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## Wisconsin's BadgerCare Plus Coverage Expansion and Simplification: Early Data on Program Impact

– Donna Friedsam, M.P.H., Lindsey Leininger, Ph.D., Alison Bergum, M.P.A., Shannon Mok, Milda Aksamitauskas, M.P.P., Thomas R. Oliver, Ph.D., Thomas DeLeire, Ph.D.

### INTRODUCTION

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Many states, prior to and even during the current economic downturn, have been moving forward with efforts to expand health insurance coverage for their residents. Some of these programs have been scaled back due to state budget difficulties, and others await the outcome of the current federal health reform debates before further development. Comprehensive reform in Massachusetts has attracted great interest and scrutiny as states consider reform strategies—because of its broad scope, its reliance on mandates, its apparent success in bringing Massachusetts to the lowest uninsured rate in the country, and its challenges with cost and access. Wisconsin's efforts are less widely known, but they warrant attention as well: The state has undertaken perhaps the most ambitious effort in lieu of comprehensive system reform—expanding coverage by building on and simplifying existing public programs, with a goal of near-universal coverage.

Wisconsin launched BadgerCare Plus, its expanded state health insurance program, on February 1, 2008. The program expanded Wisconsin's existing SCHIP program (called BadgerCare) that was itself a 1999 expansion of Wisconsin's Medicaid and Healthy Start Programs. BadgerCare Plus combines SCHIP, Medicaid, and Healthy Start program dollars, in addition to other funds, to create one larger, more streamlined program with expanded eligibility guidelines.(1) (2)

The objectives of Badgercare Plus are to assure access to health insurance coverage to virtually all Wisconsin children and to bolster coverage for parents and other caretaker adults. The program relies on simplified eligibility and enrollment processes, seamless coverage across multiple programs, and expanded income eligibility rules to achieve its goals. Wisconsin's larger aim, at program outset, was to provide access to insurance coverage for 98% of its population through BadgerCare Plus and related coverage expansions.

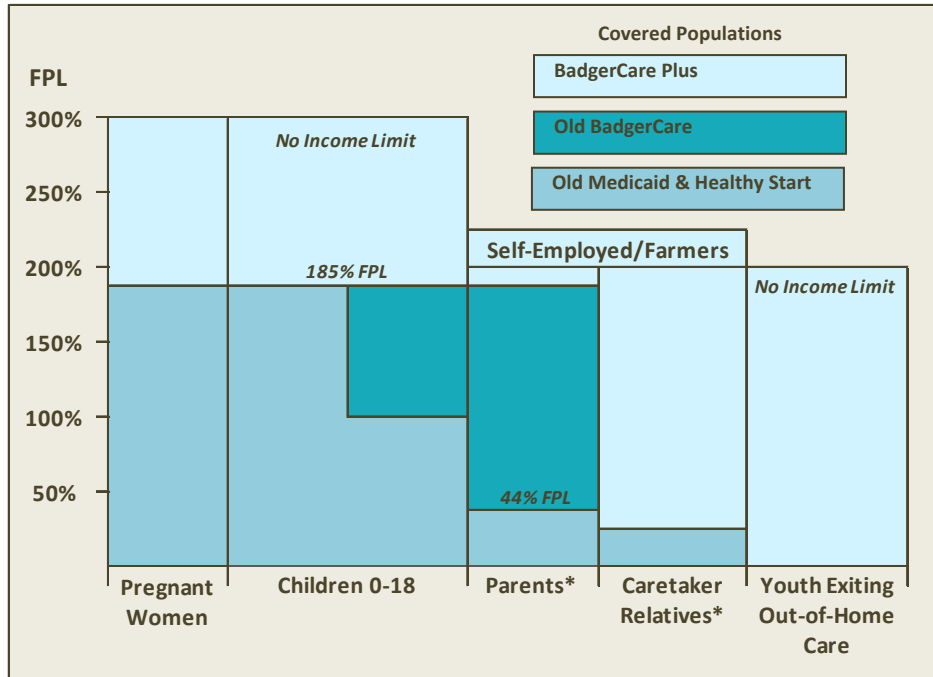
This issue brief presents preliminary findings from an evaluation of BadgerCare Plus since its February 2008 inception. The evaluation is being conducted by a team at the University of Wisconsin Population Health Institute in collaboration with the Wisconsin Department of Health Services. The analysis looks specifically at the various program elements and considers how they have affected take-up rates, overall enrollment, and continuity of coverage thus far.

**BACKGROUND**

**Program Implementation**

The state of Wisconsin proposed a multi-phase path toward its goal of providing access to coverage for 98% of Wisconsin residents. The first phase—the focus of this brief—expands coverage for children and caretaker adults. The second phase, implemented in June 2009, extends a Core Benefit plan opportunity for low-income childless adults. Figure 1 illustrates the income eligibility expansions implemented in Phase I.

**Figure 1. BadgerCare Plus Population: Phase I**



\*Parents/Caretakers must pay monthly premiums on a sliding scale starting at 150% FPL.

Program simplification is the bedrock of the BadgerCare Plus program. Wisconsin, like other states, previously had a complicated patchwork of eligibility rules and laws that had become expensive to administer and difficult to navigate. This complexity often discouraged qualified families from applying for or enrolling in Medicaid and other public health benefit programs. Those enrolled in BadgerCare, Medicaid, or Healthy Start faced onerous requirements for reporting, verification, and re-certification of income, employment, insurance access, and citizenship status. These requirements, along with variations in the criteria governing eligibility for each program, appeared to result in unnecessary exiting and churning. (1)

The new BadgerCare Plus program is branded as a single program with two insurance products: the Standard Plan, for enrollees < 200% FPL, and the Benchmark Plan for enrollees >200% FPL. Program eligibility rules pertaining to the calculation of income, income disregards, and insurance access are consistent for all applicants and are notably simpler. Application, reporting, and verification processes have also been streamlined.

**Crowd-Out and Verification Provisions Altered**

Applicants below 150% FPL are no longer subject to anti-crowd-out provisions, recognizing that employer-sponsored insurance, even when offered, is often unaffordable or inadequate for those in the lowest income groups. Applicants with incomes over 150% FPL remain subject to anti-crowd-out provisions. These individuals face a three-month

waiting period for dropped coverage (with good-cause exceptions), and they cannot have been offered employer-sponsored insurance (ESI) during the past 12 months or have the opportunity to enroll in ESI during the upcoming three months (good-cause exceptions apply, and the employer must cover at least 80% of the premium for coverage to be deemed affordable). (3)

BadgerCare Plus has relieved applicants of the responsibility to document lack of access to employer-sponsored insurance. This responsibility has shifted to a reporting relationship between employers and the State. Employers of applicants for BadgerCare Plus are required to report health insurance benefit offerings to the state-administered Employer Verification of Health Insurance (EVHI) database. BadgerCare Plus applications for individuals over 150% FPL reference the EVHI database to verify insurance access. Like BadgerCare, Medicaid, and Healthy Start before it, BadgerCare Plus consults Wisconsin's Third-Party Liability database to ensure that any liable third parties are billed for medical services provided to BadgerCare Plus members before the program is billed.(3)

## Outreach and Enrollment Efforts

To implement the new BadgerCare Plus eligibility system, the Wisconsin Department of Health Services carried out a one-time auto-conversion effort at the launch of the program, applying new program eligibility criteria to automatically enroll previously ineligible individuals for whom there was current information in the state's eligibility and enrollment database. For example, the state "auto-converted" newly eligible siblings and parents of children who were already enrolled in state health programs, along with eligible children and parents whose applications for BadgerCare were pending. BadgerCare Plus enrolled just over 40,000 individuals through this auto-conversion process, which contributed significantly to the large enrollment increases seen after the program's launch. The evaluation team is currently assessing the degree to which these "auto-converts" remain in the program, particularly when eligibility rules require them to pay monthly premiums.

The State also enhanced and promoted an online application tool called ACCESS. Applicants can navigate through a simple "Am I eligible?" module and then use the "Apply for Benefits" tool to submit applications online. The Wisconsin DHS also partnered with over 200 community organizations to help sign up families for the program. These community partners can log in to ACCESS and help a person submit an application. Finally, the Wisconsin DHS awarded "mini-grants" to 31 organizations (up to \$25,000 per organization), wherein the organizations received a \$50 "finder's fee" per approved BadgerCare Plus application. These organizations were also able to walk applicants through the ACCESS portal. The development of the ACCESS application tool and the facilitation of enrollment by community organizations using this tool made it much simpler for people to apply for and enroll in BadgerCare Plus. Thus far, about 39 percent of all BadgerCare Plus applications have come through ACCESS.

## EVALUATION STRATEGY

The evaluation has quantitative and qualitative components. The preliminary quantitative evaluation of Phase I of BadgerCare Plus estimates program enrollment and take-up and assesses continuity of coverage by measuring exits and churning. Data sources include monthly Wisconsin administrative panel data (which provide eligibility and enrollment for all applicants), along with data from the Current Population Survey (CPS), the American Community Survey (ACS), and Wisconsin's Family Health Survey. Populations studied include all children and eligible low-income parents/caretaker adults (<200% FPL). Both groups are stratified by FPL and whether county of residence is urban or rural. A qualitative component adds background on the process of program design and implementation, including the intent of policy makers and program administrators, and facilitates interpretation of the findings of quantitative analysis. Data sources for the qualitative component include one-on-one interviews with key stakeholders along with analysis of program documents and media reports.

## PRELIMINARY FINDINGS

### Enrollment of Children

The evaluation thus far has assessed enrollment in BadgerCare Plus as of September 2008 (eight months of implementation) and compared it to a December 2007 baseline enrollment in the former BadgerCare, family Medicaid, and Healthy Start programs. Data through May 2009 are currently being analyzed. Preliminary data indicate that children in lower income groups contributed more to increases in enrollment than did children of higher income levels (Figure 2): two-thirds of this increase was among children under 200% FPL, and fully half (53%) were children who had been eligible for BadgerCare, Healthy Start, or family Medicaid (<185% FPL). This suggests that program simplification measures, branding, and targeted outreach strategies were effective in drawing in newly eligible and also many eligible-but-not-enrolled individuals.

	December 2007	September 2008	Change	% of Change
All	337,817	379,825	42,008	
<150 FPL	317,502	327,375	9,873	24%
150-200 FPL	19,157	37,447	18,290	44%
200-300 FPL	829	12,480	11,651	28%
300+ FPL	196	2,520	2,324	6%

Overall, the percentage of Wisconsin children enrolled in Wisconsin's state health program increased 12% relative to the number of children enrolled at the December 2007 baseline. The largest gains were seen among children between 150% and 200% FPL, for whom enrollment increased 95%.

Preliminary comparison of BadgerCare Plus enrollment numbers to CPS estimates of uninsured Wisconsin children in 2006-2007 suggests a robust rate of program take-up, but with significant numbers remaining eligible (uninsured) in the lowest income group. Wisconsin children as a whole show a ratio of the change in enrollment to the number of uninsured (a measure of take-up) of 58%, while this ratio is 30% for children below 150% FPL. For children between 150% and 200% FPL, this ratio is 209%--that is, a greater number of children enrolled than had previously been classified as uninsured in this group. This ratio is 73% for children between 200% and 300% FPL and 15% for children above 300% FPL. For children in rural counties, this ratio is 71%, while for urban children the ratio is 53%.

To the extent that the CPS estimate undercounts the number of uninsured children in Wisconsin in 2008, the ratio of change in enrollment to the number of uninsured will overstate the take-up rate. Additionally, the high rate of take-up for children between 150% and 200% FPL may be an artifact of the likely increase in uninsured from 2007 to 2008, as an increase in the uninsured would increase the pool of income-eligible uninsured children. The ratio is affected by differences in income-reporting within CPS and BadgerCare as well. Finally, an increase in take-up may also suggest migration from private insurance to public coverage. The second phase of this evaluation will investigate whether such migration is occurring and, if so, to what degree.

## Enrollment of Parents and Caretaker Adults (“Caretakers”)

As with children, caretakers in lower income groups contributed more to BadgerCare Plus enrollment than did caretakers of higher income (Figure 3): Caretakers below 150% FPL comprised 48% of enrollment growth among caretakers, while caretakers between 150% and 200% FPL comprised 39% of this increase, and caretakers above 200% FPL accounted for just 13%. As many as three-quarters of new caretakers might have been financially eligible prior to the February 1, 2008, launch of BadgerCare Plus, again indicating a potential positive impact from outreach efforts.

	December 2007	September 2008	Change	% of Change
All	178,163	209,332	31,169	
<150	167,551	182,591	15,040	48%
150-200	10,093	22,284	12,191	39%
200-300	389	4,457	4,068	13%

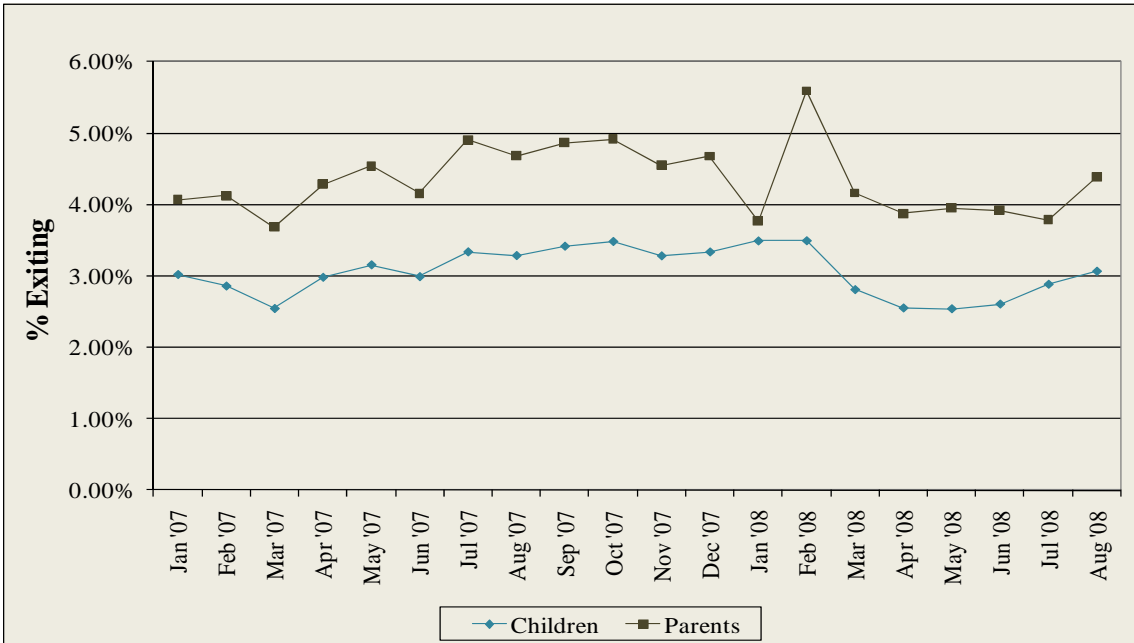
Overall, the percentage of Wisconsin caretakers enrolled in Wisconsin's state health program increased 18%, relative to the number of caretakers enrolled at a December 2007 baseline. Enrollment increased 9% for caretakers below 150% FPL and 121% for those between 150% and 200% FPL.

Preliminary comparison of BadgerCare Plus enrollment to CPS estimates of uninsured caretakers indicates robust take-up rates (again measured as the ratio of the change in enrollment to the number of uninsured) for some segments of this newly eligible population, while others lag: Uninsured caretakers as a whole show a take-up rate of 17%, while caretakers below 150% FPL show a 19% take-up rate, and caretakers between 150% and 200% FPL show a 53% take-up rate. Uninsured caretaker adults in rural counties show a 25% take-up rate, compared to only 14% for their urban counterparts. Here again, these ratios for adults could be overstated, to the extent that the CPS estimate undercounts the number of uninsured adults in Wisconsin in 2008.

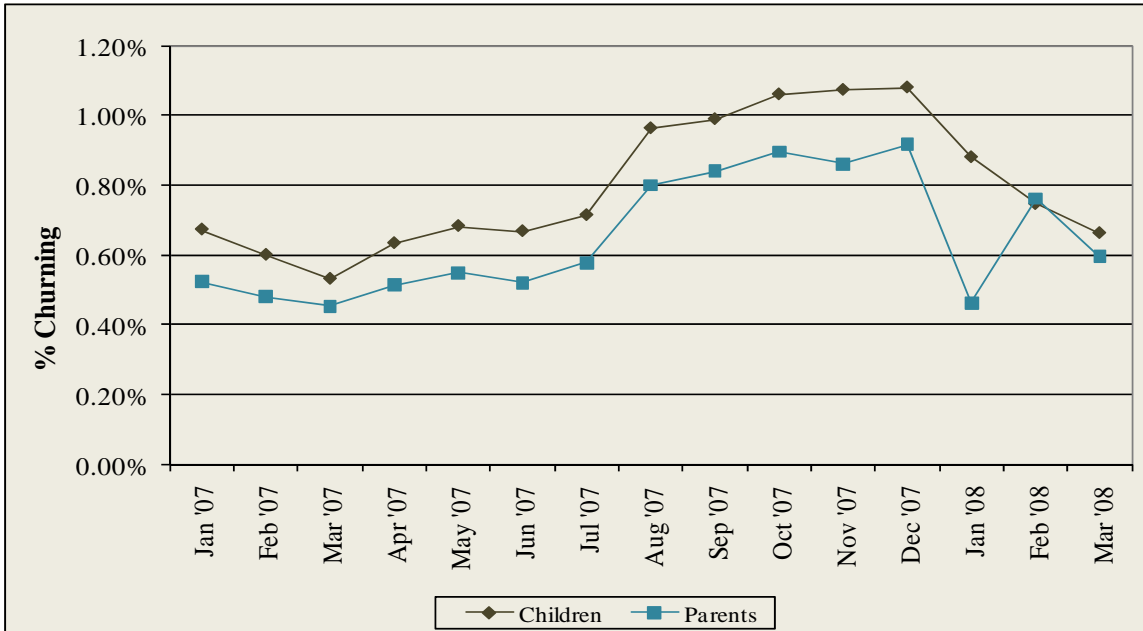
## Program Exits and Churning

Data indicate a slight decrease and a leveling-off in program exits after the implementation of BadgerCare Plus (Figure 4) along with a modest decrease in six-month churning (Figure 5) following instability around program changeover. The next months of data, once the program has settled in and stabilized, will allow a better understanding of the exit and churning experience. These early trends suggest a positive impact of program simplification on enrollees' ability to retain coverage. Additionally, with expanded income eligibility limits, enrollees can retain coverage even while experiencing the income and employment fluctuations that are common in lower-income populations.

**Figure 4. Program Exits: Percent of enrollees who exit the program each month**



**Figure 5. Churning: Percent of enrollees in a given month who exit and re-enter the program within a 6-month window**



## DISCUSSION/CONCLUSION

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These preliminary findings hold important lessons about program design for those involved in health reform at both the state and national level. These lessons are particularly applicable to those concerned with reaching the large portion of uninsured children nationally that are currently eligible but not enrolled in Medicaid or SCHIP. These results indicate that substantial enrollment increases can be achieved through the following program elements:

- concerted branding message (“all kids eligible”)
- whole family coverage by expanding eligibility for lower-income parents and caretakers
- targeted auto-enrollment
- expansion of income eligibility limits, with various coverage opportunities as income and employment fluctuates
- relaxing of anti-crowd-out provisions for lower income applicants
- relieving applicants of employer insurance verification requirements
- aggressive outreach and enrollment strategy with community partners

The preliminary findings reported in this brief indicate that incremental reforms – eligibility expansion and program simplification–within the Medicaid and CHIP programs can substantially increase program enrollment. Using this incremental approach, Wisconsin is moving toward its goal of near-universal coverage even in the absence of comprehensive insurance market or health care industry reforms at the state or federal level.

The UW evaluation team will expand its analysis throughout the next year, moving into an examination of program affordability and sustainability, and assessing any potential or actual crowd-out effects in the private employer-sponsored insurance market. Additionally, Wisconsin's BadgerCare Plus program launched a Core Plan coverage opportunity for low-income childless adults in June 2009. The UW evaluation team will continue to work with the Wisconsin Department of Health Services to evaluate the coverage, cost, and utilization within this newly enrolled population. Here again, Wisconsin's experiment promises lessons about the utility of various program design elements toward expanding coverage, containing costs, and promoting appropriate health care utilization.

## REFERENCES

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- (1) State Coverage Initiatives. April 2009. “Profiles in Coverage: Wisconsin's BadgerCare Plus (BCP) Program.” Retrieved July 13, 2009, from <http://www.statecoverage.org/node/1751>
- (2) Witgert K. August 2009. “BadgerCare Plus: Medicaid and Subsidies Under One Umbrella”. Issue Brief. National Academy for State Health Policy.
- (3) State of Wisconsin Department of Health Services. June 2009. “BadgerCare Plus Eligibility Handbook.” Retrieved July 13, 2009, from <http://www.emhandbooks.wi.gov/bcplus/>

## ABOUT THE SHARE INITIATIVE

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SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

## CONTACTING SHARE

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The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at [www.shadac.org/share/](http://www.shadac.org/share/).

State Health Access Data Assistance Center  
2221 University Avenue, Suite 345  
Minneapolis, MN 55414  
Phone (612) 624-4802