Milbank Memorial Fund

The Origins and Implementation of BadgerCare:
Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP)

By Coimbra Sirica

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FOREWORD

This report describes the history of BadgerCare, a program in Wisconsin that since 1999 has provided health insurance to working parents with low incomes and their children. Parents are covered by Medicaid, children under the State Children's Health Insurance Program (SCHIP) enacted by the U.S. Congress in 1997.

By November 2000, Wisconsin under the leadership of Governor Tommy G. Thompson had enrolled almost 95 percent of all uninsured children in families with incomes up to 200 percent of the federal poverty level in either BadgerCare or Medicaid. During the same period, many other states experienced difficulty in enrolling children in SCHIP. Some states may lose a portion of the federal funds granted to them for the program. As a result, the premise of BadgerCare is attracting national attention. That premise, simply stated, is that adults with health insurance are more likely to seek coverage for their children.

This report describes how leaders in Wisconsin developed and implemented BadgerCare. Because the program uses both state and federal funds, Wisconsin officials and their counterparts in the federal Health Care Financing Administration had intense discussions about the interpretation of federal law and regulation. To their credit, they reached sufficient consensus to enable the program to go forward.

The Milbank Memorial Fund is an endowed national foundation that engages in nonpartisan analysis, study, research and communication on significant issues in health policy. Staff of the Fund followed the development of BadgerCare in conversations with officials in the legislative and executive branches of government in Wisconsin. After the program was implemented, the Fund asked these officials if they would give a journalist access to information necessary to write this report with the understanding that, although they would review the report in draft, the author and the Fund would make the final decision about its accuracy and fairness.

We thank the leaders in Wisconsin who granted interviews and provided documents to Coimbra Sirica and then reviewed a draft of the report. Their names are listed in the Acknowledgments.

Daniel M. Fox
President

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EXECUTIVE SUMMARY

In July 1999, Wisconsin's governor, Tommy G. Thompson, formally launched BadgerCare, its version of the federal government's $40-billion State Children's Health Insurance Program (SCHIP), also known as Title XXI of the Social Security Act. Despite a late start, Wisconsin succeeded in enrolling such a large proportion of the state's uninsured low-income children that policymakers in other states took notice.

What became BadgerCare had its origin in Governor Thompson's long-standing interest in making health care affordable for low-

income working families. The governor had expressed his interest from the time he served as a state legislator. The governor's Wisconsin Works ("W-2") program included a health care plan to replace Medicaid for families leaving welfare to enter the workforce. However, the federal Health Care Financing Administration (HCFA) did not approve the waiver that would permit the plan to operate.

Even before SCHIP was enacted in 1997, Governor Thompson directed the Department of Health and Family Services to design a family health care plan. In the summer of 1997, the governor asked the department to expand that plan to include funds from both SCHIP and Medicaid. Staff of the department conducted research and analysis and began to draft a waiver request to HCFA. After staff of the department developed an outline of the plan, legislators, state and local officials, and academics joined the planning process. These advisors added details and helped to achieve bipartisan support for the final plan that the governor approved and forwarded to HCFA.

BadgerCare began with a small group of about 3,400 adolescents who had been enrolled in the spring of 1999, under new Medicaid rules that allowed the coverage of children born after September 1983 with a family income of no more than 100 percent of the federal poverty level. By Novemer 2000, enrollment in BadgerCare, including additional Medicaid children, had increased to 51,172.

No adults were allowed insurance coverage under the new federal program, but Wisconsin used a mixture of state and other federal funds to open BadgerCare to low-income uninsured parents as well. Almost 95 percent of the 54,000 low-income uninsured children the state targeted have now been enrolled in BadgerCare, and state officials say the children are on the rolls because the program also covers parents, a group that was specifically left out of the 1997 legislation by which the U.S. Congress created SCHIP.

There are indications that Wisconsin's experience with offering insurance coverage to low-income uninsured families may become increasingly relevant to both state and federal policymakers. In September 2000, the President's Council of Economic Advisors noted that "direct provision of health insurance through public programs is the most efficient way of targeting low-income families." President Bill Clinton in early 2000 proposed a national insurance program for low-income families, and legislation introduced in Congress in July 2000 would allow states to use SCHIP funds to cover parents. HCFA officials say they are considering a number of waiver requests that would allow states to experiment with using SCHIP funds to cover low-income parents.

In the 15 months that followed the August 1997 passage of the SCHIP legislation, Wisconsin was not able to convince the federal government to let the state use SCHIP funds to cover parents, but in January 1999, HCFA did allow a waiver of Medicaid (also known as Title XIX) that increased the amount of money low-income parents could earn and still be covered under the federal program. Families can now enroll if they have net incomes up to 185 percent of the federal poverty level, or about $31,000 for a family of four, and they can remain on the rolls if their incomes rise to as much as 200 percent of the poverty level.

Policymakers around the country have been impressed by the BadgerCare program, because it offers enrollees one of the most comprehensive benefit packages in the nation and has until now successfully resisted "crowd-out," a phenomenon in which the government-sponsored program, because it is cheaper, becomes a preferred alternative to private insurance coverage. Another aspect of the BadgerCare program that has drawn interest is an option in which the state "buys into" private group health insurance, paying an employee's share of the premium in cases where the employer offers a high-quality insurance plan and pays between 60 and 80 percent of the premium.

Because of the high number of low-income uninsured children newly enrolled in BadgerCare and Medicaid—51,172 children through November 2000—the state's outreach and enrollment efforts have been of particular interest, as have its efforts to address high costs and greater-than-budgeted enrollment increases while maintaining political support for the program.

The BadgerCare program has proved more expensive than originally projected. In addition to bringing in more enrollees than budgeted, outreach for BadgerCare has attracted parents, whose coverage costs more per enrollee than children. (BadgerCare and Medicaid costs for parents appear to be similar, or slightly less for BadgerCare.) Also, almost half the children screened for BadgerCare have turned out to be eligible for Medicaid, dramatically increasing the state's Medicaid program.

Wisconsin legislators may approve a bill to provide the additional money needed to cover the unanticipated costs and keep BadgerCare running through June 2001, the end of the state fiscal year. State legislators are awaiting decisions by the federal government that will affect how much of the burden the state will have to bear.

Wisconsin is apparently close to obtaining a waiver from HCFA that would allow the state to cover low-income parents with its current and future SCHIP allocations. The debate had centered on whether the original legislation, passed as part of the 1997 Balanced Budget Act, can be interpreted to allow coverage of parents. HCFA has asked the state to show that it is making every possible effort to enroll children, a condition of the waiver's approval.

Wisconsin's negotiations to obtain a waiver of Title XXI are not unusual, as many states are trying to navigate the relatively new waiver process that HCFA administers. The story of BadgerCare illustrates the political and policy issues that must be addressed as states work to implement innovative health policy.

INTRODUCTION

Participants in the process that gave birth to BadgerCare—Wisconsin's health care program covering low-income children and their uninsured families—say that Wisconsin's state and federal legislators, regardless of party affiliation, agreed from the start on

the program's importance. "Differences were matters of degree, not substance," noted Republican State Senator Peggy Rosenzweig. "Democrats and Republicans in Wisconsin were equally committed to getting the necessary waivers from the Clinton administration." In a recent interview, Rosenzweig and David Riemer, director of the City of Milwaukee Department of Administration, described BadgerCare as "the triumph of the middle over the extremes."

The united front that the Wisconsin congressional delegation presented to the U.S. Department of Health and Human Services (HHS) illustrates the single-mindedness of the state's policymakers. On April 24, 2000, all of Wisconsin's federal legislators—seven Democrats and four Republicans—signed a letter asking HHS Secretary Donna Shalala to approve a Title XXI waiver that would allow the state to cover parents as well as children.

"HHS has received data on the success of Wisconsin's BadgerCare program, and knows the great value of a family-based coverage model in addressing the needs of low-income uninsured populations," wrote the Wisconsin lawmakers. "Wisconsin has demonstrated its commitment to BadgerCare through hard work and state funding, and is working to further increase state funding for the program."

Some of the support that the program has in Wisconsin seems rooted in state residents' pride in Wisconsin's history of being at the forefront of progressive social policy in the United States, but some support seems to have grown out of fear of potential rips in the safety net. Following Wisconsin's widely reported experiment with welfare reform, the state's Medicaid rolls showed a steep decline. Of all the states, Wisconsin's Medicaid rolls registered the sharpest decreases in percentage terms: from 1995 through 1997, 29 percent of the caseload, or 76,000 people, left or were dropped from the state's Medicaid rolls. In mid-1997, however, the state began an aggressive outreach program (the precursor to its campaign to enroll low-income families in BadgerCare), and this trend began to reverse itself in 1998.

THE ORIGINS OF BADGERCARE

Although BadgerCare has been influenced by stakeholders who represent a variety of geographical and political interests, Governor Thompson had a strong interest in making health care affordable for low-income working families since his service in the state legislature. He had proposed a health care plan to replace Medicaid for families leaving welfare to enter the workforce in 1995 as part of Wisconsin Works (nicknamed W-2). Once the federal government denied that plan, the governor directed state officials to develop a plan that would be approved.

"Everyone gets credit," said Linda Reivitz, a University of Wisconsin researcher and professor who was Secretary of Health and Family Services under the state's last Democratic administration and who advised in the design of what became BadgerCare and promoted it to Democratic legislators. "The Thompson administration did very well. They roped in all the people who would support BadgerCare—everybody from the Chamber of Commerce to the advocacy groups. They said we need help from everyone to get this through the Feds."

On August 5, 1997, the U.S. Congress passed the federal Balanced Budget Act, which included the ten-year, $40-billion State Children's Health Insurance Program. The purpose of this program, also known as Title XXI of the Social Security Act, was to expand health insurance for uninsured low-income children. But the origins of BadgerCare can be found earlier, in Wisconsin's efforts to provide supportive services to the people it was trying to ease off welfare.

Wisconsin, a state with just over 5 million residents, began its efforts toward welfare reform in 1987. Over the next ten years, its AFDC (Aid to Families with Dependent Children) caseload declined from 287,488 to 94,802. When Governor Thompson introduced W-2 in 1995, it was "the culmination of a decade of welfare experimentation that transformed the motif of social assistance in the state from income maintenance to help to work," in the words of Michael Wiseman, a senior fellow with the Urban Institute.

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act, which replaced AFDC with Temporary Assistance for Needy Families (TANF), an action that severed the link between Medicaid and welfare and ended the entitlement to cash assistance for low-income families. Wisconsin was ready. In October 1996, it became one of the first states to implement a TANF program. The state requested a waiver from the Health Care Financing Administration (HCFA) that would have allowed it to transform its Medicaid program and implement a health services component of W-2, but the federal government denied the waiver.

"One of the flaws in W-2 was its health care plan," said David Riemer, who serves a Democratic mayor and has been closely associated with the state's welfare reform efforts. "Under TANF, Wisconsin did not need a waiver, except for the health care piece."

The W-2 health plan would have done away with insurance for anyone with an income higher than 165 percent of the poverty level—even pregnant women and children under the age of six. It would also have denied state health insurance to anyone whose employer paid at least 50 percent of the cost of the insurance. Anyone participating in the program would have had to pay a premium and to accept services that were not as comprehensive as those that were offered under Medicaid. At that time, a low-income parent had to be very poor to be covered by Medicaid in Wisconsin. Some poor children were covered by Medicaid's Healthy Start program, which insures young children with family incomes up to 185 percent of the federal poverty level, but a parent could be insured under Healthy Start only if she were pregnant. And Medicaid covered other parents only if they earned less than 60 percent of the poverty level in combined income from any source.

HCFA rejected the W-2 health plan because, some sources say, it was not comprehensive enough. At the governor's request, Joe Leean, Wisconsin's current secretary of Health and Family Services, and his staff began to meet with other key officials and

policymakers in the state to discuss how best to resolve the impasse with the federal government.

In the midst of Wisconsin's efforts to come up with a more palatable health care plan, the U.S. Congress approved SCHIP and appropriated $4.2 billion a year to the program for 1998 and 1999. Wisconsin's share in the first year was estimated at about $39 million. Despite the help of a number of well-connected Democrats and Republicans in Washington and Wisconsin, however, almost two years elapsed before Wisconsin obtained a federal waiver and was able to launch BadgerCare.

At the direction of the governor, staff of the Department of Health and Family Services revised the state's approach and created a proposal, presented to federal officials in July 1997, that would use Medicaid funds to cover low-income parents and children. That proposal was modified in the fall of 1997 to take advantage of funds available under SCHIP. At the same time, Riemer, David Kindig, who is a professor of preventive medicine at the University of Wisconsin, and two other academics began independently to develop a plan for covering low-income families, which they submitted to Secretary Leean. This plan paralleled and supplemented work of department staff. Hence Leean turned to a "kitchen cabinet" of academics, state officials, and local legislators to hammer out a plan that might be acceptable to the federal government and to legislators in both parties.

DESIGNING BADGERCARE

State officials chose not to start a separate program to insure children under the SCHIP legislation. They decided instead to make BadgerCare an expansion of Medicaid in order to cover parents and to try to decrease the stigma associated with the traditional Medicaid program.

"If we had had to start out with a whole new system, it would have led to the paralyzing confusion we've seen in other states," said Peggy L. Bartels, administrator of the Division of Health Care Financing of Wisconsin's Department of Health and Family Services (DHFS). "Also, over half the families had someone in Medicaid, and we wanted families not to have to know what they were applying for. To them, it's all BadgerCare."

"One of our concerns was that different family members might have different benefit packages and even different providers," said Riemer. "There was broad consensus that we should make BadgerCare the same as Medicaid. "The real issue was the money, so we decided not to argue about the other things."

Nonetheless, there were discussions regarding how to define eligibility. Medicaid in Wisconsin had traditionally covered children over the age of six only if family income was less than 68 percent of the federal poverty level and nondisabled custodial parents only if they did not earn more than 55 percent of the federal poverty level. Pregnant women and children up to age six were covered if income did not exceed 185 percent of the federal poverty level. The planning group also debated the cutoff point for eligibility in terms of how much people could earn as well as what percentage of gross income recipients should pay if they earned more than 150 percent of the poverty level and how much of the premium employers should be paying before an employee would become ineligible for BadgerCare. In the end, administrators and the state legislature made the final decision. They compromised on 185 percent of the federal poverty level as the cutoff, but family incomes could increase to as much as 200 percent before recipients would become ineligible for the program.

"The makeup of the planning group was very important to bringing about legislative support," said State Senator Rosenzweig, whose Milwaukee district takes in both urban and suburban areas. "At the very outset, there was a coalition of moderates and conservatives, as well as representatives of the governor and his department [Health and Family Services]. We were trying to frame a plan that was driven by needs but also by politics. We wanted to make it so that people on both sides could go back to their colleagues and refer back to who was at the table when we started to shape the model. This gave us legitimacy from the very beginning."

Parents had been part of the mix, even in the initial W-2 proposal, according to DHFS administrator Bartels. But the importance of including parents in the program to ensure that eligible children would receive coverage had been reinforced by the findings of researcher Kenneth Thorpe, now at Emory University in Atlanta, who in a 1998 report suggested that family-based Medicaid expansions can increase the percentage of children enrolled in the program.

FEDERAL CONSTRAINTS—POLITICS AND POLICY

The first plan for financing BadgerCare had envisioned doing so, in part, through a waiver of Title XXI that would allow the state to cover parents. An initial conversation between Secretary Leean and then—HCFA administrator Bruce Vladeck in mid-1997 led state officials to believe they were on the right track. They submitted a "concept paper" outlining their waiver request in September 1997, and in December, based on information obtained informally from HCFA staff, Governor Tommy Thompson announced an agreement with the federal government that would allow the launching of BadgerCare. Between December 1997 and June 1998, however, it became clear that HCFA was not comfortable with the state's request to include parents under Title XXI.

Then, in August 1998, HCFA told Wisconsin officials that their Title XXI waiver request had been denied. State officials responded angrily. "We've come to the conclusion [that HCFA officials] have misled us and misled those [BadgerCare] families," Bartels told the *Chicago Tribune* in an August 20 article.

Sally Richardson, who was director of HCFA's Center for Medicaid and State Operations until mid-1999, said that HCFA's decision was made out of concern that approval of Wisconsin's Title XXI waiver request would set an undesirable precedent, leading

federal legislators to question the agency's actions. According to Richardson, "The undesirable precedent was the concept that providing health insurance for families would violate [the intent of the legislation] that the cost for insuring families not exceed the cost of covering only children."

Richardson said that officials in many states find it hard to understand the federal perspective. "Wisconsin saw what we were doing as too rigid at the federal level. States don't recognize that if you set a precedent in one state that goes beyond what the law intends, then you are liable to do it for any state," she said. "I think it's difficult to explain that you cannot treat the states inequitably. . . . It was a long, hard negotiation, but what came out of it was pretty much what Wisconsin wanted—but done in ways that were feasible."

Richardson added that this sort of tension between state and federal interests is present in most interactions that involve federal funds, regardless of the state. "It is difficult to accommodate local circumstances and diversity when you are making federal policy, and at the state level you have to account for that diversity, so you get very frustrated when that big, monolithic policy machine can't be flexible enough to see things your way."

Richardson noted that HCFA only began granting Medicaid waivers in 1993 and that, despite the successes, there are still some "financial people" at the agency who worry that states will fail to use funds as intended by Congress or will use federal money to subsidize programs that should be paid for with state funds.

Despite state frustration with "that big, monolithic policy machine," Richardson said that "after 1993, you can begin to see that the flexibility has become increasingly visible. The use of waivers to accommodate state diversity is pretty phenomenal under the Clinton administration."

State officials and local policymakers on both sides of the aisle say that politics may have played a role in blocking approval of the Title XXI waiver for so long. Some of them believe that the Clinton administration was reluctant to further a program so closely associated with Wisconsin's Republican governor. Rep. Tom Barrett, a Democratic Wisconsin congressman, countered that the problem lay in SCHIP's language and Congress's intent in passing the law, which clearly directs states to use the funds "to initiate and expand the provision of child health assistance to uninsured low-income children."

"That was the only legislation the [Clinton] administration could get through the Republican Congress," said Barrett, who reportedly played a key role in obtaining unanimous support for the state's waiver request from the Wisconsin congressional delegation.

Though the Title XXI waiver had been denied, on January 22, 1999, after 15 months of negotiations, HCFA did give Wisconsin permission to cover parents through a Medicaid (Title XIX) waiver that would allow them to enroll low-income parents who earned no more than 185 percent of the federal poverty level. One of the sticking points, however, was the state's concern that a waiver under Title XIX, which is an entitlement, would force Wisconsin to raise the eligibility level for Medicaid permanently. The state therefore preferred a waiver of Title XXI, which is not an entitlement and which reimburses the state at a higher rate than does Medicaid. Therefore, when HCFA granted the Title XIX waiver, the agency consented to allow Wisconsin's legislature to have an "enrollment trigger," which would impose lower income limits for applicants if the state ran out of money after reaching the projected enrollment. State officials had committed themselves, however, to continue to cover anyone who was already signed up for BadgerCare if income limits were rolled back.

"The debate over the cap was going on behind the scenes," said Bartels. "The administration here did not want a program that would lead to an open-ended fiscal responsibility. The White House wanted a Medicaid entitlement. The compromise we reached was a capped Medicaid entitlement, which neither side wanted to claim victory for or point fingers over." She noted, however, that the Thompson administration had assured Democrats in and out of the state that "if it looks like we need money for more enrollment, we will go back to the [state legislature] and ask for that money."

HCFA's Richardson said that, before granting the Title XIX waiver, the federal agency has assured itself that no one would be disenfranchised by changes to the program, that the changes would not set a precedent that would undermine the national program, and that the waiver would be "budget neutral"—in other words, that it would not make the program more expensive to the federal government than it would have been without the waiver.

"The most difficult part was the budget neutrality," Richardson said. "That is always the most difficult part of any waiver we negotiate. We had to agree on a baseline of expenditure, and the state had to demonstrate that what they would spend would be no greater than what they would have spent without the waiver. . . . It was a matter of both sides coming to believe that they were as close to 'best estimates' for the future as they could reasonably come."

The Title XXI waiver was not a dead issue, however. Undaunted by its first, failed effort and armed with a year of experience, in March 2000 the state again asked for a waiver that would allow Wisconsin to use its SCHIP funds to cover the cost of insuring low-income uninsured parents. To support the state's request, Bartels and her colleagues pointed to President Bill Clinton's January 2000 announcement that he would request funding for a program to insure families as a way to reach more children. In their waiver request, Wisconsin officials also noted that the federal government's slow response to the state's original waiver request had delayed the full implementation of BadgerCare by more than a year. (For a chronology of events, see box.)

Chronology of Events

October 1996	U.S. Congress passes Personal Responsibility and Work Opportunity Reconciliation Act, replacing AFDC with TANF (Temporary Assistance for Needy Families). Wisconsin becomes one of the first states to gain approval of its TANF program, Wisconsin Works (W-2).
November 1996	Federal Health Care Financing Administration (HCFA) denies the state's Title XIX waiver request for its W-2 health care plan.
August 1997	Wisconsin officials from Madison and Milwaukee meet with HCFA Administrator Bruce Vladeck to discuss design of proposed W-2 health care plan. U.S. Congress passes the federal Balanced Budget Act, creating a $40-billion SCHIP program, Title XXI of the Social Security Act.
October 1997	Wisconsin state legislature incorporates funding for BadgerCare as amendment of delayed biennial budget for 1997–1999.
December 1997	Wisconsin Governor Tommy Thompson, based on information received informally from HCFA staff, announces agreement for Title XXI waiver, which will allow parents to be covered with SCHIP funds.
August 1998	HCFA denies Wisconsin's Title XXI waiver request.
January 1999	HCFA grants a waiver of Title XIX that allows Wisconsin to raise the Medicaid eligibility level for low-income parents to 185 percent of federal poverty level.

Chronology of Events (continued)

April 1999	Enrollment in BadgerCare begins under a 1993 Medicaid expansion for low-income teenagers whose families earn no more than 100 percent of the federal poverty level.
July 1999	Enrollment begins in BadgerCare for all other eligible parents and children.
January 2000	Wisconsin's State Legislative Fiscal Bureau reports that the state's reimbursement rate to HMOs for BadgerCare recipients is far below the costs they must pay to provide care.
March 2000	The state agrees to raise HMO per-person payments for BadgerCare recipients by 12 percent. Wisconsin again submits a waiver request for Title XXI to allow the state to cover parents with SCHIP funds.
September 2000	Wisconsin and approximately 20 other states prepare to lose unspent SCHIP funds unless the U.S. Congress takes action to allow the states to keep at least a portion of those funds.

The Thompson administration gained a major ally in Washington in early 2000, when Wisconsin Democratic congressman David Obey agreed to sign the Wisconsin delegation's letter to HHS Secretary Shalala, urging her to support the state's new Title XXI request. Before doing so, Obey reportedly wanted assurances that the state was committed on a long-term basis to the BadgerCare program. "He agreed to sign the letter because the state assured us that they would lose a significant amount of federal funds without the waiver and that they will step up their efforts to find more kids," said an Obey staff member. "We do not want to cover parents at the expense of kids. We have asked the secretary [of HHS] to make sure this does not happen."

In 1999, as part of the congressional budget negotiations, Obey had succeeded in obtaining a $15 million appropriation for HHS that will be used to help 11 states develop models for providing insurance coverage to residents who now lack it. Wisconsin, a state with a fairly low percentage of uninsured residents (4 percent), received a federal grant of $1.3 million in September 2000.

As of this writing, Wisconsin's second Title XXI waiver request is still pending, and the outcome is uncertain. Interviews with Capitol Hill staff indicate that HCFA officials did indeed have grounds for their past concern that federal legislators would resist a Title XXI waiver that would allow Wisconsin to cover parents. "It's not like we are talking about legislation that was passed 50 years ago," said a staff member of the majority leadership, who asked not to be identified. "We specifically set the program up for children. Everyone who designed that legislation is still here, and they are going to say that covering parents was not our intention. There would definitely be a strong reaction."

FINANCING ISSUES

Wisconsin has a sizable budget for BadgerCare to cover the years 1999 through 2001: $56.6 million in state funding and $101.8 million in federal funding. But because of Title XXI regulations, about 20 states, including Wisconsin, were expecting to lose a total of $1.9 billion in September 2000. The Title XXI legislation gives each state three years to spend its SCHIP allocation for a given year; if it does not do so, the funds "lapse," which means they revert to the federal government for distribution among states that have spent their SCHIP funds. Wisconsin was anticipating losing $18.3 million in September 2000, $13.7 million in September 2001, and $13.7 million in September 2002. It was possible that this might change, however, as negotiations were under way that, if successful, would allow the states more time to spend a reported 60 percent of their lapsed grants. Moreover, as reported above, HCFA was still considering granting Wisconsin a Title XXI waiver that would allow the state to use future SCHIP funds to cover parents. At this writing, Congress had returned for a lame duck session that would determine the outcome of these and other

components of the fiscal year 2001 federal budget.

The need for additional funding is particularly acute in Wisconsin because of unanticipated costs discovered after BadgerCare had been implemented. It cost more to cover parents than had been expected, and they signed up in greater numbers—45,679, rather than the approximately 25,000 adults the state had originally projected for HCFA. Other reasons that more funds are needed include the large number of Medicaid-eligible children enrolled as a result of BadgerCare outreach efforts and the fact that many new BadgerCare enrollees are in fee-for-service programs, where services cost more than in HMOs. Between 1999 and 2001, the state will have spent an additional $20.5 million in Medicaid alone, for children found eligible when their families applied for BadgerCare.

Wisconsin DHFS administrator Bartels noted that the cost of the new enrollees will be known only after the state has analyzed utilization data and accounted for the time lag between when services are provided and when claims are paid. "Sufficient time is needed to gather enough data to make accurate statements about costs for the entire BadgerCare population," Bartels said.

An HMO official with experience in Medicaid said that her company discovered that the influx of parents into BadgerCare doubled —and in some cases tripled—per capita costs for pharmaceuticals for BadgerCare adult enrollees, as compared to the adult population traditionally covered by Medicaid. The repercussions of these unexpectedly high costs are already being seen: for example, Compcare Health Services Insurance Corporation, a Milwaukee HMO, decided to stop participating in BadgerCare after realizing how much it cost to care for adults. "The demographics of BadgerCare are very different from those of Medicaid before BadgerCare," said Coreen Dicus-Johnson, contract manager at Compcare. "Medicaid had been comprised of people with an average age of 11 or 13. Now we were looking at 26 or 27 as an average age. Our concern is that the rates that were being offered to cover this block of business were not adequate."

Other HMOs agreed that the newly enrolled adults cost more to cover, but they were willing to stay on board after the state offered a 12 percent per capita increase (or 8 percent with participation in a risk pool) in March 2000. For fiscal year 2000 (July 1–June 30), the per member per month capitation rate for all BadgerCare HMO enrollees—adults and children—was $131.56. For the same year, the per member per month capitation rate for Medicaid/Healthy Start was $120.98.

"The HMO industry and the state Department of Health and Family Services have long had a cooperative relationship, and we supported the BadgerCare initiative," said Nancy Wenzel, executive director of the Wisconsin Association of Health Plans. "As this program evolves, new issues are discovered and new solutions will have to be developed. The program is not really a year old, so we agreed that we are going to work with the state, and we agreed that we still have some concerns about what the actual cost of care will be. We also agreed that it is early in the process and very difficult to absolutely project what the costs will be."

For purposes of comparison with the BadgerCare capitation rates, table 1 lists the latest survey results of commercial health insurance premium rates from the Wisconsin Office of the Commissioner of Insurance. These rates assume a $250 deductible and a maximum of $750 per year in coinsurance/copayments, according to sources at Wisconsin's Department of Health and Family Services, Division of Health Care Financing.

Table 1. Monthly Health Insurance Premium Rates (Single Coverage)

	JAN '94	JAN '95	JAN '96	JAN '97	JAN '98	JAN '99	JAN '00
Group 1. 25 employees (Milwaukee)							
Minimum	$146.56	$133.13	$153.95	$161.60	$160.76	$166.50	$183.06
Maximum	196.56	221.59	245.31	220.65	261.67	259.54	332.93
Average	**$171.56**	**$174.69**	**$191.83**	**$198.43**	**$209.65**	**$209.98**	**$252.44**
Group 2. 75 employees (Milwaukee)							
Minimum	$138.79	$132.68	$142.71	$152.19	$157.08	$140.97	$177.04
Maximum	182.65	204.07	225.90	215.36	252.82	259.54	276.98
Average	**$159.37**	**$163.59**	**$180.21**	**$189.95**	**$197.86**	**$195.04**	**$224.02**
Group 3. 75 employees (Wisconsin Rapids)							
Minimum	$120.35	$112.71	$140.92	$141.40	$132.73	$139.37	$142.85
Maximum	142.20	147.92	164.30	171.36	211.67	209.47	238.70
Average	**$132.40**	**$136.19**	**$153.95**	**$158.33**	**$170.00**	**$179.54**	**$202.27**

Wisconsin's policymakers seem willing to appropriate the extra $15 million that Secretary Leean is requesting in order to cover costs the state had not included in its original BadgerCare budget—the 12 percent per capita rate increase and the unexpected increase in the number of enrollees. But the legislature is arguing over who should control the process, according to Wisconsin Senate and Assembly leadership staff. Each house has passed its own legislation supporting continued and increased funding for BadgerCare, but legislators adjourned the 2000 session without passing a final bill. Leean said that the Wisconsin legislature will again take up the question of funding for BadgerCare in January 2001, when the state will run out of money to fund the program. He noted that HCFA's approval of the Title XXI waiver request would make it easier to sell state legislators on increasing funding, though he added that the federally sanctioned enrollment trigger will also help, since it allows the state to begin enrolling fewer people by lowering the income level at which they become ineligible. "I have the authorization to limit enrollment if I am going to run out of money," Leean said. "But no one wants me to do that. There is a lot of bipartisan support for this program."

Table 2 shows the projected costs of covering parents and children under BadgerCare. These data, which the state of Wisconsin provided to HCFA as part of the latest effort to obtain a waiver of Title XXI, project costs both with and without the waiver. (The state fiscal year [SFY] is from July 1 through June 30.)

Table 2. BadgerCare Funding and Enrollment

	WISCONSIN ACT 9 BUDGETED FUNDING AND ENROLLMENT		ACTUAL AND PROJECTED FUNDING AND ENROLLMENT WITHOUT TITLE XXI WAIVER		PROJECTED FUNDING WITH TITLE XXI WAIVER[a]	
	SFY 2000	SFY 2001	SFY 2000	SFY 2001	SFY 2001	SAVINGS/REVENUE
Funding						
State Funding[b]	$22,356,500	$34,218,300	$24,421,418	$47,153,382	$43,805,320	$(3,348,062)
Federal Funding	40,033,563	61,758,131	40,376,918	84,914,782	88,262,844	3,348,062
BadgerCare Premiums	1,199,300	1,660,200	1,265,235	1,763,310	1,763,310	0
Total Funding	**$63,589,363**	**$97,636,631**	**$66,063,571**	**$133,831,474**	**$133,831,474**	**$0**
Enrollment						
Children	23,383	24,787	18,228	22,991	22,991	
Parents	38,152	42,748	47,068	58,481	58,481	
Total	**61,535**	**67,535**	**65,296**	**81,472**	**81,472**	

	FUNDING FOR ADDITIONAL BADGERCARE, OBRA, AND MEDICAID CHILDREN JULY 1999–JUNE 2000			
	BADGERCARE	OBRA	MEDICAID	TOTAL
State Funding	$5,762,339	$2,493,161	$5,200,000	$13,455,500
Federal Funding	8,110,132	3,508,968	8,813,600	20,432,700
Premiums	629,502	N/A	N/A	629,502
Total	**$14,501,973**	**$6,002,129**	**$14,013,600**	**$34,517,702**
Enrollment				
June	18,182	4,175	16,211	38,568
August	19,280	3,943	20,012	43,235

[a] Assumes a Title XXI waiver start date of October 1, 2000.

[b] Biennial budget deficit totals $15 million in state funds.

IMPLEMENTING BADGERCARE

The first group of BadgerCare enrollees—all low-income uninsured teenagers—became eligible to receive health care services on April 1, 1999, when Wisconsin opted to include children born after September 1983 in Medicaid, as long as their families earned no more than the federal poverty level. Other children and their parents who were eligible under Title XXI and under Title XIX and the Title XIX waiver began to receive coverage as BadgerCare recipients on July 1, 1999.

When the plan for BadgerCare was completed and had been approved by the various branches of the state government, it included the following components.

Benefits

Wisconsin provided low-income uninsured families with children in the BadgerCare program benefits identical to those provided under its Medicaid program. Medicaid recipients in Wisconsin receive one of the nation's most comprehensive benefits packages. It includes coverage for the services of medical social workers and chiropractors, nurse midwives, podiatrists, dentists, and optometrists as well as respiratory care and hospice care services. This benefits package was chosen as the model for BadgerCare for two reasons: first, because the state wanted to offer a comprehensive package of services and found only a marginal benefit in adopting the reduced benefit package allowed under federal law, and second, because adopting the Medicaid model made the administration of BadgerCare much easier. By integrating the programs, the state avoided having to make changes in its computer-based Medicaid Management Information System (MMIS). Also, providers and recipients were saved the confusion of figuring out who in a family should receive services covered by Medicaid and who should receive those covered by BadgerCare.

Service Delivery System

BadgerCare recipients participate in the managed care health services delivery system that is already in place to serve the state's Medicaid recipients. Like Medicaid recipients, enrollees in BadgerCare must enroll in an HMO if there are at least two in their service area. Otherwise, they are permitted to obtain health care through a traditional fee-for-service system. Fee-for-service often requires a copayment, however, as well as prior authorization for certain services. HMOs that have contracts to care for Medicaid recipients must also accept BadgerCare enrollees. Approximately 80 percent of Wisconsin Medicaid beneficiaries are signed up with HMOs, and it is expected that an equal percentage of BadgerCare enrollees will eventually participate in HMOs. Because the program was so new, only about 45 percent of BadgerCare enrollees were in the fee-for-service system as of mid-2000.

Avoiding Crowd-Out

Wisconsin uses several methods for avoiding "crowd-out," a phenomenon in which the government-sponsored program, because it is cheaper, becomes a preferred alternative to private insurance coverage, leading people to drop—or not to accept—coverage offered by their employers.

Before being able to apply for BadgerCare, a Wisconsin resident has to have been without coverage from any properly accredited health insurance plan during a three-month "look-back period." BadgerCare coverage is also denied to individuals who in the previous 18 months have had access to an insurance plan in which an employer pays 80 percent or more of the monthly premium.

Electronic Data Systems (EDS), a private company under contract to the state to act as its fiscal agent, has a system in place for regularly checking information on recipients' third-party liability coverage through the use of private health insurance company databases. EDS contacts employers of new recipients to see whether appropriate health care coverage is available or whether applicants have been covered during the look-back period. If EDS discovers unreported insurance coverage, the company sends a report to the state's eligibility system. Also, employers who offer health insurance are required by law to offer the same health care plan to all their employees, which prevents companies from providing insurance only to well-paid workers.

Another piece of state legislation, passed in 1999, will create a risk pool to allow small-business employers to purchase group health insurance for their employees. This legislation should also help the BadgerCare program avoid crowd-out.

Buy-In of Group Health Insurance

Along with BadgerCare's implementation, Wisconsin began a premium-payment program, known as the BadgerCare Health Insurance Premium Program (HIPP). According to the SCHIP legislation, a state can consider paying the employee's share of a private, group health insurance premium, but only if the employer pays between 60 and 80 percent of the premium and if the state finds that paying the employee's share of the premium and the required wraparound services costs the same as or less than enrolling the employee in an HMO participating in the state's SCHIP-supported program. The legislation also requires that the employer's health care plan must be a major medical plan that meets the standards of the federal Health Insurance Portability and Accountability Act. If paying the premium is not found to be cost-effective by the state's fiscal agent, the employee chooses from the options open to other BadgerCare enrollees in the area.

The state asks any employer who is paying between 60 and 80 percent of the premium for an eligible employee to fill out a form that the state uses to determine whether it would be cost-effective for the state to purchase the employer's health insurance plan for the employee's family members, as well. Enrollees can access BadgerCare services during the several months it takes to investigate their eligibility. If it becomes clear that an employee has, or has had, access to private insurance as explained above, the family is dropped from the BadgerCare rolls.

Enrollment Trigger

Wisconsin's agreement with the federal government requires the state to request a "waiver amendment" three months before state officials think they will need to lower the eligibility level for BadgerCare in order to maintain the state's fiscal health. The public must also be given three months' warning of the change in eligibility levels, although anyone who is already enrolled in BadgerCare will continue to receive services. The state expects not to have to use the enrollment trigger if coverage of parents is allowed under a Title XXI waiver.

Asked by HCFA if Wisconsin would consider "removing the enrollment trigger for children," the state replied in a September 14, 2000, letter that "additional funds will be required to support program costs during the last months of the 2000-2001 fiscal year," which runs from July 1 through June 30. "Without approval of the waiver it is more likely that we may need to implement the 'enrollment trigger' for BadgerCare," the state wrote.

Outreach

State officials have said that they thought all along that BadgerCare would be "a huge popular success," but, even so, the great response to BadgerCare's outreach efforts has come as a surprise. The state has tried to be creative in getting the message out to low-income residents that they may be eligible for free, government-sponsored medical care. A private contractor has trained hundreds of workers in the basics of Medicaid/BadgerCare eligibility. Among the agencies and other organizations whose workers attended the training sessions were schools, public health agencies, dental providers, utility companies, legal service agencies, food pantries, and homeless shelters. These trained staff refer people who they think might be eligible to sites where they can apply for the program.

Other outreach efforts included the distribution of 850,000 brochures in English, Spanish, and Hmong to health care providers, public health departments, community organizations, and school systems; a "back-to-school" initiative to promote BadgerCare and

Medicaid among the state's schoolchildren; and actions by public health officials who took advantage of an immunization program for children to educate parents about the state's new insurance program.

The Department of Health and Family Services has learned some lessons about what works—and what does not—in attempting to reach the public with information about government health insurance programs. For example, a mass mailing to 18,000 former Medicaid recipients in 1998 was not successful, an observation that was confirmed through a survey of the state's larger social service agencies, according to DHFS staff. To find out which outreach efforts were effective, DHFS instituted a procedure whereby people who called a toll-free number for information about BadgerCare were asked how they had heard about the program. Forty percent said they had learned about it from a television ad, 26 percent from friends or relatives, 11 percent from a notice enclosed with a Medicaid card, 8 percent from their W-2 caseworkers, and 15 percent from other sources.

The state is now focusing its enrollment efforts on immigrant families, families with adolescent children, and families with incomes over 150 percent of the poverty level. Currently, only 10 percent of the BadgerCare enrollees come from families with incomes over 150 percent of poverty. Among the new efforts is the formation of a working group, led by DHFS, which will bring together representatives of state agencies to implement targeted outreach and enrollment efforts in the state's 425 school districts. DHFS is also working with the analysts who conduct the state Bureau of Health Information's Family Health Survey to learn why applications are denied and why families drop BadgerCare coverage. And in Milwaukee, 50,000 applications mailed out to families for enrollment in the Free and Reduced-Price School Lunch Program also contain an additional form for families interested in applying for Medicaid or BadgerCare.

Enrollment

When it works effectively, the enrollment process is simple and straightforward. Wisconsin residents who believe they are eligible for the program can apply at almost any agency or organization in the state that provides services to low-income people: there are county enrollment staff stationed at the W-2 agencies and other social service agencies run by the state's 72 counties as well as at hospitals, advocacy organizations, offices, and other locations, and at tribal social and human service departments.

Jon Peacock, director of the Wisconsin Budget Project for the Wisconsin Council on Children and Families, said that enrollment efforts have been hampered by a 14-page application form that takes two hours to fill out and by the requirement for a face-to-face interview with an enrollment specialist. But state officials pointed out that an applicant choosing a face-to-face interview does not have to fill out a paper form and that former Medicaid beneficiaries can be enrolled by telephone.

The state was intending to send out a shorter and simpler BadgerCare application form to enrollment centers in the fall of 2000. A mail-in application form is being tested in at least four areas of the state. But Bartels pointed out that the information collected on the long form has helped to prevent crowd-out and catches people who should be covered under Medicaid rather than Title XXI, a major concern of congressional leaders. As evidence of the need to proceed with some caution when enrolling children in BadgerCare, Bartels pointed to New York's September 2000 discovery that half its SCHIP enrollees may actually be eligible for Medicaid, making them ineligible to receive coverage paid for with SCHIP funds.

Bartels also noted that the application process in Wisconsin has not slowed enrollment. By November 2000, the state had enrolled 25,609 children in BadgerCare, and the outreach effort had also found an additional 25,563 children who were eligible for Medicaid's Healthy Start program, which covers pregnant mothers and younger children whose family incomes are under 185 percent of the poverty level. (Another 90,000 children under the age of 19 are already covered under Medicaid categories that are tied to the old AFDC program.)

Unlike a family applying for Medicaid, a low-income family applying for BadgerCare does not need to pass an "asset test." If a family's assets disqualify it for Medicaid, the family is immediately tested to see whether its members are eligible for BadgerCare. DHFS officials are considering asking the state legislature to eliminate the asset test for Medicaid, which would simplify the state's application process.

Analysts are hampered in their efforts to make national enrollment comparisons because states compile data using different variables and because the starting dates for implementing SCHIP programs have varied greatly from state to state. According to a report issued by the Kaiser Commission on Medicaid and the Uninsured in July 2000, Wisconsin's total SCHIP enrollment from June 1999 through December 1999 jumped more than 1,300 percent—a greater percentage than in any other state during the same time period. The report's author, Vernon K. Smith, calls Wisconsin "rightfully proud of its results," but he notes that Wisconsin's efforts to enroll children were just beginning in June 1999, so it is difficult to compare its enrollment rates to those of states whose programs were launched earlier in the year or the year before.

Determining Eligibility

BadgerCare and Medicaid participants must have their eligibility reviewed every 12 months, a process that can be conducted over the telephone or through the mail. Changes in income must be reported at any time, however, and can immediately affect eligibility. Individuals who become ineligible for Medicaid are automatically tested for BadgerCare by the state's computerized eligibility system.

When someone applies for BadgerCare, the information is entered into the state's computer system, known as CARES (Client Assistance for Reemployment and Economic Support). A state report on BadgerCare issued to HCFA on March 31, 2000, describes the CARES system as having been adapted to address the needs of BadgerCare enrollees, "with county workers processing applications, using the CARES system for the interactive interview and eligibility determination. This minimized administrative costs, and integrated the program delivery to families."

The CARES program checks eligibility for the W-2 program, food stamps, Medicaid, and child care, as well as BadgerCare, and is supposed to check automatically to see if a person leaving Medicaid or applying for one of the other services or entitlements might be eligible for BadgerCare. As of August 2000, the state had processed almost 90,000 applications for BadgerCare. The state denied 20,731 as ineligible, and, among those approved, 12,914 applicants later lost their eligibility for various reasons.

Because an enrollee can become ineligible from one doctor's visit to another, some providers have been creative in coming up with ways to make sure that patients arrive for appointments with their papers in order. The Wisconsin Independent Physicians Group, for example, checks the state computer system to determine a patient's status several days before an appointment. "The patients can often be re-enrolled by telephone, and we help them to do that, before they come in for the appointment," said Charlette Heyer, executive director and CEO of the physicians' group. She notes that her group's doctors are all connected by computer to the main database providing information on patient eligibility.

ISSUES AND CHALLENGES IN IMPLEMENTING BADGERCARE

Overcoming Institutional Tensions

There seems to be a basic conflict between trying to encourage people to get off public assistance and trying, simultaneously, to make sure that those who are eligible receive government health care services. Several states have reported problems arising from this conflict, and Wisconsin, too, has had to contend with it. In Wisconsin's case, one challenge associated with enrolling eligible people in Medicaid/BadgerCare and maintaining them on the rolls seems rooted in the sometimes conflicting missions of two state agencies—the Department of Family and Health Services, which oversees the BadgerCare and Medicaid programs, and the Department of Workforce Development, which administers Wisconsin's TANF program (W-2), operates the CARES system, and contracts with counties for their services in enrolling people in W-2 and the entitlement programs.

"There was a whole philosophical difference between a welfare agency working to get people off welfare and Medicaid," said Bartels. "We now had two agencies that were going about their important business with different philosophies. . . . We had to make sure that the people who saw the incoming families understood that even if a person did not want or need welfare, they might be entitled to food stamps or Medicaid and that Medicaid and food stamps remain an entitlement." Bartels noted that overcoming the conflicting messages from the two agencies has required intensive training of workers who come into contact with BadgerCare applicants.

Complaints about CARES

Shirin Cabraal, a staff attorney for Legal Action for Wisconsin in Milwaukee who represents BadgerCare and Medicaid recipients, complained to both HCFA and DHFS Secretary Leean about clients wrongfully losing their insurance coverage. Though Cabraal now concedes that there have been improvements in enrollment workers' training, in April 2000 she wrote to Leean, noting that caseworkers in Milwaukee were still not prepared to deal with continuing problems in the CARES system. She described the problems as follows: "In the course of our representation of clients we have found that, contrary to federal law, Medicaid benefits to eligible individuals are being denied or terminated due to problems related to the CARES computer system. The problems arise primarily from the fact that the CARES system is not programmed to automatically determine eligibility for certain categories of Medicaid."

Bartels noted that one of the barriers to eliminating human error is the federal government's requirement that potential enrollees be screened for Medicaid before they are considered for BadgerCare. Federal law requires that children who are found eligible for Medicaid during the SCHIP screening process be enrolled in Medicaid, but some federal legislators have been concerned that states might sign up Medicaid-eligible children for SCHIP, which has a more generous federal subsidy than traditional Medicaid. In Wisconsin, for example, the federal government pays 60 percent of health costs under Medicaid and 71 percent under SCHIP. This has meant that children must first be tested to see whether they are eligible for Medicaid, a requirement that, Bartels said, has prevented the state from simplifying the application process. She noted that Wisconsin's careful methods of determining whether a child is eligible for Medicaid seem justified given New York's admission in September 2000 that as many as 50 percent of the children enrolled in New York's SCHIP program should actually be covered by Medicaid.

Bartels said, however, that state officials have resolved the issues raised by Cabraal. In a recent letter to Timothy Westmoreland, director of HCFA's Center for Medicaid and State Operations, state officials tried to address Cabraal's concerns, outlining their painstaking efforts to address concerns that former welfare recipients were being dropped from Medicaid before their eligibility had been "redetermined." According to the letter Bartels wrote to Westmoreland on June 9, 2000, these efforts include "programming the CARES computer system to automatically cascade to other subprograms to check for possible eligibility."

State Senator Rosenzweig pointed out that the concerns of Cabraal's organization and those of other community-based groups are aired and addressed at a monthly meeting of the BadgerCare Implementation Work Group, which is usually led by Milwaukee Health Commissioner Seth Foldy and is open to representatives of any organization involved in helping to implement the program.

Wisconsin's success in signing up about 80 percent of the state's uninsured, low-income children is evidence that "outreach efforts have played a significant role in our caseload growth," Bartels wrote to HCFA in June. According to data released by Wisconsin BadgerCare in early December 2000, and summarized in table 3, more than 25,000 children were enrolled in BadgerCare as of November 2000. Another 25,000 children had been signed up for Medicaid, a program whose enrollment had been relatively flat before the launch of BadgerCare.

Table 3. BadgerCare Enrollment by Category, November 2000

	Actual Enrollment November 2000[a]	Budgeted Enrollment FY 2001[b]
Children		
Up to 150% of FPL	17,384	
Over 150% of FPL	4,636	
Total children	22,020	25,663
Adults		
Up to 150% of FPL	45,589	
Over 150% of FPL	5,849	
Total adults	51,438	41,872
Total children and adults	73,458	67,535
Low-income teenagers[c]	3,589	
Total BadgerCare enrollment as of November 2000	77,047	

Source: © 1999 Wisconsin BadgerCare, DHCF. Updated December 7, 2000

[a] "Actual enrollment" represents individuals who have enrolled to date in BadgerCare.

[b] "Budgeted enrollment" represents the number of individuals who were projected to enroll in BadgerCare. "FY 2001" = July 1, 2000–June 30, 2001.

[c] "Low-income teenagers" represents children between the ages of 15 and 18 whose income is at or below 100 percent of the federal poverty level.

Rivalry between Urban and Rural Communities

Another issue that arose in BadgerCare's implementation concerned competition between rural and urban areas for BadgerCare funds. Milwaukee has about one-third of the state's Medicaid caseload and 20 percent of the BadgerCare caseload. Bartels pointed out that this is because, in terms of its total population, the city has a larger proportion of people who qualify for Medicaid than do rural areas, so it was expected that Milwaukee would have relatively fewer BadgerCare families, who qualify at a higher income level. But advocates have complained that the state has neglected to assign adequate outreach and enrollment resources to the city. The state responds that it has spent more than $4 million in outreach funds in the city alone. Leean said that BadgerCare enrollment numbers are now spread more evenly across the state, but advocates for rural health care are not shy about discussing their competition with Milwaukee for resources.

"The initial enrollment estimate was 47,000, and I heard people from Milwaukee saying they wanted to put 47,000 people on the rolls," said Greg Nycz of the Family Health Center of Marshfield, Inc. "I came back here and I said, 'Okay, guys. There is tremendous first-mover advantage if we get off our duffs and reach our enrollment targets before Milwaukee sucks up all the money.'"

Within three months, Nycz said, his center helped 1,400 people sign up for BadgerCare. "We told people we will be customer friendly. We will help you get on to BadgerCare. We will not provide a sliding scale for services if you do not sign up for BadgerCare."

How Many Are Eligible for BadgerCare?

The state estimates that 144,000 Wisconsin residents have incomes under 200 percent of poverty and that many of them are eligible for BadgerCare. The percentage of uninsured people found by the state's Family Health Survey has decreased from 1997, when the survey reported a 6 percent uninsured rate (for the entire year), to 1998 and 1999, when surveys reported an uninsured rate of 4 percent. The 1998 survey credits changes in interview questions for some of the difference in the results. The authors note, however, that the changes affected only 7 percent of the interviews, "so it is likely that some of the change in proportion currently uninsured is due to actual changes in insurance coverage."

The 1999 survey results concerned state health officials, despite the stable 4 percent rate of uninsured residents, because the results also showed an increase in the percentage of people uninsured for part of the year-up from 6 percent in 1998 to 8 percent in 1999. The survey also found that 93 percent of Wisconsin household residents were insured at the time of the survey, as compared to 94 percent in 1998. At the time of the 1999 survey's release, DHFS Secretary Leean noted that the impact of BadgerCare was not yet reflected in the survey results, as the program had only been formally launched in the fall of that year. Table 4 gives survey results for the years 1995 through 1999.

Table 4. Wisconsin Residents Covered by Health Insurance during Previous Year

	1995	1996	1997	1998	1999
Insured all year:	88%	89%	87%	89%	86%
Uninsured part of year:	7%	6%	7%	6%	8%
Uninsured all year:	5%	4%	5%	4%	4%

Source: Preliminary results from "Wisconsin Health Insurance Coverage, 1999."

The state's numbers contrast with those cited by some advocates, who have questioned the state's baseline estimates of how many eligible children there are in Wisconsin. Legal Action for Wisconsin's Cabraal cited the U.S. Census Bureau's 1998 Current Population Survey (CPS), which estimated that the percentage of Wisconsin residents without health insurance increased from 8 percent in 1997 to 11.8 percent in 1998. But some analysts reviewing SCHIP programs nationwide have questioned the use of CPS data to determine the number of uninsured, noting that such data are based on relatively small samples. These analysts contend that CPS overestimates the number of uninsured—and that this may be one reason that some states have had a difficult time enrolling as many children as projected. In a March 2000 brief, University of Wisconsin researcher Catherine A. Frey noted that participants in the U.S. Census survey "are assumed to be uninsured if they do not report having insurance through Medicare, Medicaid or employer-sponsored programs . . . unlike the [Family Health Survey], which asks directly if the respondents were uninsured" and which relies on a larger sample than that used by CPS.

Jon Peacock, of the Wisconsin Council on Children and Families, conceded that the Census data is "faulty." But he nevertheless wondered whether Wisconsin has signed up its full complement of uninsured children. "The total of BadgerCare and Medicaid is still under what Medicaid was in January of 1995, when the eligibility standards for Medicaid were far lower than they are now," Peacock said. "Has the private sector been doing such a wonderful job that we have significantly reduced the number of the uninsured? I'm not sure that's the case. But we don't have the data."

Opinions of BadgerCare from Opposite Camps

To understand the political tightrope that state officials must walk in implementing BadgerCare, one can look at the concerns expressed by some representatives of the business community, on the one hand, and those of some advocates of the state's low-income residents, on the other.

At the 4,500-member Wisconsin Manufacturers and Commerce (Wisconsin's equivalent of a state chamber of commerce), Eric Borgerding, director of legislative relations, says that his organization is concerned about two issues in particular: the possibility that some companies could gain an unfair advantage by sending their employees to BadgerCare for insurance coverage and that the program's cost could spur tax increases. "Even in the current competitive labor market, as health care costs rise, the way to afford coverage is either to reduce the amount of the premium the company pays or drop coverage entirely," said Borgerding. "And that makes people eligible for BadgerCare."

Leean and Bartels pointed out, however, that state law requires companies to offer all employees the same insurance coverage and that dropping insurance coverage for lower-income employees would require that a company also drop coverage for employees who are not eligible for BadgerCare. But Borgerding responded that the state should not underestimate the ability of an entrepreneur to get around the rules. And his colleague, Russ Cain, pointed out that the quality of the coverage provided by BadgerCare might itself be an incentive for some people to break the rules: "None of us feels there should not be some level of coverage for the uninsured, but the nature of the services offered in BadgerCare is so rich. When you compare it to the package offered other employees, you know people are going to find a way to become eligible and pay only 3 percent of their income in premiums."

Leean said that, although he is concerned about the issue of crowd-out, he has seen no evidence of it, and Borgerding has only anecdotal evidence. A downturn in the economy would concern state officials, however. In the meantime, Leean pointed to the makeup of the BadgerCare population—with more than 90 percent of enrollees falling below 150 percent of the poverty level—as evidence that crowd-out has not become a problem.

The Wisconsin Council's Peacock viewed the same data from another perspective. He voiced concern that the 3 percent premium is preventing the program from drawing in people who earn between 150 percent and 185 percent of poverty. "We should have a lot more people in that income level," Peacock said. "While the premium is not real steep, if you are struggling to make a living, you are going to put off enrolling as long as you can."

LESSONS LEARNED

In the process of implementing BadgerCare, Wisconsin health officials have learned a number of lessons. These include the following.

Role of Parents

The state has learned that a program that covers working parents brings in children. The greatest demonstration of this point is the increased number of children who were found eligible for the Healthy Start program when their parents signed up for BadgerCare. From June 1998 to June 1999, enrollment in Healthy Start remained virtually unchanged, at about 67,000. By contrast, 13,000 children were added to the Healthy Start rolls in the 11 months that followed the July 1999 launch of BadgerCare.

Coverage for Adults

The state also learned that insurance for low-income families draws in relatively more adults than do traditional Medicaid programs because the level of income allowed is so much higher. At the outset of the program, some HMO officials reported that the costs of covering adults in BadgerCare were higher than for the adult population traditionally covered by Medicaid, mainly because of higher pharmaceutical costs. More recently, the Department of Health and Family Services reported that data submitted by the HMOs do not support this early fear.

Integrated Application Process

The BadgerCare application process had to be integrated with Medicaid and made as seamless as possible. This required stationing staff at multiple sites and having the staff work hours convenient for the target population.

Targeted Outreach

Finally, state officials learned that mass mailings to former AFDC recipients are not useful. To improve outreach, the state has concentrated resources on training the people—social workers, health care providers, religious leaders, and teachers—who come into contact with those most likely to lack insurance. Television also turns out to have played a key role in outreach: during the first three months of the BadgerCare program, a special hotline received 8,000 calls, and almost 40 percent of the callers had seen the television commercial, featuring Governor Thompson, that was part of the campaign to enroll low-income families. "Outreach needs to be targeted, and a simple message needs to be marketed—Medicaid and BadgerCare are health insurance for working families," said Bartels.

THE FUTURE

On July 31, 2000, HFCA issued new guidelines for proposed demonstration projects allowed under a waiver of Title XXI of the Social Security Act. "States that meet the applicable criteria and show how the demonstration will improve or expand coverage may have access to SCHIP funds for parent expansions that were implemented on or before March 31, 2000," the new guidelines state. This was the first indication that Wisconsin might indeed qualify for such a waiver, as the letter indicates that coverage of parents will be considered "as long as the initiative is related to the purposes of the SCHIP law and is designed to improve enrollment of uninsured children."

The burden of BadgerCare's increasing enrollment is being felt by state legislators, however, and one of them expressed his concern in an August 27, 2000, article in the *Wisconsin State Journal*. Wisconsin Republican State Representative John Gard, chairman of the state legislature's Joint Finance Committee, told the *Journal*, "We should feel good about the thousands of families that are taking advantage of BadgerCare, but you don't want to expand so quickly that the whole program is at risk."

State Senator Rosenzweig, who believes that BadgerCare will survive, said that it represents a return to Wisconsin's progressive roots in the early 20th century, when university faculty tried to work with all political parties to find solutions to society's thorniest problems. "It's a marriage to forge new ideas between the governor and executive branch, the legislature, the university, and the people," said Rosenzweig. "BadgerCare is a return to a tradition that has been lost. . . . Some people suggest that the Wisconsin Idea has frayed, but this is an example that shows it has not."

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