Wisconsin's BadgerCare Plus
Health Coverage Program

Qualitative Evaluation
Timeline of Program Development
Report on Interviews with Key Stakeholders

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TIMELINE OF BADGERCARE PLUS
PROGRAM PLANNING, DEVELOPMENT and IMPLEMENTATION

Note: The early development of BadgerCare and its history, prior to the development of BadgerCare Plus, has been reviewed in Milbank Foundation Report[1] and discussed by program administrators writing in Health Affairs[2].

January 17, 2006
In the 2006 State of the State address, Governor Doyle announces BadgerCare Plus program to provide a health insurance option for all kids.

January 2006
Details of program outlined in BadgerCare Plus Policy Memo.

January 2006 – September 2006
Town Hall Meetings held across state including current Medicaid/BadgerCare participants, health care providers, county staff, advocates, reporters, and others. [More press releases about town hall meetings available: Milwaukee, etc.]

February 2006
BadgerCare Plus Steering Committee formed with representatives from multiple divisions of the Department of Health and Family Services as well as the Department of Administration and the Governor's Office.

March 2006
Policy Design Teams Formed: Six Department workgroups were formed to analyze and shape policy related to BadgerCare Plus. Workgroups included: Premium structure, premium assistance and insurance crowd-out, benefit plans, financing and budget neutrality, waiver, eligibility simplification and expansion, and communications.

March 2006 - Present
Advisors Group formed: Responsible for providing guidance and advice to the State on all policy and program design issues. The Advisors Group includes representatives from business, health plans, providers, public health, farmers, Native American tribes, the State Legislature, faith-based organizations, county government, children's advocacy groups, and the University of Wisconsin.

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[1] Sirica C. The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP). New York: The Milbank Foundation. January 2001.

[2] Bartels PL, Boroniec P. BadgerCare: A Case Study of the Elusive New Federalism. Health Affairs. 1998; 17(6):165-169.

April 2006
Project leadership briefed Governor Doyle on program planning.
BC+ Internet Site, Email Address and Business Cards: BadgerCare Plus cards with the Initiative's e-mail address were distributed at each meeting with encouragement to participants to send written comments.

May 2006
Governor Doyle meets with U.S. DHHS Secretary Michael Leavitt. BadgerCare Plus Concept Paper and Summary released.

May 2006 – August 2006
Policy development: Departmental workgroups developing BadgerCare Plus policy received and considered input from the Town Hall Meetings, focus groups, and advisors. All workgroup recommendations went through the project Steering Committee and the external Advisors Group.

July 25, 2006
Governor Doyle announces plan to change the way farmers' income is calculated to provide farm families with access to affordable health insurance. [Actual plan proposed in February 2007].

August 2006
Submitted biennial budget proposal, SB40

September 2006
Detailed Paper and Summary outlines BadgerCare Plus.
DHFS had commissioned eight focus group discussions to identify problems with current programs, suggest improvements, and provide feedback on concepts and strategies proposed for BadgerCare Plus. [Focus Group Reports including BadgerCare Plus Focus Groups Summary Report and Detailed Report submitted September 5, 2006].

Waiver Request: Section 1115(a) Demonstration Waiver Proposal and state plan amendments submitted to U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

October 11, 2006
Doyle administration announces $4.25 million to improve dental access to kids and families

November 2006
Implementation teams created: Workgroups included: benefits & cost sharing, dental access, eligibility, evaluation & monitoring, healthy living, marketing & outreach, provider communication & training, rate setting, statutory language, systems, and waiver/state plan amendments.

November 2006 – January 2007
Statutory Language Change Recommendations: Determined statutory updates or replacements that were required for BadgerCare Plus implementation. BadgerCare Plus in state statutes, Chapter 49.

December 2006 – January 2008
System Development: Analysis and design of business requirements specifications and development for eligibility systems and fiscal agent.

January 30, 2007
In the 2007 State of the State address, Governor Doyle reiterates need for BadgerCare Plus and announces an additional expansion of BadgerCare Plus to childless adults.

January 2007 – Present
Town Halls Continued: Town halls meetings also included discussions of plans to provide coverage for childless adults through BadgerCare Plus

February 13, 2007
In 2007 Budget Address, Governor Doyle describes importance of BadgerCare Plus, how it will be paid for and basic function.

March 5, 2007
Wisconsin DHS Secretary Kevin Hayden meets with leaders of CMS in Washington, D.C. to discuss BadgerCare Plus and other WI health care initiatives.

March 22, 2007
Governor Doyle announces plan to expand dental access for WI kids and families. "The Governor's plan will address the shortage of providers that offer care, dedicate more than $4 million to growing successful programs targeting underserved kids and families, and invest $8.8 million to create a new statewide system that will expand access to dental care for children and families across Wisconsin."

May 2007 – November 2007
Provider Communication and Training: Developed and issued provider communications detailing BC+ policies and procedures. Conducted State-wide Provider Training. Incorporated information into the portal for recipients, providers, partners and MCOs.

June 2007 – Present
Marketing and Outreach: Marketing items such as logo, fact sheets, brochures, web site, posters, etc.

July 2007
CMS Visit: Review of BC+ by CMS. CMS states they can approve everything except they want:
- No cost sharing for pregnant women at all (no co-payments or premiums), regardless of income
- No cost sharing for kids < 100% FPL (kids otherwise eligible for MA groups or the old AFDC)
- All Parents must be on MA - No SCHIP funding for parents

August 17, 2007
CMS Directive is issued which limited federal funds for Medicaid and SCHIP for eligible individuals above 250% of the FPL unless certain requirements were met, primarily expanded enrollment of eligible individuals in lower income groups. In order to be compliant with the directive and still reach the BC+ goal of covering up to 300% of the FPL, Wisconsin decides to cover between 250% and 300% of the FPL with state money.

August 2007
Doyle Administration submits final plans to the federal government to expand BadgerCare by combining funds from Medicaid and SCHIP.

October 26, 2007
Wisconsin Budget Approved: Includes BadgerCare Plus which "ensures that at least 98% of WI citizens have access to health coverage…expands coverage to more than 70,000 hardworking adults…makes health care premiums tax free…[and] increases the cigarette tax by $1 to decrease smoking rates."

November 27, 2007
CMS Waiver Approval: CMS approved waiver request and state plan amendments.

January 23, 2008
In the 2008 State of the State Address, Governor Doyle announces that BadgerCare Plus will be implemented on February 1 to provide health care to all children.

January 2008
Mini-Grants Awarded: DHS awards $447,142 to 32 community-based organizations to reach out to Wisconsin families and enroll children in BadgerCare Plus starting February 1, 2008.

February 1, 2008
Badgercare Plus begins operations. 42,000 individuals automatically enrolled at the start of the program, greatly exceeding the original estimate of 26,000 new enrollees by June 30, 2009.

April 30, 2008
Governor Doyle announces nearly 72,000 have signed up for BadgerCare Plus which greatly exceeds initial expectations but is a great success for WI.

July 2008
Legal Action of Wisconsin, which represents low-income clients, files class-action lawsuit against state DHS and the Milwaukee County Health DHHS stating that the state and county are moving too slowly to get public assistance to Milwaukee County's neediest residents leading to long delays for food stamps and medical care.

January 29, 2009
In the 2009 State of the State Address, Governor Doyle discusses the national recession, the federal economic stimulus package and the WI budget shortfall. He reminds WI citizens that "over the last year, 100,000 new people signed up for BadgerCare Plus, and more than two-thirds of them were kids."

February 2009
President Obama signs federal legislation reauthorizing and expanding the Children's Health Insurance Program offering health care coverage for children. "Bill is projected to increase federal funding for one component of BadgerCare Plus to at least $88 million a year, up from about $70 million now."
Wisconsin Department of Health Services announces takeover of Milwaukee County benefits as part of the lawsuit settlement. Beginning May 1, DHS will process all Milwaukee County applications for health and public assistance benefits from access.wi.gov and will expand access points across the county. Beginning July 1, DHS will assume control of the public assistance call center. On January 1, 2010, DHS will assume responsibility for the remainder of the county's income maintenance functions.

The American Recovery and Reinvestment Act signed into law. "The additional money means the federal government will pay about 70% of the cost of BadgerCare Plus and other Medicaid programs for roughly the next two years."

WI tax on hospital revenues passes legislature bringing an additional $900 million in federal dollars to help cover costs for the state-federal Medicaid health care programs. "The tax, which is supported by the WI Hospital Association, would reward hospitals that provide the most care to participants in BadgerCare Plus and other Medicaid programs."

February 17, 2009
In the 2009-2011 Budget Address, Governor Doyle states that, though times are tough, BadgerCare Plus will not be cut or cut back.

April 2009
WI chosen as one of eight states to receive $1 million grant from Robert Wood Johnson Foundation's *Maximizing Enrollment for Kids* program. Governor Doyle states: "This grant will help us continue our efforts in streamlining our enrollment process to make it easier for families to get the health insurance they need."

Lawsuit settlement reached in federal court gives the state two years to fix problems in public assistance programs it will take over from Milwaukee. "The state must demonstrate that during 2010 that it met federal standards for accuracy and timeliness in processing applications for Food Share, BadgerCare Plus and Medical Assistance health benefits and state subsidized child care aid."

May 26, 2009
Governor Doyle signs Senate Bill 161 into law which is meant to provide "accurate and timely services for the people of Milwaukee County…. It requires the Department of Health Services to take over administration and eligibility determination of income maintenance and supplemental payment programs in Milwaukee County. These programs include Medicaid, BadgerCare Plus, Food Share, funeral and burial expenses, and Wisconsin Shares, managed by the Department of Children and Families."

Sources for this timeline include:

- Documents obtained both online and in person from the Wisconsin Department of Health Services
- Information from interviews and personal correspondence with officials from the Wisconsin Department of Health Services
- Speeches and press releases from the office of Wisconsin Governor Jim Doyle
- Media articles from various state periodicals
- Other online state and federal resources

INTRODUCTION

Wisconsin's BadgerCare Plus program stands as Wisconsin's most recent effort to expand health insurance coverage to low and moderate income residents. BadgerCare Plus was designed to ensure access to health insurance coverage to virtually all Wisconsin children and to bolster coverage for parents and other caretaker adults, while maintaining a robust private insurance market. The program, launched in February of 2008, expanded BadgerCare, Wisconsin's existing Children's Health Insurance Program (CHIP) that was itself a 1999 expansion of Wisconsin's Medicaid and Healthy Start Programs. BadgerCare Plus combines CHIP, Medicaid, and Healthy Start program dollars, as well as other funds, to create one larger, more streamlined program. The initiative was built around 1) eligibility expansions; 2) simplification of eligibility rules and enrollment processes; and 3) an aggressive marketing and outreach campaign.

The University of Wisconsin Population Health Institute, in partnership with the Wisconsin Department of Health Services (DHS), has been conducting an ongoing evaluation of various components of BadgerCare Plus. The qualitative component of the BadgerCare Plus evaluation aims to improve understanding of the program's development and help interpret the results of quantitative data. This component included interviews with key stakeholders and a review of health policy literature, official program documents, interviews conducted by external organizations and media reports. The evaluation research is supported in part by a grant from the Robert Wood Johnson Foundation, through its State Health Access Reform Evaluation program.

Methods

Between December 11, 2008 and January 26, 2009, Dr. Thomas Oliver, the principal investigator of the qualitative portion of the evaluation, conducted 15 in-depth, semi-structured interviews with 17 key informants from local and state government, health care associations and advocacy groups. Follow-up interviews were conducted in November 2009 and included three state program directors and managers from the first round of interviews and three county-level economic support and eligibility workers. The interviews may reflect some self-selection, as several legislators, including some more likely to be critical of the program, declined to be interviewed. Digital recordings of interviews were gathered when possible to provide accurate quotations from interviewees. The interview time varied in length between 30 and 90 minutes. [See Attachment A for a comprehensive list of interviewees and their affiliated organizations, See Attachment B for a sample of the interview request letter sent to potential interviewees.]

The investigators sent requests for interviews to 34 persons. The invited subjects were selected by DHS and project leaders. Of those originally invited, 17 ultimately had interviews arranged and completed. Follow-up interviews were conducted with four of the original interviewees, along with three additional interviewees to add context to information gathered during the original interviews. As well, the National Academy for State Health Policy (NASHP) had conducted four other interviews under a separate project,[3] and the NASHP team shared its interview data to supplement our material. (See Attachment A for detailed list of those invited and those who participated in interviews.)

[3] National Academy for State Health Policy. BadgerCare Plus: Medicaid and Subsidies Under One Umbrella. Available at http://www.nashp.org/node/1237.

The interview participants did differ from the original pool of invitees in several regards: Our team completed interviews with two Democratic and no Republican legislators. Our analysis, however, does include two legislative interviews conducted by NASHP - one with a Republican legislator and another with a Democratic legislator. In these regards, the interviews may reflect some self-selection in that the study may not have gathered interview responses from persons that may have been more likely to be critical or skeptical or the program. Beyond the elected officials in our pool, however, we did complete interviews with a more diverse set of interview participants. The other interviewees represent a range of business, professional, and advocacy groups with varying perspectives about BadgerCare and the role of government.

The investigators relied on transcripts from digital recordings of interviews and interview notes when recordings were unavailable. The responses to interview questions were entered into a table by topic. Representative quotes from interviewees on every topic were compiled into a summary document. Key issues on which respondents demonstrated agreement and disagreement were identified. A copy of the draft report was distributed to the persons who participated in interviews, who were invited to review and comment. Edits were made based on feedback received.

The following report provides a summary of interview responses in aggregate form followed by an in-depth description of interview responses, including unattributed, direct quotes from respondents that represent the larger themes uncovered in the interviews.

The qualitative component of the BadgerCare study also included review of program documents, media reports, and published literature to build the timeline, inform the discussion section of this document, and provide context to the quantitative components of our study. The Wisconsin Department of Health services provided access to the archive of program documents. Our team conducted an archival newspaper search of the major Wisconsin newspapers and a full search on LexisNexis Academic, starting from October 2005 -- three months preceding the Governor Doyle's announcement of BadgerCare Plus.

Context of BadgerCare Plus Development

BadgerCare Plus is one of the major policy initiatives of Governor Doyle (D) and his administration. The governor first announced the concept of affordable, comprehensive coverage for every child in Wisconsin in his State of the State Address in January 2006. After a year of town hall meetings, detailed planning by state health officials and task force representatives, and budgetary estimates, Governor Doyle reiterated his plans for health care reform in his State of the State Address on January 30, 2007.

> "Tonight, I propose a bold effort to make Wisconsin America's health care leader. It represents a comprehensive strategy to reduce cost, improve quality, and expand access to affordable health care coverage. At the heart of this effort is BadgerCare Plus, which begins with a simple premise: In Wisconsin, no child should go without health care."

In addition to expanding eligibility for children and their adult caretakers, the governor's proposals in 2007 also included plans to expand BadgerCare Plus coverage to tens of thousands of low and moderate

income adults without dependent children in their household, and to establish a state-sponsored health insurance purchasing pool for small businesses.[4]

The BadgerCare Plus proposal came at a time of increasing activity in several states aimed at significant expansions of health insurance coverage. Most notable was the 2005 legislation enacted in Massachusetts and signed by Governor Romney (R), which attracted widespread media attention and discussion among national and state political leaders and experts. Proposals for comprehensive reform emerged in California and Vermont in 2006-7, adding momentum to deliberations in other states. In Wisconsin, the Democratic leadership of the state Senate introduced and successfully passed legislation in 2007 to establish a statewide health insurance authority intended to cover all state residents under age 65. The Healthy Wisconsin proposal failed to gain support from either the Republican-controlled Assembly or Governor Doyle, however. At the conclusion of the 2007 legislative session, legislative leaders from both parties coalesced support around the BadgerCare Plus proposal as a middle-ground strategy for the state.

The implementation of BadgerCare Plus began in February 2008, less than a year after the legislative plan was approved, and was a multi-faceted process involving the development of new data systems for enrollment and eligibility determination, communications and outreach activities by both public and private organizations, consultation with health care plans, providers, and advocates, negotiations with federal officials for their approval, and constant monitoring of activities by program officials in the state Department of Health and Family Services (now Department of Health Services, or DHS). As the report below documents, enrollment in BadgerCare Plus greatly exceeded preliminary estimates and made Wisconsin a focal point for analysis and discussion heading into national health care reform efforts in 2009-10.[5]

Summary Observations

Overall, the key participants and close observers interviewed provided very positive feedback about the development and early implementation of BadgerCare Plus. This likely reflected a lengthy period of program planning and development, a substantial degree of bipartisan support for the legislation authorizing the program, and a belief that BadgerCare Plus was an appropriate expansion of public aid to individuals and families for whom there were very limited opportunities for health care coverage in the private sector.

There was broad agreement among interviewees that the development of BadgerCare Plus was well-planned and implemented. Most interviewees credited program administrators in DHS for establishing a broadly representative group of advisors, requesting input from them, and responding to feedback as

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[4] http://www.wisgov.state.wi.us/journal_media_detail.asp?locid=19&prid=2508

[5] See, for example: http://www.rwjf.org/healthpolicy/product.jsp?id=47472; http://www.rwjf.org/healthpolicy/product.jsp?id=49949; http://www.commonwealthfund.org/Content/Newsletters/States-in-Action/2009/August/August-September-2009/Snapshots/Wisconsin-Strategies-for-Increasing-Coverage-Eligibility-and-Enrollment.aspx

plans emerged. A couple of respondents believed that the advisory process was used mostly to inform key stakeholders about program design and implementation plans, rather than to solicit and act upon stakeholders' comments and suggestions.

The chief criticism of the initial planning process, including by DHS administrators themselves, was that actual enrollment in BadgerCare Plus—over 100,000 in the first year alone—substantially exceeded original projection of 26,000 new enrollees over two years. Program administrators partly attributed the underestimate to the limitations of survey data upon which DHS and its contractors based their models of eligibility and likely enrollment and, also, to unexpected deterioration of economic conditions across the state and country as a whole.

Interviewees also credited several changes in program design and implementation for the unanticipated enrollment growth. The changes included streamlining of the eligibility process; the simplified online application; the automatic enrollment of persons who had previously applied, left the program, or had family members enrolled and under the new rules became eligible themselves; and the marketing shift to an "all kids" coverage message. Many also attributed the large enrollment to DHS recruitment of hundreds of organizational partners for community-based outreach and to the media attention surrounding the new program.

Interviewees unanimously agreed that BadgerCare Plus has greatly increased access to health insurance and health care as a result of the expanded eligibility and the increased use of managed care organizations to provide services. Many interviewees also believed that programmatic changes have led to a reduction in churning and an increase in continuity of coverage for individuals and families.

Several interviewees familiar with program administration cited areas of improved efficiency: The consolidation of programs under the umbrella of BadgerCare Plus made marketing easier, and the promotion of the online application eased outreach and the enrollment process for applicants and county agency staff. Interviewees also described a generally positive public perception of the program and a reduction in stigma that has occurred as a result of the transition to BadgerCare Plus.

Some interviewees discussed concerns about some aspects of the program's design and implementation. Problems with premium payments were the most common concerns discussed by interviewees. Many respondents believed the transition to the sliding scale premium determination has caused some confusion for eligibility workers and new members, primarily because it creates uncertainty about the specific amount members will be required to pay upon enrollment once a full accounting of income is complete and how stable that amount will be over time. Additionally, some advocates remain uncomfortable with the limited benefits available on the benchmark plan designed for higher income members and what they believe is an erosion of benefits at the expense of expanded eligibility. Several interviewees also brought up a few specific access issues for specialty care like dental services or mental health, including medications. Finally, some respondents remain concerned about the affordability of the program for families required to make premium payments.

Only a few interviewees expressed concern that expanded coverage through BadgerCare Plus would "crowd-out" coverage in the private insurance market. Most respondents believed that the enrolled population generally has no access to affordable employer-sponsored health insurance or individual insurance policies and thus are very unlikely to drop private coverage for the public program. Some

representatives of business and health care organizations, however, voiced concerns that BadgerCare Plus and other public insurance programs could crowd-out private coverage if they continue to expand.

Nearly all interviewees noted that long-term financial sustainability of BadgerCare Plus would be a challenge given the unanticipated rate of enrollment and the current pressure on the state budget from the economic recession. Still, there was broad agreement that Governor Doyle and other political leaders would protect the program against significant funding cuts or limits on eligibility despite budget difficulties. A few interviewees suggested that it is important to reduce the growth of health care costs in general. In their view, greater accountability among all parties—government, health care providers, and consumers—will be required to reduce the underlying drivers of health care costs and reduce the likelihood that public health insurance programs like BadgerCare Plus simply control their own payments to health plans and providers and shift more costs to the private sector.

INTERVIEW RESPONSES IN DETAIL

The following sections divide the interview responses by topic. Within each topic are key areas of agreement or disagreement between interviewees. Responses in each category are briefly summarized and representative quotes from interviewees are provided.

BadgerCare Plus Design and Development

Initiation of BadgerCare Plus Seen as Top-down

Legislators and program administrators described the initial development of BadgerCare Plus as being very top-down. Governor Doyle proposed the expansion as part of his State of the State address in January 2006 and followed up by incorporating it into his budget proposal in February 2007. He pursued this approach rather than engaging legislators who were developing a separate major health insurance reform bill. [1] An interview with a legislator conducted by another organization illustrates the legislature's reaction: "We responded to the governor's budget, which included an expansion of BadgerCare Plus. The legislature was going in a slightly different direction with Health Reform [prior to BadgerCare Plus] – we were trying to get passed a larger effort. The governor decided to take a more incremental approach. His approach was a little easier to swallow." [22]

One legislator (in another interview conducted by an external organization) framed the governor's initiative in negative terms: "By putting BadgerCare Plus in the budget, it became much less of a policy than a fiscal discussion. When debating BadgerCare Plus, the program parts were never vetted as they would have been had it been a stand alone bill…[He] can't get [it] in through the front door so bring it in the back door." [19] [See the development and implementation timeline.]

The DHS Approach to Consultation and Feedback

A group of external advisors to DHS (BadgerCare Plus Advisors) was appointed and consulted throughout the original design of BadgerCare Plus. A program administrator explained that "The Advisors group included representatives from business, health plans, providers, public health, farmers, Native American tribes, the state legislature, faith-based organizations, county government, children's advocacy groups, and the University of Wisconsin." Also, government representatives and program administrators "hosted twenty town hall meetings across the state throughout the planning process to discuss the new program, gather comments about existing programs, and obtain input from interested parties."

DHS Requested Input and Took Feedback Well

Interviewees largely agreed that DHS sought constructive feedback on their program design recommendations from the Advisors Group. Advocates, in particular, were complimentary of this approach. Several statements reflect this sentiment: "[This is] how you would want government to work in addressing a problem and it really did seem to work." [8] Another advocate said that there was "very firm responding in a constructive way." [3] Representatives from health care associations also approved of the department's buy-in tactic: "I seldom give state agencies an A grade for doing anything, but this is a gold star startup… The department identified the right people from the start - the right people, right technology, and right communications." [10] The department's communication efforts were repeatedly commended: **"**The state does a good job of communicating

with all stakeholders; engaging stakeholders, identifying issues; [the program is] well designed and planned out." [5]

Alternative Views of the DHS Advisory Process

Some interviewees expressed frustration about the Advisors Group. A health care association representative voiced frustration, noting that the Advisors Group seemed to be less for feedback and more for keeping stakeholders informed: "I think that the impression from our perspective is that it was a group of interested parties that didn't really function as advisors. It was really sort of more updates as opposed to "what do you guys think?" and "How should we do this?" It was really more "here's what we're doing." [4] In an interview conducted by an external organization, one legislator noted that legislators were largely uninvolved in the design process: **"**To the extent that [the Advisor's Group] involved legislators, the involvement was not that great." [22]

Projected Enrollment Numbers Were Inaccurate

Most respondents, including nearly all legislators and DHS program administrators interviewed, referred to the inaccuracy of the original enrollment projection that 26,000 new enrollees would be added to the program during the first two years of operation.. A program administrator describes how, in fact, 42,000 people became instantly enrolled on the first day of BadgerCare Plus: "We took every open case across the state and we re-ran all of those cases on the new eligibility system under the new merged, simplified and streamlined criteria and we were able to make 42,000 people eligible on the first day of the program. That was a big surprise. We had not anticipated that we would be able to pick up that many people on the first day of the system." [1]

Yet, department administrators emphasized that significant money and effort was spent trying to predict what the enrollment rate would be: "We think we did a lot to estimate the impact. We spent $200,000 of grant money on a model unique to Wisconsin which was designed to estimate take-up rates and costs of the new population and as a result, the changes. So they estimated that we'd pick up 26,000 and here we are sitting on 94,000 [in early 2009]." [1] This underestimation came with an important lesson for future program design: "If we learned anything through this process, it is that the survey tools that are available to us - whether it's our state surveys or the federal resources from the census bureau - those measures of the uninsured are less than exact to say the least. " [1]

Interviewee sentiment varied about the unanticipated enrollment rate. One legislator described how the program was initially presented as budget neutral and expressed concern about the budgetary impact of the unexpected enrollment rate: "When BadgerCare Plus was presented to the budget committee, we were told that by expanding BadgerCare into BadgerCare Plus we would be looking at 25,000 new enrollees and that cost would be covered by efficiencies in the program. We were told that BadgerCare Plus would be cost neutral…The efficiencies didn't come to fruition to be able to pay for 25,000 new enrollees and certainly didn't cover 46,000." [19]

In contrast, program officials and others frame the take-up in positive terms: "We are not going to apologize for enrolling poor kids - which is basically 70% of who these people were. We're not going to apologize for enrolling more kids than we anticipated. The governor said we should never, ever be defensive about making sure that poor kids have health care and I mean that's what we did." [1] Advocates and most legislators interviewed expressed agreement with this sentiment. In an interview done by an external organization, a legislator said: "[I give] the governor and his staff credit – the number of people who signed up is much larger than they thought, 90,000 versus 26,000." [22]

What's Working

Interviewees believed that a variety of program design changes made improvements in access, efficiency and public perception of the program. Specifically, interviewees valued a perceived reduction in churning and improved continuity of coverage for families. They attributed this to the switch to a sliding scale premium payment, the presumptive eligibility opportunities and the expanded eligibility criteria. In addition, interviewees believed the simplification of the program's structure and online application were major improvements that helped advocates find and enroll applicants. Interviewees also described the external benefits that have occurred as a result of the transition to BadgerCare Plus including an increase in applications for other income maintenance programs like FoodShare and a reduction in overall program stigma.

Improved Access

Interviewees were clear that the expansion in eligibility levels significantly improved access and they believed it also resulted in less churning of people in and out of the system. Program administrators also believe that using managed care organizations helped save money and improved access for individuals.

Expanded Eligibility

Expanded eligibility levels were one component of the increase in access. Prior to the rollout of BadgerCare Plus, low-income children, parents and pregnant women were ineligible to enroll in state-subsidized health programs (whether it was Healthy Start, Medicaid or BadgerCare) if their income was above 185% of the federal poverty level [FPL] and once enrolled in the program participants became ineligible if their income exceeded 200% of the FPL. Also, under the BadgerCare program, a flat premium payment of 5% of income was required when income exceeded 150% of the FPL (though no premiums were required for family Medicaid or Healthy Start programs).

These eligibility rules resulted in some people churning in and out of the program monthly due to income fluctuations around the 200% of FPL eligibility requirement and others being unable to pay a sudden premium requirement when their income reached 150% of the FPL. Under the new BadgerCare Plus eligibility requirements, all children under age 19 are eligible regardless of income, pregnant women are eligible up to 300% of the FPL and parents and caretaker relatives are eligible up to 200% of the FPL. In addition, the program switched from the 5% of income flat rate premium at 150% of the FPL to a sliding scale premium payment starting at 200% of FPL for children, 150% of the FPL for parents and caretakers, and no premium payments at any income level for eligible pregnant women (though premium requirements are different for self-employed parents who qualify via special depreciation rules).

Advocates were particularly enthusiastic about the expansion of BadgerCare Plus to all kids: "We're really pleased that the program [expanded income eligibility for] children from age 6 through 18. That was a big help because previously eligibility ended after Healthy Start and it was very difficult for those children to get covered - so that was great. It was a big deal." [3] A county eligibility expert agreed with the importance of including all kids: "The biggest change was that the moment we transitioned to BadgerCare Plus, the number of kids in the past who were in spend-down mode [when they must incur enough expenses to make them income eligible] was largely reduced and then almost overnight those kids became eligible with a premium and some even without a premium. On Day 1 it ended up covering a lot more kids." [16]

Use of Managed Care Organizations Improves Access to Providers

In addition to the eligibility expansion, program administrators believe that part of the expansion in access was a result of the deliberate increase in using managed care organizations to get people in to see a doctor. A program administrator describes the importance of HMO participation in the following way: "We believe that managed care - and we've documented this in the past - does, in fact, save us some money on a per person basis. A key reason for us is that we actually think the coordinated care is more effective than sending you out in the wilderness with a card. The other big thing that managed care does - and we have some clear evidence now in Milwaukee: we just recently did an analysis of access to specialty care in Milwaukee and the HMOs whose networks are more expansive [are better off] than the fee-for-service on the specialty side, contrary to what some may think. Basically…because they sign contracts saying they'll have sufficient networks and we hold them accountable to those contracts it means that they're inclined to have individuals have a phone number to call and say 'hey I need a doctor for xyz, where do I go?' and there's actually a process to get them in to see the physicians that they need whereas before in fee-for-service you were kind of out there and you had a card and 'hey good luck, figure it out.'" [1]

Reduction in Churning and Improved Continuity of Coverage

Program administrators report a reduction in churning and continuity of coverage that resulted from the program eligibility changes: "It's rarely "I wasn't eligible before and now I'm eligible." For most of the people who were added it is more along the lines of "I was eligible sporadically before but now I'm eligible on a continuous basis." This reduces the churn and treats whole families the same. There are no different rules – one set of rules." [1] Legislators also recognized the importance of program changes in making whole families eligible, which at least one legislator reported has helped improve public perception of the program: "Presumptive eligibility and eligibility for family members is important so different members of the family wouldn't be eligible or ineligible depending on slight changes in monthly income. [It helps to] avoid bad experiences and [people] communicating to others how this was another example of government at its worst." [6]

Interviewees expressed broad agreement that the rollout of BadgerCare Plus resulted in a dramatic increase in access to health care for low-income individuals. A legislator captures the enthusiasm expressed among several of the interviewees: "The BadgerCare Plus program is amazing. It's been a great thing for our state… the governor now has 98% of people in Wisconsin insured…I think BadgerCare Plus has done a great job." [7]

Improved Efficiency

Interviewees largely agreed that program design changes -- such as putting all low-income individuals into one program rather than several different programs and the promotion of the online application -- helped to improve enrollment efficiency. In addition, interviewees believed that the transition to BadgerCare Plus and the outreach that went with it has also led to the spike in enrollment seen in other income maintenance programs, specifically FoodShare, Wisconsin's Supplemental Nutrition Assistance Program (SNAP) for low-income individuals.

Putting All Programs Under One Umbrella Program

Prior to BadgerCare Plus, low-income individuals were placed in a variety of different programs based on their income, age, whether they had dependent children, pregnancy status, employment status and other factors. One of the major changes implemented on February 1, 2008 was that all low-income individuals would apply for a single program, BadgerCare Plus, regardless of

demographic characteristics. Behind the scenes, the department would place individuals into separate funding categories based on various factors. The switch to putting all prior programs and funding sources like Medicaid and Healthy Start under the umbrella of BadgerCare Plus helped streamline the marketing message. This helped people to understand whether or not they were eligible. . A program contractor summarized this change: "The idea of putting everyone into one group - the whole concept has worked well." [5]

Expansion and Promotion of the Online Application Process

Many interviewees also discussed how the online application website (ACCESS) greatly improved efficiency of enrollment and the program overall. The only major change to the online application with the transition to BadgerCare Plus was the addition of an Express Enrollment option for providers and community partners to provide immediate presumptive eligibility to individuals in order to avoid the 30 day wait that occurs while the application is processed. DHS also heavily promoted the use of the ACCESS website which helped to increase the number of applicants who went through the online system [See Attachment D for a chart depicting the increased use of the ACCESS website over time].

A program contractor describes the online application as a valuable resource for members to use: "The new ACCESS website is a resource for members to check their enrollment, make changes, get feedback from members, etc. I haven't heard of any issues in getting members to use it or understand it." [5]

Members are not the only users of the ACCESS website. When discussing the online application, county eligibility experts were among the most enthusiastic about the changes. Though some interviewees mentioned some significant technical problems with ACCESS early on, once the glitches were solved and people were trained to use the website, interviewees say it greatly improved efficiency and speed of enrollment. One county enrollment expert says the online application has made the worker's job easie , and the clients are also benefiting: "It's made my job easier with everything going online and with being able to do the express enrollment and the full application. When people come in they have one appointment where they do it all. When they come in, we're trying to do everything all at once. It really has made it a lot easier for us. Just to know that the services are going to be in place because we've made sure that the t's are crossed and the i's are dotted. The way we are working it – it's a benefit not only to us but to the client as well." [18]

County eligibility experts also feel that the new online application procedure is much faster and more portable, allowing them to seek out applicants wherever they may be: "Now, it's much faster – I'm doing 3-4 applications a week. I use the application so much now that I can kick out an application in 15 minutes versus somebody doing it on their own it could take them an hour. In the beginning it was more like 30-50 minutes. It's much less time than it was before BadgerCare Plus which I attribute to the online access program. It's so convenient and it doesn't matter where you're at. What we ended up doing with our DHS grant was to get a wireless card. So tonight when I leave here, I'm taking my printer, copier and scanner- I'm going tonight to meet with a pregnant woman and I'll be able to give her the application and do her express enrollment all at once with her. It's been really nice to be able to pick up and go. I've done them in homes, in public places – I mean we could go to a park and do it because we have a wireless card. A lot of the parks and shelters and stuff have outlets and that's all we need to print them off. We can go to the schools and not bother

a staff member for their computers." [18] [See Attachment C for an overview flow chart of the online application process.]

DHS Assistance with Problems

County eligibility experts were also complimentary of the DHS approach to helping community partners navigate problems, which made it quicker and more efficient to find solutions to complex cases. One eligibility expert nicely captures this sentiment: "We felt that DHS has made itself very available to help troubleshoot. We've been very pleased...we have really felt like the state has bent over backwards to make serious advocacy connections both on individual cases and patterns of cases." [17]

Enhanced Ability to use Application Materials to Apply for Other Programs

Interviewees were also satisfied with the ability to use ACCESS to apply for other income maintenance programs such as FoodShare. A department administrator believes the BadgerCare Plus rollout was the best FoodShare outreach they've ever done: "Now the interesting thing about BadgerCare Plus which is sort of a side benefit is its incredible impact on our FoodShare program, our food stamp [SNAP] program. It has had an incredible effect - like the best outreach we've ever done has been BadgerCare and BadgerCare Plus. It has increased our case load in that program more than anything we've ever done - changing the name, etc. We're at the highest levels of FoodShare participation in the state's history." [1] A county eligibility expert reiterates the efficiency and client appreciation of being able to apply for several income maintenance programs at once "[Clients] are very impressed with the way we bundle it. They are just so impressed that they can come to one place, to one appointment and get four or five things done. It saves them time and it saves us time. They're very impressed with how well we can work together. We package it."[18] [See Attachment E for a chart depicting the increase in FoodShare Caseload Recipients between January 2008 and October 2009].

Positive Public Perception

Many of the interviewees believed that the public perception of the program had greatly improved since the transition to BadgerCare Plus. Generally, interviewees stated that the public is well-informed about the program and that the response has been positive. Additionally, several interviewees believed that there has been a significant reduction in stigma and that, since the transition, the program is considered to be more like private health insurance than public assistance or welfare.

Feedback has been Positive

Legislators were among the interviewees who described the generally positive public response to BadgerCare Plus: "Once we pass a program, unless we hear a lot of feedback from constituents or health care providers, we don't pay a lot of attention to it. We have not heard [any consistent complaints] other than a few anecdotes. That means to me that BadgerCare Plus is working. In fact we have had additional enrollment and the governor has had to come up with new funds. The program is very important with the economic downturn of the economy. [The program] is a lifeblood for the economy right now." [6] A legislative interview conducted by an external organization reports a similar statement: "[Public perception is] hugely positive. It has not been a controversial issue at all. It's not something that people are really upset about. No one wants to be the person to take health care away from women, children, or low income childless adults; this is not politically palatable. [Attacks against BadgerCare Plus have been] muted compared to other

things that are being attacked. The public has been reasonably well informed about the program." [22]

Another legislator summarized the positive feedback surrounding the program: "I think that they did a wonderful job with education for people to understand how to enroll and they continue to do that. They continue to have informational seminars in resource centers and job centers that are phenomenal. They have obviously implemented it in a way where people are happy. More people are enrolling, word is out, more people are enrolling. And I think that helps too - if you know someone and they've had a good experience, I think that goes a long way. I certainly haven't heard any horror stories. I mean it's bipartisan people who are praising BadgerCare Plus. I think you'll find that across the board. And while there are some fiscal hawks that would say "we can't continue to maintain this kind of a program with the current fiscal state of affairs" I think that they support the program but that they believe we need to work on the budgeting. I don't think that you'd find anybody who is opposed to BadgerCare Plus." [7]

Reduction in Stigma due to Expanded Premium Requirements

County eligibility experts described a noticeable reduction in stigma associated with the program. They attribute this stigma reduction to the increase in the number of people participating at a level that requires payment of monthly premiums, which the interviewees believe makes it look more like health insurance than a welfare program. One county eligibility expert stated: "It's helped to relieve the stigma of welfare because it made it look more like health insurance. There is something about premium payments that makes it feel less like an entitlement and helps people feel like their contributing to a cost pool. Their card says Forward Health rather than Medicaid. The premium payments really helped to relieve stigma." [16] Another county eligibility expert echoed that statement: "I have seen more people in the community talk about it as insurance…I do think that there has been a reduction of stigma." [17] One legislator, in an interview conducted by an external organization, did express concern that program participants were still experiencing occasional stigma. The legislator stated: "Moms feel as though they are being treated with some kind of stigma**.** One mom [said] no one in the waiting room would address her – the receptionist labeled her a BadgerCare Plus patient." [19]

Overall, interviewees believed program changes improved access to previously ineligible or sporadically ineligible populations, that still other changes helped improve efficiency of enrollment in BadgerCare Plus and other income maintenance programs and that the program as a whole has been well-received by the public.

Current Challenges

Though there was broad agreement among interviewees that the transition to BadgerCare Plus was an improvement overall, nearly all interviewees describe aspects of the program that were problematic at the outset. Many of these challenges have since been resolved, while others have yet to be remedied. The reported challenges have been grouped here into four general categories: program design challenges, enrollment challenges, specific access issues, affordability challenges and specific changes suggested by interviewees or that are currently being pursued by DHS.

Program Design Challenges

Respondents described a few elements of program design that have created confusion or problems for eligibility workers and BadgerCare Plus members. Problems included the complexities of premium

payments due to the new sliding scale premium determination and the limited benefits available under the benchmark plan.

Premium Payments

One of the most prominent problems discussed by interviewees was about premium payments, even though only 3% of children and 9% of parents are required to make such payments as a condition of participation in BadgerCare Plus. Several respondents said that the sliding scale premium determination generated some logistical challenges. DHS program administrators, county eligibility experts and advocates noted the difficulties associated with determining the initial premium payment, since income is not yet verified and the actual premium will often change after verification. A county eligibility expert aptly described this issue: "The main complaint we hear is about premiums…Maybe a simplified premium payment may help – at flat rate for a period of time – rather than the changing premiums due to the sliding scale. What happens is – based on what they tell you in the first place – you get one premium payment and then when we verify your income - it likely changes. A lot of people don't consider rental income or employment compensation income – so people don't always know what's counted and that's why it's different some times. And people still confuse gross and not gross income." [16]

Program administrators explained why they decided to switch to the sliding scale premium payment, but also indicated awareness of the problems it has caused. Administrators hope to implement a fix for the issues: "One issue has been premiums in general. What we tried to do with premiums was (and we're implementing a fix which is part of our effort to maintain continuous improvement) that we wanted to get away from just you hit the premium level - you're income goes from 149 to 151- and then boom you get hit with 5% and so what we did is we came up with a sliding scale premium schedule that is based on a polynomial equation…[But] what we found was that there were some issues with regard to first month payments and calculating that [equation]….So what we've decided we're going to do is we're going to make the first payment a flat fee…[so we'll] say "Based on the income you gave us, you owe a premium of x. Just so you know, once we verify your income, your third month premium may be higher." But the idea here is you send me your pay stub and you send me your check - that's what we want. And then you're eligible and we don't have to go back and forth…We've called it a premium coupon - the first one is collected by the worker and every one after that is collected centrally by our fiscal agent. So hopefully that will make it easier." [1]

Increased Eligibility at the Expense of Benefits and Access

Advocacy groups and county eligibility experts largely appreciated the expansion in program eligibility, but some interviewees felt that the State did so at the cost of important benefits or improvement in access for members. One county eligibility expert illustrated the benefit problem and asserted that existing access problems should have fixed before the expansion went underway: "There are increasing complexities around eligibility and benefits that result from the way that they sliced and diced eligibility and also the addition of the benchmark plan and different kinds of coverage for people. My sense is that we have made a tradeoff that in order to extend coverage to more people, we fiddled with the eligibility criteria and fiddled with the benefits packages and I think that we have seriously weakened the fabric of healthcare coverage by stripping down the benefits. I think what's happened is that we've continued evolutionary erosion of benefits under the standard plan and a structured erosion of benefits under the benchmark plan. For instance, dental coverage: making the decision to cover more

people while not fixing the availability of coverage problem for core enrollees of Badgercare Plus and letting stand the status quo of dental care on Badgercare Plus where people can't get in to see a dentist. We will pay for this in spades in the next generations. That should have been fixed before expanding populations and limiting benefits." [17]

Advocacy groups seemed most concerned about the limited benefits on the new benchmark plan. One advocacy group representative stated: "the benchmark plan was something that we really did not like...because it's such a drop off and we're creating more chaos within the system. What happens when that family and those children tip over the income by a fraction of a percentage point of the FPL and then they're in the benchmark plan. Then they have much more limited coverage for therapy services that they might need, prescription drug coverage changes, durable medical equipment changes…The difference between the benchmark plan and the standard plan is very significant, especially if you have a child with a chronic illness or disability." [3]

Enrollment Challenges

The enrollment challenges described by respondents related primarily to a belief that county level workers are overloaded and unable to get to cases on time. The other enrollment problem frequently described was that existing difficulties with the enrollment system in Milwaukee County were made worse with the inception of BadgerCare Plus.

Some County Level Worker Overload

Several interviewees suggested that, at the inception of BadgerCare Plus and in some locations even in late 2009, county level workers have experienced an overload of cases resulting in members not getting adequate assistance. One county eligibility expert believes members are not receiving adequate time to amend their application: "I don't know if this is a result of the eligible population being expanded or perhaps it's related to the budget problems that would force the county to have a static enrollment cadre of workers – one thing I've noticed now more than ever before – that an application is on a workers desk and they get to it about 20 days into its filing and then notices that something isn't there and then sends a notice to the family to get the form in on time and it looks to all the world like it's the silly applicants fault for missing their 30 days mark when really it's that they're not getting the adequate timeline for making changes." [17]

A program contractor echoed a similar statement about worker backlog and the effect on members as the program got underway: "One of the difficulties we experienced was that individuals were eligible but due to the county workload backlog they were not able to get eligibility. There have been some problems with members not being able to get a county resource in person or over the phone and not understanding whether they have active eligibility or not, and what the timeline is for that." [5]

A county level worker believes that current rules for verifying income maintenance application information could be better implemented to eliminate some of the unnecessary work and applicant denials: "I think that there are too many cases of over-verification that pushes people to do things more than once needlessly. Part of the course of normal business is that there is a rubric in income maintenance that says that when there is difficulty getting an item of verification, the worker is a) in certain circumstances, supposed to try to assist the applicant to

get that – which is spotty and b) is supposed to use the best information available if they are not able to get the best information – this is not communicated to clients and not used very frequently. More often than not, they're denied and neither of those worker rules are utilized enough. Perhaps there's not a real clear pathway between the growth or the development of the kinds of verification and information that's needed and the threshold for applying the best information available rubric." [17]

Difficulties with Backlog in Milwaukee County

The enrollment backlog in Milwaukee County has been one of the most significant problems that the state has had to deal with since the start of BadgerCare Plus. It is widely believed that similar problems existed long before BadgerCare Plus expansion took hold. The transition to BadgerCare Plus and subsequent increase in applications exacerbated the existing problems. Several respondents mentioned the enrollment problems present in Milwaukee County. Program administrators were the most vocal about these concerns. One described the extent of the problem in Milwaukee: "There's no question that Milwaukee County is the highest in terms of the raw amount of work that needs to be done but there are also issues of a 35%-40% absentee rate of workers, positions going unfilled, a call-center where nobody ever answers the phone and you can sit on hold for a lot of hours, poor customer service, less than 1% of their phone calls are answered. They get over a million phone calls per month and they only have 95,000 cases. People call dozens, literally dozens of times to ever get through with their cases…They had a whole lot of ACCESS applications that were sitting untouched, running out of their 30 days, we allocated state staff to try and go in and deal with that big back log. We've asked other counties to try and help us with that. If you talked to people in Milwaukee I would not be surprised for you to hear and we hear quite often about problems with access." [1]

In an attempt to fix the backlog in the county, DHS took over some of the processing of Milwaukee applications: I think [Milwaukee County has] been one of our biggest problems because of just a lack of customer service or an inability of people to navigate through the county to get resources. That's part of the reason we created a special partnerships in Milwaukee…We actually have a unit just down the hall here [at DHS] and actually we process those applications here, you don't go to the county. So we've tried to provide expedited service and so that's been a special, unique partnership." [1]

Since the interviews were conducted, the backlog problem in Milwaukee County has been largely addressed. The attached BadgerCare Plus Timeline indicates that the Wisconsin Department of Health Services took over the processing of all Milwaukee County applications for health and public assistance benefits in May 2009, the public assistance call center in July 2009 and will assume the rest of Milwaukee County's income maintenance functions in January 2010.

Specific Access Issues

Though interviewees generally agreed that there were many positive improvements in access, some respondents expressed continued concern about access to specific services such as dental care and mental health specialists. In addition, some interviewees believe there needs to be increased outreach to certain populations in order to increase access for those underserved groups.

Access to Dental Services

Department administrators were among those who acknowledged the existing dental health access problem: “With the exception of Milwaukee County and the four counties around Milwaukee, dentists remain a fee-for-service benefit, but it's in the managed care contracts in Milwaukee and they don't really do any better. It remains a big issue. I won't sugar coat it… the one area where there's the biggest problem is dental and that's a national issue. It's something we're looking at with this budget to see if there's something we can do on dental but with a $5.4 billion budgetary shortfall it's a challenge.” [1] In an interview conducted by an external organization, a legislator referred to this problem: “Our reimbursement rates for dentists are low - many providers are saying no.” [19]

Advocacy groups also expressed frustration about this continued problem. An advocacy group representative stated: “we're looking at people paying premiums for benefits that are really non-existent. Why are you paying premiums for dental services that you can't get? There are tremendous access problems with access to dentists that will accept Medicaid and will accept new patients. Same thing with some mental health services.” [3]

Access to Mental Health Services

Access to mental health services also continues to be a problem. Program administrators described some of the difficulties they are experiencing in attempts to mitigate the problem: “…it depends on what part of the state you’re in…[in one area] we have one large provider in child psychology,,,and they don't like contracting with the county or the HMOs .. It's also hard to get some of the mental health professionals in the rural areas [to take our patients]. And getting culturally sensitive mental health professionals to work with the tribes has also been an issue.” [1]

Access for Specific Communities

Some interviewees described specific populations that need to be targeted for BadgerCare Plus enrollment. One advocate said that a problem is that lack of “outreach to the farming community and self-employed families – they have no idea about the changes that drastically affect them.” [1] In an interview conducted by an external organization, a respondent asserted further need in urban areas: “[There’s a] need to increase enrollment numbers and visibility – especially amongst people who are traditionally underserved by health insurance…We have pockets of poverty, in Milwaukee and in rural areas – we need to reach into those areas – need to communicate with people. People there aren’t on traditional phone or work networks – the easy ways to reach people don’t work.” [22]

Affordability

Though most agreed that the premiums, when they are required, are appropriate for families, some respondents believe that some families struggle to pay premiums and others believe that the premium costs may be keeping some eligible individuals off the program.

County eligibility experts generally believed the premiums to be affordable. One county expert said: “The families that I work with that are required to pay the premium think they are a fair premium. Particularly compared to if they were to go into the private market. The services that they are receiving through BadgerCare Plus are definitely worth the premium.” [18] Another county expert added nuance to this sentiment: “I think by and large that people are okay with the premium requirement. I think

families that don't manage it are outliers but it does happen frequently enough that we worry about them. We worry about the kids." [17]

One department administrator thinks that some families choose who to cover or not cover within the family due to limited income: "We have gotten requests for 'I can't afford the premium for myself and my kids but I want to sign up my kids' so we've gotten some requests for that. I have also gotten some that say 'I really need to cover this kid but not this one.'… The issue though is that you have people who have difficult lives with complexity and they've got one kid who's really sick and the kid needs healthcare and how much can they afford and they've got another kid who's really healthy and just want to roll the dice. When we're talking about kids we're talking about $10 at 200% of poverty and it does go all the way up to 300% we're talking about $180 which is by the way an incredibly inexpensive health insurance policy." [1]

Another county eligibility worker stated that the premiums result in people having to make difficult financial decisions, families then rush to make last minute payments, which can lead to more burden for county level workers: "I think it does end up in having them make choices. For some individuals, it's a question of am I going to pay rent or am I going to pay my premium. We have I think a lot of people just trying to do both and time it though it's not possible to change when your premium is due but there is a few day time lapse allowed after the due date and people know they can come straight to the office rather than mail it out which is where more of the workload comes in." [16].

A program contractor believed cost-sharing (premiums and co-payments) to be the primary concern for members: "The only thing members really care about is "how much do I have to pay out of my pocket?" Why do I have to make copayments?" We hear from members when they [learn of their responsibilities], they say "because I have to pay a premium, I no longer want this plan." The contractor interpreted this as a sense of entitlement as well as a sign of financial distress, at least for some members who have previously received coverage without any cost-sharing requirements. Though the program contractor believes people are often choosing to go without insurance rather than participate in BadgerCare Plus when a premium required, the interviewee did not know how often this was happening: "Although this is happening, I don't know to what extent." [5]

Specific Changes Suggested by Interviewees or Changes Being Pursued by DHS

One interviewee, a business representative, believed that members should have to go through a formal orientation process in order to be educated about their responsibilities in the program and that they should be held accountable for getting appropriate care and fulfilling obligations such as connecting with a primary care doctor: "We would look up who their primary care doctor was and we would say "when was the last time you saw Dr. Miller." And they would say "Who's Dr. Miller" and we would say "well, he's your primary care doctor." "What's a primary care doctor?" They don't even know what it is. So, to me, they should have to go through a very formal orientation. Before you get enrolled in the program, your first obligation should be to select your primary care doctor and I think the state should provide assistance for that so in case somebody has certain linguistic needs or whatever that they get them a good match and they are not enrolled in the program until they actually go see that doctor. And that doctor has to complete a full assessment and determine which programs within the HMO that that person needs to participate in. And then it should be "you must participate in this program in order to have this coverage." There's just no way that the state should be giving away our taxpayer dollars without strings attached to it and accountability and that's the biggest piece. I understand that, especially in the Medicaid population, some of these people have very difficult home lives and I do think

you need to meet them where they're at and that's fine but provide them with the proper education, get them to understand what they're job is, you know what they need to do to get proper health care. Be an advocate for them but don't make them not have any responsibility – [they should] do certain things in order to have that coverage." [13]

A community advocate suggested a markedly different approach to engaging members in their health care process. This interviewee believed that a centralized outreach network is necessary to give people adequate resources for questions and problems: "We can't have an attitude of "if we build it, they will come." It just doesn't work that way. People need help navigating these systems. They're complex because it's still Medicaid after all. There are still private insurance rules and people don't understand the rules and regulations and contract provisions that underpin all of these programs…It is really something that requires more of a network and more of a coordinated effort and not just thirty different disparate groups." [3]

Yet another interviewee believed that an increase in the number of community health clinics should be part of the answer for ensuring access to care for BadgerCare Plus members. This health association representative said: "We really do need to develop community clinics—they do a great job and are the right place to be [for many in this population]…Coverage without access is not health reform." [10]
DHS has made a commitment to "continual improvement" [1] of the BadgerCare Plus program. The Department is working on improvements that include the following:

1. Furthering program simplification, including re-engineering the premium payment process to make it easier for members to understand;
2. Training more community partners; and
3. Improving access in Milwaukee County. The state is in the process of taking over responsibility for enrollment services in the county, which should decrease processing times and strengthen customer service." [21]

Reasons for the Unanticipated Increase in Program Enrollment

One of the most widely discussed elements of the new program has been the dramatic increase in enrollment that has occurred since the transition to BadgerCare Plus. Interviewees attributed this unexpected increase in enrollment to many different program and implementation strategies, including a more streamlined eligibility and enrollment process, promotion of the online application, the outreach effort enhanced by grants to community organizations, and media publicity of the program. They also acknowledged that an unknown portion of the program's growth was due to the decline in the general economy and the resulting loss of jobs and income for a large number of Wisconsin families that coincided with program implementation.

Streamlining Eligibility Guidelines and Enrollment Process

DHS worked to simplify the program in several ways, particularly focused on streamlining eligibility requirements. Several interviewees, including department administrators, legislators and health care association representatives attributed the high unexpected enrollment numbers at least partially to this change.

A department administrator pointed to the importance of simplifying the application process for multiple programs: "One of [the reasons for the increased enrollment of the eligible population] is making some policies for FoodShare and BadgerCare Plus/Medicaid consistent. You wouldn't think of it necessarily but if somebody comes in and applies for FoodShare they might also be eligible for

BadgerCare Plus. If you can make it as consistent as you can in terms of reporting changes, etc it makes it easier for people. So streamlining the program is one example." [2] Another department administrator believed the "all kids" message helped to simplify the marketing message and reduce stigma both of which contributed to the unexpected enrollment numbers: "We also think, and we learned this lesson from Illinois, that the "All Kids" message is very helpful for marketing even for people who are otherwise eligible for the program. I think that was one of the things that we hoped and talked about is that we wanted to end the stigma." [1]

A health care association representative believed that some simplification had occurred prior to the rollout of BadgerCare Plus, but that the increased streamlining helped to increase enrollment: "I think certainly the simplified eligibility…The department had already taken steps through the access online application to really simplify and streamline the process and then modify some of the policy to make it even easier [to enroll] with BadgerCare Plus." [4]

A legislator was complimentary of DHS' effort to remove barriers for potential applicants by simplifying the enrollment process: "I think they have made a great effort this session to increase the entry point so that a person doesn't need to go to six different places to get six different services. I think that they've done a great job of that…. And that was definitely a goal of the Department to increase the advertisement of the program and to increase education. I think they did exactly what they intended to do." [7]

Promotion of the Online Application

Department administrators, in particular, believed that the focus on promoting the online application tool contributed to the significant increase in enrollment. One commented that the use of the online application increased enrollment and also helped save valuable worker time: "The other thing is that the internet and accessing it. In the month of February, for the first time ever, online applications exceeded mail-in and almost exceeded face to face application and it has almost stayed there. ACCESS is now greater than mail-in and greater than phone-in. And if you put mail-in and ACCESS together, they are greater than the face to face which is pretty good considering Milwaukee County still does 80% of their applications face to face. So across the state, ACCESS and using this new model in which people don't have to come in to the agency and can send it in either through the internet or through the mail has really, really saved workload in some ways because the face encounter takes a longer time and is harder than actually doing it through the mail or over the internet." [1]

Enhanced Outreach

The enhanced outreach that occurred with the rollout of BadgerCare Plus was the factor most often cited by interviewees as contributing to the large unexpected enrollment. Respondents who believed that outreach had a significant effect on program take-up addressed two aspects of the outreach component. The first and most widely cited strategy was the community-based outreach that DHS encouraged by way of "mini-grants" to community partners. The other outreach strategy was the substantial media coverage that occurred, both through a marketing campaign and unsolicited media reports.

Community-Based Outreach

The Department of Health Services pursued increased program enrollment in part by providing community-based organizations with a monetary incentive for enrolling eligible members. A department administrator described this strategy best in an external interview: "To ensure that

community organizations became involved in enrollment assistance, we awarded mini-grants of up to $25,000 per organization to 31 community partners around the state so they could share information about the program's benefits and provide direct, confidential application assistance to families. In addition, DHS helped train close to 200 community organizations who did not receive the grants but were nonetheless very involved in the outreach activities. …. The outreach team trained approximately 3,000 people in more than 150 sessions statewide. More than 500,000 pieces of marketing materials, including brochures, wallet cards, posters, magnets, and pencils were distributed through community agencies into the hands of Wisconsin families." [21] The program administrator believed that, in addition to the valuable training the department provided, the bilingual and culturally-specific promotional materials assisted in the enrollment of certain target populations]

County eligibility experts were among the biggest proponents of the mini-grants and community-based outreach. One county eligibility expert said that the mini-grants provided the funds necessary to accommodate the influx of applicants that came with the transition to BadgerCare Plus: "The mini-grants were really effective. We're getting referrals from everywhere and if we didn't have that mini-grant, I don't know how much time we would be able to allow or allot for that. But because of that funding, we are doing as much as we can as soon as we can based on the needs of the community." [18]

Another county eligibility expert believed that it was the collaboration among many community partners that facilitated the dramatic enrollment increase: "There is greater awareness. I think that there's been such an emphasis on the program from multiple players involving outreach and enrollment so many community-based organizations and local public health offices and health care centers that there is more attention being placed on it that is more thorough-going than it has ever been. I would say that media attention has been good but I don't think that's the most significant factor, I think it's the involvement of so many external partners that has generated a level of buzz that is unprecedented." [17] A second county eligibility expert also spoke to the importance of the partnerships and networks they created in efforts to get applicants enrolled in BadgerCare Plus: "I think we've done a lot of good outreach. We've worked with the schools, the faith communities, the free clinic, the reproductive health clinic….Getting connections in the professional community has really helped to promote it community-wide. We've really maintained those relationships" [18]

Though most interviewees spoke positively of the mini-grants and outreach strategy overall, some respondents worried about the long-term sustainability of the mini-grants. A program contractor asserts: **"[**Community partners have had a] considerable impact on growing the enrollment. They take a member all the way up to the point where the counties need to be involved. My fear is that the mini-grants would go away under the current budget situation" [5]. A county eligibility expert echoed this sentiment but then added that the transition of some of the mini-grants into long-term matching contracts helped to ensure continued enrollment success: "Mini-grants were useful because several of them transitioned into Medicaid Overmatching Contracts which will really help in the long-term." [17]

An interviewee representing an advocacy group similarly believed that the mini-grants helped increase enrollment but also acknowledged that the initial enrollment projections were too low: "I think that the outreach was designed to be effective statewide and good, to really put capacity at the local level where people who may have health insurance needs go…but I also think that you

have to base costs on projections but I think their projections were low, not intentionally low, but low." [8]

Publicity

Many interviewees believed that the media attention surrounding the rollout of BadgerCare Plus contributed to the unanticipated enrollment increase. An advocacy representative believed that the publicity played a role in helping get the word out to people who were eligible even before the expanded eligibility guidelines: "Some of the numbers that came out of BadgerCare Plus showed that 85% of the people that are in the program were eligible for the original BadgerCare program. What does that show you? That shows that there was not enough attention paid to outreach and helping people through the program. When there was a big publicity push, people became more aware of it and got into the program but they were eligible for it before. So we can see that we need to have better dedication of resources to not only the outreach and awareness but then also the advocacy to link those people to the brokers and help them cut through the red tape and navigate through those systems." [3]

The advocacy representative went on to summarize: "It isn't the program expansion; really it was more awareness in health and getting more folks who were eligible enrolled in the program…More likely it was the press, the newspapers, local health departments. There was just a lot of attention on the issue" [3]

Another advocate simply believed that it was outreach in general that made the difference: "I think it's because they did such a good job of outreach. I think the outreach was effective" [8]

Observations on Employer Sponsored Coverage

One issue that elicited a somewhat wider range of interviewee responses was whether the state-subsidized BadgerCare Plus program had an effect on the number of people enrolled in employer-sponsored insurance or other private health care coverage. Applicants are not eligible for coverage if they have access to "affordable" employer-sponsored coverage, whereby the employer contributes at least 80% to the premium. The large majority of interviewees believed that crowd-out of the private insurance market has not occurred as they believe the majority of BadgerCare Plus members have not had access to private insurance. Some interviewees believed that this crowd-out provision is too stringent of a requirement for employers and not consistent with private industry standards. Other interviewees described their belief that the premium assistance program, which is designed to help employees keep employer-sponsored coverage by assisting them with premium payments, is ineffective and inefficient.

DHS Efforts to Avoid Crowd-Out

Several provisions in the program are designed to ensure that people who are eligible for or have private health insurance are not enrolled in BadgerCare Plus. The crowd-out provisions that took effect with BadgerCare Plus were as follows:

- Three month waiting period for dropped coverage; 12 month look back and three month look forward for access to employer-sponsored insurance if income is above 150 percent FPL (good cause reasons apply).

- Employer-sponsored insurance is deemed unaffordable if employer pays less than 80 percent of the premium.
- An Employer Health Insurance Verification database is used to see if applicants/members have access to employer-sponsored insurance.
- Private insurance disclosure tapes are used to check whether members are covered by private insurance.
- DHS determines if it is cost-effective to enroll people in employer-sponsored insurance, pay their premiums, and provide wrap-around benefits.
- Parents and caretaker relatives pay monthly premiums on a sliding scale starting at 150 percent FPL, while premiums are charged for children in families starting at 200 percent FPL.
- The Benchmark plan (for those above 200 percent FPL) has higher copayments than the Standard Plan. [21]

DHS asserts there is ongoing commitment to avoiding crowd-out of the private insurance "We didn't want people to be enrolled if they had other insurance. So we tried really hard not to crowd out other insurance...we are careful and tried to be as careful as we could to make sure that if people had other insurance that they weren't enrolled and we continue to try to be careful about that." [2]

Crowd-Out Not Perceived as a Significant Concern

Only one representative of the business community expressed any concern that BadgerCare Plus might crowd out private insurance coverage. In contrast, most interviewees believed that crowd out is not an issue because they think the population enrolling in BadgerCare Plus has not had access to the private insurance market. This belief was expressed not only by advocates and legislators, but by representatives of health care associations who are concerned about the comparatively low payments from public insurance programs.

One advocate argued: "They're all concerned about crowd-out. We don't want people to go into BadgerCare Plus and to leave the private marketplace. And my point is that the private market place for this group has largely failed. They had the individual marketplace which is full of high-cost deductible plans. The pooling concept is really gone for these folks. You've got people in puddles. So we've got puddles of care that quickly become dirty puddles because somebody has a pre-existing condition and they can't get coverage and we're working so hard to protect a failed marketplace for small employers and for individuals. Instead we should be really working at the pooling concept. Medicaid or BadgerCare at that time was a 600,000 person pool. That's a big pool." [3]

A program administrator echoed this statement and added that the reason that the people enrolling in BadgerCare Plus have not been eligible for private insurance is because they are poor: "I think the big thing is that if you actually looked at who we signed up, the vast, vast majority are poor people - poor kids and parents and pregnant woman but the vast majority of them are kids and the vast majority of them are poor. I mean as I said only about 13,000 are on the benchmark plan so of the 94,000, the rest of them were probably income eligible at least but then they fell through the cracks of one of these different things but at least they appeared to be income eligible before so they haven't had much opportunity for private insurance before." [1] Another program administrator added that the job prospects for this population result in many of them not having the option of private health care: "I think part of the issue is that lot of the people we're covering don't have any insurance. And so whoever is left - a lot of the folks we see have part time jobs, I can tell you their employment changes constantly

because we can see that in the updates we get on eligibility. It isn't a group that has stable long-term employment or insurance associated with it. I mean that's the bottom line." [2]

A legislator made a similar statement about the lack of availability and affordability of the private market for many people: "The private market isn't working for people and if it was it would be affordable but I think that we've seen more and more stories coming into our office about 40% increases for businesses with individual premium increases and there's no health difference." [7]
DHS has not been able to verify any actual case of crowd-out: "The only people we hear from about crowd-out have been agents. They're the main issue about crowd-out and we have asked for tangible examples that we can investigate. And we have crowd-out provisions and there are concerns about whether or not people are violating our crowd-out provisions…But if there are areas where we had examples of people purposefully dumping we wanted to get at it. I mean obviously people say 'oh well they're going to dump coverage and tell their folks to go sign up for BadgerCare Plus.' We have not seen any examples of that. We were given a few where we did some investigation but we were not able to determine that dumping had actually occurred but that is something we had watched very closely." [1]

When asked to what extent employers were dropping family health coverage due to the expansion of BadgerCare Plus and the "all kids" message, a business representative said: "No, none. You have to understand that employers are probably the most responsible group that you have in the state. They don't play those games. They just don't. I have not seen it. Even in our small businesses, of our 700 companies about 600 are small businesses with less than 100 employees and I think we have about 400 that are less than 50...that's too complex for them. They're not going there. They don't even understand what's going on. I'm working with a small business now that has 35 employees and they have a very large case - they have a girl who's 19 who has a very complex case and it has caused their premiums to go way up. They've never once said...you know. Now ultimately that girl is going to become an age where she doesn't qualify anymore on their plan and we're currently working on getting her on SSDI but that's not going to happen - they're not going to segregate out employees who have children: "we're going to offer this to you versus other people." There's way too much risk involved in employee morale and complexity of management of that. They're either going to offer it or not going to offer it. I'd say there's no concern of that" [13]

Disagreement about Definition of Affordable Employer-Sponsored Insurance

One of the crowd-out provisions deems employer-sponsored insurance affordable if the employer pays at least 80% of the premium. A business representative asserts: "I would say that employers pay more like 70% and the employee pays 30% - that's much more standard." [13] A health association representative also questioned the 80% requirement: "One question that we have is whether the 80% threshold is consistent with or how does it relate to what is happening in the marketplace and is it the appropriate health insurance?" [4]

A department administrator counters: "I've heard anecdotally that a couple of things are happening: we have this rule in place for crowd-out provision that if your employer pays 80% of the premium you're ineligible and we've heard some examples of individuals who have written a letter saying "yeah, you say my employer does and I guess they do but it's still too much I can't afford it" or that "they're paying 80% but it's a horrible plan" or "80% of the premium is still too high." [1]

Premium Assistance is Not an Effective Crowd-Out Provision

Interviewees generally agreed that the premium assistance program is ineffective. The Health Insurance Premium Payment program (HIPP) is designed to help people remain on their employer-sponsored insurance by helping them pay their required premium.

A program administrator illustrates some of the reasons why the premium assistance program could be useful if it worked: “I like it if it's possible and the reason I like it is because if someone's income rises it leads to greater continuity of care potentially, as opposed to going from our program to commercial insurance that can sometimes mean [less continuity]. I like the idea of taking out the disincentives to earn more so that I, you know, don't lose my insurance - those kinds of things.” [1]

However, another program administrator describes why the program has not worked well thus far, attributing it mostly to a federal government requirement that the state provide “wrap-around benefits” -- add benefits that are included in BadgerCare Plus but not in the employer’s plan: “One issue with premium assistance is that we have to wrap-around benefits for the standard or benchmark plan depending on what it is that the person has and that’s complicated. So that’s one issue. And then the employer, of course, has to agree and they have to cooperate. So I think the premium assistance program, if we would not have to do some of those wrap-around benefits, it might be a bit easier to implement. But right now, it’s complicated to have all of that information and have the employer willing to participate and still meet the thresholds we have for coverage. In other words, the coverage has to be cost-effective otherwise it doesn’t pay for us to do it. There are a lot of requirements associated with it.” [2] A community advocate similarly acknowledged the difficulty: “It's [the HIPP] probably not getting the traction that they wanted partly because of the complexity, partly because of the time that they have to evaluate the employer-sponsored plan benefit versus Medicaid and to build wrap-around coverage for certain plans.” [3]

Another program administrator discussed the difficulty of meeting the federal requirement for cost effectiveness: “What we said and I said all along is that I was always less than optimistic about the effectiveness of the changes to our HIPP program just because private insurance costs are so high, the costs to wrap-around are so expensive that at the end of the day especially for a lot of the new enrollees who are kids - kids are pretty inexpensive for us to insure - that it would be pretty hard to make that calculation. You have to show cost effectiveness…The cost effectiveness just isn't happening so it's just cheaper for us to put them into full-fledged BadgerCare Plus.” [1] The administrator went on to question whether any state has really solved that conundrum of how to do wrap-around employer sponsored coverage. [1]

Continued Concern about the Possibility of Crowd-Out

Some interviewees remained concerned about the long-term possibility of crowd-out with the expansion of government-subsidized health insurance options. A business representative and health care association representative were the primary voices for these concerns.

A business representative believes that the expansion of BadgerCare Plus may be bad for the private sector: “If we rely on programs like BadgerCare, we continue to spend them on populations that really should be served by the private sector, we will continue to erode private sector health care and we don't want to go in that direction. We're very concerned about crowd-out that BadgerCare Plus will drive people to government subsided health care and we think that's the wrong direction to go.” [14]

A health care association member argues, “The concerns are a couple: one is whether everybody who has been enrolled is actually eligible in terms of the crowd-out provisions and have the crowd-out provisions been implemented the way they’re supposed to. I think that’s a concern…I think the other thing that we’ve been hearing is employers dropping family coverage since kids can be covered on BadgerCare Plus.” [4]

Program Sustainability

In the current economic climate, many interviewees expressed concern about the long-term sustainability of BadgerCare Plus. Interviewee opinions on this topic were divided, primarily reflecting their ideological beliefs about the role of government in health care. Some respondents believe that DHS should do more to control and stabilize the program’s costs, while other respondents believe the costs of health care overall are the root of the problem. Others believe that BadgerCare Plus is a vital safety net for families, particularly in the weak economy.

Need to Control and Stabilize Health Care Costs Within Program and Overall

Business representatives, health care association representatives and legislators were among the interviewees most concerned about the long-term costs of the program and health care in general. Some interviewees described the problem and others offered potential solutions.

One legislator described the cost and sustainability problems as follows: “BadgerCare significantly drove up enrollment numbers and has created a lot of issues on a lot of levels: 1) Cost is one issue 2) Another issue is the question of how high above FPL a state program should set its eligibility level. Government health care is often better than private so 1) this gets rid of the incentive to move off Badger Care 2) We need to wean people off – that’s not happening 3) The cost is horrific.” [19]

One business representative believed the government should have worked to fix the existing programs before adding another one: “I'm not sure the government should be in the business of providing subsidies regardless of income. I said earlier there's a role for government but I'm thinking of really low income people and the elderly for sure are going to need some assistance but let's fix Medicaid and Medicare before we just start layering in another government program on this population. Let's make sure those programs are at peak efficiency and they're doing what they're designed to do.... Let's not just start pouring more dollars into this problem 'cause that's never going to resolve the issue so let's look at the reimbursement rate and solve that problem. If it's about raising taxes, let's be honest about it and raise taxes… We should be looking at every issue we can to lower the cost, control the cost, stabilize the cost of health care.” [14]

One business representative described the need for a change in the incentive and accountability structure in order to control long-term health care costs: “The concern that I have is when the government expands access (which I think is wonderful - I do think that every resident of Wisconsin should have the right to minimal or basic health care)...the dilemma is that the government often does it without addressing the cost containment issues… To expand access without addressing the cost management aspect of it is negligent in my mind, pure negligence. There is accountability at all levels. I think that's the biggest problem in health care is that there is a lack of accountability at all levels. Providers are not held accountable. Consumers are not held accountable. Employers have not been held accountable. That's really what our group is trying to do - restructure all levels of accountability.” [13]

Another business representative further argued the need for efficiency: “First of all, we believe there's a role for government. There's a segment of the uninsured population that will probably never get reached…. We're not totally convinced that people are being denied healthcare but of course those costs of treating that population are being shifted to the rest of us and we understand that and that may be...maybe there's nothing wrong with that. I think cost-shifting will always continue I mean that's the nature of insurance - shifting the costs of unhealthy people to healthy people…. I think access...most people have access to healthcare. They may not have access to insurance but most people have access to health care. So we've got to figure out a way to control the costs of health care and in some ways we kind of lose sight of that with some of these government-based programs. The fact that BadgerCare Plus came in so underfunded [and] so underestimated the population that was going to be served by BadgerCare, I think that shows how careful we have to be in terms of not throwing more money at the problem and trying to fix the mechanics of the problem.” [14]

A health care association representative asserted: “…[O]ur members believe strongly that we are not going to make health insurance more affordable unless we start talking about health care costs, the underlying cost drivers, and we have administrative costs but 80-90% of costs are in medical services and until we can get a handle on medical costs we’re not going to make a dent on affordability.” [4]

Program is a Necessary Safety Net for Wisconsin Families

Legislators and department administrators were the most adamant about the program’s role in mitigating the economic difficulties of Wisconsin families in the current economic climate. Both groups said, at the time of the interviews, that it would be possible to balance the budget without cutting the program and believed that BadgerCare Plus would not be cut despite the state’s budget deficit.

One interviewee from the legislature described the “amazing job BadgerCare Plus and the people in DHS and the governor have done to get almost all of the people in Wisconsin insured, and it's been a great deal for that…” The interviewee continued by adding some national context to the state budget problem: “Every state right now is having budget shortfalls ….It's not mismanagement or any fault or anyone budgetary or miscalculations that way. I think it's just the fact that there are so many people who need it….” [7]

One legislator believed that enrollment caps on the program may occur due to budget problems but then added that Wisconsin has a history of maintaining services despite fiscal problems: “I believe that federal assistance is absolutely critical to sustaining the expanded enrollment under BadgerCare Plus…BadgerCare Plus enrollment might be capped (not necessarily cut) and we may be discussing eligibility requirements. [However,] Wisconsin was one of the few states that didn’t cut back Medicaid under previous budget pressures.” [6]

A department administrator also expressed optimism: “We are going to have to ride out a storm. We are a shock absorber and any economic downturn. It's a key part of why we exist. When people lose their job and they lose their health insurance through their employer, we're there to help make sure that they can keep getting their medications and that kids can see doctors and things like that. So we anticipate that we're going to be able to continue.” [1]

A legislator provided one answer to the sustainability problem: “Just keep going. We’ll find a way to make it work. [Have a] commitment not to cut people off of publicly funded assistance. Our answer is maybe to slow the growth of programs that haven’t been fully implemented – pilot programs.” [22]

ATTACHMENT A: LIST OF PERSONS INTERVIEWED

Interviews Conducted by Thomas Oliver, Principal Investigator

Interviewee	Organization
Joanne Alig	Wisconsin Association of Health Plans
Steve Brenton	Wisconsin Hospital Association
Angie Dombrowicki + *follow-up*	WI Department of Health Services
Charity Eleson	Wisconsin Council on Children and Families
Jason Helgerson + *follow-up*	WI Department of Health Services
Kelly Johnson-Becker	Office of Senator Jon Erpenbach, State Legislature
Jim Jones	WI Department of Health Services
Kathy Kaelin	Automated Health Systems
Lou Kelsey	Eau Claire County Healthwatch
Dianne Kiehl	Business Health Care Group
Kari Mattson	Community Advocates/Milwaukee County Healthwatch
Danyel McNeil	City of Milwaukee Health Department
Bobby Peterson	ABC for Health
Senator Judy Robson	State Legislature
Bill Smith	Wisconsin Federation of Independent Business
Dr. Susan Turney	Wisconsin Medical Society
Jim Vavra + *follow-up*	Department of Health Services

Interviews Conducted by Emma Hynes, Project Assistant

Interviewee	Organization
Edward Kamin	Milwaukee/Kenosha County Eligibility Expert
Mike Rust	Polk County Eligibility Expert
Lindsay Schwarz	LaCrosse County Eligibility Expert

Interviews Conducted by External Organizations

Interviewee	Organization	Organization Conducting Interview
Angie Dombrowicki	WI Department of Health Services	Georgetown Center for Children and Families
Jason Helgerson	WI Department of Health Services	RWJ State Coverage Initiatives Program
Rep. Kitty Rhoades	State Legislature	National Academy for State Health Policy (NASHP)
Rep. Jon Richards	State Legislature	National Academy for State Health Policy (NASHP)

List of Invited and Completed Interviewees

Invited but not Interviewed		
Patsy Beining	Benefits Specialist	Marshfield Clinic Owen Dental Center
Chuck Benedict	State Representative	Wisconsin State Assembly
Wayne Corey	Executive Director	Independent Business Association
Alberta Darling	State Senator	Wisconsin State Senate
Cheryl DeMars	CEO	Employer Health Care Alliance
Stephanie Harrison	Executive Director	Wisconsin Primary Health Care Association
Ted Kanavas	State Senator	Wisconsin State Senate
Mary Lazich	State Senator	Wisconsin State Senate
John Meurer	Pediatrician	Medical College of Wisconsin
Mark Miller	State Senator	Wisconsin State Senate
R.J. Pirlot	Government Affairs	Wisconsin Manufacturers and Commerce
Gail Sumi	Government Affairs	AARP-Wisconsin
Joy Tapper	Executive Director	Milwaukee Health Care Partnership
Lena Taylor	State Senator	Wisconsin State Senate
Karen Timberlake	Secretary	WI Department of Health Services
Leah Vukmir	State Representative	Wisconsin State Assembly
Invited and Interviewed		
Kari Mattson	Coalition Coordinator	Community Advocates/Milwaukee County Healthwatch
Bobby Peterson	Executive Director	ABC for Health, Inc.
Steve Brenton	President	Wisconsin Hospital Association
Angie Dombrowicki	Director	Bureau of Enrollment Management
Charity Eleson	Executive Director	Wisconsin Council on Children and Families
Jason Helgerson	Medicaid Director	WI Department of Health Services
Jim Jones	Deputy Mcaid Dir	WI Department of Health Services
Kathy Kaelin	Government Affairs	Automated Health Systems
Diane Kehl	Executive Director	Southeast Wisconsin Business Health Care Group
Lou Kelsey	Benefits Specialist	Eau Claire County Healthwatch
Kitty Rhoades	State Representative	Wisconsin State Assembly
Judy Robson	State Senator	Wisconsin State Senate
Bill Smith	Wisconsin State Director	Wisconsin Federation of Independent Business
Susan Turney	CEO/Executive Vice President	Wisconsin Medical Society
Jim Vavra	Director	WI Bureau of Benefit Management
Edward Kamin	County Elig Expert	Milwaukee County
Mike Rust	County Elig Expert	Polk County
Lindsay Schwarz	County Elig Expert	LaCrosse County
Invited and Represented by Staff in Interview		
Bevan Baker	Milwaukee Health Commissioner	City of Milwaukee Health Department
Jon Erpenbach	State Senator	Wisconsin State Senate
Nancy Wenzel	Executive Director	Wisconsin Association of Health Plans

ATTACHMENT B: INTERVIEW REQUEST LETTER

Dear [Name of Potential Interviewee],

In partnership with the Wisconsin Department of Health Services, the University of Wisconsin Population Health Institute is conducting an evaluation of the early development and implementation of the Wisconsin BadgerCare Plus program, the state's most recent effort to expand health insurance coverage to low and moderate income residents. The evaluation research is supported in part by a grant from the Robert Wood Johnson Foundation, through its State Health Access Reform Evaluation program.

To better understand the context of BadgerCare Plus and early data on program performance, we are seeking to interview a wide range of individuals who have participated in, or closely observed, the development of the program. We are interested in understanding both what aspects of the program are working well and areas for improvement. In addition, we are interested in identifying the key factors influencing the early performance of the program. Our interviews will include officials from the legislative and executive branches of state government, county agencies, and representatives of beneficiaries, employers, health plans and providers involved in the implementation process.

I am writing to request the opportunity to interview you as part of this evaluation, which we hope will guide efforts to make BadgerCare Plus as accessible, effective, and efficient as possible. I expect the interview would take a maximum of one hour, with no preparation required on your part. It would take place in your office or another place you designate. (We can do the interview by phone if an in-person meeting is not possible.) I would like to audio record the session as a more complete account of the discussion. All interview notes and recordings will be kept secure and confidential.

Emma Hynes, a project assistant at the Population Health Institute who is working with me on the evaluation, will contact your shortly to confirm your willingness and availability to participate in this important study. I greatly appreciate you giving this request favorable consideration and look forward to an interesting and valuable discussion.

Yours sincerely,
Tom Oliver

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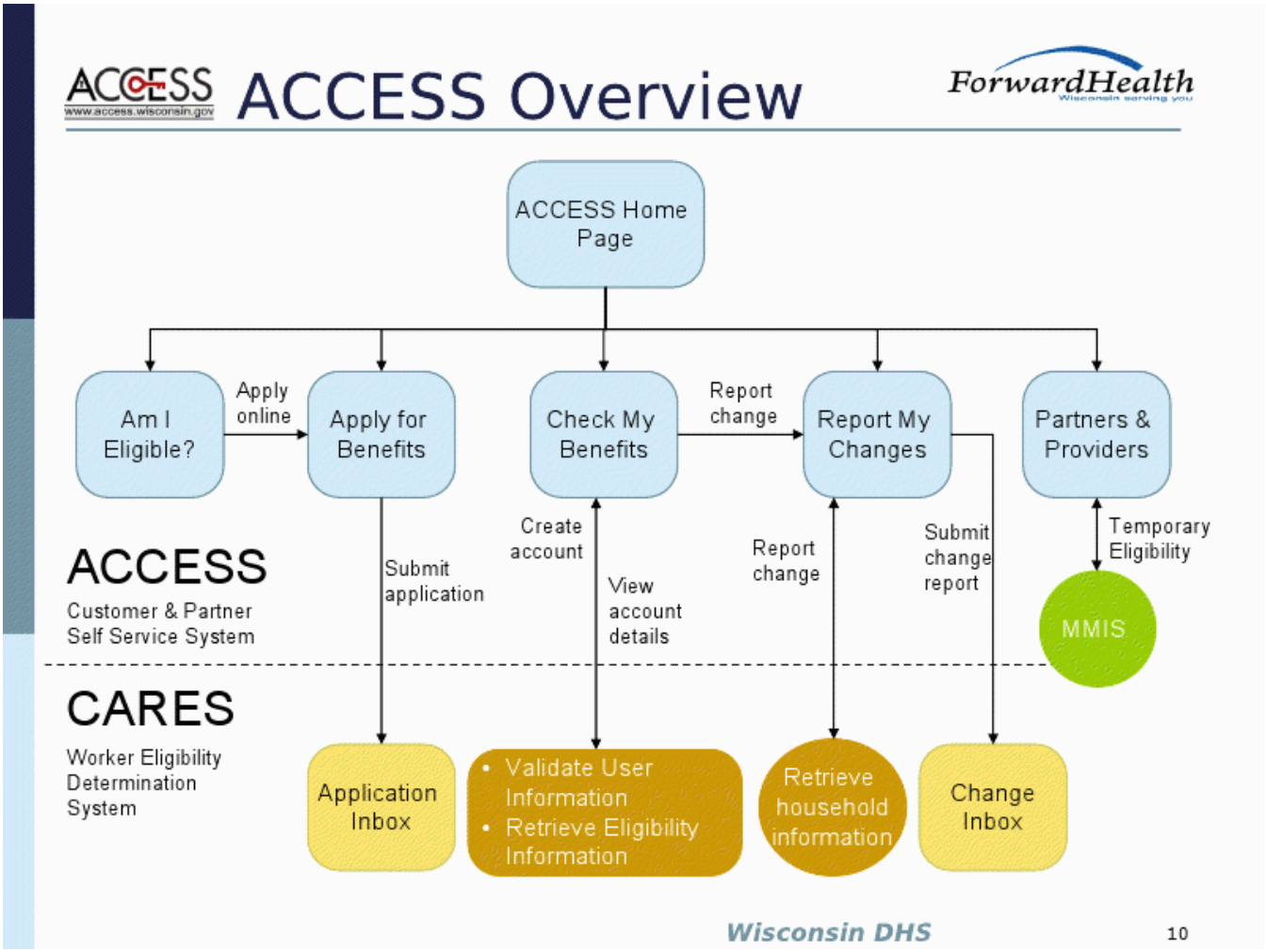
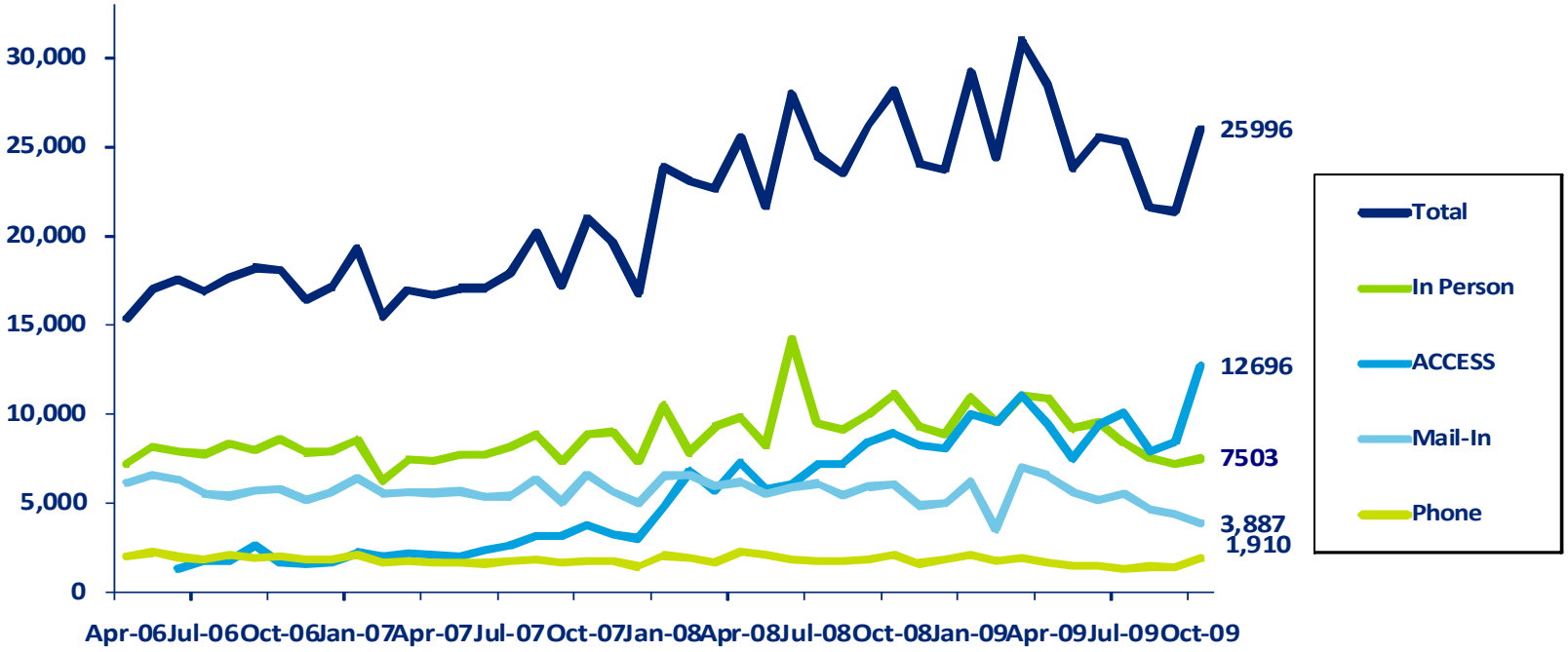
ATTACHMENT C: OVERVIEW OF ONLINE APPLICATION PROCESS



Reproduced from powerpoint provided by the Wisconsin Department of Health Services

ATTACHMENT D:
HEALTH CARE, FOODSHARE AND FAMILY PLANNING WAIVER PROGRAM
REQUEST FOR ASSISTANCE COUNTS BY CONTACY METHOD



Reproduced from powerpoint slides detailing the Complete ACCESS Utilization Report created by the Wisconsin Department of Health Service. This slide is from the August 2004 to October 2009 powerpoint.

ATTACHMENT E:
FOODSHARE CASELOAD RECIPIENTS
[January 2008 to October 2009]

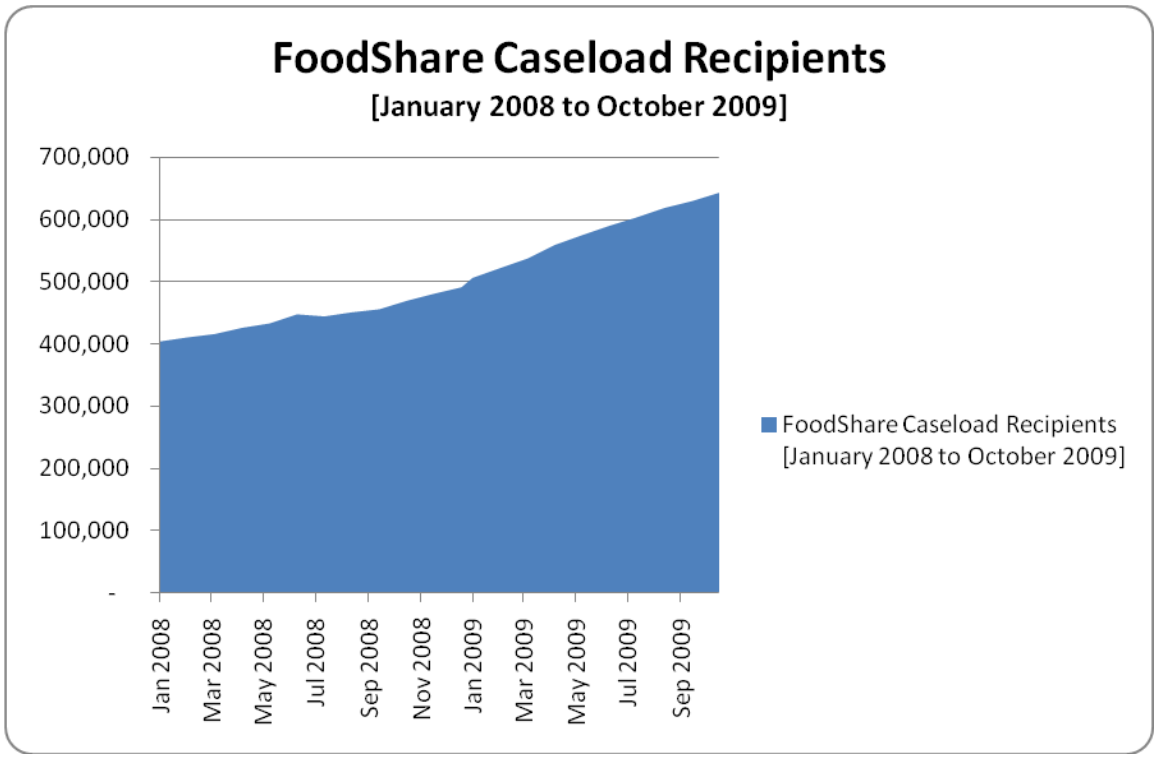


Chart created from data provided by the Wisconsin Department of Health Services

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Emma Hynes and Tom Oliver
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