Badger Care Coming Of Age: Promise And Reality

The BadgerCare program (Wisconsin's Child Health Insurance Program, CHIP) concluded one year of operation on July 1, 2000. 65,000 enrollees have reason to celebrate their access to health insurance. Now, policy makers and citizens need to know exactly what has the program accomplished? Do challenges remain? What are the implications of Wisconsin's waiver application awaiting a federal decision?

Background

"We should be proud that more of Wisconsin's families are protected by health insurance than ever before. But I won't rest until everyone is provided for, particularly poor women and families…We want to make sure that hard-working families don't have to go without health care for their children as they climb the economic ladder."
(Press release from Governor Thompson, September 29, 1998.)

Governor Thompson has made a strong commitment to making health care accessible and affordable for Wisconsin's working families. BadgerCare is an expression of his commitment, and the support of the Legislature for improving access to health care for uninsured, low-income Wisconsin families.

The BadgerCare program covers families with incomes up to 185 percent of the federal poverty level (FPL). Once enrolled, families may remain in BadgerCare until family income exceeds 200 percent of the FPL.

The BadgerCare program, which is available to children under age 19 and parents, provides the Medicaid package of benefits. Federal funds pay for approximately 71 percent of the cost for children and 59 percent for adults. The state pays most of the rest, although a small portion comes from premiums. Families with incomes over 150 percent of poverty pay monthly premiums of about 3 percent of their income.

BadgerCare was approved by the Wisconsin Legislature and Governor Thompson in the fall of 1997 (1997 Act 27). It was intended to begin on July 1, 1998. However, its implementation was held up for a year because of lengthy negotiations between state and federal officials reconciling the state legislation covering parents as well as children under the new federal law expanding coverage of children (Although the state blames the federal government for the delays, it should be noted that the compromise hailed by both sides in January 1999 was the same plan the state rejected in August 1998.)

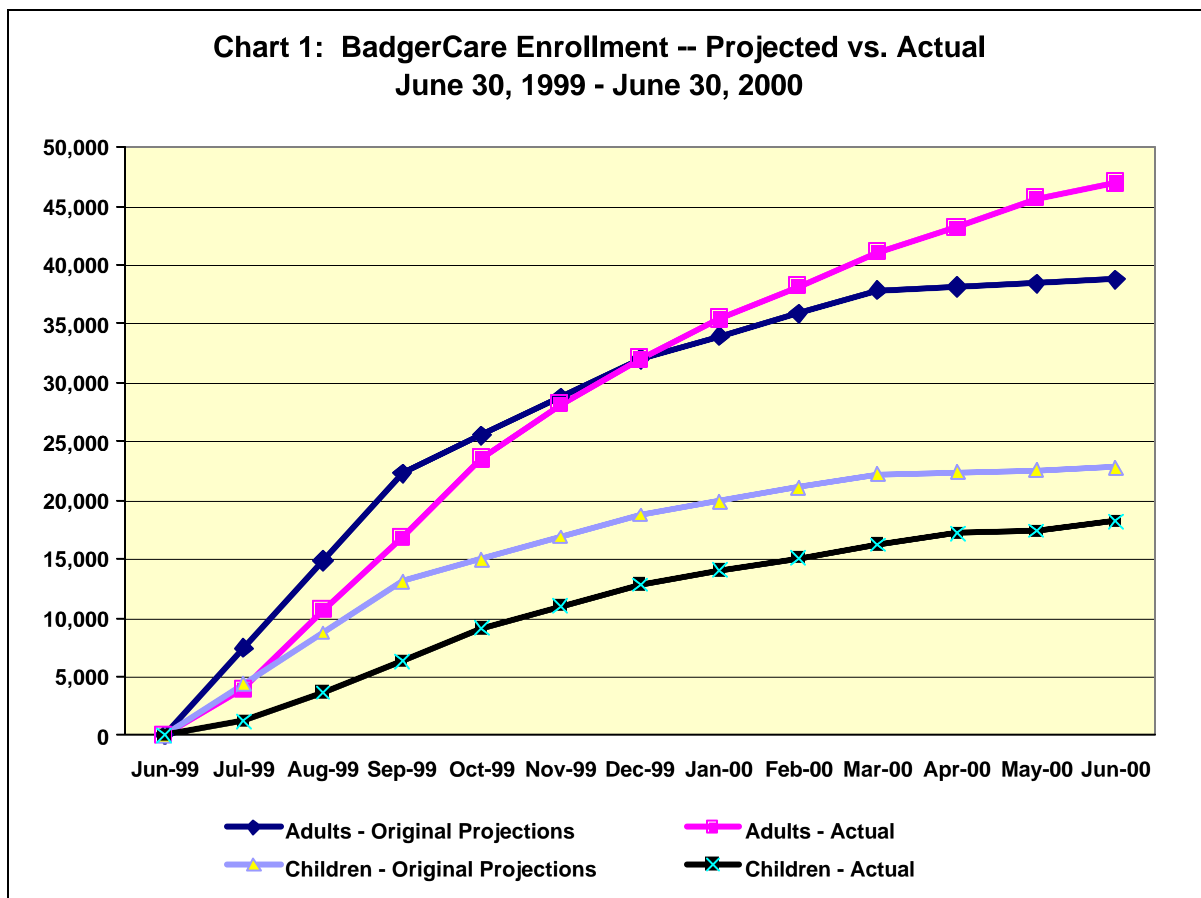
Enrollment

BadgerCare has experienced rapid growth in its first 12 months. Figures as of June 30, 2000 show the following.:

- Enrollment reached 65,147 – 6 percent higher than projections during the development of the biennial budget bill.
- The program covers nearly 47,000 parents and more than 18,000 children under age 19.
- In addition, 4,175 teenagers are insured by a related program, known by the federal acronym OBRA, which covers older teens below 100 percent of the poverty level.

Enrollment of Children -- Although BadgerCare has been extremely successful in enrolling parents, it has not been as effective in reaching the targeted number of children.

Chart 1 illustrates that the number of adult enrollees is 21 percent higher than projected. The number of children in the program is 20 percent below anticipated enrollment. Original projections anticipated a ratio of 1.7 parents in BadgerCare for each child enrolled, but the current ratio is 2.6 adults to each child. This higher-than-expected proportion of parents to children is important for several reasons, particularly because of its relationship to the program's cost. (see "Financial Challenges")



Since families applying for BadgerCare must first be screened for Medicaid (MA) and Healthy Start, the publicity and outreach for the new program has increased enrollment in those two programs. The consequences of the influence of BadgerCare are:

- Healthy Start and MA have grown by about 16,200 children, a greater boost than fiscal analysts anticipated.
- Total new enrollment of children one of the four health insurance programs, Healthy Start, MA, OBRA and BadgerCare and OBRA has increased by 38,568 in 12 months.

The growth of children in Healthy Start and MA, which has been particularly strong since January, helps mitigate the fiscal problems caused for HMOs by the high ratio of adults to children in BadgerCare.

Enrollment of Families over 150 Percent of Poverty -- A disappointing aspect of BadgerCare enrollment has been the relatively small number of families between 150 and 200 percent of the poverty level. They represent only about 9 percent of the families with one or more individuals in BadgerCare and about 13 percent of the individual enrollees. While causes of this low enrollment need further study, the premiums charged to these families may be a deterrent to enrollment as well as other factors such as the ties to the welfare system.

The relatively low participation of families with incomes above 150 percent of FPL may be one factor affecting the unanticipated lower number of children enrolled in BadgerCare compared with parents. Families at the higher end of the income eligibility range tend to have more children eligible for BadgerCare than the lower-income households since more children at the lower end are eligible for MA or Healthy Start. As of June 30, 2000, children comprised less than 26 percent of total enrollment below 150 FPL, but nearly 43 percent of the enrollees over the 150 percent level.

Although the low enrollment of families above 150 FPL is disappointing, it does have one positive implication. It strongly suggests that there has not been a significant number of employees or employers dropping their private health insurance coverage.

Substitution of BadgerCare for private insurance would be expected to cause a greater influx of participants toward the higher end of the income eligibility range. Although there have been some anecdotal reports of employers shifting their workers to BadgerCare, the empirical data appears to show that substitution has not been a problem.

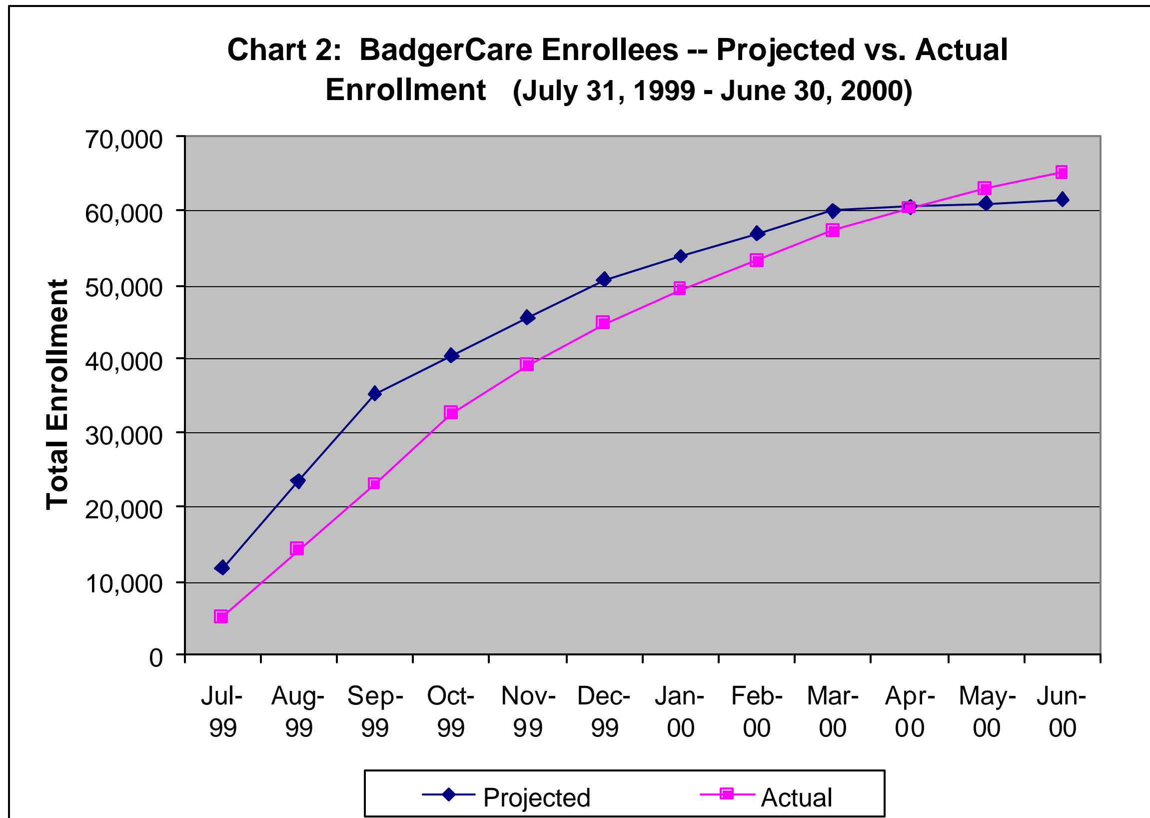
Financial Challenges

BadgerCare has been somewhat more costly than anticipated. The cost figures are not available for all of the first fiscal year, but it is likely that the program went a little over budget (or would have if all bills were paid in a timely fashion). That cost-overrun was manageable because the program started slowly in the early months and did not exceed the enrollment target until May (see Chart 2, below). However, barring significant changes in federal reimbursement policies, the program will go substantially over budget in the new fiscal year (2000-01).

The growing price tag of BadgerCare results from two factors:

- the higher-than-anticipated enrollment,
- And the greater-than-expected ratio of parents to children enrolled in the program.

The second factor influences costs in two very significant ways. First, the state gets a lower reimbursement rate for parents than for children (the 59% MA reimbursement vs. the 71% CHIP rate). Second, because adults are more expensive to cover, the state



found it necessary to agree to give the HMOs higher capitation rates when the BadgerCare contracts were renegotiated. Those contracts were increased by 12 percent, retroactive to July 1, 1999. It is still uncertain whether this level of expense for parents who do have not access to health care will continue.

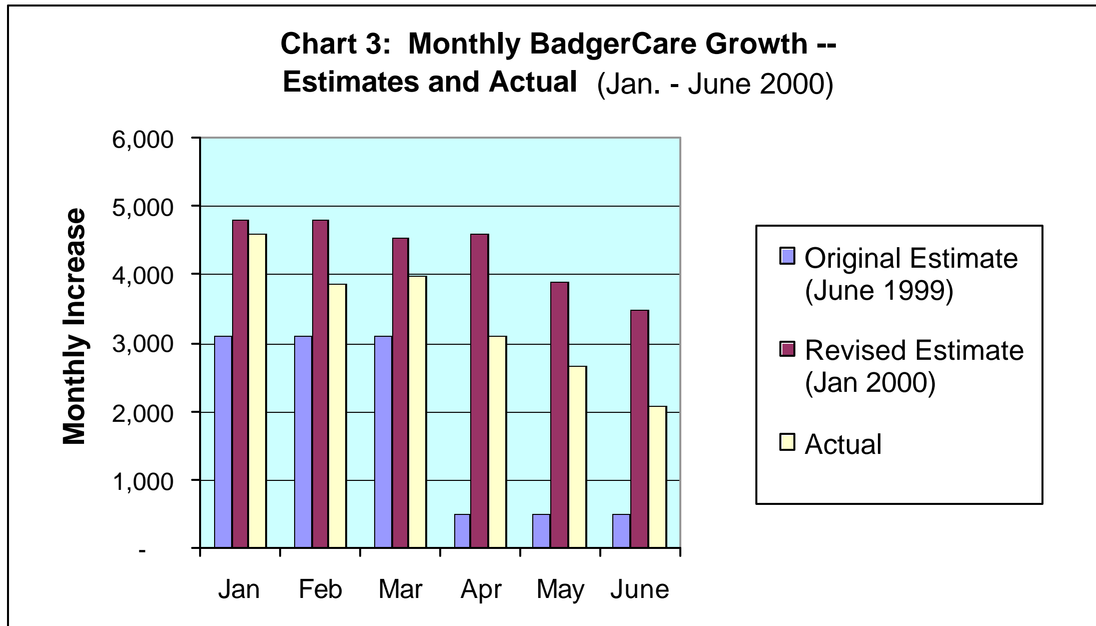
As previously noted, BadgerCare got off to a slow start. However, the program's growth was substantially greater than expected over the last three months of 1999. That growth rate prompted the Legislative Fiscal Bureau (LFB) to issue revised enrollment estimates in late January 2000 as follows

Original DHFS Projections for June 20, 2000	61,535
LFB Projections June 30, 2000	70,944
Actual June 30, 2000,	65,147
LFB Projections June 30,2001	82,236

The actual June 2000 enrollment is closer to original estimate.

Chart 3 compares the actual monthly growth in BadgerCare enrollment over the first half of 2000 with original projections and the revised LFB estimates. It illustrates a decelerating growth, but is still significantly above the rate that formed the basis for budget appropriations. It is the growth rate, more than the current enrollment level that raises concerns about the program's cost in FY 2000-01. Although BadgerCare's growth has been slower in recent

months LFB projections could materialize if the state is more aggressive in outreach and simplifying enrollment.



One consequence of the looming shortfall in the BadgerCare budget is that the state has not put as much emphasis on outreach as it might have minus a cloud of fiscal uncertainty. The state's reticence to do outreach is best illustrated by the fact that Wisconsin has not fully tapped a large pot of federal funds that can be used (with a 10 percent state, local or private match) to do outreach and improve enrollment in Medicaid and BadgerCare. Some outreach funds were used early on, but about $7 million remains unspent. The Department of Health and Family Services (DHFS) must submit a plan to the Joint Finance Committee for the expenditure of those funds. However, there seem to be reluctance by DHFS to promote the growth of BadgerCare, while it is unclear how the Legislature and Governor will handle the likely shortfall.

The CHIP Waiver Application

In light of BadgerCare's continued growth and the cost implications of the higher-than-expected enrollment of parents, DHFS has turned to the federal government for financial assistance.

The department is seeking a federal waiver to allow Wisconsin to use some of its allocation under the CHIP to pay for the coverage of parents. A waiver would have the practical effect of increasing the federal reimbursement rate for parents to 71 percent of costs, rather than the 59 percent rate paid under the Medicaid program. It would also potentially decrease the CHIP funding available for expanding coverage for children.

When the state submitted its waiver request to the federal Health Care Financing Authority (HCFA), it estimated that without the waiver Wisconsin would lose $15.7 million of CHIP funds on September 30, 2000, and $12 million to $13 million in each of the following two

fiscal years. The waiver would save the state roughly $12 million per year in general fund revenue.

Some national advocacy groups have questioned whether waivers should allow federal funding intended for children's health coverage to be used to pay for the coverage of parents. They argue that this is counter to the clear intent of Congress to use the CHIP funds for children, and that additional federal funding should be used specifically to expand the CHIP program to adults. Wisconsin officials respond that the CHIP legislation should be given a more flexible interpretation, and they believe an exception should be made for BadgerCare because the family-based approach increases enrollment among eligible children. They also argue that Wisconsin is a special case because our state has a relatively low number of uninsured children.

HCFA is in the process of developing guidelines for the approval of CHIP waivers. Advocates who have been closely monitoring the CHIP program expect the guidelines to follow the outline of a bill the President proposed that would have increased CHIP funding to extend it to parents. They speculate that waivers approving the use of CHIP funds for coverage of parents would be contingent upon meeting standards such as:

- Providing coverage for all uninsured children below 200 percent of the poverty level.
- Implementing measures to streamline enrollment, such as using short application forms and mail-in applications.
- Eliminating the Medicaid assets test for children.
- Using all of the state's allocation of federal outreach funds to promote enrollment in Medicaid and CHIP.

Any one of those standards could potentially prevent Wisconsin from getting a waiver; yet they are hurdles that the state could clear without much expense or difficulty. The most problematic standard is the requirement to cover children up to 200 percent of the poverty level. Since Wisconsin already covers families who enter BadgerCare with incomes below 185 percent of poverty, and allows them to remain in the program until their income reaches 200 percent, this standard probably would not pose a significant fiscal or political barrier. However, it might hold up a waiver for 6 to 12 months, until the Legislature can amend the income ceiling.

BadgerCare's Reduction of the Uninsured Population

The BadgerCare program has clearly caused a significant reduction in the number of uninsured children and parents in Wisconsin, though the exact size of that impact is debatable.

Survey data on the number of uninsured people in the state predates BadgerCare, and the results of the surveys have varied widely:

- The state's last Family Health Survey concluded that only about 57,000 children were uninsured in 1998 – 4 percent of Wisconsin's children.
- A recent report by the Kaiser Commission, using the average of the U.S. Census Bureau's March 1997 through 1999 Current Population Surveys, estimated that 100,000 children in Wisconsin, or 7.1 percent, were uninsured.

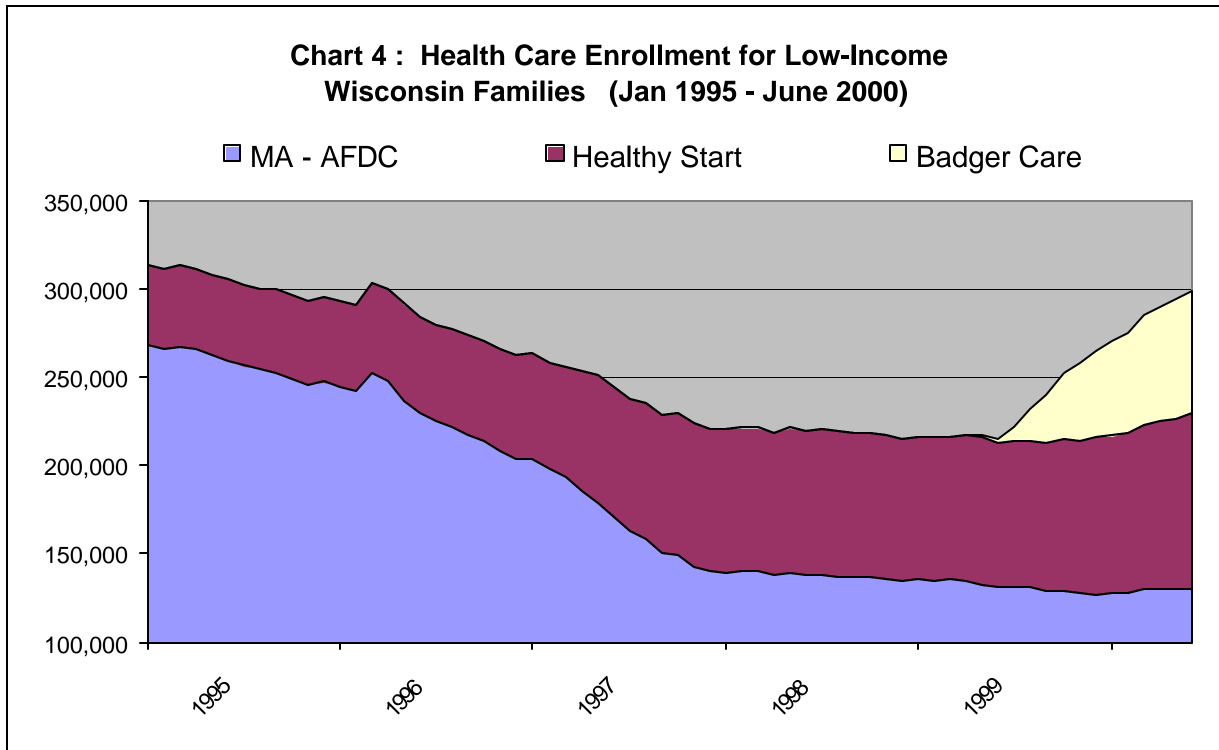
- A 1997 Urban Institute study determined that 6.3 percent of Wisconsin children were uninsured, including 68,000 (14.7 percent) of children below 200 percent of the poverty level.

To calculate the impact of BadgerCare, DHFS has generally used composite figures from the 1997 and 1998 Family Health Survey showing that there were 54,000 uninsured children under 200 percent of the poverty level. Using that figure, DHFS contends that BadgerCare has succeeded in covering more than 70 percent of the Wisconsin's low-income, uninsured children. That percentage reduction appears to be high, for several reasons:

- The number of uninsured children used as a base appears to be low, perhaps in part because the Family Health Survey is a telephone survey that could miss a sizeable number of low-income families without telephone service.
- DHFS counts 18 year-old BadgerCare and OBRA enrollees among the ranks of the newly insured, but it does not count 18 year-olds in its estimates of the uninsured.
- The department's calculation presumes that none of the new enrollees in BadgerCare previously had insurance; yet the state's original waiver application acknowledges that BadgerCare would and should also serve some low-income families who were already insured, but struggling with very high premiums, copays or deductibles.

When evaluating the impact of BadgerCare on the number of uninsured people in Wisconsin, it is important to note that enrollment in Medicaid declined sharply from 1995 through 1998. Chart 4, below, shows the cumulative enrollment in BadgerCare, Healthy Start, and Medicaid (the portion based on the old AFDC-MA standards) over the past five years. It illustrates that the total number of low-income children and parents covered by these programs dropped by about one third from January 1995 to January 1999, as families that left the old AFDC system also lost their health care coverage.

Chart 4 also shows the steep increase in coverage since BadgerCare began. Nevertheless, the total enrollment in those three components of "family health coverage" was nearly 15,000 lower on June 30, 2000, than it was in January 1995, when income eligibility limits were far more restrictive. Unfortunately, one of the things we do not know is the degree to which families that were covered by Medicaid in the past are now covered by private insurance. The next Family Health Survey should shed more light this issue.



Although the state's calculation of BadgerCare's impact on the number of uninsured children seems to be overly optimistic, the program does appear to have produced a very significant reduction in the ranks of Wisconsin's uninsured children – particularly those in families below 150 percent of the poverty level. We should have better data on the number of uninsured children and parents this fall, after the release of new survey results from the state, the Census Bureau and the Urban Institute.

Learning from Other States

The BadgerCare program has given Wisconsin a national reputation as a leader and innovator in improving access to health care. To a large extent that reputation is deserved. Yet many states are doing a better job than Wisconsin in improving the enrollment process and expanding eligibility. In addition, numerous states have gone beyond Wisconsin in the coverage of children, and some states are covering childless adults.

Insuring Adults –Wisconsin has led nationally in expanding coverage for parents. However, our state is not alone in making health insurance more accessible for parents. For example:

- Minnesota covers uninsured parents and children to 275 percent of the federal poverty level.
- New Jersey recently approved expansion of coverage to parents to 200 percent of the poverty level, using its tobacco settlement funds, and it covers children to 350 percent of the poverty level.
- Vermont provides insurance for parents and other uninsured adults to 185 percent of the poverty level and covers children to 300 percent.

Like the majority of states, Wisconsin does not generally provide health insurance for low-income adults who do not have children. However, Vermont, New Jersey and a number of states are beginning to cover uninsured, childless adults.

Eligibility Standards for Children – As of March 2000, 32 states had either implemented or adopted legislation to cover children to 200% of FPL or higher. Nine of those states cover kids up to at least 250% of FPL, and six have extended health care eligibility for children to at least 300 percent of the federal poverty level.

Most states have higher income eligibility ceiling for children than for parents. Wisconsin officials contend that the two-tier eligibility systems are more complicated and confusing for families. That may be true, but it is worth exploring whether BadgerCare participants would welcome that added bit of complexity if it means that they can maintain health care for their children when their income reaches 200 percent of the poverty level.

One advantage of setting a higher eligibility ceiling for children is that it allows the system to be structured so health care subsidies phase out more slowly as income increases. A recent study published by the Public Policy Forum shows the steep drop-off in disposable income faced by families with children when their income reaches 200 percent of the FPL (and they lose eligibility for both health care and child care subsidies).

Streamlining Enrollment – To increase program participation, 41 states allow applications to be mailed rather than requiring a visit to a worker at the county office. At least 30 states use shortened applications, which facilitate the mail-in process. Piloting of these approaches in selected Wisconsin counties has been promised for several years and is still planned for later this year. With so much experience in other states, advocates suggest that Wisconsin should be well beyond the planning stage on these proven methods of simplifying enrollment.

Conclusion

The first year of BadgerCare has generally been quite successful. It is a program that legislators and the Governor can be proud of. However, that pride should not blind policymakers from seeing that many states have surpassed Wisconsin in streamlining the Medicaid enrollment process and in expanding eligibility for children. Several states have also recently set aside large portions of their tobacco settlement funds or new tobacco taxes to expand coverage to low-income parents and other uninsured adults.

By learning from the model practices in other states, as well as from our own successes and shortcomings, Wisconsin can continue to progress toward Governor Thompson's goal of ensuring that "hard-working families don't have to go without health care for their children as they climb the economic ladder."