questions relate to the processes used by the State to develop and implement the demonstration. To address these questions, we used the site visit interviews to investigate how inputs from the various stakeholders were obtained and used to secure their support for or acceptance of the program. We looked for key factors and conditions that made the program work for Wisconsin and evaluated whether they were replicable in other states.

Questions relating to program outreach and enrollment simplification were also investigated in the case study. In particular, we queried State officials and other key stakeholders on the steps taken by the State to publicize the existence of the BadgerCare program and to encourage qualifying families to apply. We also queried them on the enrollment procedures, barriers to enrollment, and steps the State was taking to remove or reduce barriers. Furthermore, we conducted an analysis of enrollment trends to determine the effectiveness of the State's efforts in reaching and enrolling program eligibles and the characteristics and geographic dispersion of enrollees. We also sought information on the impact of the program on coverage of W-2 participants and the uninsured.

CMS posed another set of questions related to factors motivating participation in the BadgerCare program. Therefore, we queried program eligibles on their enrollment experiences and factors motivating their participation decisions. We specifically asked about the effect of eligibility criteria, family-based coverage, premium payments, and crowd-out provisions on enrollment decisions.

Exhibit 1. BadgerCare Evaluation Questions Posed by CMS and Addressed by the Case Study

Program Planning and Implementation

- What was the process used by the State to develop and implement the demonstration?
- How was the participation of various interested parties in the planning process secured?
- Are there lessons to be learned in this area that would be beneficial to other states?

Outreach and Enrollment Simplification

- What steps were taken by the State to publicize the existence of the BadgerCare program and to encourage qualifying families to apply?
- How effective were these efforts?

Enrollment Analysis

- How many people participate in BadgerCare?
- What are the demographic and enrollment characteristics of the BadgerCare participants?
- Has the demonstration increased the percentage of the W-2 participating population who have health insurance?
- Has the demonstration succeeded in increasing the percentage of the population with incomes below 200 percent of the FPL who have health insurance?

Factors Motivating Participation

- What motivates families to participate or not participate in BadgerCare?
- Is there any evidence that family coverage has increased participation of children in Medicaid/SCHIP?
- Have premiums deterred families from enrolling in BadgerCare?
- How many persons and/or families are deemed ineligible for BadgerCare coverage due to the anti-crowd-out provisions?

Integration with ESI and Medicaid Managed Care

- What percentage of the BadgerCare population receives coverage through Medicaid managed care, through exclusively FFS Medicaid/BadgerCare, and through ESI?

Stakeholder Satisfaction

- How do the various interested parties view the demonstration now that it has been implemented and is operating?

Revenue and Costs

- What are the funding sources for the BadgerCare program, and what is the relative importance of each?
 - How much do premiums contribute to total revenues?
-

Note: CMS = Centers for Medicare and Medicaid Services; W-2 = Wisconsin Works; FPL = federal poverty level; SCHIP = State Children's Health Insurance Program; ESI = employer-sponsored insurance; FFS = fee-for-service.

The case study component of the BadgerCare evaluation also investigated BadgerCare's integration with ESI. In particular, we queried State officials, employers, and managed care companies on their experience with the insurance verification process and the HIPPP program. In addition, we investigated the integration of BadgerCare with the Medicaid managed care delivery system and participants' experience with the delivery system. In so doing, we determined the percentages of the BadgerCare population receiving coverage through Medicaid managed care, ESI, and exclusively through FFS coverage.

Two additional issues addressed in the case study included stakeholder satisfaction and funding sources. We queried the various stakeholders on how they viewed the demonstration now that it has been implemented and is operating, and we sought out information on the program's revenue sources and its impact on the State's budget.

Section 2 provides a description of the methods we used to gather the information to address these questions. Section 3 presents our findings, and Section 4 summarizes our findings and presents the lessons learned from the case study component of the BadgerCare evaluation.

2

Methods

Case study activities began early in the project with a review of relevant documents that will continue throughout the study. Site visit interviews were held in February 2001, followed by telephone interviews with informants who were not available at that time. Focus groups with eligible participants and nonparticipants were held during September 2001. This section describes the design and implementation of each of these case study activities.

2.1 CASE STUDY INTERVIEWS

Case study interviews provide information from a variety of perspectives to create a comprehensive picture of BadgerCare's development and implementation process and views on its effectiveness. Topics for interviews included the respondent's assessment of program features, such as outreach efforts, the enrollment process, family coverage, premium payment, crowd-out provisions, and ESI integration.

Project staff used an interview guide designed to ensure that all relevant topics were addressed. However, the specific content of the discussion was varied according to the respondent's expertise, role, and responses to initial questions. Thus, the number of persons who were asked specific questions varied, and the same questions were never asked of more than nine persons (see *Exhibit 2*). A copy of the interview guide is included as *Appendix A*.

Exhibit 2. Overview of Interview Topics by Respondent's Role

BadgerCare Role							
	State	Advocate	Employer	Insurer	Local gov't	Provider	Researcher
Number of Interviews	9	2	5	3	3	4	2
Topic	Specific Aspects Discussed						
Introduction	Study description Purpose of interview Confidentiality provisions						
Family Coverage	Role in program design	Effect on family interest	Family benefits under current ESI	Impact of adult enrollment on claims	Effect on enrollment	Effect on family interest	Effect on enrollment
Income Eligibility	Factors influencing decisions	Extent to which families excluded	Income level of employees	Provisions for determining coverage	Target population's understanding of program provisions	Extent to which families excluded	Extent to which families excluded
Crowd-Out			Provisions for determining coverage				
Cost Sharing	Assessment of program operations to date	Effect on enrollment	Comparison of BadgerCare to ESI	Provisions for determining coverage	Effect on enrollment	Effect on enrollment; tribal issues	Determination of premiums
ESI		Reasons for low participation	Barriers to participation				
Outreach	Assessment of program success	Effectiveness of outreach	Outreach at workplace	Plan's outreach to new enrollees	Outreach activities	Outreach activities	Effectiveness of outreach
Enrollment		Assessment of program success	Reasons for non-participation by eligibles	Plan's enrollment; financial issues	Assessment of program success	Reasons for non-participation by eligibles	Assessment of program success

Note: ESI = employer-sponsored insurance.

Staff interviewed key informants at the State level and those involved at the local level in Madison, Milwaukee, and Marshfield. Persons interviewed represented individuals and organizations involved in the program's development and operation at the State level, as well as local outreach staff, managed care organizations, advocates, employers, and primary care providers. Interviewees were identified based on recommendations from DHFS. A list of all persons interviewed and the organizations they represent is provided in **Appendix B**.

Our process for contacting interviewees and arranging the site visit was designed to ensure that interviewees were informed about the study and the purpose of the interview. James Vavra, Director of the DHFS Bureau of Fee-for-Service Health Care Benefits, assisted RTI with case study planning. RTI provided him with a lead letter describing the study and RTI's role as contractor and asked him to forward the letter to the individuals to be interviewed, along with a brief note asking for their cooperation. RTI staff followed up on this initial contact with a telephone call to each individual to answer any questions about the study and to schedule the interview.

A four-person team conducted the site visit interviews. The entire team participated in initial interviews with key State staff, and two-person teams conducted the remaining interviews. Interviews lasted between 60 and 90 minutes, depending on the number of topics covered. Handwritten interview notes were transcribed shortly after the interview. The typed, electronic notes were then sent to the interviewee for correction of any factual errors.

All interview notes were entered into a database using NVivo,⁴ a widely used qualitative software package, and a hierarchical coding structure was developed to categorize text according to respondent characteristics and topic. The initial topic codes followed the structure of the interview guide. Following completion of interview coding, the study team reviewed and sorted the data by topic to facilitate the review process and then summarized key themes.

⁴ NVivo is an enhanced version of QSR NUD*IST, published by Qualitative Solutions and Research (QSR).

2.2 FOCUS GROUPS

Focus groups add the perspectives of eligible families as a counterpoint to those of the program planners and leaders interviewed during the site visits. Because a skilled moderator is able to observe misunderstandings and modify questions as needed, focus groups are a particularly valuable approach for collecting data on individuals' understanding of complex systems and from persons with low education levels. Topics pursued in focus groups include satisfaction with program design and operation, responses to outreach activities, the effect of premiums and family coverage on program participation, and understanding of provisions for ongoing coverage of children.

We held four focus groups in Milwaukee, where a large proportion of the State's low-income and BadgerCare-eligible population is located. Focus group composition was defined to facilitate explorations of specific relevance to the research questions. Three groups were composed of current BadgerCare enrollees, two of which were defined by income (below 150 percent PFL and between 150 and 185 percent of FPL). This stratification created more homogeneous groups and reduced the possibility of inhibited response among lower income participants. A third enrollee group was not restricted by income, but consisted of enrollees with current or former W-2 experience. The fourth group consisted of adults who were eligible for BadgerCare but not enrolled, to allow discussion of reasons for nonparticipation. The number of participants in each focus group is shown in *Exhibit 3*.

Exhibit 3. Focus Group Participation

Group	Description	Number of Participants
1	BadgerCare enrollees with incomes <150% of the FPL	8
2	BadgerCare enrollees with incomes 150% to 185% of the FPL	6
3	Eligible nonenrollees with incomes 150% to 185% of the FPL	6
4	BadgerCare enrollees with current or prior W-2 experience	5

Focus group findings are generally not generalizable to larger populations. In this instance, the limited number of groups and the fact that only a single group was held in each of the strata of interest underscores the importance of caution in using their findings. Perspectives of focus group participants are reported only when they were consistently voiced within or even across groups. They are presented within this report as an additional perspective on the issues discussed, but are not purported to be representative of all BadgerCare eligibles.

2.2.1 Topic Guides

The focus group topic guide was developed to provide adequate structure to ensure consistency while allowing the moderator to probe for additional detail and pursue unanticipated topics of interest that might develop spontaneously. Questions for each group were tailored to the income, enrollment status, and welfare history of its participants, as shown in *Exhibit 4*. In addition, specific questions were varied according to the circumstances of the group members and their responses to general questions. For example, the topic guide's question, "Do you think people with BadgerCare get treated like people with any other type of health insurance, or are they treated differently?" sparked a vigorous discussion in Group 2 about public perception of the "Forward" card used to access BadgerCare benefits. In Group 3, the same question led to an extended conversation about how BadgerCare clients were treated by health care workers. The two other groups had no response to this opening question. Thus, although the opening question was similar, the majority of questions raised by the moderator were specific to the group. The focus group topic guides are included as *Appendix C*.

Exhibit 4. Overview of Focus Group Topics

Topic	Enrolled Groups	Nonenrolled Group
Introduction	<ul style="list-style-type: none"> ➤ Purpose of group ➤ Confidentiality ➤ Logistics ➤ Group introductions 	<ul style="list-style-type: none"> ➤ Purpose of group ➤ Confidentiality ➤ Logistics ➤ Group introductions
Outreach	<ul style="list-style-type: none"> ➤ How first heard about program ➤ Initial impressions 	<ul style="list-style-type: none"> ➤ How first heard about program ➤ Initial impressions
Enrollment Decision	<ul style="list-style-type: none"> ➤ Reasons for enrolling ➤ Any concerns about enrolling 	<ul style="list-style-type: none"> ➤ Reasons for not enrolling ➤ Reasons might consider enrolling
Premium	<ul style="list-style-type: none"> ➤ Importance of premium ➤ Effect of premium on enrollment decision 	<ul style="list-style-type: none"> ➤ Impression of premium ➤ Effect of premium on decision not to enroll
Family Coverage	<ul style="list-style-type: none"> ➤ Importance of family coverage in decision 	<ul style="list-style-type: none"> ➤ Importance of family coverage in decision
Enrollment Process	<ul style="list-style-type: none"> ➤ Description of process and any difficulties 	<ul style="list-style-type: none"> ➤ Impressions of enrollment process
Enrollment Changes	<ul style="list-style-type: none"> ➤ If any lapses in enrollment, why, how easy to re-enroll 	<ul style="list-style-type: none"> ➤ If any periods of enrollment, why dropped
Program Operation	<ul style="list-style-type: none"> ➤ Experiences in using program 	<ul style="list-style-type: none"> ➤ Impressions of program operation
Wisconsin Works (W-2 group only)	<ul style="list-style-type: none"> ➤ Understanding of how transition from W-2 affects BadgerCare 	

2.2.2 Recruitment

Recruitment of focus group participants proved to be unexpectedly challenging. Our first strategy was a combination of direct and broad-based outreach, building on contacts developed during the site visit. A flyer asking parents to join a discussion group on their experiences getting health insurance for their families was distributed through advocates and community workers and to summer school students in five schools located in neighborhoods with a high proportion of working families. Although this approach has been productive with similar populations, we received little response from potential focus group participants in Milwaukee. We

therefore contracted with a market research firm to recruit participants. The firm used a screening process developed in consultation with RTI to identify participants who met the criteria for each of the groups. Staff of a community advocacy organization located additional participants.

2.2.3 Logistics

Focus groups were held in two locations in downtown Milwaukee. Locations were chosen based on their accessibility to likely participants, as recommended by a local community advocate. Two-person teams staffed all focus groups, with one person moderating and the other taking detailed notes. With participants' permission, groups were audiotaped. Participants received a cash incentive.

Following completion of each group, the team used handwritten notes and audiotapes to prepare a structured debriefing for the group. The debriefing, entered on a laptop computer using a predefined format, described response themes for each topic within the moderator's guide. The debriefing format also provided areas for illustrative participant quotes on each topic, moderators' subjective impressions of emerging themes, and comments on group dynamics that might be relevant to data interpretation. Analysis of focus group findings was based on the debriefing, written notes, and audiotapes.

2.3 DOCUMENT REVIEW

Program documents and news clippings have been and continue to be collected and reviewed to provide an understanding of the program's major features and the implementation process, to determine reactions to the program, and to gather data on selected program outcomes. This information has been used to inform the site visit and focus group protocols and will provide a context for data analysis.

We have used a variety of methods to identify relevant program documents, including CMS's Medicaid and SCHIP web sites, Wisconsin's BadgerCare web site, list-serve notices of recent findings and reports on Medicaid and SCHIP, site visit interviews, other contacts with State and local officials, and computerized literature searches. In addition, a number of local Wisconsin

newspapers are searched weekly for relevant articles. All relevant documents, reports, articles, and news stories are entered into a bibliographic database for use throughout the course of the project.

The following documents were reviewed and used as background for both the design report and this document:

- ▶ **CMS Web Site.** The CMS Medicaid web site (<http://www.hcfa.gov/medicaid/1115/wifact.htm>) provides a fact sheet on the Section 1115 waiver approved by CMS for the BadgerCare demonstration. A fact sheet on BadgerCare is also available on the CMS SCHIP web site (<http://www.hcfa.gov/init/chipwi.htm>), along with the original and amended State plan submissions, CMS approval letters, U.S. Department of Health and Human Services (DHHS) new releases on the approvals, and the Wisconsin SCHIP Evaluation reports for 1999, 2000, and 2001.
- ▶ **Wisconsin's BadgerCare Web Site.** Wisconsin's DHFS web site (<http://www.dhfs.state.wi.us/badgercare/general.htm>) contains a series of fact sheets on BadgerCare providing details on eligibility requirements, application and enrollment procedures, covered services, the HIPP program, and premium payment levels. The DHFS web site also contains a link to Medicaid/BadgerCare enrollment statistics, which are provided in tabular and graphic form for the State as a whole and for each county and tribe in the State by enrollment category.
- ▶ **List-Serve Notices.** RTI staff members belong to several list-serves that provide notices of research findings on Medicaid, SCHIP, and other related health policy topics. These list-serves include MEDPulse, the Kaiser Daily Health Policy Report, the Children's Defense Fund's Child Health Information Project, and the National Center for Education in Maternal and Child Health's MCH Alert.
- ▶ **Newspaper Articles.** On a weekly basis, RTI staff access the *Milwaukee Journal Sentinel*, *The Capital Times*, and the *Wisconsin State Journal* through the Internet and search for articles related to BadgerCare and the uninsured in the State. To obtain a broader perspective of the local sentiment toward BadgerCare, we also periodically search other local

Wisconsin online newspapers. A list of these newspapers is provided in **Exhibit 5**.

**Exhibit 5. Newspapers
Monitored for Case Study**

City	Newspaper
Appleton	<i>Post-Crescent</i>
Ashland	<i>Press</i>
Baraboo	<i>News Republic</i>
Beaver Dam	<i>Daily Citizen</i>
Beloit	<i>Daily News</i>
Chippewa Falls	<i>Chippewa Herald</i>
Eau Claire	<i>Leader-Telegram</i>
Fond du Lac	<i>Reporter</i>
Green Bay	<i>News-Chronicle, Press-Gazette</i>
Janesville	<i>Gazette</i>
Kenosha	<i>News</i>
La Crosse	<i>Tribune</i>
Madison	<i>Capital Times, Wisconsin State Journal</i>
Manitowoc	<i>Herald Times Reporter</i>
Marshfield	<i>News-Herald</i>
Oshkosh	<i>Northwestern</i>
Portage	<i>Register</i>
Racine	<i>Journal Times</i>
Shawano	<i>Leader</i>
Sheboygan	<i>Press</i>
Stevens Point	<i>Journal</i>
Superior	<i>Daily Telegram</i>
Watertown	<i>Daily Times</i>
Waukesha	<i>Freeman</i>
Wausau	<i>Daily Herald</i>
West Bend	<i>Daily News</i>
Wisconsin Rapids	<i>Daily Tribune</i>

2.4 ADMINISTRATIVE DATA

To investigate trends in BadgerCare and Medicaid enrollment and the characteristics of enrollees, we obtained enrollment data for all individuals who were enrolled in Medicaid or BadgerCare under a family coverage category in Wisconsin between January 1997 and April 2001. These categories included (1) AFDC-related eligibility categories (i.e., families meeting the categorical and financial eligibility criteria of the AFDC program that were in effect on July 16, 1996, before the program was dissolved); (2) Healthy Start (i.e.,

the poverty-related expansion categories for pregnant women and children through age 6 with family incomes up to 185 percent of the FPL and older children with family incomes up to 100 percent of the FPL); and (3) BadgerCare. From these files, we computed annual counts of enrollees, person-years enrolled, and the average numbers of months enrolled by different characteristics, including program type, age group, urbanicity of county of residence, and delivery system. We also computed the number of families and individuals in families with a member participating in the W-2 program.

3

Findings

Data from the interviews, focus groups, and document review have been synthesized to create a review of BadgerCare’s development and implementation and its outreach and enrollment simplification measures. The findings of these reviews are provided in the first two sections below. The same information sources were then used along with data from the program’s enrollment files in a review and synthesis of key program outcomes, including enrollment, enrollees’ participation in Medicaid managed care, integration with ESI, access to providers, stakeholder satisfaction, and revenues and costs.

3.1 PROGRAM DEVELOPMENT AND IMPLEMENTATION

The planning and development of the BadgerCare program was a collaborative process marked by compromise and persistence among policy makers and other stakeholders determined to find a workable solution to Wisconsin’s growing number of uninsured persons. Implementation was facilitated by the use of existing infrastructure, including the State’s Medicaid eligibility determination and health care delivery system.

3.1.1 Program Planning and Development

The development of BadgerCare has been well documented in an earlier case study (Sirica, 2001) and will be summarized only briefly here. Extending health insurance to Wisconsin’s working poor was a long-held goal of former governor Tommy Thompson, one which fit well in the context of the State’s progressive tradition. The need for such measures became pressing with the success of W-2 and its predecessor programs in reducing welfare caseloads. The loss of

automatic Medicaid enrollment for many poor families as they transitioned to work led to declining Medicaid caseloads and rising rates of uninsurance in the State.

To address this unintended consequence of welfare reform, the State's W-2 plan, submitted in October 1996, was accompanied by a request to the Health Care Financing Administration (HCFA) for a Medicaid waiver. The waiver would have extended Medicaid coverage to working low-income families who lacked access to affordable private health insurance. The Family Health Plan, as the waiver program was called, provided coverage for working parents with incomes up to 165 percent of the FPL. The Family Health Plan was met with opposition from advocates and the federal government. Many advocates within the State criticized the proposed plan because of its stringent income ceilings, relatively high premium level (set at 8 percent of family income), and limited benefit provisions. HCFA rejected the State's application for a Title XIX waiver because the plan was not comprehensive enough and because it would set a precedent establishing a Medicaid waiver program that was not an entitlement program. Following the rejection, at the request of the governor, State officials renewed their planning efforts.

Wisconsin collaborated with key stakeholders from the outset.

Case study respondents describe the planning process that ensued as inclusive and focused on a common goal of reducing the number of uninsured. They particularly give credit to the State for not restricting the process to those likely to agree with their views. State officials met with representatives from all the groups to whom they needed to sell the program and asked for help in finding the uninsured and getting them enrolled. They included people both inside and outside of Madison—local government officials, health care providers, managed care organizations, employers, advocates, and others. The collaborative planning process behind the development of the new program was deliberate; it was believed that commitment from all stakeholders was necessary to ensure approval of the program.

DHFS built a coalition composed of these diverse stakeholders that worked together to design BadgerCare, as the new program was called. DHFS worked with the coalition members one on one but also brought them together. They held several large planning meetings to discuss the issues and drive the process. In addition,

Opposition to BadgerCare surrounded the details, not the concept.

drafts of the waiver and concept papers were shared with the stakeholders. Final negotiations on the plan's elements, however, occurred in internal government meetings.

Despite varied social and political views, all the stakeholders in the process had a desire to insure families. Opposition to the program was based not on the concept itself but on the details. Controversial issues included (1) adult coverage, (2) crowd-out provisions, (3) premium levels, and (4) the benefit package.

As in the Family Health Plan, coverage for parents remained a key component of the package, both to support transition of families to ESI and to encourage enrollment of children. "There was great support that the Wisconsin approach was far superior to the SCHIP approach," noted John Chapin, administrator of DHFS's Division of Public Health. "If you were really serious about welfare reform and you wanted people to work towards greater independence, you need a system that would ensure that you provide health care coverage to working families. That is why Wisconsin aggressively went for insuring the working poor as a family entity, instead of just insuring kids and letting the family float."

Nevertheless, family coverage met with varying levels of enthusiasm during initial discussions. Both federal officials and advocacy groups were initially concerned about changing the focus of coverage from "children" to "parents and children." They were concerned that covering families would take away from children's coverage. This concern was alleviated by other accommodations made by the State.

Compromise on crowd-out provisions was key to gaining stakeholder support.

Interviewees involved in the design process described extensive discussions of crowd-out with employer groups and business owners, leading to the inclusion of several provisions designed to reduce or eliminate the problem. These changes included verification that the family applying for BadgerCare did not refuse an employer-sponsored health plan or other insurance and a 3-month waiting period between private insurance coverage and eligibility for BadgerCare.

Premium payment was seen as another strategy toward this goal, with the additional advantage of reducing the potential stigma associated with public assistance. Premiums were important for getting buy-in from some public officials and insurance companies.

The income cut-off for premium payment and the level of payments brought much discussion. In response to pressure from advocates and the provisions of the newly approved SCHIP guidelines (which capped cost sharing at 5 percent of family income), the premium level was reduced. Instead of the Family Health Plan's 8 percent premium on incomes up to 165 percent of the FPL, BadgerCare premiums were set at 3 percent for families with incomes between 150 percent and 200 percent of the FPL.

Two additional issues of concern for the State were whether to have the same benefit package as the Medicaid program and whether BadgerCare should be an expansion of the Medicaid program or a separate program. The Family Health Plan package was less generous than the State's Medicaid benefits. Advocates demanded that BadgerCare participants receive Medicaid benefits; to them, a generous benefit package was the bottom line.

After looking at their options under federal SCHIP guidelines, the State decided to design BadgerCare as a Medicaid expansion because it would facilitate program administration and be less confusing for participants. As an expansion program, the State could absorb the increased caseload within existing eligibility determination and service delivery systems without having to design and set up new systems. Furthermore, the State anticipated that many families would have some members qualifying under Medicaid and some under BadgerCare and that considerable movement between the two programs would occur with changing family circumstances. As a single program, the distinctions between the Medicaid and BadgerCare enrollment would be transparent to recipients and continuity of care would be maintained. The revised plan was submitted as a Title XXI (SCHIP) waiver application in September 1997, following a meeting with then-HCFA administrator Bruce Vladeck to present the concept of family coverage.

Persistent negotiation led to approval of BadgerCare.

In August 1998, HCFA denied the State's application for a Title XXI waiver. HCFA officials expressed concern over the possibility of setting precedents for other states and viewed the State's proposed cap on enrollment based on funding availability as incompatible with the nature of Medicaid, an entitlement program. By January 1999, a compromise was negotiated between the State and HCFA—the federal government retained the entitlement aspect and the State was allowed a cost containment measure via an enrollment trigger.

In the new program, coverage for uninsured children in families with incomes under 185 percent of FPL was extended through Title XXI. Coverage for parents of these children was approved under a waiver to Title XIX. In place of the State's proposed cap on enrollment, the waiver allowed the State to lower the income eligibility threshold if necessary to avoid budget overruns, thus reducing the number of families eligible and effectively limiting enrollment.

New waiver gives BadgerCare increased federal dollars with conditions.

In January 2001, within weeks of Tommy Thompson's nomination as secretary of the U.S. DHHS, HCFA approved waivers allowing Wisconsin, Rhode Island, and New Jersey to receive Title XXI matching funds for coverage of income-eligible parents. HCFA required the states to develop measures to streamline enrollment procedures with a simplified form and mail-in application process. The waiver also required Wisconsin to eliminate the asset test for Medicaid eligibility, a measure implemented in September 2001.

Federal approval of the Title XXI waiver gave Wisconsin access to a higher federal match rate for adult coverage than was provided under Title XIX (71 percent rather than 59 percent). As a condition for the waiver, Wisconsin agreed that it would not lower the eligibility levels for children through the enrollment trigger. Because invoking the enrollment trigger would mean that the match rate for parents reverted to the lower Title XIX rate, doing so would be unlikely to reduce costs for the State, according to Susan Wood, then director of DHFS's Bureau of Health Care Eligibility.

3.1.2 Program Implementation

Integration with Medicaid infrastructure key to quick and effective start-up.

Wisconsin achieved considerable efficiency in design and start-up by building BadgerCare on the infrastructure of Wisconsin's Medicaid program. The State's existing Medicaid benefits and delivery system were adopted for the BadgerCare program. Medicaid managed care providers were given the option of participating in BadgerCare during that program's first year but were told that they would be required to participate in both programs in the subsequent years. Most HMOs opted to participate in BadgerCare from the outset. The State also incorporated the eligibility determination process for BadgerCare into the statewide automated process used for W-2, Medicaid, food stamps, and child care.

This pragmatic approach to program design has continued into the implementation phase. The State maintains communication with a range of stakeholders to identify concerns with program operation and continues to develop strategies to address these concerns. Examples of ongoing program modification, described in following sections, include simplification of the enrollment and redetermination processes and expanding access to the HIPP program.

3.1.3 Looking to the Future: Planning and Development

Although the program is widely viewed as a success, debate over its funding and structure continues. Business representatives object to the State providing “Cadillac” coverage while they face skyrocketing premiums. With support from business groups, Governor Scott McCallum proposed extending the waiting period for applicants with private insurance from 3 months to 6 months. Republican legislators endorsed a proposal to increase premiums from 3 percent to 5 percent, arguing that an increased copayment could save the State \$3.2 million. Program supporters proposed extending coverage to noncustodial parents and removing farm equipment depreciation from income calculations. However, none of these measures was incorporated into the biennial budget approved in August 2001.

3.2 OUTREACH AND ENROLLMENT

Wisconsin’s approach to BadgerCare outreach reflects many of the principles seen elsewhere in the program: building on existing programmatic infrastructure, collaboration with a wide range of partners, and an ongoing commitment to program improvement. Considerable resources have been mobilized to publicize the program and bring information and the enrollment process itself to eligible families. At the same time, the State has worked to reduce barriers that may make families hesitant to enroll. Goals for future outreach focus on enrollment of hard-to-reach populations who are currently underrepresented in the program.

3.2.1 Statewide Program Launch

Prior to BadgerCare, the State engaged in a Medicaid enrollment outreach campaign to counteract the enrollment losses that coincided with decreases in the numbers of families receiving cash

State conducts multifaceted statewide outreach campaign.

assistance. This experience helped the State formulate outreach approaches for BadgerCare. Activities included raising public awareness about the program, training outreach workers, and increasing access to outreach workers by increasing their numbers and stationing them at a variety of health care and community sites.

The State made a concerted effort to market BadgerCare through a public information campaign that included distribution of brochures, establishment of a toll-free hotline, and production of televised public service announcements. The State's former governor, Tommy Thompson, appeared in television advertisements for 2 weeks following the program's implementation. During the first 3 months after program launch, the hotline received more than 8,000 calls. One-third of these callers reported having heard of BadgerCare from the television advertisement. The State also developed general and targeted program brochures, including a brochure tailored to Native American families.

The State uses two related strategies to facilitate enrollment. First, eligibility workers, who accept applications and make eligibility determinations, have been outstationed at locales such as food pantries, hospitals, clinics, and schools in order to increase their accessibility. Second, the State provided training for outreach workers. Outreach workers are those employed in agencies and settings where they are likely to interact with potentially eligible families; they cannot make eligibility determinations, but can provide information about BadgerCare coverage and eligibility and assist families in completing an application. Although some training was provided by DHFS, advocacy organizations were funded to train outreach workers across the State.

State's outreach efforts enhanced through RWJF's Covering Kids initiative

The State's outreach efforts were further enhanced through the Robert Wood Johnson Foundation's (RWJF's) *Covering Kids* initiative, for which ABC for Health, a consumer advocacy group, was the lead grantee from the program's inception to July 2002. Initial efforts targeted pilot sites in north-central Wisconsin and Milwaukee County. The program is now implemented statewide. Statewide activities supported by the initiative encompass training, capacity building among community agencies, information dissemination, and process improvements. The training programs are geared toward teaching others to help families with enrollment on a one-on-one basis. ABC for Health staff members have trained

outreach workers, health advocates, health providers, economic support workers, and others who frequently come into contact with potentially eligible families. They also teach providers how to obtain reimbursement from third parties and develop infrastructure to keep going after RWJ funding is gone. These capacity-building activities are also targeted to health facilities, schools, job programs, and community organizations. Information dissemination efforts target both the public and those involved in outreach, with public awareness campaigns, information sharing using information kits, a bimonthly newsletter, e-mail networking, and targeted outreach. The statewide project is also involved in the simplification of eligibility rules and enrollment processes and improving the level of customer friendliness at application sites.

Personal contact found important in getting eligibles enrolled.

Focus group participants reported having heard of BadgerCare through all of the above channels, as well as through relatives and friends. Those with existing ties to county offices for income maintenance, food stamps, or case management were most likely to have heard of BadgerCare through their caseworker. In addition to providing information about the program, caseworkers and health care providers assist clients in navigating the application process. By contrast, focus group participants who were eligible but not enrolled had heard of the program through mass media, but they lacked a personal connection that might have encouraged them to apply.

3.2.2 Targeted Outreach Activities

Some key BadgerCare outreach efforts have been conducted at locations offering access to low-income families: the State's largest urban center, schools, and tribal health facilities. The Marshfield Clinic, in north-central Wisconsin, has also spearheaded efforts in its service area.

Milwaukee

Because a significant number of the State's low-income families reside in Milwaukee County, outreach in that area has been an important strategy for increasing total BadgerCare enrollment. The State facilitated creation of the BadgerCare Coordinating Committee in Milwaukee to provide a forum to share information on policy and program changes and to coordinate strategic outreach efforts. The committee comprises a range of individuals representing the State,

local government (e.g., school district and health department), health advocacy organizations, and businesses.

The Milwaukee City Health Department has been particularly active in efforts to promote and coordinate outreach activities. Its staff serve as outreach workers while also working with the county and State on policy and programmatic issues in Milwaukee through the Coordinating Committee. The outreach office manages a toll-free number for Milwaukee families and a program web site on the city's Internet homepage. The audience for outreach activities has been eligible families and service providers coming into contact with these families. Funding for city health department–sponsored outreach draws from a patchwork of resources from city and State funds, federal block grant funds, and grants from community-based agencies.

Outreach in Milwaukee is also supported by community advocates through the Milwaukee County *Covering Kids* pilot site. Staff operate a help line that receives calls from individuals with health coverage concerns, providing information and advocacy as needed. They offer training tailored to the needs of a variety of audiences and participate in community-wide coalitions.

Examples of Outreach in Milwaukee

- enrollment events at community health clinics, schools, hospitals, and community-based organizations
- presentations by health department staff to teachers, parents (parent-teacher conferences), and religious congregations
- placement of enrollment workers at community learning centers and after-school programs
- distribution of laptop computers to outreach workers

Schools

Schools offer an ideal opportunity for reaching out to families, particularly when located in low-income communities. School-based outreach was the focus of an informal committee that met during BadgerCare's planning and early implementation phases. Membership included representatives from State agencies such as the Department of Public Instruction (DPI), Department of Public Health, and DHFS. Members of the group provided outreach support to eight of the State's largest school districts as part of their

Kindergarten Round-Up, an event that provides information and screenings prior to school entry.

According to DPI's Linda Caldart-Olson, a member of the school outreach committee, BadgerCare is a tough sell for schools: "The environment in Wisconsin is that schools are strapped for money. There are revenue caps for spending on general school costs and caps on teacher salaries." It is difficult to get the schools to buy in to an activity that may take staff attention away from other duties. One approach that the committee has taken to promote the program among schools is to emphasize the interrelatedness of health and education benefits, "the connection of better health with better educational outcomes." In addition, the committee has been attempting to tie BadgerCare outreach to training school clinic personnel in Medicaid claiming, as Caldart-Olson noted, "If we can sell this to them with the understanding that this is a way for them to get some money then they will pay attention."

Nevertheless, they have had some limited success. For example, because the income requirements for the two programs are similar, the committee has worked to integrate BadgerCare outreach with the free and reduced school lunch program. They proposed development of a statewide standard application for the school lunch program, which would allow parents or guardians to indicate whether school officials can relay their name and contact information to DHFS, so that a worker could contact the family with BadgerCare information and enrollment assistance. Although plans for the application were not adopted, some districts did add the check-off boxes for sharing contact information with DHFS or sent flyers with their forms. In Milwaukee, the distribution of flyers with the school lunch applications resulted in enrollment of approximately 3,000 to 4,000 families into BadgerCare during the first school year after the program began. The following year, the inclusion of check-off boxes allowing parents to be contacted about the program resulted in another 4,000 enrolled families. Brochures were also delivered to private schools in Milwaukee and some rural counties.

Tribal Outreach

The State of Wisconsin works with local tribal leaders through regional forums and meetings with tribal clinic directors. Several

clinics reported instituting outreach activities. Jerry Waukau, director of the Menominee Tribal Clinic, stated that outreach efforts began soon after the program was implemented when a second outreach worker position supported by State funds was added. The State has also engaged tribal communities through monthly meetings with tribal clinic directors and by producing culturally appropriate brochures and holding regular meetings between State officials and tribal clinic directors.

Sarah Lewis, executive director of the Wisconsin Primary Health Care Association, noted that tribal members have little incentive to go through the process of enrolling when they are already eligible to receive health care at no cost through the Indian Health Service (IHS). However, benefits do accrue to the IHS clinics by opening up another funding source. Waukau reported that the effort required for outreach “pays for itself” in moving people from contract health services (supported by the clinic) to BadgerCare. Another tribal facility director, Robin Carufel of the Peter Christensen Health Center, reports that outreach efforts geared toward Medicaid and Healthy Start have been successful, but BadgerCare outreach has not. He noted that it was difficult to enroll tribal members in families with incomes from 150 percent to 185 percent of the FPL who would have to pay premiums under BadgerCare when they have access to IHS-funded health services with no premium or copayment requirements. In addition, many families with children meeting the income requirements of the program are not eligible because they are employed by the tribe and tribal employment offers health insurance.

Marshfield Clinic

A notable rural outreach effort was initiated by this multisite provider in north-central Wisconsin, under the direction of the clinic’s research director, Greg Nycz. Concerned that families in Milwaukee would be enrolled at such high levels that the enrollment trigger level would be reached and rural families excluded, Nycz mobilized staff at the clinic’s Patient Assistance Center (PAC), which works with families to determine access to health insurance. PAC staff sent letters to patients on a waiting list for free care and assisted them in applying for the program. In addition, the HMO associated with the clinic, Security Health Plan,

sent letters to all enrolled families who might have other family members eligible for the new program.

PAC staff are located at the main clinic and at satellite clinics. Prior to BadgerCare, they assisted approximately 300 families each year in completing the combined application for Medicaid and Healthy Start. In the year following the launch of BadgerCare, PAC staff helped nearly 700 families complete applications for Medicaid/Healthy Start/BadgerCare. This number rose to more than 800 applications per year for the following 2 years.

After PAC staff members help families fill out the applications, the staff send the applications to the county office and coordinate with county eligibility workers until they know the outcome of the review. PAC staff have received training about BadgerCare enrollment guidelines through the State and associated health advocacy organizations, including the Wisconsin Primary Health Care Association and ABC for Health. Monthly televideo meetings allow outreach staff at different locations to communicate about the challenges and opportunities facing their patients.

The outreach effort at the Marshfield Clinic is highly successful. Sirica (2001) reported that approximately 1,400 individuals in the Marshfield Clinic service area enrolled during BadgerCare's first 3 months of operation, and enrollment in these counties remains high. The PAC staff estimate their success rate—applications sent to the county that are approved—at 80 percent. They believe the key to successful outstationing is their follow-up with applicants. They also feel that their outreach efforts are successful because they offer families an alternative location to begin the application process. Pat Beining, outreach worker for the clinic, noted that families in small communities do not want to be “labeled” as being on public assistance. The clinic's experience suggests that personal interactions in a setting outside the traditional income support system can result in a high level of enrollment.

The Marshfield Clinic's Family Health Center, a federally funded community health center, is the lead organization for the *Covering Kids* north-central Wisconsin pilot site, which includes four surrounding counties. The site's efforts include working with locally developed benefits counseling networks, where broad-based coalitions of health and human services policy and program officials

discuss BadgerCare enrollment strategies and provide training on the program. Staff train outreach workers and link BadgerCare outreach training with other services for families, such as support for special needs children. The networks have broached the concept of including a check-off box on the school lunch application to allow families to be contacted about the BadgerCare program. In addition, they have sent applications to banking institutions on the premise that the bank staff are aware of families encountering financial difficulties.

3.2.3 Barriers to Enrollment

Among the possible barriers to enrollment are the stigma associated with publicly funded insurance, the effort required to understand and navigate the enrollment process, and the quality of interactions with personnel involved in the enrollment process. The State has recognized these potential barriers, many of which are ongoing, and has implemented efforts to address them.

BadgerCare's Image

Families' perception of BadgerCare can influence how they respond to its outreach and whether they apply for the program. Recognizing this, the State created BadgerCare with a distinct image, even as it built the program on the infrastructure of Medicaid providers and benefits package. The State believes that BadgerCare's distinct name and identity "sent a message to new applicants that health insurance for working families was no longer associated with welfare" (Wisconsin Division of Health Care Financing, 2002). Informants and focus group participants report that BadgerCare is seen as a separate program from Medicaid/Healthy Start, primarily because it has a different name and covers all eligible family members, and that this distinction is important to families.

BadgerCare is given its own identity, distinct from Medicaid.

Outreach efforts that extend beyond the traditional Medicaid/Healthy Start outreach locales (e.g., offices of the Women, Infants, and Children [WIC] program) to food pantries and afterschool programs have reinforced the unique nature of the program. Advocate Shirin Cabraal of Legal Action of Wisconsin believes that expanding the number of locations where families can apply for the program has helped mitigate the stigma associated with going to the county offices. Employers may be similarly

sensitive to the possible stigma of public assistance when they consider their involvement in BadgerCare. According to Bill Smith, spokesman for the National Federation of Independent Business (NFIB), a small employer business association, NFIB membership will be cautious about enrolling in or promoting BadgerCare if it looks like welfare. He says that access to BadgerCare through job centers is acceptable but that it should be “kept out of county welfare offices.”

The effort to communicate BadgerCare’s intended membership to the public is susceptible to various misperceptions. Advocates from ABC for Health note that the focus on marketing BadgerCare as coverage for working families may have had the unintended consequence of creating a perception that families who are low income but not working are not eligible. Those supported by disability benefits, unemployment benefits, or seasonal employment may not realize that they are eligible for BadgerCare. At the same time, Paula Roberts, outreach coordinator of the Milwaukee Health Department, reports that some families with higher incomes continue to see the program as targeting the “traditionally needy” and do not consider themselves eligible. She typically encounters these families when they inquire about energy assistance, at which point she can also suggest BadgerCare.

While marketing a distinct identity for BadgerCare, the State has used a common membership card for BadgerCare, Healthy Start, and Medicaid. The “Forward” card is a machine-readable card that confirms the family’s current enrollment for the medical care provider. However, many focus group participants, particularly those paying a premium, disliked the card’s association with Medicaid. They felt that medical office staff and other patients assumed that they were on public assistance when they used the card. “A woman with five kids has a card and is collecting welfare,” said one participant, “but I work five nights a week. I don’t want to walk into a clinic and show the same card as her and get crazy looks because they think I’m getting free stuff from the state.”

Wisconsin focused on enrollment simplification after program roll-out.

Enrollment Simplification

Because State officials did not want to overwhelm the existing delivery system, they waited until BadgerCare was up and running before initiating enrollment simplification measures. Following BadgerCare's implementation, the State has made several changes that simplify the enrollment process, including (1) increasing outstation application sites; (2) adopting both a short, mail-in application form and phone-in applications; (3) accepting self-declaration of income; (4) eliminating the assets test and face-to-face interviews for Medicaid; (5) extending Medicaid reviews to 1 year; and (6) establishing a unit to troubleshoot problems in Milwaukee County. Some of these measures were required by the federal government. The waiver allowing the enhanced federal SCHIP match for parents enrolled in BadgerCare was contingent upon elimination of the Medicaid assets test and implementation of a simplified mail-in application form. Other measures resulted from persistent efforts by advocates, health care professionals, legislators, and bureaucrats to improve the process.

The determination letter received by families in response to their application has been the subject of streamlining as well. Several respondents described how the original letter was often confusing for families because it itemized eligibility of each family member for each program, even those for which the family was not applying. Advocates reported that some individuals were unable to sort through the information provided and may have incorrectly concluded that they were not eligible for BadgerCare. In response to these concerns, State officials implemented several changes in February 2001 to make the letter more user-friendly. These modifications include a summary of eligibility decisions on the letter's first page, reduced use of program jargon and acronyms, and reorganization of text. Additional changes are being studied for future implementation.

Enrolling in BadgerCare

Wisconsin residents can apply for BadgerCare at many agencies and organizations in the State that provide services to low-income families. These include W-2 and other social service agencies run by the State's 72 counties, as well as hospitals, clinics, advocacy organizations, and tribal social and human service departments. Prior to July 2001, with a few exceptions, all enrollees had to apply in person at a county/tribal office or outstation site. Since July 2001, applicants have the option of mailing in a two-page application form. Outreach workers may assist families in preparing the application but do not have the authority to make eligibility decisions.

BadgerCare uses the statewide, automated, integrated eligibility determination and redetermination system, called Client Assistance for Reemployment and Economic Support (CARES). During the face-to-face meeting, the eligibility worker collects family and financial data through an interactive interview prompted by CARES or enters it from the mailed-in application form. CARES determines eligibility by applying federal and State laws for Medicaid and BadgerCare, as well as food stamps, childcare, and W-2. The system allows coordination between Medicaid and BadgerCare with applicants being tested for Medicaid eligibility prior to being tested for BadgerCare.

Eligibility information is then transmitted to the Medicaid Management Information System (MMIS) through the preexisting CARES/MMIS Interface Subsystem. The MMIS uses the eligibility data to issue identification cards, enroll families in HMOs, and process claims.

Establishment of Paternity

The requirement that women identify their children's fathers was also cited as a potential deterrent to enrollment by several case study respondents. Once paternity is established, a court child support order is likely to be issued, directing the father to pay child support. "Many folks ... will not apply because of child support enforcement rules," according to Beining. These women are concerned about the court order putting pressure on the fathers and, in some extreme cases, putting the women at risk of domestic violence. This concern was raised by focus group participants who were eligible but not enrolled in BadgerCare. "I just wanted BadgerCare for the baby," said one, "but they said they were going to make my boyfriend pay all the bills from his paycheck, and I didn't want that." Establishment of paternity and cooperation with child support enforcement is actually a federal requirement. Because county offices do not collect information on why families are not finishing the enrollment process, the State cannot quantify the magnitude of this problem.

Interactions With Eligibility Workers

Health advocates and outreach workers feel that one of the key factors to successful enrollment is supporting the family through the

enrollment process and helping them resolve any problems they may encounter. Roberts noted that direct contact helps to address anxieties that make families hesitant to apply for the program. She notes that those in need of additional support include families who had bad initial experiences with public health insurance programs, are nervous about giving information to the county, or are led by older women who have reservations about enrolling. Marshfield Clinic outreach workers report that they must work to allay families' concerns that it is inappropriate to ask for help from the government.

Training of county eligibility workers is a key component of BadgerCare outreach.

While much outreach is handled by advocates, health care providers, and community workers, many applicants will interact with eligibility workers at county social service offices. The operations of these offices and the attitudes of individual workers are frequently identified as barriers to initial and continued enrollment. As a result, training of county workers has been an important component of Wisconsin's outreach strategy for BadgerCare.

For some families, the office closest to them may not have evening office hours that allow working families to apply without making alternate arrangements for leaving work or finding childcare. Nycz described how one rural county required its applicants to have written proof of residence from a landlord (if renting). This restriction may inhibit applications if families do not want to alert the landlord that they are applying for government assistance. Nycz also noted that county leadership could influence whether the county works to provide outreach and encourage enrollment. A health advocate reported that because Wisconsin county agencies are autonomous, they vary a great deal in their approach to BadgerCare enrollment.

Because eligibility is determined using a uniform process that is largely automated, eligibility decisions should in theory also be uniform. However, because individual county workers process the applications, under the direction of different county supervisors, their responses may be inconsistent. The State recognizes the element of subjectivity that affects the enrollment process and has worked to minimize it through uniform eligibility standards and training.

Some informants stated that as a group, eligibility workers in county offices are less supportive than outreach workers in shepherding families through the enrollment process and in explaining the determination letter. Health clinic staff, outreach staff, and State officials expressed concern about the sometimes conflicting philosophical foundations of the different government programs for which families are applying. A major emphasis in W-2 is on reducing the number enrolled; for food stamps, the emphasis is on careful documentation. In contrast, the thrust of BadgerCare is on enrolling as many children as possible and simplifying enrollment. In addition to philosophical differences, one health advocate believes that the county workers are not adequately informing families that they are potentially eligible for other programs, including BadgerCare. Participants in three of the four focus groups complained of their treatment by county workers, saying they “treat you like less than a number.”

Maintaining Enrollment

Eligibility for BadgerCare is re-determined on an annual basis so that county eligibility workers can assess whether any previously unreported changes in circumstances, such as increased income, warrant a change in enrollment status. Families receiving only BadgerCare can choose to complete the annual redetermination procedure by telephone, mail, or in person. Families receiving both BadgerCare and food stamps must complete an in-person food stamp redetermination interview every 6 months.⁵ This interview serves as the BadgerCare review as well, and BadgerCare eligibility is extended for 12 months following the semi-annual review for families who continue to meet all program requirements. If a family misses their food stamp redetermination interview, they may be terminated from food stamps but will continue in BadgerCare for another 6 months or until a change in circumstances that makes them ineligible is reported.

Comments from focus group participants suggest that the distinction between the two programs’ requirements is not clear to many eligibles, so that problems in the food stamp redetermination process are attributed to BadgerCare. These problems include appointments scheduled during working hours with little advance

⁵ Prior to mid-2001, food stamp redetermination occurred every 3 months.

Redetermination process may contribute to churning.

notice, difficulty in contacting workers to change an appointment time, being kept waiting for hours after arriving at the scheduled time, and rude treatment from workers. The erroneous perception that frequent and arduous effort is necessary to continue BadgerCare coverage, “you have to run around through so many circles,” may discourage participation among some eligibles.

Shirin Cabraal claimed that problems in the redetermination process result in churning, where families go on and off and back on the program. She feels that families are dropped unwittingly by not actively re-enrolling in the program. However, State officials question whether a totally passive redetermination is viable. Cabraal is concerned that the redetermination process, the CARES system, and caseworker overload and turnover may jeopardize the ability of these families to remain in the program and maintain continuity in their health care.

3.2.4 Looking to the Future: Outreach and Enrollment Simplification

As the BadgerCare program completes its third year, Wisconsin continues to support outreach and enrollment simplification efforts. Some efforts have been reduced as the initial enrollment push has subsided. For example, statewide television spots were limited to the program’s kick-off. However, the State continues to outstation eligibility workers and train county staff. In addition, administration of the food stamp program is being transferred to DHFS from the Department of Workforce Development (DWD) on July 1, 2002 to ensure better coordination between the programs.

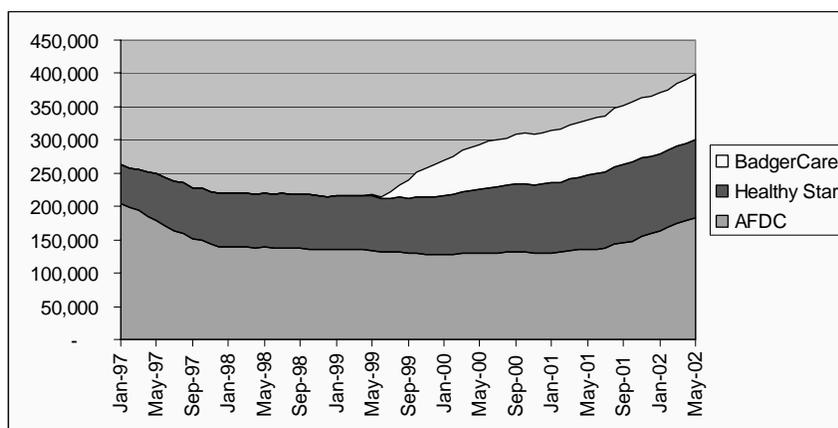
With statewide enrollment close to the program’s funded level, the focus of outreach is shifting to more targeted efforts to attract families with adolescents, legal immigrants, and higher income families who might not be enrolling at a pace similar to the general eligible population. Statewide implementation of the *Covering Kids* initiative is likely to support community-based efforts in both urban and rural communities, which can tailor outreach to local needs and priority populations.

3.3 BADGERCARE ENROLLMENT

Wisconsin has been phenomenally successful in enrolling eligible families in BadgerCare. As Patricia Simms, a health reporter for the

Wisconsin State Journal reported in an August 27, 2000, article, “[BadgerCare enrollment] is topping its creators’ wildest hopes” (Simms, 2000). The original budget for the program was based on an enrollment of 67,535 individuals by June 2001. This enrollment was reached an entire year earlier; in June 2000, 69,322 individuals were enrolled in the program. By June 2001, 83,911 individuals were enrolled. Enrollment has continued to climb with the recent economic downturn; it stood at 97,790 individuals in May 2002 (see *Exhibit 6*).

Exhibit 6. Monthly Medicaid Family Coverage Enrollment by Program, 1997-2002



Source: Bureau of Health Care Eligibility, Division of Health Care Financing, Department of Health and Family Services, State of Wisconsin.

3.3.1 Trends in Enrollment

Exhibits 7 and *8* show annual enrollment totals by program type and age group computed from the enrollment data we received from the State. These data include enrollment information for all individuals who were enrolled in Wisconsin’s Medicaid program under an AFDC-related, Healthy Start, or BadgerCare eligibility category from January 1997 to April 2001. These categories are referred to by the State as family coverage categories; enrollees in these categories are members of families with children. However, family members from any given family may be enrolled in different eligibility categories—for example, children may be enrolled under Healthy Start and their parents under BadgerCare. Therefore, “family coverage” in this context differs from the concept of family coverage in private insurance plans.

Exhibit 7. Annual Numbers of Medicaid Family Coverage Enrollees and Annual Percentage Increase by Eligibility Category and Age Group, 1997-2000

	1997	1998	1999	2000
AFDC-Related				
Total	267,635	215,635	212,043	209,648
		-19.4%	-1.7%	-1.1%
Adults	86,276	67,981	68,521	69,255
		-21.2%	0.8%	1.1%
Children	181,359	147,654	143,522	140,393
		-18.6%	-2.8%	-2.2%
Healthy Start				
Total	154,957	157,641	164,800	179,761
		1.7%	4.5%	9.1%
Pregnant Women	19,736	20,738	19,926	19,660
		5.1%	-3.9%	-1.3%
Children	135,221	136,903	144,874	160,101
		1.2%	5.8%	10.5%
Other Medicaid				
Total	18,908	23,018	26,036	26,320
		21.7%	13.1%	1.1%
Adults	6,703	7,816	8,522	8,480
		16.6%	9.0%	-0.5%
Children	12,205	15,202	17,514	17,840
		24.6%	15.2%	1.9%
BadgerCare				
Total	—	—	60,555	132,379
				118.6%
Adults	—	—	36,711	82,711
				125.3%
Children	—	—	23,844	49,668
				108.3%
All Programs				
Total	363,070	333,680	375,423	428,828
		-8.1%	12.5%	14.2%
Adults	103,062	87,358	112,932	145,084
		-15.2%	29.3%	28.5%
Children	260,008	246,322	262,491	283,744
		-5.3%	6.6%	8.1%

Note: AFDC = Aid to Families with Dependent Children.

Exhibit 8. Annual Numbers of Medicaid Family Coverage Child Enrollees and Annual Percentage Increase by Eligibility Category and Age Group, 1997-2000

	1997	1998	1999	2000
AFDC-Related				
0-5 years	70,711	57,775	56,670	57,323
		-18.3%	-1.9%	1.2%
6-14 years	84,715	67,706	65,886	63,182
		-20.1%	-2.7%	-4.1%
15-18 years	25,933	22,173	20,966	19,888
		-14.5%	-5.4%	-5.1%
Healthy Start				
0-5 years	82,695	80,192	82,177	86,403
		-3.0%	2.5%	5.1%
6-14 years	50,312	53,486	55,962	62,133
		6.3%	4.6%	11.0%
15-18 years	2,214	3,225	6,735	11,565
		45.7%	108.8%	71.7%
Other Medicaid				
0-5 years	3,005	4,124	4,999	5,236
		37.2%	21.2%	4.7%
6-14 years	5,286	6,715	7,948	8,363
		27.0%	18.7%	5.2%
15-18 years	3,914	4,363	4,567	4,241
		11.5%	4.7%	-7.1%
BadgerCare				
0-5 years	—	—	1,067	3,841
				260.0%
6-14 years	—	—	12,762	31,158
				144.2%
15-18 years	—	—	10,015	14,669
				46.5%
All Programs				
0-5 years	120,237	115,661	117,304	121,939
		-3.8%	1.4%	4.0%
6-14 years	110,123	103,761	111,861	122,906
		-5.8%	7.8%	9.8%
15-18 years	29,648	26,900	33,326	38,899
		-9.3%	23.9%	16.7%

Note: AFDC = Aid to Families with Dependent Children.

Besides the three family coverage eligibility categories, we have also included rows in the table for enrollees in other Medicaid coverage categories. These categories include immigrants, migrant workers, children in foster care or subsidized adoption, Supplemental Security Income recipients, and other disabled individuals eligible for Medicaid coverage. All of the individuals shown in this category were enrolled at some time during the analysis period in a Medicaid/BadgerCare family coverage eligibility category but for the year in question they were enrolled for at least 1 month under one of these other Medicaid eligibility categories. Individuals who were only enrolled in one of the other eligibility categories from January 1997 to April 2001 are not represented in the tables.

Because an individual may have been enrolled in more than one eligibility category during the year, the sum of the enrollment figures across eligibility categories is greater than the total number of enrollees over all categories at the end of the tables. These latter figures are unduplicated counts of individuals ever enrolled in at least one of the eligibility categories during the year.

Traditional Medicaid and Healthy Start Enrollment

Medicaid family coverage enrollment declines prior to BadgerCare.

In 1997, 363,070 individuals in families with children were covered under Medicaid for at least part of the year; 28.4 percent of these enrollees were adults (aged 19 years or older), and 71.6 percent were children (aged 18 years or younger). Total Medicaid enrollment among individuals in families with children declined by 8.1 percent from this 1997 figure to 333,680 individuals in 1998. The drop in enrollment was seen among both adults and children but was greater for adults (15.2 percent) than for children (5.3 percent). Furthermore, the enrollment decline was concentrated in AFDC-related eligibility categories; total enrollment in these categories fell by 19.4 percent, with a 21.2 percent drop among adults and an 18.6 percent drop among children.

Some enrollees who would have been covered under the AFDC-related categories may have picked up coverage under Healthy Start and other Medicaid categories. The number of pregnant women enrolled under Healthy Start grew by 5.1 percent from 1997 to 1998, and adult coverage under other Medicaid categories grew by 16.6 percent. The number of children enrolled in Healthy Start grew by a small 1.2 percent from 1997 to 1998, and the number of

Growth occurs in child coverage under Healthy Start following BadgerCare implementation.

children in other Medicaid categories grew by about 2,000, or 24.6 percent.

Enrollment in AFDC-related categories continued to decline but at a much more modest rate of 1.7 percent from 1998 to 1999 and 1.1 percent from 1999 to 2000. Enrollment of Healthy Start pregnant women also declined in both years and in 2000 was at about the same level as it was in 1997. In contrast, enrollment of Healthy Start children grew at an increasing rate—5.8 percent from 1998 to 1999 and 10.5 percent from 1999 to 2000. The greatest growth was among teens aged 15 to 18 years, for which Healthy Start enrollment almost tripled in the 2 years from 1998 to 2000. This latter trend is largely due to the accelerated phase-in of OBRA teens (children aged 15 to 18 years in families with incomes below 100 percent of the FPL) beginning in April 1999. Enrollment in other Medicaid categories among individuals who were enrolled in family coverage at some point during the analysis period continued to grow substantially from 1998 to 1999 with a 13.1 percent increase but leveled off from 1999 to 2000 with only a 1.1 percent increase. The latter increase was concentrated among children under 15 years of age.

BadgerCare Enrollment

In July 1999, the State began enrolling parents and children in families with incomes below 185 percent of the FPL in BadgerCare. By the end of December 1999, 60,555 individuals had been enrolled in BadgerCare. Three-fifths (60.6 percent) of the enrollees were adults, and two-fifths (39.4 percent) were children.

BadgerCare reverses declining enrollment trends in family coverage.

The declining trend in overall Medicaid family coverage enrollment in Wisconsin turned around with the implementation of BadgerCare. Total enrollment in family coverage began climbing in 1999, reaching 428,828 in 2000. From 1998 to 1999, enrollment among individuals ever enrolled in a family coverage category increased 12.5 percent and rose another 14.2 percent from 1999 to 2000. Adult coverage grew the fastest, with a 29.3 percent increase from 1998 to 1999 and a 28.5 percent increase from 1999 to 2000. During the same 2 years, child coverage grew by 6.6 percent and 8.1 percent, respectively. By 2000, the number of child enrollees per adult enrollee in Medicaid family coverage had dropped to 2.0 children from 2.5 children in 1997.

BadgerCare enrolls more adults than children; traditional Medicaid and Healthy Start enroll more children than adults.

Exhibit 8 breaks out the annual number and percentage increase in child enrollees by age group. Among BadgerCare child enrollees in 1999, 53.5 percent were aged 6 to 14 years, and 42.0 percent were aged 15 to 18 years. Only 4.5 percent of the BadgerCare child enrollees were under 6 years of age because most of the children in that age group meet enrollment criteria for AFDC-related categories or Healthy Start and therefore are enrolled under these eligibility categories. (Children eligible for a state's Medicaid program under either traditional eligibility categories or Healthy Start are not eligible for the higher SCHIP federal matching funds.)

BadgerCare enrollment more than doubled from 1999 to 2000. Enrollment of adults grew slightly faster than enrollment of children. By 2000, 62.5 percent of BadgerCare enrollees were adults and 37.5 percent were children (see **Exhibit 9**). Among child enrollees, enrollment of teens slowed down, resulting in a shift in the age distribution to the younger ages. In 2000, 2.9 percent of BadgerCare enrollees were under 6 years of age, 23.5 percent were aged 6 to 14 years, and 11.1 percent were aged 15 to 18 years.

Exhibit 9. Percentage Distribution of Medicaid Family Coverage Enrollees Over Age Group Categories by Eligibility Category, 2000

	AFDC-Related	Healthy Start	Other Medicaid	BadgerCare	Total
Total Enrollees	209,648	179,761	26,320	132,379	428,828
	100.0%	100.0%	100.0%	100.0%	100.0%
Adults (> 18 years)	33.0%	10.9%	32.2%	62.5%	33.8%
Children	67.0%	89.1%	67.8%	37.5%	66.2%
0-5 years	27.3%	48.1%	19.9%	2.9%	28.4%
6-14 years	30.1%	34.6%	31.8%	23.5%	28.7%
15-18 years	9.5%	6.4%	16.1%	11.1%	9.1%

Note: AFDC = Aid to Families with Dependent Children.

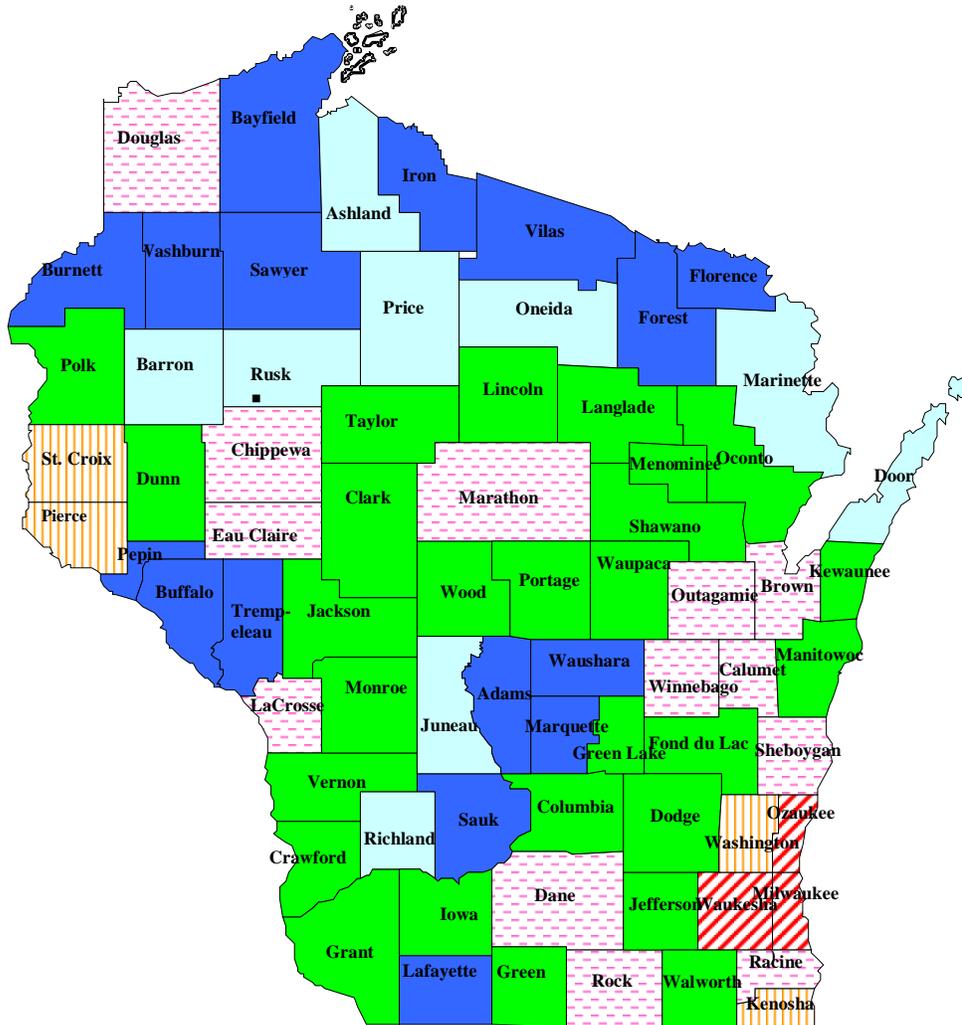
BadgerCare enrollees are geographically dispersed.

Wisconsin has a single major metropolitan area—Milwaukee—with a population of more than 1 million. Kenosha County in the lower eastern corner is a fringe county of Chicago, and St. Croix and Pierce counties in the midwestern section of the State are fringe counties of the Minneapolis/St. Paul metropolitan area. A map of

the State designating each county by its level of urbanicity and population size is provided in **Exhibit 10**.

The percentage distribution of Medicaid family coverage enrollees in the year 2000 by the metropolitan designation of their county/tribe of residence is shown in **Exhibit 11**. More than half of all AFDC-related Medicaid enrollees (51.6 percent) reside in the three counties that make up the Milwaukee metropolitan area (Ozaukee, Waukesha, and Milwaukee counties). Almost one-half (46.1 percent) of enrollees in non-family-based Medicaid eligibility categories also reside in the central city counties of Milwaukee. In contrast, enrollees in BadgerCare and Healthy Start are more geographically dispersed in counties of different population sizes. About one-third of these enrollees live in major metropolitan areas, including fringe and central city counties; slightly less than one-third live in other metropolitan areas in the State; and just under one-quarter live in nonmetropolitan areas adjacent to metropolitan areas. About 8 percent of BadgerCare enrollees and 6 percent of Healthy Start enrollees live in small cities, and another 8 percent of BadgerCare enrollees and 6 percent of Healthy Start enrollees live in the State's rural counties. Less than 1 percent of the enrolled Medicaid population lives on tribal lands.

Exhibit 10. Wisconsin Counties by Metropolitan Area Designation



Urban/Rural Categories

-  Rural areas, either adjacent or not adjacent to metropolitan areas (population < 2,500).
-  Nonmetropolitan areas, not adjacent to a metropolitan area (population ≥ 2,500).
-  Nonmetropolitan areas, adjacent to a metropolitan area (population ≥ 2,500).
-  Counties in other metropolitan areas (population < 1 million).
-  Fringe counties of metropolitan areas (population ≥ 1 million).
-  Central counties of metropolitan areas (population ≥ 1 million).

Exhibit 11. Percentage Distribution of Medicaid Family Coverage Enrollees Over Metropolitan Designation of County/Tribe by Eligibility Category, 2000

	AFDC-Related	Healthy Start	Other Medicaid	BadgerCare	Total
Total Enrollees	206,867 100.0%	178,847 100.0%	21,507 100.0%	131,380 100.0%	421,790 100.0%
Central City of Large Metropolitan Area (population > 1 M)	51.6%	28.4%	46.1%	26.9%	37.6%
Fringe County of Large Metropolitan Area (population > 1 M)	4.8%	5.2%	4.7%	5.3%	5.0%
Other Metropolitan Area (population < 1 M)	23.9%	31.2%	28.4%	28.2%	27.4%
Adjacent Nonmetropolitan Area (population ≥ 2,500)	12.2%	22.3%	13.9%	23.1%	18.5%
Other Nonmetropolitan Area (population ≥ 2,500)	3.3%	6.4%	3.1%	8.2%	5.6%
Rural Area (population < 2,500)	3.1%	5.7%	2.9%	7.7%	5.1%
Tribe	1.0%	0.9%	0.8%	0.6%	0.8%

Note: The county of residence is missing for 7,038 enrollees in 2000. AFDC = Aid to Families with Dependent Children.

3.3.2 Medicaid/BadgerCare Coverage of W-2 Participants

The breaking of the link between cash assistance and Medicaid eligibility had a profound effect in Wisconsin, with some people eligible for W-2 but not Medicaid and vice versa (Coughlin et al., 1998). With the implementation of BadgerCare, W-2 participants are now all “potentially” eligible for Medicaid/BadgerCare coverage depending on their income level and their access to employer-sponsored coverage. That is, W-2 participants are not categorically eligible for Medicaid/BadgerCare like participants of AFDC were eligible for Medicaid prior to welfare reform. Like all other

applicants, W-2 participants must meet the eligibility criteria of the BadgerCare program.

Nevertheless, State officials report that virtually all W-2 participants are enrolled in Medicaid or BadgerCare. We obtained the number of individuals aged 18 years and over who were served through the W-2 program in 1999 and 2000 from the Wisconsin DWD. We compared these figures to the number of Medicaid/BadgerCare enrollees over age 18 who participated in W-2 in each of those years. As shown in **Exhibit 12**, these numbers are very close in both years, with the Medicaid/BadgerCare enrollee count actually slightly higher than the figures from DWD.

Exhibit 12. Wisconsin Works (W-2) Participants Served and Number of Medicaid/BadgerCare Enrollees Participating in W-2

	1999	2000
Department of Workforce Development (DWD)		
Number of persons over 18 years served	21,312	20,799
Medicaid/BadgerCare Enrollment Files		
Number of W-2 participants over 18 years	22,093	21,571
Number of families in W-2	20,297	19,510
Number of children in families	43,403	41,430

3.3.3 Impact on the Uninsured

Prior to BadgerCare implementation, State estimates indicated that Wisconsin had 90,000 uninsured adults and 54,000 uninsured children in families with incomes under 200 percent of the FPL. In December 2001, 61,832 adults were covered under BadgerCare—more than two-thirds of the State’s estimated low-income, uninsured adult population. Furthermore, 29,661 children were covered by BadgerCare and an additional 53,300 children were added to the Medicaid rolls for a total of 82,961 covered children—more than one and a half times the original estimate of uninsured children.

On the surface, these numbers suggest that the State enrolled more than the number of eligible children. Explanations for the apparent discrepancy include natural fluctuations in the Medicaid/

BadgerCare population as families gain and lose eligibility, along with the use of sample survey data to estimate a low-income population. Furthermore, the economy has worsened since BadgerCare was implemented (Bruen and Wiener, 2002). In June 1999, the State's unemployment rate was 3.0 percent. By February 2002, it had more than doubled to stand at 6.7 percent (Wisconsin Department of Workforce Development, 2002). These job losses may be accompanied by increased numbers of uninsured and thereby greater numbers of Wisconsin residents eligible for BadgerCare.

*Drop in uninsured
accompanies
BadgerCare enrollment
rise.*

All available data indicate that the uninsurance rate in Wisconsin dropped significantly following BadgerCare implementation. According to data from the Census Bureau's Current Population Survey (CPS), the proportion of residents without health insurance in Wisconsin dropped to 7 percent in 2000, down from 11 percent in the State in 1999 and 13 percent in 1998. Wisconsin's uninsurance rate in 2000 was half the rate for the nation as a whole and the lowest it has been since 1990 (U.S. Census Bureau, 2001). The 2000 Wisconsin Family Health Survey indicated that 11 percent of Wisconsin's residents went without health insurance during part or all of the year (DHFS, 2001); the 1999 Wisconsin Family Health Survey (DHFS, 2000) estimated that 13 percent were uninsured during part or all of the year. The CPS findings differ from figures prepared by DHFS from the Wisconsin Family Health Survey due to different survey methods and different definitions of the uninsured (Frey, 2000). These Family Health Survey results include people who both had insurance during part of the year and were uninsured part of the year. The CPS includes only those uninsured for the entire year. Both surveys, however, show that the rate of uninsured in Wisconsin declined following BadgerCare implementation.

3.3.4 Looking to the Future: Enrollment

Many counties have enrolled more than 100 percent of their initial projected BadgerCare enrollment. However, the seeming overenrollment is at least partially related to the methodology used for the projections, which are based on census data estimates of households below 200 percent of the FPL without regard for the presence of children or regional variations in the types of employers in the area. Neither State officials nor the consumer advocates we interviewed have observed enrollment saturation in any area of

Wisconsin. They have found that some counties have been more successful than others in enrolling eligibles but attribute the differences to county-specific barriers, such as overrestrictive application processes. Vickie Baker, benefits counselor for ABC for Health, explains that Wisconsin counties vary a great deal in their approach to BadgerCare enrollment.

Wisconsin was one of 20 states receiving a State Planning Grant from the Health Resources and Services Administration (HRSA) to determine the size and characteristics of the uninsured population and develop policy approaches to meeting their needs. Using data from the 2000 Family Health Survey, the State estimates that 6 percent of residents were uninsured at a given point in time during the year. Among those most likely to be uninsured are young adults, ethnic minorities, low-income residents, and farm residents. Nearly three-quarters of the uninsured live in a household that includes a full-time worker. Surveys and focus groups targeting specific groups at increased risk of uninsurance revealed that each has “unique circumstances creating a variety of barriers to accessing health insurance coverage” (Wisconsin State Planning Grant, 2001), which will require diverse strategies to address.

Ongoing concerns focus on how income is calculated for self-employed individuals, including Wisconsin’s large agricultural population. For the self-employed, income is figured as net profit from farm or business. The value of depreciation of farm equipment or capital assets, which is an allowable deduction for tax purposes, is not deducted from income for determining BadgerCare eligibility. This provision has been of particular concern to rural areas. “Depreciation can cause these groups to extend beyond the income limit and be denied,” according to Beining of the Marshfield Clinic.

Angie Dombrowicki of the DHFS Division of Health Care Financing believes that those who are enrolled in BadgerCare represent the population that the program was designed to reach, in that most are very poor and were not previously on Medicaid. However, DHFS’s Wood notes that BadgerCare eligibility requirements do not necessarily capture all of the neediest people. Many income-eligible families are excluded from the program based on their access to minimal (if unaffordable) health insurance, under crowd-out provisions discussed in the following section.

3.4 FACTORS MOTIVATING PARTICIPATION

In Section 3.2.3 above, we noted factors that help to motivate potentially eligible families to enroll in the program, such as personal interaction and support throughout the application process. In addition to these factors, we asked interviewees and focus group participants about the impact of family coverage, premium payments, and crowd-out provisions on the enrollment decisions of eligible family members.

3.4.1 Family-Based Coverage

Family coverage has been an essential feature of BadgerCare since the earliest discussions, and support for it continues to be evident. Numerous respondents agreed that family coverage has two benefits: it extends coverage to uninsured adults, and enrollment of these adults identifies children who are eligible for, but not enrolled in, Healthy Start or Medicaid. David Riemer, former director of the City of Milwaukee Department of Administration, stated that recent increases in the number of children enrolled in Medicaid and BadgerCare are due to enrollment by adults who sought health insurance for their children. Staff from ABC for Health agreed that offering family enrollment has provided an incentive for parents to enroll their children.

Although focus group participants agreed that coverage for adults was important, most insisted that they would have enrolled their children in the program even if they were not covered themselves. They believed children required more health care, both for well-child care and for minor illnesses and injuries. “We all need it,” said one participant. “For most of us, though, as parents, it’s more important that our kids have it.” The only participants who stated that the chance for adult coverage attracted them to the program were those whose families included an adult with serious health problems.

3.4.2 Premium Payment

Premium payments were a controversial issue in the planning and development of the BadgerCare program. Premiums for families at the high end of BadgerCare income eligibility are intended to reduce crowd-out and promote personal responsibility among those transitioning from welfare to work. The governor and his administration strongly supported the inclusion of premium

payments in BadgerCare and saw it as essential for obtaining the support of their constituency for the program. Linda Reivitz of the University of Wisconsin School of Nursing and former secretary of DHFS suggests that, without the mandatory premium payments, the program would not have been as generous with respect to reaching higher income levels. However, the initial premium level proposed by the administration was 8 percent to 10 percent of income. Advocates did not support a premium of any size. A compromise of 3 percent of family income was finally reached.

Opinions vary as to the impact of premium payments. Advocates are concerned that premiums may be a deterrent to enrollment, a position supported by the Center on Wisconsin Strategy. However, the State believes that families who must pay premiums are participating in proportion to their share of the eligible population. They estimate that only 10 percent of the BadgerCare population has income levels between 150 percent and 200 percent of the FPL. Because these families are more likely to have access to ESI than those below 150 percent of the FPL, they expect a disproportionately low number to be enrolled in BadgerCare.

Focus group participants consider premium payments reasonable.

Focus group participants who paid premiums for BadgerCare, many of whom have been covered at some point by ESI, consider the premiums they pay now to be “very reasonable” relative to what private insurance would cost. These participants lent support to policy makers’ belief that premiums reduce the social stigma associated with public programs. “I feel good [about the premium]” reported one. “It may sound dumb that I like paying a premium, but I don’t feel like I’m leeching off the system.” In a focus group composed of nonenrolled eligibles, the possibility of a premium was not among the reasons cited for not enrolling. “I’m not worried about paying a premium,” one participant reasoned. “It’s cheaper than paying the doctor bills.”

BadgerCare Premiums

Eligible families with countable family income above 150 percent of the FPL must pay a monthly premium of 3 percent of their countable family income. The monthly premium schedule is depicted in **Exhibit 13**. Monthly premium amounts are based on \$500 “income bands” so premiums remain stable even with small monthly income changes. Once BadgerCare eligibility is established, the family applies and pays their initial premium to the county or W-2 agency worker. Additional premiums are owed 1 month in advance of the month covered. Late payments trigger a warning letter and eventually termination. Termination of BadgerCare eligibility for failure to pay the monthly premium does not affect the eligibility of any household members who are enrolled in AFDC-related, Healthy Start, or other Medicaid eligibility categories.

Exhibit 13. BadgerCare Monthly Premium Schedule

Family Size	150% Federal Poverty Level (FPL) Premium Begins ^a	Monthly Premium	185% FPL Applicant BadgerCare Income Limit	Monthly Premium	200% FPL Ongoing BadgerCare Recipient Income Limit	Monthly Premium
1	\$1,073.75	\$30.00	\$1,324.29	\$30.00	\$1,431.67	\$30.00
2	\$1,451.25	\$30.00	\$1,789.88	\$45.00	\$1,935.00	\$45.00
3	\$1,828.75	\$45.00	\$2,255.46	\$60.00	\$2,438.33	\$60.00
4	\$2,206.25	\$60.00	\$2,721.04	\$75.00	\$2,941.67	\$75.00
5	\$2,583.75	\$60.00	\$3,186.63	\$90.00	\$3,445.00	\$90.00
6	\$2,961.25	\$75.00	\$3,652.21	\$105.00	\$3,948.33	\$105.00
7	\$3,338.75	\$75.00	\$4,117.79	\$120.00	\$4,451.67	\$120.00
8	\$3,716.25	\$90.00	\$4,583.38	\$135.00	\$4,955.00	\$135.00
9	\$4,093.75	\$105.00	\$5,048.96	\$150.00	\$5,458.33	\$150.00
10	\$4,471.25	\$120.00	\$5,514.54	\$165.00	\$5,961.67	\$165.00

^a Countable Family Income = gross income, minus the following deductions:
 - \$90/month work-related expenses per working adult
 - up to \$175/month or \$200/month per child for childcare expenses
 - \$50/month deduction from any child support payments from an absent parent

However, premium payment has been particularly difficult to promote among Wisconsin’s substantial Native American population. Tribal members have historically had access to health services at no cost through IHS facilities and tribal health facilities. Because federal SCHIP regulations bar states from charging premiums for Native American children, Wisconsin collaborated with tribal health leaders to develop a process by which the premium would be pro-rated to the equivalent of the adult portion of the premium only. In July 2001, the State refunded the portion of premiums that had previously been paid for children by tribal members. Although BadgerCare participation benefits the community by freeing up IHS resources for other services, individuals may be reluctant to pay a premium for services to which they feel entitled. Robin Carufel of the Peter Christensen Health Center, which serves the Lac du Flambeau Band of the Lake Superior Chippewa, notes that many tribal communities feel they have “pre-paid” for services through treaties with the government and that attempts to collect premiums violate these agreements. Jerry Waukau of the Menominee Tribal Clinic reports that most tribal members who would be subject to the premium have elected not to enroll.

The State tightened late payment notification procedures, reducing confusion, but advocates contend that the 45-day grace period remains inadequate.

Advocates also raised concerns that the program does not allow for reasonable exceptions for failure to pay a premium, resulting in periods of uninsurance for those who are unable to pay on schedule. Dombrowicki of DHFS, however, does not believe that premiums are a factor in churning. She does note that, after the implementation of BadgerCare, several “fixes” occurred with respect to premiums. In particular, procedures for notifying families of late payments and impending termination for failure to pay premiums were simplified in October 2000. The State found that there were too many notices sent out over a long period of time, confusing beneficiaries. To simplify the process, fewer notices are sent out in a shorter period of time. Although these changes may have reduced confusion among beneficiaries, some advocates believe that the 45-day grace period was inadequate for families with unexpected expenses (e.g., car repairs).

3.4.3 Crowd-Out Provisions

Several policies are in place to prevent crowd-out of private health insurance. First, BadgerCare applicants are eligible only if they are currently not covered by health insurance and have not been covered for 3 calendar months prior to the month of application. Second, as noted above, families with incomes between 150 percent and 200 percent of the FPL must pay a premium. Third, families who have had access at any time during the past 18 months to ESI where the employer pays at least 80 percent of the cost of family coverage are ineligible for BadgerCare. Finally, the State will provide premium assistance to families with access to qualifying family coverage where the employer pays 40 percent to 80 percent of the premium costs.

No constituency is entirely pleased with the crowd-out provisions. Business groups believe the measures are not stringent enough and disadvantage small businesses; advocates are concerned that they create hardship for those with access to insurance they can only barely afford. All agree that the crowd-out provisions are error prone and administratively cumbersome.

Little evidence of crowd-out exists.

Nevertheless, none of the informants interviewed considered crowd-out to be a significant problem. Don Schneider, section chief for coordination of benefits in the DHFS Bureau of Health Care Systems and Operations, reports that, while the number of employers

offering insurance has declined slightly, he believes that this change is in response to increasing premium costs rather than the existence of BadgerCare. Dombrowicki maintains that crowd-out is not an issue because few eligible families have health insurance available to them. Her statement is confirmed by data from the employer insurance verification forms completed and returned for BadgerCare applicants (Wisconsin Division of Health Care Financing, 2002). These data show that half of the applicants do not have access to family coverage. Among the applicants with access to ESI family coverage, less than 7 percent of employers paid 80 percent or more of the premium costs.

Advocates fear waiting periods could cause hardship among chronically ill.

Whereas business representatives and policy makers support the waiting periods, advocates are concerned about their potential effects on the chronically ill. Smith of NFIB believes that the 3-month waiting period for BadgerCare enrollment effectively decreases crowd-out. However, advocate Cabraal contends that the waiting period creates an untenable situation for low-income people who may have purchased bare-bones coverage, often at considerable cost, because of poor health. “Some people with minimal insurance ... drop their coverage and apply for BadgerCare after 3 months. People with chronic illnesses such as cancer can’t afford to do that.”

To ensure that BadgerCare applicants are not covered by private health insurance or have access to ESI family coverage, the State mails a form to all employers of family members to verify their insurance coverage offerings and, monthly, compares names on the BadgerCare enrollment files with names on tapes provided by insurance companies within the State. The State’s experience with the employer verification process is discussed in the next section. Its experience with verification using the tapes from insurance companies has been less than optimal. Dombrowicki acknowledges that individuals sometimes show up on the tapes as insured but, in the lag time required for names to appear on the tapes, their circumstances change—for example, they have left a job with private insurance and are not insured by the time they apply for BadgerCare. Therefore, some applicants may be erroneously denied coverage.

3.4.4 Looking to the Future: Factors Motivating Participation

BadgerCare eligibility provisions appear to be balanced between competing agendas. Although health and community workers advocate for changes that would increase access to the program, business leaders and conservative State legislators have attempted to limit eligibility. During the 2001 legislative sessions, measures were considered that would have extended coverage to noncustodial parents, exempted depreciation from self-employment income calculations for eligibility, and extended the waiting period after coverage by private health insurance to 6 months. None of these changes were included in the budget that was eventually passed. As the State absorbs the effects of recent economic downturns, there will likely be interest in extending BadgerCare to affected citizens, as well as concern about its effect on the State budget.

3.5 INTEGRATION WITH EMPLOYER-SPONSORED INSURANCE

Another innovative feature of the BadgerCare program is its integration with ESI. Wisconsin has historically had a strong base of ESI; it ranks highest among states in the nation for ESI coverage. In 1995, nearly 80 percent of Wisconsin's population had health insurance through an employer, whereas nationally only 66 percent of the population had such insurance (Coughlin et al., 1998). This distinction results from a higher percentage of residents employed in manufacturing industries, a strong union presence in the State, and a vibrant State economy throughout the 1990s. Furthermore, three-quarters of uninsured individuals in Wisconsin reside in households that include a full-time worker (Pederson, 2001).

In designing the BadgerCare program, planners wished to preserve its solid ESI base and maximize the use of private support in place of public funds. This objective resulted in the adoption of two major features of the BadgerCare program:

- Families are not eligible for BadgerCare if, in the past 18 months, they have had access to a family ESI plan for which the employer pays at least 80 percent of the costs of family coverage.

- The State will buy into an ESI for a family if the following three conditions hold: (1) the employer pays between 40 percent and 80 percent of the premiums, (2) the family was not covered by an ESI plan in the previous 6 months, and (3) it is cost effective to buy into the ESI plan.

3.5.1 Verification of ESI Coverage

To implement these features, the State had to develop procedures to verify insurance status with employers. State officials worked with employer representatives to develop a form to be mailed out to all employers of potential BadgerCare enrollees. The State reported good compliance among employers in mailing back the requested information. However, consumer advocates complained about the delays in getting the information from the employers.

The success of the employer insurance verification process relies on voluntary compliance among the State's employers. Schneider of DHFS reports that they get a 69.4 percent return rate on the Employer Verification of Insurance Coverage (EVIC) forms they send out. He believes this response is "good" for a voluntary system. For most employers, the burden of filling out the form is fairly low. June Hannemann, benefits administrator at Figi's, Inc., a producer of cheese and specialty foods, reported that she receives requests for information on employees' insurance coverage from DHFS daily. Most of Figi's employees are seasonal and therefore are not eligible for health insurance benefits. For these employees, Hannemann just needs to state that fact and return the form. For employees who are eligible for Figi's health plan, the plan information is all the same; she just needs to copy it. Eric Borgerding, director of legislative relations for Wisconsin Manufacturers and Commerce, reports that they have heard few complaints about the form from their members.

Verification Process

During the application process, the applicant is asked whether he or she or another family member is employed and, if so, the names and addresses of their employers. The applicant then signs a waiver that authorizes DHFS to request information regarding his or her employment and available health insurance coverage. The State follows up by mailing every employer of potential BadgerCare enrollees an EVIC form. The form asks employers to provide information on employer-provided health and/or dental insurance plans that are available to the employee. DHFS uses this information to verify whether an ESI plan that meets the definition of the HIPAA standard plan and for which the employer pays at least 80 percent of the premium costs is available to the family and to determine the cost effectiveness of buying into such plans for which the employer pays between 40 percent and 80 percent of the premiums.

The verification process takes about 2 months to complete, during which family members meeting other program requirements for eligibility are covered under BadgerCare. If the family has said that they do not have access to insurance with their employer, the family will begin the HMO enrollment process while receiving BadgerCare FFS coverage as the State follows up with their employer. If the family has said that they have access to insurance with their employer, the family will receive BadgerCare FFS coverage, and the Medicaid HMO enrollment process is put on hold until follow-up with the employer is completed. If the State determines that an individual could have signed up and received coverage from a current employer contributing 80 percent to an ESI plan during the past 18 months, the family is terminated from the program and is ineligible for 18 months, counting from the first month when they could have been covered. There are several “good cause” reasons why a family may be exempt from the above requirements. These reasons include loss of employment, employment change to a job that does not offer coverage, discontinuation of employer-provided insurance, or noncoverage of family members due to preexisting conditions. Noncoverage of services by the ESI plan due to a preexisting condition does not constitute a “good cause” reason.

3.5.2 Health Insurance Premium Payment Program

Compliance with insurance verification process reported as “good.”

The BadgerCare HIPP program helps low-income working families with children receive health care through ESI plans. As Dombrowicki explained, “The HIPP program is seen as a step towards the goal of transitioning families to ESI or other private insurance.” The specific, stated goals of the HIPP program are as follows:

- to provide continuity of care with health care providers as families move to private insurance
- to promote comparable access to health care for all employees
- to coordinate with employers to supplement, not supplant, employer insurance pools
- to maximize the use of private support, in place of public funds, for BadgerCare

To date, the program has enrolled only a handful of BadgerCare enrollees. Interviewees cited the transitory nature of employment among the eligible population and “rigid” eligibility rules for families, employers, and health plans among the main reasons for low enrollment in the program. Low familiarity and understanding of the program and a general opposition to expanded government involvement in health care among Wisconsin employers and their representatives could also be hampering enrollment.

Enrollment in HIPP remains low after 2½ years of operation.

At the end of May 2002, only 93 families had ever been enrolled in HIPP, including 112 adults and 169 children. Current enrollment that month stood at 62 families with another 197 families with ESI plans that had met the cost-effectiveness criteria and were awaiting their employers’ open enrollment period. For the most part, families who had left the HIPP program had either lost employment with the employer offering the qualifying ESI plan or had lost BadgerCare eligibility through either an increase in income or a decrease in income that made them Medicaid-eligible and thereby ineligible for the BadgerCare ESI buy-in program.

Reasons for the low enrollment in HIPP include characteristics of the jobs BadgerCare enrollees typically hold, the plans their employers offer, and other program restrictions. Alberga (2001) reports that, in the first year of the program, the State mailed more than 25,000 EVIC forms to employers to collect information about their plans. Among the employers returning forms, 53 percent did not offer coverage or their coverage did not qualify under the Health Insurance Portability and Accountability Act (HIPAA) rules; in 31 percent of cases, the worker was no longer employed at the firm. Only 6 percent of cases indicated access to family coverage under ESI. Of these 907 cases with access to ESI, only 5 families were enrolled in HIPP.

Thus, many low-income families are not eligible due to their employment characteristics. That is, either their employers do not offer coverage, they offer coverage only to the employee, and/or the workers are not at a job long enough to qualify for insurance. Transitory employment makes it difficult for employees to be assessed for HIPP eligibility, particularly if the process moves slowly.

Cost-Effectiveness Determination

Prior to the January 2001 waiver allowing Wisconsin to receive federal matching funds for all BadgerCare parents at the Title XXI rate, the State made two cost-effectiveness comparisons: (1) the cost of BadgerCare enrollment of children only versus ESI coverage for the family, and (2) the cost of BadgerCare enrollment of the family versus ESI coverage for the family. If the cost of ESI was less than enrollment of only children in BadgerCare, the State claimed costs for purchase of ESI under Title XXI for adults. If ESI was more expensive than enrollment of only children in BadgerCare but less expensive than enrollment of the family in BadgerCare, the State claimed costs for purchase of ESI under the regular federal matching rate under Title XIX. Since January 2001, only the comparison of the whole family is done to determine cost effectiveness of ESI plans, and the State claims costs for purchase of ESI at the Title XXI rate.

In the cost-effectiveness determination, the cost of BadgerCare includes the cost of HMO enrollment plus the cost of certain additional services not included in the HMO capitation rate that are paid on an FFS basis, such as family planning, dental care, and chiropractic services. The cost of ESI includes the monthly premium, the cost of deductibles and co-insurance, plus the cost of wraparound services to provide the full Medicaid level of services. In addition, the State includes a small administrative fee for the costs of data collection, processing, notifications, telephone charges, and other maintenance costs of the HIPP process. The EVIC supplies the major coverage types under the ESI plan and hence identifies the required wraparound services. DHFS has estimated the costs of various wraparound services using their claims data; these numbers are updated annually for use in the cost-effectiveness determination.

If the family members were covered by an ESI plan in the previous 6 months, the ESI plan is not a HIPAA standard plan, the employer does not pay between 40 percent and 80 percent of the monthly premium, or the State determines that the plan is not cost effective to buy in the family, then the family is not eligible for the HIPP program and the Medicaid HMO enrollment process begins. Families found eligible for the HIPP program will be enrolled in the ESI plan at the earliest available open enrollment period of the plan. If the earliest available open enrollment period is less than 6 months in the future, the family will receive benefits from FFS BadgerCare until they can be enrolled in the ESI plan. If the earliest available open enrollment period is 6 or more months in the future, the family will be enrolled in a BadgerCare HMO until they can be enrolled in the ESI plan. If the employer provides two or more cost-effective health plans, the family will be asked to choose the health plan they prefer.

Chris Kluck, human resources director of Golden County Foods, a food processing firm, was worried that families, because of the seasonal nature of his business, might be going on and off the HIPP program due to variations in income. He noted occasions when employees are required to work overtime to get shipments out because demand is high. Thus, if a family is dropped from the program because they cross over the income threshold one month, the company has to re-enroll the family the next month. He noted that this restriction creates a tremendous administrative burden on the company. Enrollment has been too low to analyze turnover in the HIPP program.

Stringent eligibility criteria restrict enrollment in HIPP.

It was generally believed that the eligibility requirements for HIPP were too stringent, severely restricting the number of employer plans and BadgerCare families that are eligible for the premium assistance program. Many interviewees noted that the requirement that firms pay 60 to 80 percent of the monthly premium was difficult to meet. However, the lowering of the employer premium contribution to 40 percent since November 2001 has brought in only 40 new HIPP enrolled families and another 25 pending cases.

DHFS' Schneider noted several other criteria that further restricted eligibility. For example, plans of self-funded employers also were not eligible for BadgerCare buy-in until recently. In addition, if the family has any children in Medicaid or Healthy Start, the family does not qualify, restricting the number of potential enrollees for the HIPP program. Furthermore, the health care providers for the employer's plan have to be Medicaid providers. Thus, if an employer's managed care plan does not participate in Medicaid, the plan does not qualify. Although this requirement facilitates payment of plan deductibles and coinsurance amounts, it could narrow the range of eligible plans. However, Schneider believes that, to date, the latter restriction has not actually eliminated any cases.

Few employers are aware of the program.

Employers noted that information about HIPP was not readily available to help them facilitate employee enrollment in HIPP. Kluck stated that formal coordinated outreach from the local and State levels would have greatly reduced the confusion and difficulties surrounding the nature of the HIPP program. He also remarked that the valuable contribution of regional State contacts in assisting family enrollment only occurred after he made overtures to the government. Steve Sobiek, executive director of the Independent Business Association of Wisconsin, suggests that employers do not understand the program because the State has not reached out successfully to small businesses.

Employers have not received much information on BadgerCare from their business associations either. Borgerding stated that Wisconsin Manufacturers and Commerce has not promoted BadgerCare to its membership because the members have "generally opposed expansion of government involvement in health care due to the impact on taxes." Smith reported that NFIB likes the idea of HIPP but is concerned that BadgerCare is close to becoming "a

government mandated health insurance program for small business.”

These business representatives feel that small businesses cannot match the BadgerCare benefit packages. Borgerding suggests that “BadgerCare is a Cadillac program compared to what tax-paying employers are able to offer employees in the private sector.” He sees BadgerCare as raising a host of policy questions about government-provided health care: “When tax paying small businesses that are barely able to offer health insurance to their own employees are paying for a Medicaid level of benefits through BadgerCare, that gets some of our members asking what they’re doing wrong.”

Business leaders see a bigger role for HIPP in the future.

Business leaders in Wisconsin favor a small group insurance pool over public coverage. However, Wisconsin’s attempt at creating such a pool has been stymied by difficulties in contracting for plan administration. With the recent large increases in insurance premiums, they are concerned about impending ESI coverage losses among smaller firms. Therefore, despite their reluctance to promote BadgerCare to their membership, business association representatives see an important safety net role for the HIPP program and would like the standards to be less restrictive to allow more employers and their employees to take advantage of BadgerCare.

3.5.3 Looking to the Future: HIPP

Wisconsin remains committed to ESI integration of the BadgerCare program and to its premium assistance program and is making changes so that it can succeed in the future. The State has already made two changes that should increase enrollment in HIPP in the coming months. First, starting November 1, 2001, the lower limit for employer premium contributions was lowered from 60 percent to 40 percent to allow more plans to qualify. Second, the State is now allowing self-funded employer plans to qualify for the program.

Furthermore, State officials and policy makers are considering two additional changes to the program. They are currently looking into whether their waiver will allow the State to buy into ESI plans for families with children in Healthy Start/Medicaid. The Wisconsin Medicaid plan would need to be amended, because this change would constitute a Medicaid buy-in. Although the current plan

includes language about how the State would undertake a Medicaid buy-in, it was never operationalized. The State is also looking into requiring that BadgerCare enrollment be a qualifying event for ESI. Currently, BadgerCare enrollees must wait until their employer's open enrollment period to join the plan.

3.6 HEALTH CARE DELIVERY SYSTEM

The primary health care delivery system used in the BadgerCare program is Wisconsin's current statewide Medicaid managed care delivery system for the AFDC-related/Healthy Start population. Wisconsin has a long history of Medicaid managed care; it was one of the first states to implement mandatory enrollment in HMOs (Coughlin et al., 1998). Mandatory HMO enrollment was first implemented in 1984 under a 1915(b) waiver in Milwaukee and Dane counties and was gradually expanded to other counties. In 1996, a statewide implementation of mandatory HMO enrollment began that was completed in mid 1997.

Currently, 13 HMOs participate in the Wisconsin Medicaid managed care system. Not all counties have mandatory HMO enrollment. Enrollment is mandated only in those zip codes where two or more HMOs are available. *Exhibit 14* shows the counties by their HMO participation status.

3.6.1 HMO Enrollment

Families may choose between HMO programs if more than one serves their area. If only one HMO is available, the family has a choice between the HMO and FFS. For geographic areas not served by an HMO, BadgerCare families are covered by FFS. During the time it takes to enroll in an HMO, eligible families are covered by BadgerCare FFS. The State may also buy into ESI coverage for some BadgerCare enrollees through the HIP, described previously. The delivery systems of these plans may be FFS, HMO, or some other type of managed care.

Most BadgerCare enrollees are enrolled in HMO plans.

Exhibit 15 shows the percentages of family coverage enrollees in 2000 with HMO coverage only, those with FFS coverage only, and those with some months of coverage in an HMO and some months of coverage under FFS during the calendar year. Three-fourths (76 percent) of BadgerCare enrollees in 2000 were enrolled in an HMO plan during 2000, either exclusively or in combination with FFS coverage. This percentage is lower than that of AFDC-related (87 percent) and Healthy Start (81 percent) enrollees with any HMO coverage during 2000 but significantly higher than the percentage of other Medicaid enrollees (38 percent) with HMO coverage. Many individuals in the latter eligibility category are either exempt or are not eligible for Medicaid HMO enrollment in Wisconsin.

Exhibit 15. Percentage Distribution of Medicaid Family Coverage Enrollees Over Delivery System Categories by Program Type, 2000

	AFDC-Related	Healthy Start	Other Medicaid	BadgerCare	Total
All Enrollees	100.0%	100.0%	100.0%	100.0%	100.0%
HMO exclusively	36.9%	32.6%	9.8%	22.1%	31.6%
FFS exclusively	13.0%	19.0%	62.1%	24.1%	21.8%
HMO and FFS	50.1%	48.4%	28.1%	53.9%	46.6%
Adults	100.0%	100.0%	100.0%	100.0%	100.0%
HMO exclusively	32.4%	16.0%	23.8%	21.6%	26.6%
FFS exclusively	16.5%	32.1%	53.6%	26.0%	26.5%
HMO and FFS	51.0%	52.0%	22.6%	52.4%	46.9%
Children	100.0%	100.0%	100.0%	100.0%	100.0%
HMO exclusively	38.8%	34.2%	1.1%	22.4%	33.3%
FFS exclusively	11.5%	17.7%	67.4%	23.0%	20.3%
HMO and FFS	49.7%	48.1%	31.6%	54.6%	46.4%

Note: AFDC = Aid to Families with Dependent Children; HMO = health maintenance organization; FFS = Medicaid fee-for-service.

BadgerCare has relatively more enrollees in FFS exclusively.

BadgerCare enrollees were more likely to have both HMO and FFS coverage in 2000 than the other family coverage categories because these enrollees included relatively more new enrollees who received care under FFS before enrolling in an HMO plan. The relatively greater number of new enrollees also partly explains the higher percentage of BadgerCare enrollees in FFS exclusively compared with AFDC-related enrollees (24 percent versus 13 percent). However, the greater likelihood for BadgerCare enrollees

than AFDC-related enrollees to reside in nonmetropolitan and rural areas of the State not served by Medicaid HMO plans also contributes to the higher percentage. Healthy Start children were somewhat less likely than BadgerCare children to be enrolled exclusively in FFS (18 percent versus 23 percent); many families have some or all of their children enrolled in Healthy Start while the parents are enrolled in BadgerCare. Healthy Start pregnant women were more likely to be in FFS only (32 percent).

3.6.2 Managed Care Providers in BadgerCare

Managed care organizations are required to participate in both programs so that family members can enroll in the same plan even if covered by different programs. Provider directories and other materials designed to help participants understand their options are identical for the two programs. A toll-free number connects BadgerCare and Medicaid participants with an enrollment specialist who can answer questions and help with the managed care enrollment process.

HMOs concerned about impact of adult enrollment on their costs.

As in many state Medicaid programs, however, sustaining provider participation has remained a challenge. Managed care organizations welcome the increased membership offered by BadgerCare but remain concerned about the program's financial impact. During BadgerCare's first implementation year, several HMOs threatened to withdraw from the program unless reimbursements were increased, citing excessive costs resulting from pent-up demand and high pharmaceutical charges among adult recipients. CompCare, the only insurer to actually leave the program, projected losses of \$3 million had it remained in BadgerCare during 2000.

The State responded to insurers' concerns by increasing rates by 12 percent in 2000. Insurers were also offered a risk-sharing plan that would provide additional State reimbursement if costs were higher than expected, although only four HMOs took advantage of this option. Managed care providers interviewed for this study report mixed financial experience with BadgerCare but are generally positive about the overall program. Similar to those involved in the planning process, they praise the State's collaborative working style and responsiveness to their concerns.

3.6.3 Access to Providers

BadgerCare enrollees who receive coverage through a managed care plan have access to all providers participating in that plan. The HMOs are required to find primary care providers for all their BadgerCare members. However, focus group participants consistently reported difficulties in finding primary care providers who would accept new patients covered by BadgerCare. “I’m a working parent, like they say on TV,” said one, “but nobody will take the BadgerCare card.”

Many BadgerCare enrollees experience difficulty in finding providers.

The difficulty of finding participating providers was among the most frequently cited concerns about BadgerCare by participants in the nonenrolled focus group. Their perception was that BadgerCare was “too much of a hassle,” in that they would be required to spend extensive time on the telephone trying to find a doctor who would see them, using provider lists that are out of date. Nonenrolled participants also believed that BadgerCare does not adequately reimburse providers and that they would receive poor-quality care as a result. Some enrolled participants reported that the only providers taking new BadgerCare patients were located in dangerous neighborhoods, had limited English proficiency, or treated them rudely.

Access to dental care is particularly challenging.

As in many states, BadgerCare recipients have difficulty accessing dental care. Data from the 1999 Family Health Survey indicated that only 23 percent of BadgerCare and Medicaid enrollees were able to find a dentist who would treat them. Mara Brooks, legislative liaison at the Wisconsin Dental Association, reports that only 37 percent of the State’s dentists provide services to BadgerCare and Medicaid enrollees (Maller, 2001). One focus group participant reported having called 152 dentists from the State’s list of participating providers without finding one who would see her.

In testimony to a Joint Legislative Committee on dental access, James Vavra, director of the DHFS Bureau of Fee-for-Service Health Care Benefits, noted several concerns raised by dentists about Medicaid, including inadequate reimbursement, burdensome paperwork, and poor patient compliance. Newspaper reports cite several examples of dentists who choose to treat a limited number of patients at no charge rather than negotiate the paperwork

required to collect the State’s limited fee. In response to Vavra’s testimony, the legislative committee proposed increasing dental reimbursement to the 75th percentile of rates for the region, rather than the current 55 percent of the dentist’s own usual and customary fee. The increase was excluded from the 2001 biennial budget because it was too costly, according to John Gard, co-chair of the Joint Finance Committee.

DHFS is working with dentists to resolve issues, but fees remain low.

Vavra’s testimony also described measures taken by DHFS to address the other issues identified. He reported that DHFS is working with the Wisconsin Dental Association to identify strategies for streamlining paperwork, including a specialized unit that works to resolve paperwork errors and omissions that might otherwise result in denied claims. The State reports that denied claims fell by 40 percent as a result of its efforts. To address patient compliance problems, DHFS collaborated with professional groups and State agencies to develop a patient education plan that would emphasize the importance of oral health and educate providers about strategies for serving diverse patient populations.

3.7 STAKEHOLDER SATISFACTION

Stakeholders view BadgerCare as a success but remain attentive to specific concerns.

BadgerCare is widely viewed as a success by those involved with the program. The nature of its perceived success, as well as remaining concerns, vary according to the stakeholder’s perspective. State officials view BadgerCare enrollment as addressing two fundamental goals: reducing uninsurance and supporting the transition from welfare to work. They cite the program’s quick start-up and efficient administration as successful outcomes of early design decisions to build BadgerCare on existing Medicaid infrastructure. DHFS staff continue to address specific concerns with targeted efforts such as improved outreach to underenrolled populations and enrollment simplification.

Health care advocates applaud BadgerCare’s success in increasing access to health care, hailing BadgerCare as a “lifeline” and praising its success in extending insurance among adults and rural residents. At the same time, they remain attentive to specific aspects of program operations that may create barriers for individuals. Areas of ongoing concern include reducing barriers to enrollment and retention by improving processes, creating a more customer-friendly

culture, and addressing specific eligibility policies, such as that requiring establishment of paternity.

BadgerCare eligibles participating in focus groups confirmed the advocates' perspective in their appreciation of the program as well as their concern over specific barriers to participation. In particular, those with prior experience with private insurance find BadgerCare's enrollment and redetermination processes burdensome and are frustrated by the difficulty of accessing dental care. As intended by program developers, they view BadgerCare as distinct from Medicaid. However, because they want to maintain this distinction, they therefore dislike the shared "Forward" card.

Among all stakeholders, representatives of business associations expressed the greatest reservations about BadgerCare. Their concerns center on the program's effect on government costs and potential for crowd-out of ESI. In particular, they object to State provision of a relatively rich benefits package at a time when small businesses and other employers are facing rapid premium escalation that makes it increasingly difficult for them to offer insurance.

Health care and managed care providers value BadgerCare in terms of its effectiveness in extending coverage to previously uninsured individuals. Managed care providers remain concerned over the cost effect of the program's higher proportion of adult enrollees. However, they praise the responsiveness of State health officials to their needs and are committed to working with the program. Health care providers in primary care and tribal health centers value BadgerCare as a means of increasing the support available to provide care for previously uninsured clients. For tribal health officials, however, there are substantial barriers to increasing enrollment among tribal members who are accustomed to coverage through IHS funds.

3.8 REVENUES AND COSTS

Higher than expected enrollment led to higher than expected costs.

BadgerCare's higher than expected enrollment led to higher than expected program costs. Just 6 months after the program's implementation, then-governor Tommy Thompson asked the State legislature for \$11 million more to cover the higher than expected costs (Walters, 2000). A year later, the State was facing an even greater cost overrun for the BadgerCare program.

As mentioned previously, the original budget for the program was based on an enrollment of 67,535 individuals by June 2001, but this enrollment was reached a year earlier and continued to grow. Also, relatively more adults than children were enrolling in the program. In early 2001, 69 percent of BadgerCare enrollees were adults, whereas 63 percent had been anticipated. This imbalance increased program costs to the State, not only because health care for adults is generally more expensive but also because the federal reimbursement rate for adults was lower than that for children.

Furthermore, in September 2000, Wisconsin was at risk of losing \$17.5 million in unused SCHIP funds until U.S. Representative Tom Barrett, D-Milwaukee, helped engineer a compromise under which the 39 states with unused SCHIP funds could keep 60 percent of the unused money but must spend it in the next 2 years.⁶ State officials said that Wisconsin did not use its entire SCHIP allocation because they were waiting for federal approval of a waiver to cover some parents in the program under BadgerCare.

By January 2001, the budget situation was becoming critical. “Unless we provide money, they will actually have to stop enrolling people in the program sometime in February, and that would be a tragedy,” said Senate Majority Leader Chuck Chvala, D-Madison, in a January 8 article in the *Milwaukee Journal Sentinel*.

The Title XXI waiver provided an urgently needed boost in program revenue.

The federal waiver was approved that month. Under the terms of the waiver, the State is able to claim enhanced federal reimbursement of 71 percent under Title XXI for parents with incomes above 100 percent of the FPL. Parents with incomes at or below 100 percent of the FPL continue to be funded under the Title XIX waiver with a federal matching rate of 59 percent. If the enrollment trigger under Title XIX is used to decrease the income level for initial eligibility, funding and waiver provisions revert to the original Title XIX waiver, resulting in the loss of the higher federal match rate for parents. The 2001–2003 State budget projects that the Title XXI waiver will generate approximately \$6.2 million in federal funds in state fiscal year (SFY) 2002 and \$6.7 million in SFY 2003.

⁶ Section 801 of the Benefit Improvement and Patient Protection Act of 2001 changed the process of redistributing SCHIP funds and allowed states to retain funds.

BadgerCare revenue sources for SFY 2001, 2002, and 2003 are shown in **Exhibit 16**. Very little revenue for the program is collected from premium payments. Total revenue from this source was only 1.1 percent of total program revenues in 2001 and is projected to grow to only 2.1 percent in 2003.

Exhibit 16. Projected BadgerCare Funding, State Fiscal Years (SFY) 2001-2003

	SFY 2001		SFY 2002		SFY 2003	
	Revenues	Percentage	Revenues	Percentage	Revenues	Percentage
State (GPR)	\$46,164,618	35.8%	\$48,005,300	32.8%	\$52,234,300	32.7%
Federal	\$81,449,439	63.1%	\$95,472,700	65.2%	\$104,167,500	65.2%
Premium Payments	\$1,410,649	1.1%	\$2,994,400	2.0%	\$3,293,400	2.1%
Total	\$129,024,706	100%	\$146,472,400	100%	\$159,695,200	100%

Note: Data supplied by Greg DiMiceli, Division of Health Care Financing, Department of Health and Family Services, State of Wisconsin. GPR = general purpose revenues.

4

Summary and Conclusions

This section draws on the findings presented in Section 3 on BadgerCare’s planning process, outreach and enrollment, factors motivating participation, ESI integration, interactions with the health care delivery systems, stakeholder satisfaction, and revenues. These findings, based on interviews, focus groups, and document review, are synthesized to address the case study research questions. The summary demonstrates the considerable achievements of the BadgerCare program, as well as its remaining challenges.

4.1 PROGRAM PLANNING AND IMPLEMENTATION

What was the process used by the State to develop and implement the demonstration? How was the participation of various interested parties in the planning process secured? Are there lessons to be learned in this area that would be beneficial to other states?

The process used by the State to develop and implement the BadgerCare demonstration is best characterized as collaborative and marked by compromise. Because State planners believed that a commitment from all stakeholders was key to getting BadgerCare approved, they involved a wide range of stakeholders from the outset. Stakeholders were identified from previous planning efforts. State officials worked with them one on one and jointly in a series of meetings held to discuss the issues. All stakeholders in the process agreed on the need to extend health insurance to the working poor; disagreements arose only in the details of how to do so. Compromises on crowd-out provisions, including premium payments for the higher income eligibles, were vital to gaining stakeholder support.

Collaboration and compromise extended to the State's interaction with CMS in obtaining approval for the program. The State's initial BadgerCare application, like the predecessor waiver application for the W-2 Family Health Plan, was denied because, among other things, the proposed cap on enrollment was incompatible with the entitlement nature of the Medicaid program. By January 1999, a compromise was negotiated in which BadgerCare would be an entitlement program and, in place of an enrollment cap, the State would be allowed to lower the income eligibility threshold if necessary to avoid budget overruns.

The BadgerCare planning process worked in part because of the pride Wisconsin residents feel in their progressive tradition and in the determination of a handful of policy makers to develop a workable solution to the State's growing number of uninsured. These factors may be hard to replicate in other states. However, the use of a collaborative process that includes representation from all major stakeholders was also key and can be replicated.

The State's use of existing infrastructure is also potentially reproducible by other states. Recognizing that the system was not perfect, State officials chose to use the State's existing Medicaid eligibility and health delivery system for the BadgerCare program and to fine tune the systems later as needed. As a result, implementation was quick and effective.

4.2 OUTREACH AND ENROLLMENT SIMPLIFICATION

What steps were taken by the State to publicize the existence of the BadgerCare program and to encourage qualifying families to apply? How effective were these efforts?

Wisconsin conducted a variety of statewide outreach activities for the BadgerCare program. These included a public information campaign with brochures, a toll-free hotline, and televised public service announcements featuring then-governor Tommy Thompson; the training of outreach workers; and placement of outreach workers at health care and community establishments frequented by low-income families (i.e., outstationing). Wisconsin also had two *Covering Kids* pilot sites—one in Milwaukee and the other in a four-county area in north-central Wisconsin—which have now been expanded statewide. Activities covered under the initiative include training, capacity building among community agencies, information dissemination, and process improvements.

Targeted outreach activities have also been conducted in Wisconsin. For example, the State facilitated creation of a BadgerCare Coordinating Committee in Milwaukee to provide a forum for sharing information on BadgerCare policy and program changes and to coordinate strategic outreach efforts. The committee is composed of State and local officials, health advocates, and business representatives. Another committee was formed to address school outreach; this group supported BadgerCare outreach as part of Kindergarten Round-Up in several large school districts and has developed proposals for other approaches to increasing enrollment through schools. Managed care companies and providers, including tribal clinics and the Marshfield Clinic, a multisite provider in north-central Wisconsin, also initiated and supported outreach efforts during the first year of program implementation.

In addition to its outreach efforts, Wisconsin has taken other approaches to encourage qualifying families to apply for BadgerCare. In particular, the State created a distinct image for the program so that it would not be associated with welfare and therefore would be more acceptable to low-income working families. The State also adopted several enrollment simplification measures, including the elimination of the Medicaid assets test, implementation of a simplified mail-in and phone-in application, and acceptance of self-declaration of income; instituted training of county workers to help them understand the philosophical differences between Medicaid/BadgerCare, W-2, and food stamps; and streamlined the redetermination process.

The effectiveness of any single measure in encouraging families to enroll in BadgerCare could not be determined. However, enrollment in the program significantly exceeded the planners' expectations, suggesting that the combination of outreach and enrollment simplification was highly effective.

4.3 BADGERCARE ENROLLMENT

How many people participate in BadgerCare? What are the demographic and enrollment characteristics of the BadgerCare participants? Has the demonstration increased the percentage of the W-2 participating population who have health insurance? Has the demonstration succeeded in increasing the percentage of the population with incomes below 200 percent of the FPL who have health insurance?

From the start, BadgerCare enrollment has exceeded expectations. More families were enrolled earlier than planners and policy makers could have dreamed, reversing the downward trend in Medicaid family coverage resulting from the declining welfare rolls. Enrollment continues to grow every month. At the end of 2001, approximately 91,500 individuals were enrolled in BadgerCare and an additional 53,300 children had been added to the Medicaid/Healthy Start rolls.

In contrast to the other Medicaid family coverage categories, BadgerCare enrolled more adults than children. About three out of five BadgerCare enrollees were parents or spouses of parents. Many of the children of BadgerCare adult enrollees were enrolled in Medicaid/Healthy Start. In 2000, only 8 percent of BadgerCare child enrollees were under 6 years of age, just under two-thirds were aged 6 to 14 years, and about 30 percent were aged 15 to 18 years.

BadgerCare enrollees were also more geographically dispersed throughout the State compared with enrollees in traditional Medicaid family coverage (AFDC-related categories), more than half of whom lived in Milwaukee County. Furthermore, virtually all W-2 participants are currently covered by Medicaid or BadgerCare.

The increase in Medicaid and BadgerCare enrollment was accompanied by a significant drop in the uninsurance rate in Wisconsin. According to estimates from the CPS, the rate of residents without health insurance in Wisconsin dropped to 7 percent in 2000, half the rate for the nation as a whole and down from a high of 13 percent in the State in 1998, the year prior to BadgerCare implementation. The Wisconsin Family Health Survey, believed by State officials to be a better estimate of the uninsured in the State, shows that approximately 6 percent of Wisconsin residents went without health insurance at any given point in time during 2000.

4.4 FACTORS MOTIVATING PARTICIPATION

What motivates families to participate or not participate in BadgerCare? Is there any evidence that family coverage has increased participation of children in Medicaid or the State Children’s Health Insurance Program (SCHIP)? Have premiums deterred families from enrolling in BadgerCare? How many persons and/or families are deemed ineligible for BadgerCare coverage due to anti-crowd-out provisions?

Focus group participants noted problems with the enrollment process and prior bad experiences with county eligibility workers. The State has been addressing these problems with enrollment simplification measures and the training of county workers. One factor identified in the focus groups as motivating participation was the availability of a person to help enrollees through the application process from start to finish. Another deterrent to BadgerCare participation identified by several case study respondents was the requirement that women establish their children’s paternity, which could lead to a court order that fathers pay child support. Many mothers are reluctant to name their children’s fathers.

Policy makers and advocates believed that family coverage helped enroll many children in BadgerCare, but focus group participants claimed they would have enrolled their children in the program even if they themselves were not covered. Focus group participants also did not view premium payments as a deterrent to coverage; in contrast, they contended that it made them feel proud to not be “leeching off the system.”

Finally, the crowd-out provisions were not viewed as preventing many families from being eligible for BadgerCare since few families had access to ESI and the premium payments were low compared with private insurance. However, advocates expressed concern that premium payments may contribute to churning and that waiting periods could cause hardship among the chronically ill.

4.5 INTEGRATION WITH ESI AND MEDICAID MANAGED CARE

Wisconsin’s Medicaid managed care delivery system for the AFDC-related/Healthy Start population is the primary health care delivery system under BadgerCare. However, if an eligible family has access to a qualifying ESI plan and the plan is determined to be cost effective compared with enrollment in a Medicaid HMO, the State buys into the ESI plan for the family.

What percentage of the BadgerCare population receives coverage through Medicaid managed care, through exclusively FFS Medicaid/BadgerCare, and through employer-sponsored insurance?

The HIPP program, Wisconsin's premium assistance plan, is one of the major innovative features of BadgerCare. However, in its first 2-1/2 years of operation, HIPP has succeeded in enrolling only a handful of program eligibles. The main reason cited for low enrollment is stringent eligibility rules for families, employers, and health plans. Low familiarity and understanding of the program and a general opposition to expanded government involvement in health care among Wisconsin employers and their representatives could also be hampering enrollment.

The State has recently reduced the lower limit of the required employer contribution amount from 60 percent to 40 percent and is now allowing self-funded employer plans to be considered as qualifying HIPP plans. It is also considering allowing families with Medicaid-covered children to qualify for HIPP and requiring that BadgerCare enrollment be a qualifying event for employer health insurance. These measures are expected to significantly increase enrollment in the program.

For BadgerCare families not in an ESI plan and residing in a geographic area served by two or more Medicaid HMOs, enrollment in a Medicaid managed care plan is mandatory. Families in a geographic area served by a single Medicaid HMO have a choice between HMO or FFS coverage. Those in areas with no Medicaid HMO service are enrolled in FFS. Furthermore, families are covered by FFS Medicaid during the time it takes for them to enroll in an HMO or ESI plan.

In 2000, three-fourths of BadgerCare enrollees were enrolled in an HMO plan for at least part of the year and one-quarter were enrolled exclusively in FFS. Some of the latter enrollees were transitioning to HMO coverage. Because BadgerCare enrollees are more geographically dispersed and more likely to live in areas not served by two or more Medicaid HMOs compared with AFDC-related Medicaid eligibles, somewhat more BadgerCare enrollees were enrolled in FFS exclusively.

4.6 STAKEHOLDER SATISFACTION

How do the various interested parties view the demonstration now that it has been implemented and is operating?

Stakeholders in State government, health care delivery, insurance, and advocacy organizations clearly consider the BadgerCare program a success. Enrollment has exceeded target levels, while some SCHIP programs struggle to attract eligible participants. Equally significant is the apparent effect of BadgerCare in reversing the decline in Title XIX enrollment, compounding BadgerCare's effectiveness in reducing uninsurance. Legislative support has been sustained despite challenges from conservative legislators. The program is widely viewed as an achievement that resonates with the State's longstanding commitment to increase access to health care and its more recent crusade to reduce welfare dependency.

Even the program's most ardent supporters readily identify areas in need of improvement. The most common concerns, cited by a variety of stakeholders, include barriers to enrollment and retention created by both program procedures and agency culture. The State is addressing these issues with systems design and training efforts. Some concerns vary among constituencies. Health care advocates, for example, would like to modify financial eligibility criteria to facilitate access to the program. At the same time, business associations argue for policies such as increased waiting periods that would limit enrollment.

4.7 REVENUES AND COSTS

What are the funding sources for the BadgerCare program, and what is the relative importance of each? How much do premiums contribute to total revenues?

BadgerCare is largely supported by federal funds, which account for nearly two-thirds of the program's revenue. The State's ability to sustain its portion of program funding was called into question soon after its initial implementation, as higher than expected growth in enrollment strained the program's economic and fiscal viability. Federal waiver approval, allowing family coverage to be funded at the Title XXI matching rate of 71 percent (rather than 59 percent under Title XIX), provided an urgently needed boost in program revenue. The Title XXI waiver essentially locked the State into its current definitions of financial eligibility. If the State were to reduce the upper income limit for financial eligibility, as envisioned under the enrollment trigger provision, the higher match rate would be revoked.

Premiums represent a small portion of total program revenue, approximately 1 to 2 percent, and add to administrative costs.

Premiums may also create a deterrent to enrollment or increase churning if families are terminated from the program for nonpayment. The State does not believe that either of these effects occurs to a significant degree. Any possible risks associated with premiums must be evaluated in light of their clear benefits in reducing the stigma associated with publicly funded insurance for participants and increasing the program's broad political appeal.

4.8 WHAT NEXT?

Wisconsin continues to refine BadgerCare operations in response to experience and emerging information. Activities conducted under the auspices of the HRSA State Planning Grant and the *Covering Kids* initiative, combined with ongoing communication across the range of stakeholders, have set an agenda for continued program improvements. These changes include simplifying enrollment processes, bolstering participation in HIPP, and conducting outreach to specific populations of nonenrolled eligible families. However, achieving further reduction in the rate of uninsurance will likely require greater effort than did early enrollment successes, as the remaining uninsured populations require more targeted efforts for outreach and enrollment.

BadgerCare was developed during a period of robust economic conditions in Wisconsin, characterized by high rates of employment and ESI coverage. Since the program's implementation in July 1999, economic conditions have shifted substantially, and employers now struggle with rising health insurance costs. As its policy and economic context evolve, it is likely that BadgerCare will continue to face further challenges and changes.

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A

**BadgerCare
Interview Guide**

A. Opening

1. Study Description

This interview is part of a study funded by the federal Health Care Financing Administration¹ to learn more about the development and operation of the BadgerCare program. Because BadgerCare represents an innovative approach to insuring low-income children and their parents, the sponsors are interested in understanding more about the program's design and operation. We appreciate your taking the time for this interview.

2. Confidentiality

- a. We'll be using the information you provide, along with other interviews we'll be doing at the state and local level, as part of a case study report.
 - The case study report will include a list of persons we've interviewed during these site visits.
 - If there is anything you think we should know but would prefer not to be attributed to you, let us know and we'll treat it as confidential.
 - We would like to tape this interview as a backup to our written notes. The tape will be used only by our interview team. Is this okay with you?

3. Interviewee Role

- a. Can you give us an overview of the ways in which this agency/organization, and you personally, have been involved in BadgerCare?

B. Program Development

BadgerCare is unusual in several respects, and we're very interested in how the program came to be developed as it was.

1. From your perspective, what were the important influences on how the program was developed?
2. Who were the important players in the program development process? Were there organizations that might have been involved but weren't?
3. What impact did the HCFA approval process have on the program design? What problems were encountered in combining the 1115 Waiver program with the SCHIP program?
4. How is the design of BadgerCare related to the state's experience with Wisconsin Works?

¹ At the time of the case study interviews, the Centers for Medicare and Medicaid Services (CMS) was still known as the Health Care Financing Administration (HCFA).

C. Program Design and Operations

1. General

- a. What is your overall assessment of the design of BadgerCare?
 - What are its most important features?

2. Eligibility

- a. What considerations were important in determining the income eligibility level?
 - What do you think of the choice, compared to other possible choices?
 - We understand that the 185% limit is based on net income, rather than gross income, as in other states. This was noted by HCFA in the Title XXI waiver. Does the state have plans to change how it computes income?
- b. When determining family income as a percent of the federal poverty level, how is family size determined? Does it include Medicaid-covered children?
- c. What is the likelihood that the income eligibility level will be lowered due to budget overruns? (Restricted from doing this under the newly awarded Title XXI waiver).
- d. Could you clarify the citizenship requirements of BadgerCare?
- e. What considerations were important in the decision to drop the asset test?
 - What do you think of the choice, compared to other possible choices?
- f. Are the eligibility requirements chosen for the program allowing it to reach the right families? If not, why not?
- g. What population is currently left out of BadgerCare and other public programs—e.g., childless adults and those deemed ineligible due to anti-crowd-out provision?
 - How large is this population?
- h. Are there any plans to expand eligibility under BadgerCare or to reduce or eliminate any of the anti-crowd-out provisions?
- i. Who are the adults with family incomes below 55% of the FPL (custodial parents eligible for Medicaid)?

3. Enrollment

- a. What factors influenced the decision to enroll families rather than children only?
 - What do you think of the choice, compared to other possible choices?
- b. How has “family-based coverage” worked?
 - Has it made the program more attractive to families?
 - Do you think it has affected the enrollment of eligible children?
- c. What happens (or is supposed to happen) when family coverage is discontinued?
- d. For families with members covered under both Medicaid/Healthy Start and BadgerCare, does the family consider the whole family to be covered by BadgerCare or will they know that some members are covered by Medicaid/Healthy Start?
- e. Is churning, the tendency for individuals and families to have multiple short periods of enrollment, a problem in Wisconsin?
 - Do administrative procedures contribute to this phenomena?
 - Are families cognizant that they were not covered by BadgerCare for a month or two?
- f. Does the state know what percentage of disenrollees leave voluntarily and what percent are terminated for failure to follow rules or for changes in circumstances?
- g. Do your enrollment files have indicators for reasons for disenrollment?

4. Enrollment Procedures

- a. Are the eligibility determination procedures burdensome for families?
- b. For the state and local eligibility workers?
 - What aspects have been successful?
 - What difficulties have been encountered?
- c. If a BadgerCare family moves to a different county, but their financial status and family composition remain unchanged, do they have to re-enroll in BadgerCare in their new county or is their coverage portable?

5. Premiums

- a. What considerations influenced the decision to require premiums for families over 150 percent of poverty level?
 - What do you think of the choice, compared to other possible choices?
- b. What do you think has been the effect of the premium for families?
 - Have premiums reduced stigma attached to public assistance?
 - Have they made the program more acceptable to the wider public?
 - Have premiums affected enrollment or continuity of coverage?
 - Have premiums prevented crowd-out?
- c. Are the benefits of cost sharing worth the administrative burden it creates?
- d. Last May, when HCFA staff visited Wisconsin, they were told that the premium deeming and collection process was going to be streamlined. Has this happened?
 - If so, how has the process changed?

6. Outreach

- a. What have been the major outreach strategies?
 - What do you think of these, compared to other possible choices?
 - Have the major strategies changed over time?
 - What are the major strategies that the state is going to take over the next year or two?
- b. Who have been the major players involved in outreach?
- c. What aspects of outreach have been effective?
 - The public information campaign?
 - Training eligibility workers and the use of CARES?
 - Outstationing eligibility workers?
 - Using schools for outreach efforts?
 - Linkages to other programs like Medicaid and food stamps?

Are there others that could be implemented?

- d. Some background material we read on BadgerCare referred to a collaborative statewide network of health care providers whose staff DHFS were trained in Medicaid and BadgerCare. What does this network do?
 - Do they enroll eligible individuals and families into Medicaid and BadgerCare?
 - Is the network ongoing? If so, how is information on program changes transmitted to them?

For local level outreach partners:

- e. Please tell us about outreach efforts that your agency/organization has been part of:
 - In what ways has this program been most effective?
 - What difficulties have you encountered?
 - Are there modifications you would like to see?

7. Integration With Employer-Sponsored Insurance

- a. How were measures chosen to avoid crowd-out and integrate BadgerCare with employer-sponsored health insurance? What do you think of these choices?
 - The 3-month waiting period
 - Denial of eligibility to families with access to qualifying employer-provided plans
 - State buy-in coverage for families with access to cost-effective employer-provided plans meeting other qualifying criteria through the Health Insurance Premium Payment (HIPP) program
- b. How effective has the integration with employer-sponsored insurance been?
- c. Has the reporting of available employer-sponsored coverage been complete and accurate?
- d. How long does the verification process of employer-sponsored plans take? How long does it take to get families with qualifying plans enrolled (including time to open enrollment)?
- e. What problems, if any, have been encountered in:
 - Verifying employer-sponsored coverage?
 - Determining cost-effectiveness?
 - Paying premiums, coinsurance, and deductible amounts?
- f. Has this integration been effective in reducing crowd-out?
- g. Has this integration decreased, contributed to, or had no effect on the number of uninsured in the state?
- h. Are the costs of administering the HIPP program worth the benefits?

8. Managed Care Issues

- a. The state pays HMOs a fee per member per month, rather than paying a family coverage premium to HMOs similar to what a private company would pay for ESI, or paying an incremental amount for each covered life. Is that correct?
- b. What are the capitation rates paid by the state to HMOs providing coverage to BadgerCare participants? Do they vary by enrollee? By HMO?
- c. The capitation rates increased since BadgerCare's implementation. When did these rates change? How much did they change?
- d. With BadgerCare family coverage, are all family members automatically placed in the same health plan, including those enrolled in Medicaid/Healthy Start, or could they be in different plans?

9. Funding

- a. What are the funding sources for the BadgerCare program?
 - ▶ How much does each contribute?
- b. How much do premiums contribute to the program's operation?
 - ▶ Have the revenues from premiums outweighed the costs of collecting and monitoring premium payments?
- c. What has been the impact of the recently granted Title XXI waiver and consequent enhanced matching rate for adults? Will parents' coverage still be paid under Title XIX or a combination of Title XIX and XXI? How will the federal:state funding ratios change? Will more children be covered with the waiver than would have been covered if the state had not received the waiver?
- d. What are the sources of state funds used to finance BadgerCare (e.g., projected savings, reduction in funding of other programs, budgeted, etc.)?

10. Overall Assessment

- a. What aspects of the program have been most successful?
- b. Are there any that are problematic?

11. Other Topics

- a. Are there topics that we haven't covered that you think should be mentioned?

D. Focus Group Plans

1. With some interviewees, discuss possible sites and outreach strategies for focus groups.
 - a. Possible sites
 - b. Who could help us with outreach?

E. Closing

1. We appreciate your taking the time to talk with us. We'll be writing up our notes in the next few weeks, and would like to send you a copy so that you can correct anything we might not have gotten down correctly.
 - Verify that we have email and fax info
 - Verify title

B

**Case Study
Interviewees**

Mary Anderson
Dean Health Plan

Vickie Baker
ABC for Health

Pat Beining
Marshfield Clinic

Phil Borden
Department of Employee Trust Funds

Eric Borgerding
Wisconsin Manufacturers and Commerce

Shirin Cabraal
Legal Action of Wisconsin

Linda Caldart-Olson
Department of Public Instruction

Robin Carufel
Peter Christensen Health Center

Eleanor Cautley
Department of Health and Family Services
Bureau of Health Information

John Chapin
Department of Health and Family Services
Division of Public Health

Angie Dombrowicki
Department of Health and Family Services
Division of Health Care Financing

Cheryl Gotts
Milwaukee Public Schools

June Hannemann
Figi's, Inc.

David Kindig
Wisconsin Network for Health Policy Research
University of Wisconsin School of Medicine

Chris Kluck
Golden County Foods

Sarah Lewis
Wisconsin Primary Health Care Association

Julie Litza
United Healthcare of Wisconsin

Cheryl McIlquham
Department of Health and Family Services
Bureau of Health Care Eligibility

Greg Nycz
Marshfield Clinic
Family Health Center

Bobby Peterson
ABC for Health

Scott Polenz
Security Health Plan

Linda Reivitz
University of Wisconsin School of Nursing

David Riemer
City of Milwaukee
Department of Administration

Paula Roberts
Milwaukee Health Department

Mary Rowin
Department of Workforce Development
Division of Workforce Solutions

Don Schneider
Department of Health and Family Services
Bureau of Health Care Systems and Operations

Bill Smith
National Federation of Independent Business
Wisconsin Chapter

Steve Sobiek
Independent Business Association of Wisconsin

Jerry Waukau
Menominee Tribal Clinic

Susan Wood
Department of Health and Family Services
Bureau of Health Care Eligibility

C

**BadgerCare Focus
Group Guide**

BadgerCare Focus Group Guide: Nonenrolled Group

Before group, as participants arrive:

- Welcome individually
- Collect participant information sheet
- Give incentive and collect signed receipt
- Offer refreshments

1) Introduction

20 minutes

a) Purpose of group

Welcome, and thank you for coming. My name is _____, and I will be leading the discussion today. We are looking forward to learning a lot from what you have to tell us. This discussion is part of a study being done by RTI for the Centers for Medicare and Medicaid Services, the government agency in charge of government-financed health insurance programs. The purpose of the study is to learn about experiences of people who are eligible for BadgerCare, the health insurance program here in Wisconsin. The information you provide may help Wisconsin and other states design better health insurance programs.

In the discussion today, I will be asking questions about your ideas about BadgerCare. The questions will be about your experiences and opinions, so there are no right or wrong answers. We are interested in hearing about both things you like and don't like.

b) Confidentiality

Your participation is voluntary and confidential. If there are any questions you would rather not answer, that's perfectly okay. We will be writing a report based on what we learn in this group and others. There will be no names in the report, and nothing that would identify any individual will be included in the report. Your health insurance will not be affected by your participation in this group.

_____ will be taking notes, and if it's okay with all of you, we will tape record the discussion to help us remember what you have to say. The notes and the tape will only be used by people working on the project and will not be released to anyone else. We also ask that you respect the confidentiality of others in the group. That means not talking to anyone outside the room about what other people have said here today. Is that okay with everyone?

c) Logistics

- i) I will keep the discussion moving along, but I hope you will be doing most of the talking. There is no need to raise your hand before speaking, but if someone else is talking, let them finish before you speak.
 - ii) The group will last until about __ o'clock. Can everyone stay that long?
 - iii) Get up and move around if you need to, but it will be less distracting if only one person gets up at a time. There are restrooms located _____. Help yourselves to more refreshments during the group.
- Are there any questions on anything I've told you so far?

Start Tape Recorder!

d) Group introductions

- i) I'd like to start by asking you to introduce yourselves. Please tell us your first name, and who else is in your family.
- ii) Since we're going to be talking about a health insurance program, let's start there. How important is it to you personally to have health insurance? What makes it important or not so important?

2) Outreach

10 minutes

We're going to start by talking about when you first heard of BadgerCare.

- a) How did you first hear of the program?
 - i) Where else have you heard about it? Prompt: ever heard about it from [schools, HeadStart, doctor or clinic, ads on TV or radio, other source]
- b) What do you remember hearing about BadgerCare? How was it described to you?
- c) What was your first reaction to what you heard about BadgerCare?
- d) When you first heard about it, did you think you would be eligible? Why or why not? What do you think now?

3) Enrollment decision

10 minutes

According to the information you gave us, everyone here may be eligible to join BadgerCare, but are not currently enrolled.

- a) What are some of the reasons why people might not enroll in a program like BadgerCare?
 - i) Which of these are important to you?
- b) Have you ever considered enrolling?
 - i) What would be the reasons to enroll in BadgerCare?

4) Premium

15 minutes

You probably know that some families pay a monthly charge, or premium, for BadgerCare coverage. Whether a family pays a premium, and how much that is, depends on the family's income. For a family of four, the premium is between \$60 and \$75.

- a) If you were thinking about enrolling in BadgerCare, how important would the possibility of having to pay a premium be?
- b) Does the fact that some people pay a premium change how people think about BadgerCare?

5) Family coverage

5 minutes

- a) Some state health insurance programs only include children, but in BadgerCare the entire family is covered. Does this make any difference when you think about whether or not you want to enroll?

6) Enrollment process

10 minutes

- a) What have you heard about the process of enrolling in BadgerCare?
- b) Where did people go to enroll?
- c) Based on what you've heard, is it difficult or easy to enroll?
 - i) What do you know about the forms that you needed to fill out?
 - ii) How about gathering the information you need to bring with you (like proof of income); do you think that would be easy or difficult?
- d) Has anyone here ever tried to enroll? What was it like for you?
- e) Has anyone ever tried to enroll, but been told that you were not eligible? Why?

7) Enrollment changes

5 minutes

- a) Has anyone ever been enrolled in the program for even a short time?
 - i) Why did you enroll?
 - ii) Why did you get off the program? (probe to explore experiences of unpaid premiums or access to employer-provided insurance)
 - iii) Do you think you will enroll again in the future? What would make you want to enroll or not?

8) Program operation

5 minutes

- a) Based on what you know about BadgerCare, how is the program working so far?
- b) Do you think people who are enrolled in it have any trouble finding doctors or dentists who will take BadgerCare coverage?
- c) Do you think people with BadgerCare get treated just like people with other types of health insurance, or differently?
- d) (other issues?)

9) W-2 integration (current/former W-2 groups only)

10 minutes

Everyone in this group is currently enrolled in the Wisconsin Works program, or has been at some time.

- a) What happens when you are no longer in Wisconsin Works? How does that affect your enrollment in BadgerCare?
- b) Do your health benefits change if you are no longer in Wisconsin Works?
- c) Do you need to go to a different doctor or health maintenance organization (HMO) once you are no longer in Wisconsin Works?
- d) What if you have access to health insurance through an employer: can you still enroll in BadgerCare?
- e) If your income changes and you are no longer eligible for BadgerCare, can your children still get coverage?

CLOSING

- Any comments or thoughts that we haven't discussed that you would like to bring up?
- Thank you for sharing your thoughts and ideas.

Total estimated time: 95 minutes

BadgerCare Focus Group Guide: Enrolled Group

Before group, as participants arrive:

- Welcome individually
- Collect participant information sheet
- Give incentive and collect signed receipt
- Offer refreshments

1) Introduction

20 minutes

a) Purpose of group

Welcome, and thank you for coming. My name is _____, and I will be leading the discussion today. We are looking forward to learning a lot from what you have to tell us. This discussion is part of a study being done by RTI for the Centers for Medicare and Medicaid Services, the government agency in charge of government-financed health insurance programs. The purpose of the study is to learn about experiences of people who are eligible for BadgerCare, the health insurance program here in Wisconsin. The information you provide may help Wisconsin and other states design better health insurance programs.

In the discussion today, I will be asking questions about your ideas about BadgerCare. The questions will be about your experiences and opinions, so there are no right or wrong answers. We are interested in hearing about both things you like and don't like.

b) Confidentiality

Your participation is voluntary and confidential. If there are any questions you would rather not answer, that's perfectly okay. We will be writing a report based on what we learn in this group and others. There will be no names in the report, and nothing that would identify any individual will be included in the report. Your health insurance will not be affected by your participation in this group.

_____ will be taking notes, and if it's okay with all of you, we will tape record the discussion to help us remember what you have to say. The notes and the tape will only be used by people working on the project and will not be released to anyone else. We also ask that you respect the confidentiality of others in the group. That means not talking to anyone outside the room about what other people have said here today. Is that okay with everyone?

c) Logistics

- i) I will keep the discussion moving along, but I hope you will be doing most of the talking. There is no need to raise your hand before speaking, but if someone else is talking, let them finish before you speak.
 - ii) The group will last until about __ o'clock. Can everyone stay that long?
 - iii) Get up and move around if you need to, but it will be less distracting if only one person gets up at a time. There are restrooms located _____. Help yourselves to more refreshments during the group.
- Are there any questions on anything I've told you so far?

Start Tape Recorder!

d) Group introductions

- i) I'd like to start by asking you to introduce yourselves. Please tell us your first name, and who else is in your family.
- ii) Since we're going to be talking about a health insurance program, let's start there. How important is it to you personally to have health insurance? What makes it important or not so important?

2) Outreach

10 minutes

We're going to start by talking about when you first heard of BadgerCare.

- a) How did you first hear of the program?
 - i) Where else have you heard about it? Prompt: ever heard about it from [schools, HeadStart, doctor or clinic, ads on TV or radio, other source]
- b) What do you remember hearing about BadgerCare? How was it described to you?
- c) What was your first reaction to what you heard about BadgerCare?
- d) When you first heard about it, did you think you would be eligible? Why or why not?

3) Enrollment decision

10 minutes

Thinking back now to when you decided to enroll in BadgerCare:

- a) What were the most important reasons for enrolling?
- b) Did you have any concerns or misgivings about enrolling?
- c) How much time was there between when you first heard of BadgerCare and when you decided to enroll?
 - i) Were there reasons for waiting to enroll, or for enrolling soon?
- d) If you had other options for health insurance, why did you choose BadgerCare?

4) Premium

15 minutes

You probably know that some families pay a monthly charge, or premium, for BadgerCare coverage. Whether a family pays a premium, and how much that is, depends on the family's income. For a family of four, the premium is between \$60 and \$75.

- a) For <150% group:

In this group, no one pays a premium – is that right?

 - i) When you were thinking about enrolling in BadgerCare, how important was the fact that there would be no premium to pay?
 - ii) Do you think you would still enroll if you had to pay a premium of \$60?
 - iii) Does the fact that some people pay a premium change how people think about BadgerCare?
- b) For 150-185% group:

In this group, everyone pays a premium – is that right?

 - i) When you were thinking about enrolling in BadgerCare, how important was the fact that you would have to pay a premium?

- ii) What do you think about the premium? Is it high, low, or about right?
- iii) Do you think the premium changes people's decision to enroll?
- iv) Does the fact that some people pay a premium change how people think about BadgerCare?

5) Family coverage**5 minutes**

- a) Some state health insurance programs only include children. How important is the fact that your whole family can be covered in BadgerCare?
 - i) If only your children were covered, would you still have enrolled?

6) Enrollment process**10 minutes**

- a) Thinking back to when you enrolled in BadgerCare, what was the process like for you?
- b) Where did you go to enroll?
- c) Was it difficult or easy to enroll?
 - i) How were the forms that you needed to fill out?
 - ii) How about gathering the information you need to bring with you (like proof of income); was that easy or difficult?
- d) Were there any problems in the enrollment process? How did they get resolved?

7) Enrollment changes**5 minutes**

- a) Since you first enrolled, have there been any times when you've stopped your enrollment in the program?
 - i) Why did you go off?
 - ii) Why did you decide to get back in the program?
 - iii) Was it easy or difficult to re-enroll?

8) Program operation**10 minutes**

- a) Based on your experiences so far, how do you like having BadgerCare as your insurance?
- b) Any trouble finding doctors or dentists who will take BadgerCare coverage?
- c) Do you think people with BadgerCare get treated like people with any other type of health insurance, or differently?
- d) (other issues?)

9) W-2 integration (current/former W-2 groups only)**10 minutes**

Everyone in this group is currently enrolled in the Wisconsin Works or W-2 program, or has been at some time.

- a) What happens when you are no longer in Wisconsin Works? How does that affect your enrollment in BadgerCare?
- b) Do your health benefits change if you are no longer in Wisconsin Works?
- c) Do you need to go to a different doctor or health maintenance organization (HMO) once you are no longer in Wisconsin Works?
- d) What if you have access to health insurance through an employer: can you still enroll in BadgerCare?

- e) If your income changes and you are no longer eligible for BadgerCare, can your children still get coverage?

CLOSING

- Any comments or thoughts that we haven't discussed that you would like to bring up?
- Thank you for sharing your thoughts and ideas.

Total estimated time: 95 minutes