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## **Expanding Access to Health Care in Wisconsin: An Outline of the New BadgerCare Plus Law Feb. 12, 2008**

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### **Introduction**

Wisconsin has long been a national leader in providing innovative health care solutions for children and families. The enactment of the BadgerCare Plus initiative (in the biennial budget bill, Act 20) continues that leadership and takes a giant step toward providing health care coverage for every child in the state, while also expanding access for parents and pregnant women.

The state still has a great deal of work to do in implementing BadgerCare Plus and realizing the potential of the new law. In addition, because there were tradeoffs made in the program's design to hold down costs, some features need to be studied and perhaps revisited. However, we believe that if the program is executed well, there are aspects of BadgerCare Plus (BC+) that could make it a national model.

The following outline looks at the strengths and weaknesses of the new law, explains how it increases eligibility, summarizes how it improves enrollment of children and parents who were already eligible, describes the financing and other program elements, and reviews the ongoing work and challenges that lie ahead.

By organizing our own thoughts about what the law does and doesn't do, we hope we can foster an exchange of ideas that will help interested parties to implement and improve BadgerCare Plus (or initiatives in other states).

### **Table of Contents**

I.	Overview of BadgerCare Plus: Strengths and Weaknesses.....	p. 1
II.	Expansion of Eligibility.....	p. 3
III.	Removing Barriers to Participation for People who are Already Eligible .....	p. 5
IV.	Application Process.....	p. 5
V.	Benefits.....	p. 6
VI.	Cost Sharing.....	p. 6
VII.	The Interface between Public and Private Insurance.....	p. 7
VIII.	Special Provisions Relating to Pregnant Women, Fetuses & Newborn Children.....	p. 8
IX.	Financing.....	p. 9
X.	Cost Containment.....	p. 10
XI.	Timing.....	p. 11
XII.	SCHIP Issues: Opportunities and Concerns.....	p.11
XIII.	Ongoing Work and Challenges.....	p.12
	Diagram: Family Health Coverage – Before and After BadgerCare Plus.....	p.14

I. Overview of BadgerCare Plus: Strengths and Weaknesses – Of course, there are many different standards that could be used in evaluating BC+. Our assessment is based on our analysis of how effective BC+ will be in making quality, affordable health care available for children and parents.

A. Strengths or improvements

1. There is no income ceiling for participation by children – which, among other advantages, enables the state to deliver a clear outreach message that virtually all children are eligible.
2. It creates a single, comprehensive system for both children and parents; and those below 200% of the federal poverty level (FPL) will be eligible for the full Medicaid benefits package.
3. There are no premiums and only nominal co-pays for children below 200% of FPL (see part VI.), and premiums will generally be lower (compared to BadgerCare) for coverage of parents – particularly for single-parent coverage.
4. It establishes “express enrollment” (presumptive eligibility) for children below 150% of FPL. That should be a big help in mitigating the unintended consequences of federal citizenship and ID documentation requirements for kids.
5. The state is working to broaden points of entry into the program. That effort includes recruiting organizations to help enroll children using the express enrollment process (see IV.C.) and encouraging community health clinics to have out-stationed intake workers.
6. The new policies to discourage displacement of employer-sponsored insurance (“crowd-out”) are more logical and consistent, and generally also narrower. For example, families with incomes below 150% of FPL will no longer be ineligible simply because they have access to employer sponsored insurance (see VII. B.).
7. It removes other impediments to enrollment, such as the current employer verification requirement (see III.C.).
8. There is coverage of several populations who previously hadn’t been covered at all: childless adults (in 2009), teens aging out of foster care, and parents whose children are temporarily removed from the home. (See attached diagram, p.14)
9. All pregnant women are covered to 300% of FPL, regardless of citizenship, and the state now provides automatic enrollment of newborn children if the birth was covered by BC+, but not for births covered by BadgerCare Prenatal (see VIII.).
10. It includes a reasonable, affordable compromise for covering farmers and other self-employed parents who were previously excluded when their depreciation was added to their income (see II.A.3.).
11. It helps underinsured families by allowing eligibility for kids if deducting expenditures for catastrophic health care costs reduces a family’s income below 150% of FPL (see II.B.1), and that change immediately helped thousands of kids who had been in the process of spending down to a much lower income standard.
12. Funding (from projected cost-savings) is set aside for a number of important purposes, including initiatives to expand access to dental care (see IX.D.).

B. Weaknesses and ongoing challenges

1. Non-citizens and recent legal immigrants are not eligible (except pregnant women).
2. The expansion of eligibility for childless adults isn’t funded (see II.C.).

3. There are a number of tradeoffs that were made in the program design to help hold down the cost or simplify eligibility determinations.
  - a. Although crowd-out provisions are eliminated for families below 150% of FPL, they will now apply for all children and parents above 150% of FPL, even though the employer sponsored coverage may be unaffordable for some families between 150% & 200% of FPL. Some children under age 6 who had been in Healthy Start might be ineligible for BC+ (see VII.A.&B.).
  - b. It creates a narrower benefits package (“benchmark plan”) for children above 200% of poverty and childless adults.
  - c. Previous income disregards were scaled back, and child support that is received will be included in income. Those changes will reduce eligibility for some parents and are likely to push some children into the narrower benefits package, with higher cost-sharing (see II.B.2).
  - d. It eliminates use of the family fiscal unit, and that may make it harder for some people to qualify, and could push others into the less generous benefit package.
  - e. It initiates small co-pays for some parents who didn’t previously have co-pays (recipients enrolled in managed care).
  - f. The expansion of premium assistance could be problematic – possibly causing administrative delays and reduced access to service (if the wraparound coverage is not implemented well).
4. Despite progress made in simplifying the program and consolidating more than 20 categories of family coverage, elements of the program are still fairly complex (which was necessitated by making distinctions in the policies that apply at different income levels, by having crowd-out policies that try to balance a number of competing considerations, and by the new policies to assist farmers and other self-employed parents).
5. Federal regulations continue to create barriers to enrollment -- As of Jan.1, 2008, nearly 33,000 Wisconsin children or parents had lost or been denied coverage in Medicaid or BadgerCare because of the federal citizenship and identity documentation requirements.
  - a. Presumptive eligibility for children under 150% of poverty will help, but there will still be problems for parents and for kids who can’t produce the documents within the two months (max.) provided by presumptive eligibility.
  - b. Automatic deeming of the eligibility of newborns will also help, but we need to find a way to expand that to the babies (born in WI) of immigrant women whose births were covered by SCHIP rather than MA.
6. Recent changes in SCHIP and Medicaid policies made by the Bush Administration have increased the state share of costs (see IX.F.), which could be problematic in the future – especially if enrollment increases exceed state expectations.

## II. Expansion of Eligibility

- A. Expansion of coverage for children and families – On Feb.1, 2008, the state began expanded coverage for the following groups: (see also the attached chart, p.14)
  1. All citizen children, with subsidies for those in families below 300% of the poverty level. (Eligibility is currently capped at 185% of FPL.)

2. Pregnant women between 185% and 300% of the poverty level
  3. Farm families and other self-employed parents with incomes up to 200% of poverty - many of whom are currently excluded because BadgerCare and Medicaid use a less generous definition of income than is used for tax purposes (see II.B.3.)
  4. Youths who leave the foster care system (including court-order kinship care) when they turn age 18, on or after Jan. 1, 2008, will be eligible, regardless of income, until they turn 21. (They have to have been in foster care on their 18<sup>th</sup> birthday.)
  5. Parents with children in out of home care (if there is a reunification plan).
  6. Caretaker relatives with income less than 200% of poverty.
- B. Income eligibility changes – In addition to the changes noted above, there are changes in how eligibility is determined. Most, but not all, of these changes expand eligibility:
1. Spendedowns – Health care costs can be subtracted from income to achieve eligibility for two categories of coverage:
    - a. Children who already have health insurance coverage or access and would otherwise be excluded from BC+ can become eligible (for the standard plan) if they have expenses for catastrophic health care and spend down to 150% of FPL (which is the threshold for the crowd-out policies to apply).
    - b. Pregnant women with incomes above 300% of FPL can enroll in BC+ if they have incurred medical expenses over the prior 6 months that bring family income below 300% of FPL.
  2. Changes in the income definition
    - a. Under prior law, there were more than 20 different categories of family coverage, many of which use different rules about how income is counted in determining eligibility.
    - b. BC+ simplifies calculations of eligibility by using a consistent policy for counting income and by significantly narrowing the deductions from gross income, which will be limited to child support payments and earnings of children under 18.
    - c. BC+ eliminates the “family fiscal unit”, which could also make it harder for some parents to be eligible.
    - d. For an estimated 2,700 parents the reduced deductions from income will more than offset the benefit of the increase in the income ceiling to 200% – particularly for parents with significant child care expenses. (Adversely affected parents will be grand-parented in for 18 months.)
    - e. There are also likely to be some parents who didn’t previously pay premiums, whose newly calculated income will exceed 150% of FPL, and they will have small premiums for parent coverage.
  3. Eligibility of farmers and other self-employed parents
    - a. Under prior law (BadgerCare), many farmers and other self-employed people were excluded from eligibility because the tax deduction they get for depreciation (of farm equipment, etc.) was added back to their net income, putting them over the 185% of FPL ceiling.
    - b. Under BC+, if a farmer or other self-employed parent has too much income to be eligible for the standard plan because of the inclusion of depreciation in their income, they can enroll in the more limited benchmark plan if their

income excluding depreciation is less than 200% of FPL. (Their premium is calculated with depreciation added back to income and will generally be 5% of that amount.)

4. Exclusion of SSI benefits – The law clarifies that SSI benefits are not to be included in income.
5. Family planning waiver – The income limit for this program is also being increased to 200% of FPL, with the same changes relating to the definition of income.

#### C. Childless adults

1. The second stage of BC+ is intended to phase in a Medicaid expansion to cover childless adults below 200% of poverty, starting in 2009 (assuming the state gets a federal waiver). That group is currently ineligible, regardless of income.
2. The budget bill doesn't appropriate any funding for this expansion. However, the inclusion of the statutory authority allows the state to:
  - a. continue to pursue a federal waiver to use Medicaid funds to cover this population;
  - b. begin to implement this expansion by reallocating funding now used for the General Assistance Medical Program (GAMP) or the Health Insurance Risk-Sharing Program (HIRSP); and
  - c. continue working on ideas for development of a connector approach to help small businesses purchase coverage for their employees or supplement state coverage.
3. Childless adults will get a much more limited package of benefits.

### III. Removing barriers to participation for people who are already eligible

BC+ makes many improvements that will help reach the large number of uninsured families who already meet eligibility standards but are deterred from BadgerCare participation by red tape or premiums. These enhancements include:

- A. Streamlining the enrollment process for children by adopting “express enrollment” (presumptive eligibility) for kids below 150% of poverty, which should be particularly helpful in avoiding delays in enrollment caused by citizenship and identity documentation requirements.
- B. Creating new points of entry into the program by allowing express enrollment by qualified providers and other entities.
- C. Replacing the previous employer verification requirements with a less burdensome process for verifying health insurance status -- The Department of Health and Family Services (DHFS) will gather this information on behalf of the applicant, and in the meantime the applicant can be enrolled. (Applicants still need to provide verification of their employment and income, but that has been far less burdensome than insurance status verification.)
- D. Eliminating premiums for children in families below 200% of poverty.
- E. Reducing reporting requirements for changes of income.

### IV. Application Process

- A. Applications may be submitted via the Internet, by telephone, by mail, or in person.
- B. The state will continue to rely heavily on county caseworkers, but will strive to move more applications to the online system.

C. Presumptive eligibility/ “express enrollment”

1. The new law authorizes “express enrollment” for two groups
  - a. children below 150% of FPL, and
  - b. pregnant women below 300% of FPL.
2. The state is recruiting qualified health care providers and community groups to do the express enrollment – including Head Start and WIC programs, community health clinics, schools, faith-based groups, etc.
3. People enrolled under this process are eligible for the remainder of the month when they are initially enrolled and the following month. (If they submit a regular application by the end of the 2nd month and their application is pending, the county can request a one-month extension.)

V. Benefits – BC+ would create two tiers of benefits:

- A. The groups that were already eligible continue to be eligible for the regular Medicaid benefit plan (aka the Standard Plan), which includes all of the optional Medicaid benefits.
- B. The Standard Plan is also available for caretaker relatives and youths aging out of foster care.
- C. A narrower benefit package, called the Benchmark Plan, is now provided for children and pregnant women above 200% of FPL and for farmers and self-employed parents who are only eligible when depreciation is subtracted from income. Differences include:
  1. The Benchmark plan will not cover: personal care, private duty nursing, case management, crisis intervention, Community Support Program services, Comprehensive Community services, eyeglasses and contact lenses, and outpatient mental health and substance abuse in the home and community for adults.
  2. Some Benchmark Plan benefits are narrower, including: prescription drug coverage is limited to preferred generics, home health is limited to 60 visits/year, skilled nursing care is limited to 30 days/year, inpatient rehab. is capped at 60 days/year, lower limits on mental health and AODA services, more limited dental coverage (and a \$750 annual cap), and smoking cessation for pregnant women only.
- D. The state is developing a different and narrower benefits plan for the new coverage category for childless adults in 2009.

VI. Cost Sharing

A. Premiums

1. Under BadgerCare, families above 150% of FPL paid a premium of roughly 5% of income, regardless of whether the whole family was covered or just a single child.
2. Under BC+, the premium structure is as follows:
  - a. There are no longer premiums for children under 200% of FPL.
  - b. For kids in families above 200% of FPL, examples of the monthly premiums (per child) are \$10 for families between 200% and 230% of FPL, \$31 for families between 250% and 260% of FPL, and \$90.74 per child (which is the full cost for the Benchmark Plan) for families above 300% of FPL.
  - c. There continue to be premiums for parents between 150% and 200% of poverty, and those premiums continue to be capped at 5% of family income

(for either or both parents), but are generally lower than the previous premiums, especially for single parents below 180% of FPL.

- d. For farmers and other self-employed parents who are eligible with income in excess of 200% of FPL (when depreciation is added to adjusted gross income) the premium for the full family coverage is generally 5% of that income figure (unless their income exceeds 300% of FPL, in which case the premium is the higher of 5% of income or \$90.74 per child per month).

#### B. Co-pays

1. For children there are no co-pays for well child check ups and other preventive services (in either the Standard Plan or Benchmark Plan).
2. There are no co-pays for any services for kids below the poverty level or for children who are tribal members (regardless of income).
3. For kids above 100% of FPL and for all parents, the Standard Plan has nominal co-pays (ranging from \$0.50 to \$3.00) for services such as prescription drugs, going to the hospital or using the emergency room.
4. The prior exemption from co-pays for people enrolled in managed care has been eliminated.
5. The Benchmark Plan (for kids above 200% of FPL) has higher co-pays, ranging from \$5.00 for prescription drugs to \$100.00 for a hospital stay.
6. Failure to pay a co-pay is not grounds for denying a service in the standard plan, but is grounds for denying a service in the benchmark plan.

#### C. Deductibles

1. Standard Plan – Has no deductibles.
2. Benchmark Plan – Has a \$200 annual deductible for dental coverage.

### VII. The interface between public and private insurance

#### A. Pre BC+ policies to limit “crowd-out” of private coverage

1. Crowd-out policies used to apply (with certain exceptions) to people who were otherwise eligible for BadgerCare, but who: already had insurance or had been insured in the previous 3 months, or who had access in the previous 18 months to employer-sponsored insurance (ESI) that paid at least 80% of the premiums.
2. Because the crowd-out policies didn’t apply to Medicaid or Healthy Start, they didn’t apply to children under age 6, but they did apply to:
  - a. kids 6 and older with incomes above the poverty level, and
  - b. parents above about 44% of FPL.

#### B. New crowd-out policies – The BC+ crowd-out policies are more consistent, more logical, and generally narrower, but they will continue to impose a hardship for some families who have access to, but cannot afford ESI.

1. With one exception (the “unborn children” of pregnant non-citizens), the new policies only apply to parents and children above 150% of poverty. Those children and parents will be precluded from enrolling in BC+ if:
  - a. the individual is able to enroll in the next 3 months in either an employer-sponsored plan that pays 80% or more of premium costs or in state employee coverage, or has had access to either such plan in the past 12 months; or

- b. the individual has been enrolled in such insurance coverage within the past 3 months.
  - 2. There continue to be good cause exceptions (which vary slightly between 1.a. and 1.b., above). The exceptions include, but aren't limited to:
    - a. the individual's employment (or that of a child's parent or caretaker relative) ended;
    - b. the employer discontinued coverage for all employees; and
    - c. the individual lost coverage because of the death of a relative or a change in marital status.
  - 3. The new crowd-out policies don't apply to youths who age out of foster care, or children whose family income exceeds 150% of FPL and who obtain eligibility under spend down provisions (see II.B.1.).
  - 4. There are also somewhat different policies for pregnant women, "unborn children," and newborns (see section VIII.).
- C. Employer registry – The state is establishing a registry with information on what employers provide in health insurance benefits, in order to have a more efficient way of determining whether employees have access to a qualified health insurance plan, and to improve the HIPP program
- D. Premium assistance (HIPP)
  - 1. Previously, the state used the Health Insurance Premium Payment (HIPP) program if it was cost effective, and if the employer paid less than 80% of the cost of the policy.
  - 2. HIPP continues to apply to families above 150% of poverty when the employer pays less 80% of premiums. In addition, it has been expanded substantially by the following changes:
    - a. It will also be used for employers who pay more than 80% of the cost, in the case of pregnant women below 300% of FPL (wrap-around benefits), or if the family is below 150% of FPL.
    - b. It will be expanded to include self-funded insurance plans and also farm and other self-employed families.
    - c. It will be applied on an individual basis, rather than for the whole family.
- E. Another policy to limit the potential for crowd-out is the creation of a different plan with a narrower benefits package and higher co-pays for families above 200% of poverty (see V. C and D). .

## VIII. Special Provisions for Pregnant Women, Fetuses, and Newborn Children

Somewhat different rules apply to pregnant women, fetuses, and infants, as described below:

### A. Pregnant women

#### 1. Eligibility

- a. All pregnant women below 300% of FPL are eligible, regardless of citizenship.
- b. Pregnant women above 300% of FPL can enroll in BC+ if they have incurred medical expenses over the prior 6 months that bring family income below 300% of FPL.
- c. Women remain eligible for two months after the last date of pregnancy.

- d. Eligibility may be backdated three months (except in the case of pregnant women in the BC Prenatal Program (VIII.B.)).
  - 2. Crowd-out policies
    - a. Except as provided under part B. (below), pregnant women are not excluded because they have access to employer sponsored insurance.
    - b. However, a woman over 200% of FPL who has insurance coverage must maintain it (although she is still be eligible for BC+ as wraparound coverage).
  - 3. Premiums aren't required for pregnant women.
  - 4. There are no co-pays for services related to a pregnancy.
- B. Fetuses (“unborn children”) – BadgerCare Prenatal Program
- 1. Wisconsin takes advantage of a provision in SCHIP law that allows states to provide health care to “unborn children” of pregnant women who are otherwise ineligible because of issues like their citizenship status
  - 2. Since 2006, Wisconsin has used that SCHIP provision to provide prenatal care to pregnant women who are non-citizens (as well as a very small number of pregnant incarcerated women).
  - 3. BC+ expands the eligibility for “unborn children”/pregnant women to 300% of FPL.
  - 4. The pregnant woman must not have health insurance now or in the prior 3 months.
- C. Newborns
- 1. Infants born to a woman covered by BC+ or emergency services Medicaid are automatically eligible for BC+, unless the birth was covered by the BadgerCare Prenatal Program (for immigrant women/ “unborn children”)
  - 2. The automatically covered newborns are continuously eligible until the end of month when they turn one year old.

IX. Financing (See also the SCHIP section, below.)

- A. The BC+ financing plan never assumed a significant increase in the state’s annual SCHIP spending (which helped keep debate over BC+ from getting ensnared in the interminable debate over SCHIP reauthorization.
- B. From the perspective of state general fund spending, the portions of the plan relating to children and families are expected to be cost-neutral, at least in the 2007-09 biennium.
- C. The budget bill assumes that BadgerCare Plus will yield net biennial savings of about \$17.4 million in total funding (state & fed.). Those savings result primarily from:
  - 1. increasing the use of managed care;
  - 2. reducing state administrative costs by consolidating and streamlining the different categories of family coverage; and
  - 3. requiring co-pays for prescription drugs from all parents, rather than continuing to exempt parents in HMOS.
- D. The new law reinvests those savings in a number of ways to improve access to health care, including the following biennial appropriations:
  - 1. \$8.8 million for initiatives to improve access to dental care
  - 2. \$3.5 million to promote healthy living behaviors
  - 3. \$2 million for HMO expansion incentives

4. \$1.8 million to expand the Milwaukee Public Schools student health initiative
  5. \$500,000 for marketing and outreach
  6. \$200,000 for benefits counseling
  7. \$200,000 for evaluation
  8. \$100,000 for health living curriculum development
- E. Local income maintenance administration – Although there will be local, as well as state, savings from program consolidation and simplification, the budget bill maintains the prior funding level for local eligibility determinations because it assumes that the savings will be offset by increased caseloads.
- F. 250% cap on federal financial participation
1. The state plan amendments approved by CMS do not allow the state to use SCHIP or MA funds for children or pregnant women above 250% of FPL. Because of a federal policy directive issued by HHS in mid-August, the state decided to modify the proposed plan amendments and not seek SCHIP for higher income families because that would require adopting much more restrictive crowd-out policies.
  2. The modifications to the plan amendments caused by the CMS policy changes do not affect BC+ from the perspective of the intended beneficiaries, but they will increase in the state share of costs by roughly \$1 million to \$2 million per year.
- G. The budget bill makes no commitment to provide state funding for the expansion of coverage to childless adults, but allows that coverage to be funded by reallocating funding for the General Assistance Medicaid Program (GAMP) or the Health Insurance Risk Sharing Program, and it shifts the GAMP funding, which makes it imperative to start the childless adult coverage in Milwaukee in 2009.
- H. Within a few years we suspect the expansion of coverage for kids and families will have a net budget cost, because we think the number of already-eligible low income households who enroll will be greater than DHFS estimated for the current biennium. In any case, covering kids is extremely cost effective. See:  
[http://www.wccf.org/pdf/hc\\_fiscallyresponsible\\_%20final.pdf](http://www.wccf.org/pdf/hc_fiscallyresponsible_%20final.pdf)
- I. The budget bill includes a substantial increase in taxes on cigarettes (a \$1 per pack increase) and other tobacco products, but that money essentially fills a hole in the Medicaid and overall budget, rather than being used to expand coverage.

## X. Cost Containment

- A. Expanded use of managed care
1. The appropriations from reinvested savings include \$660,000 in 2007-08 and \$1.34 million in 2008-09 for incentives for HMOs to enter geographic areas that have one or fewer health plans available to serve BC+ recipients.
  2. Individuals will be required to enroll in a group health plan if one is available and DHFS determines that it is cost-effective.
- B. Emergency Room Usage – BadgerCare Plus members can use the emergency room or ambulance rides for emergency use purposes only (i.e., a condition that will cause death or serious harm to your body if not treated right away). Non-emergencies include illnesses, injuries or medical needs that are usually taken care of in a doctor's office. There will be a \$74 co-pay for non-emergency use of an ER.

- C. Wellness – There will be strategies to promote healthier behaviors, including a non-binding member agreement and “healthy living” information and education classes.
- D. Pay for Performance (P4P) – \$2.3 million was appropriated to offer HMOs pay-for-performance incentive payments. Incentives will be provided for such things as
  - 1. increasing well-child visits and immunization rates; and
  - 2. reducing smoking, childhood obesity, infant mortality and inappropriate use of emergency rooms.
- E. In order to promote preventive care, rather than more costly treatment of problems, there won’t be co-pays for prevention services (including immunizations, well-child visits, smoking cessation and pre-natal care).

## XI. Timing

- A. BC+ was passed by the legislature in the long overdue biennial budget bill on October 23, 2007, and was signed by the Governor on Oct. 26.
- B. The needed plan amendments were approved by CMS on November 27, 2007.
- C. The delay in passing the budget bill precluded starting BC+ on Jan.1, 2008, as initially planned, but implementation began on Feb. 1. (The very quick start-up is commendable, but could result in some glitches in implementation as caseworkers learn the new policies.)
- D. The second phase – covering childless adults – requires a Medicaid waiver, and that is likely to be harder to get, but DHFS is optimistic about getting that approved.
- E. Working out the funding for the childless adult portion might slow its implementation, but the state had already planned to phase it in over several years, and still expects to initiate the phase-in in January 2009.

## XII. SCHIP Issues: Opportunities and Concerns

- A. SCHIP funding level
  - 1. It appears that the state isn’t getting a funding increase from the SCHIP extension bill signed in December 2007 – at least not in the state’s initial allocation.
  - 2. The state initially assumed that it would continue to spend roughly the same amount of SCHIP in the current biennium as it did in FY 2007; however, we think it is likely that SCHIP spending will increase and the state will have insufficient SCHIP funds.
  - 3. If SCHIP funds run short, the state can shift more parents from SCHIP to Medicaid, which will increase the state share of costs, but which is not an insurmountable fiscal problem.
- B. Income limit for SCHIP – In light of the guidelines issued by CMS in mid-August, DHFS did not seek approval to use SCHIP for children above 250% of poverty. Although there will also be subsidies for kids between 250 and 300% of FPL, the state will bear the full cost of those subsidies. However, if Congress blocks the CMS policy change (as proposed in the bipartisan SCHIP bill that was vetoed), Wisconsin would submit a plan amendment.
- C. Flexibility in who can be covered with SCHIP funds
  - 1. Parents
    - a. Until recently, WI was using SCHIP funds to cover parents enrolled in BadgerCare who have incomes over the poverty line, but the new

BadgerCare waiver granted in May 2007 limits the use of SCHIP to parents over 130% of FPL.

- b. Ending or phasing out the option of using SCHIP funds for parents would shift more parents into MA, and the lower MA match rate could significantly increase the state share of the cost of BadgerCare Plus. However, whether that's a problem will depend on what Congress does on some of the other issues – especially the question of increasing SCHIP flexibility for states with pre-SCHIP expansions.
2. Kids covered in pre-SCHIP expansions
    - a. One of the reasons why WI got a waiver to use SCHIP funds for parents is that prior to the 1997 enactment of the SCHIP law, WI has already expanded coverage to kids under the age of 6 to 185% of FPL, and the federal law only allows SCHIP funds to be used for subsequent expansions of coverage
    - b. The extension enacted in Dec. 2007 allows states with pre-SCHIP expansions to use SCHIP funds for those children, above 133% of FPL, and Wisconsin might be able to take advantage of that if there's an increase in SCHIP \$s.
  3. Childless adults – Congressional restrictions on use of SCHIP to cover childless adults aren't relevant for WI, because DHFS never planned to use SCHIP for that coverage.

#### D. Improving enrollment

1. SSN option – If Congress ever enacts the proposal in the bipartisan SCHIP bill giving states the option to use Social Security numbers to verify citizenship and identity, that change would make enrollment far more efficient and would significantly reduce the hundreds of eligible Wisconsin residents who are denied coverage each month.
  2. Express lane eligibility – The vetoed SCHIP bill would have allowed states to use express lane eligibility (for example by coordinating with school lunch programs), and if that is ever approved it would probably dovetail very well with the adoption in BC+ of presumptive eligibility.
- E. Incentive funding – If the SCHIP bill includes provisions to reward states that reach certain targets for coverage of low-income children, Wisconsin would have a good chance to benefit from the incentive funding.

XIII. Ongoing Work and Challenges -- A WCCF wish list of what we would tackle (or encourage others to work on) if we had sufficient resources to do so.

#### A. Effective outreach and public education

#### B. Health care for immigrants

1. Enrolling immigrants who are eligible (citizens or legally present in the U.S. for 5 years), but who may be reluctant to sign up
2. Developing options to better serve non-citizens ineligible for BC+

#### C. Coverage for childless adults

1. Getting a federal waiver
2. Finding state funding
3. Developing a Massachusetts-style connector to help smaller employers serve childless adults and other employees

D. Improving enrollment

1. Overcoming enrollment barriers – particularly the federal citizenship and identity documentation requirements, which (as of Jan. 1, 2008) had resulted in nearly 33,000 WI residents who had coverage denied or terminated.
2. Expediting enrollment
  - a. Presumptive (express track) eligibility
    - 1) Recruiting and training organizations to assist with express track eligibility, and encouraging counties to also use it
    - 2) Monitoring and improving the quality of that process
  - b. Online enrollment
  - c. Express lane enrollment – Taking advantage of any options authorized by Congress, if a SCHIP reauthorization bill allows states to use information from other programs (such as school lunches) to expedite the enrollment process.
  - d. Finding a way to automatically deem eligibility for infants born to immigrant women whose births are covered by BC+ (as we do for other births covered by BC+).

E. Maintaining and improving employer-sponsored insurance

1. Striking the right balance in using premium assistance (HIPP).
  - a. On the one hand, it's likely to be expensive and could be problematic for enrollees.
  - b. On the other hand, it may discourage crowd-out, is politically popular, and perhaps it could serve as a platform for policy changes to help people above 150% of FPL who can't afford the premiums and other cost-sharing.
2. Improving the small business market (using BadgerChoice, for example).
3. Developing a way to serve families over 150% of FPL who can't afford employer-sponsored insurance.

F. Holding down the cost of care

1. Increasing participation in HMOs
2. Getting people into medical homes
3. Emphasizing prevention and encouraging healthy behaviors

G. Improving access to services (particularly dental and mental health care)

H. Assessing the effects of program changes, including such things as:

1. How many people lose eligibility because of the changes in the income definition?
2. Are there transitional problems for children and parents in families when there income goes above 200% of poverty, or periodically fluctuates?

I. Improving quality and outcomes

J. Eliminating racial disparities

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# Family Health Coverage -- Before and After BadgerCare Plus

