
Clearing up the Confusion Surrounding CMS Approval of BadgerCare Plus

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Wisconsin is beginning to implement the BadgerCare Plus plan, which will make quality, affordable health insurance available to virtually all children in the state, regardless of income (effective on February 1, 2008). It also improves access to health care for many parents, caretaker relatives, and pregnant women. The new law continues Wisconsin's national leadership in providing innovative and cost-effective health care solutions for children and families.

The Centers for Medicare and Medicaid Services (CMS) approved the Medicaid and Children's Health Insurance Program (CHIP) plan amendments needed for BadgerCare Plus on November 27, 2007, clearing the way for Wisconsin to proceed with implementation of the significantly expanded coverage. The brief CMS press release about the approval of BadgerCare Plus may create some misunderstanding about the effects of changes that were agreed upon by state and federal officials. This paper is intended to clear up possible confusion about BadgerCare Plus and the plan amendments approved by CMS.

The Wisconsin initiative is the first significant expansion of coverage to gain federal approval in the wake of controversial new CMS policies restricting the use of federal CHIP and Medicaid funding. Those restrictions increase the state share of the cost of BadgerCare Plus, but do not change the number of people who will be covered or the benefits they will receive. One rationale for the federal restrictions is that states should focus on covering low-income children. However, Wisconsin policymakers believe that by being able to communicate a clear message that all kids are eligible, regardless of income, the state will be much more successful in enrolling lower income children.

Overview of BadgerCare Plus

The BadgerCare Plus initiative will make health insurance available to uninsured children

regardless of income, provided they are U.S. citizens or have been lawfully present immigrants in the U.S. for at least 5 years. Insurance coverage will be subsidized for children whose family income is at or below 300 percent of FPL. Families above that income level can buy coverage for their uninsured children at full cost.

In addition to removing income limits for kids, BadgerCare Plus expands coverage for a number of other groups, including pregnant women, caretaker relatives, youths who have to leave foster care at age 18, and farmers and other self-employed parents. Coverage of childless adults is planned to begin in 2009, if the state is able to obtain a federal Medicaid waiver. A diagram showing the expanded categories of coverage is included in Appendix 1.

Although the expansions of eligibility generally draw the most attention, child advocates are particularly pleased that BadgerCare Plus is designed to reach children who are already eligible but not enrolled. Roughly two-thirds of the 98,000 Wisconsin kids who were uninsured for all or part of 2006 were under 200 percent of the poverty level. Additional information about BadgerCare Plus, including the strategies for increasing participation by already-eligible families, can be found in Appendix 1.

CMS Restrictions on CHIP and Medicaid Funding

On August 17, 2007, CMS issued a directive restricting the ability of states to use their allocations of funding from the Children's Health Insurance Program (CHIP). States that are currently using or proposing to use CHIP funds for kids over 250 percent of FPL will have to meet the following four requirements:

- Demonstrating that they have enrolled at least 95 percent of eligible children who are in families with incomes below 200 percent of FPL.

- Establishing a minimum of a one-year period of uninsurance for individuals in families with incomes greater than 250 percent of FPL (regardless of how they lost their coverage).
- Demonstrating that the number of children in the target population insured through private employers has not decreased by more than 2 percentage points over the prior 5-year period.
- Adopting cost-sharing requirements for children in families with incomes greater than 250 percent of FPL that are comparable to competing private plans' cost-sharing amounts (or equal to the cost-sharing limit permitted in CHIP, 5 percent of family income).

Many analysts believe that few, if any, states will be able to satisfy all of those standards, making it nearly impossible to use CHIP for children whose family income level exceeds 250 percent of FPL. For more information about the CMS directive and the difficulty facing states seeking to comply, see the analysis by the Center on Children and Families, *Moving Backward*.¹

Initially, the CMS policy is just being applied to states like Wisconsin that are expanding or attempting to expand coverage. But starting in August 2008, it will apply to previously-approved expansions, which puts at risk the coverage of many children in 14 states that had already begun covering kids in families above 250 percent of FPL.²

In more recent months, CMS has begun extending the principles contained in the August 17 CHIP directive into the Medicaid policy arena. On December 20, 2007, CMS rejected a proposal by Ohio to expand its Medicaid program to cover

¹ *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children*, by Cindy Mann and Michael Odeh, Center for Children and Families, Georgetown University, December 2007.

² Three of those 14 states set their income ceiling at 250% of FPL but allow deductions from gross income that apparently will no longer be permitted, which means that those states will also have to comply with the new CMS policies.

35,000 children between 200 and 300 percent of FPL. An article in the January 4, 2008 *New York Times* quoted the explanation offered by CMS director Dennis Smith: "To be consistent and logical, you have to apply the criteria to Medicaid and CHIP."

States and advocates have raised legal and substantive concerns about the CHIP and Medicaid restrictions. With respect to the legal or procedural issues, some states argue that CMS lacks statutory authority for capping the use of the federal funds, and contend that policy changes of such magnitude require support in statute, or at least in administrative rule, rather than unilateral and informal policy documents issued by an agency. New Jersey has filed a lawsuit to enjoin the August 17 directive, and at least nine other states are also pursuing legal challenges to the directive.

There are a number of substantive reasons why states are concerned about setting an income cap at 250 percent of FPL on health care subsidies for working families. Many policymakers believe that health care insurance is out of reach financially for some families above 250 percent of FPL, if they do not have access to affordable employer-sponsored coverage. That is especially true in states with a higher cost of living.

In Wisconsin, there are relatively few uninsured children between 250 percent and 300 percent of FPL – probably less than 7,000 children who were uninsured for all or part of 2006.³ However, advocates and policymakers agreed that coverage of children should be subsidized (using a graduated premium schedule) for families with incomes up to 300 percent of FPL who do not

³ The state's annual Family Health Survey found that there were about 13,000 uninsured children (for all or part of 2006) who lived in households between 200 and 300% of FPL, 15,000 uninsured children in households at 300% or more of FPL, and 2,000 uninsured children in households at 200% of FPL or greater, but the interview did not provide enough information to further classify their income. Based on those figures, we think it is safe to estimate that there were less than 7,000 uninsured children between 250 and 300% of FPL. Some of those children will probably be ineligible for BC+ because of policies to discourage "crowd out" of employer sponsored coverage.

have access to affordable employer sponsored insurance for their children.

Removing the income ceiling on eligibility for children is not intended just to help the newly eligible families over 200 percent of FPL. It also allows the state to convey a clear and simple message that virtually all children are eligible, and it reduces the stigma of participating in a means-tested program. California counties with local programs to cover all kids have found the expansion of eligibility to be a very effective way of increasing participation among lower income families who were already eligible.

Effects of the CMS Policy Changes

Wisconsin officials quickly decided after the August 17 CHIP directive was issued that the state would not try to satisfy the new requirements.⁴ Instead, the state modified the proposed CHIP plan amendments by seeking to use federal funds only for children at or below 250 percent of FPL. Somewhat later in the federal review process, state officials also had to accept a similar change in the Medicaid plan amendment, limiting the use of Medicaid funds for pregnant women to those below 250 percent of FPL.

Notwithstanding those concessions, Wisconsin is extending coverage to children and pregnant women above 250 percent of FPL, but will not receive federal financial participation (FFP) for these groups where their family income is above 250 percent. The lost FFP is expected to increase the state's share of costs by close to \$600,000 per year for the children and roughly \$1.5 million for pregnant women.

The Wisconsin experience illustrates that it is still possible for a state to accomplish a substantial expansion of health insurance coverage, despite the added challenges and increased expense to the state resulting from the August 17 CMS directive. However, there were several factors that made it

⁴ State officials had several concerns about trying to comply with the new requirements for using CHIP funds for children above 250% of FPL. One of the chief fears was that uncertainty surrounding how or whether states would be able to demonstrate that they met the 95% coverage requirement would, at the least, delay the approval of the needed plan amendments.

easier for Wisconsin to comply with the CMS restrictions than appears to be the case in a number of other states:

- Compared with the 14 states that had already implemented coverage expansions above 250 percent of FPL, Wisconsin may have had more latitude in the details and financing of its plan – simply because that plan hadn't been completed and set in place.
- The Governor had made a very strong commitment to enact and implement a broad expansion of access to health insurance, so the Doyle Administration was more willing to compromise and absorb the added costs stemming from the CMS policy changes.
- Wisconsin has a high rate of employer sponsored insurance relative to other states, which helps hold down the cost of subsidies for uninsured children in families between 250 and 300 percent of FPL.

It should also be noted that the two CHIP reauthorization bills vetoed by the President contained provisions that would have preempted the August 17 directive. Because of that political backdrop, CMS may have been somewhat more inclined to reach an agreement with Wisconsin, in order to demonstrate – while Congress was still considering the CHIP legislation – that the agency's policy changes were not an insurmountable barrier to expanding coverage.

Restrictions on Eligibility for People with Access to Private Coverage

The November 27 CMS press release might be misconstrued as suggesting that Wisconsin agreed to adopt tougher policies to discourage the displacement of private coverage by public insurance coverage ("crowd-out"). That is not the case. Wisconsin has long had fairly stringent policies to deter crowd-out, and the state will continue to employ a number of significant strategies to prevent public coverage from supplanting employer-sponsored insurance. However, the new BadgerCare Plus program makes the crowd-out policies more logical and more consistent.

BadgerCare Plus will generally limit eligibility to those who in the previous year have not had

access to an employer-sponsored plan that pays at least 80 percent of the premiums. However, the policies to deter crowd-out will no longer be applied to people in families below 150 percent of FPL, or to people who have purchased private coverage for themselves.

Wisconsin will continue to allow a number of good cause exceptions to the crowd-out policies. For example, employees who have been laid off will not be excluded from BadgerCare Plus coverage. That exception and other aspects of Wisconsin's crowd-out policies would not have been allowed by CMS if state officials had sought authority to use CHIP funds for children over 250 percent of FPL.

Using CHIP for Parents

Since 1999, another key part of Wisconsin's strategy for enrolling more low-income children has been to also cover their parents. Because Wisconsin had already expanded coverage of children prior to enactment of CHIP, Wisconsin built up a large surplus of CHIP funds and in 2001 the state obtained a waiver to allow CHIP dollars to be used for parents above the poverty level.

The CMS press release about the approval of BadgerCare Plus creates the misimpression that the CHIP plan amendments were conditioned upon ending the use of CHIP funds for parents. That was not part of the November 2007 agreement reached by state and federal officials. Wisconsin plans to continue using CHIP dollars for parents through at least the end of 2008.

Perhaps the CMS release was alluding to the fact that Wisconsin has significantly reduced CHIP spending for parent coverage this year. The current BadgerCare waiver, which took effect in June 2007, narrows the use of CHIP for parents to families above 130 percent of FPL. In addition, the state is discussing with CMS the transition of the higher income parents from CHIP into Medicaid in the context of a childless adult expansion waiver.

Conclusion

Wisconsin has long been a national leader in providing innovative health care solutions for

children and families. Approval of the plan amendments for the BadgerCare Plus initiative enables Wisconsin to continue that leadership and take 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 had to make a few concessions to obtain federal approval of the CHIP and Medicaid state plan amendments for BadgerCare Plus. Those concessions reduce the federal share of the program's costs and increase the state share by roughly \$2 million per year. However, they do not alter the breadth of the expanded coverage or the changes made to reduce barriers to participation.

During the debate about reauthorization of the CHIP law, there was a great deal of rhetoric about the importance of getting states to do a better job of providing health insurance for low-income working families. BadgerCare Plus is designed to achieve that bipartisan objective. It does so through a variety of different strategies – including removing procedural barriers for participation, reducing premiums, and narrowing the policies to deter displacement of employer-sponsored insurance.

Perhaps the most important strategy for reaching children in lower-income families is making insurance coverage available for uninsured children regardless of income. That central element of BadgerCare Plus enables the state to convey a clear and simple message that all uninsured children are eligible, and it removes the stigma of participation in a low-income program.

Wisconsin officials should be commended for agreeing to absorb the additional costs that will result from the CMS policy changes and for not settling for a narrower program that would be less effective in increasing participation among low income children and parents. Unfortunately, other states working on coverage expansions have had greater difficulty in coping with the more restrictive CMS policies.

Jon Peacock, Research Director
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Appendix 1 – Summary of BadgerCare Plus

The BadgerCare Plus (BC+) initiative makes health insurance available to uninsured children regardless of income, provided they are U.S. citizens or have been lawfully present immigrants in the U.S. for at least 5 years. Insurance coverage will be subsidized for children whose family income is at or below 300 percent of FPL. Families above that income level can buy coverage for their uninsured children at full cost.

BadgerCare Plus consolidates and expands three existing programs: family Medicaid coverage (s. 1931 coverage), the Healthy Start program for pregnant women and young children (poverty level coverage), and the BadgerCare program (CHIP) for children and parents in working families. In addition to removing income limits for kids, BC+ expands coverage for a number of other groups, including pregnant women, caretaker relatives, youths who have to leave foster care at age 18, and farmers and other self-employed parents.

The state hopes to begin coverage of childless adults in January 2009. The state budget bill approved the statutory authority for that second stage of BC+, but did not appropriate any new funding for it. The Department of Health and Family Services (DHFS) will need to obtain a federal Medicaid waiver for that expansion of insurance coverage and will also need to find a way to reallocate funding to begin phasing it in.

Making a significant dent in the number of uninsured children and parents in the state requires strategies to improve participation among families who were already eligible for state-subsidized coverage but were not enrolled. BC+ makes a number of changes to reach already-eligible children and parents, including:

- Simpler enrollment procedures, such as increased use of on-line enrollment and initiating “express enrollment” (presumptive eligibility) for children below 150 percent of FPL.
- Eliminating premiums for children under 200 percent of FPL.

- Reducing red tape and other barriers, such as the previous BadgerCare employer verification process.
- Removing the upper limit, which enables the state to convey a simple message that all uninsured children are eligible, and which removes the stigma of participating in a low-income program.

One of the changes made in BC+ to simplify administration is the use of a new income standard that only allows two deductions from gross income. That change may have made it easier for the state to secure CMS approval of BC+, but that was not the primary intent. It was a change that state officials recommended nearly a year before CMS unveiled its August 2007 CHIP directive.

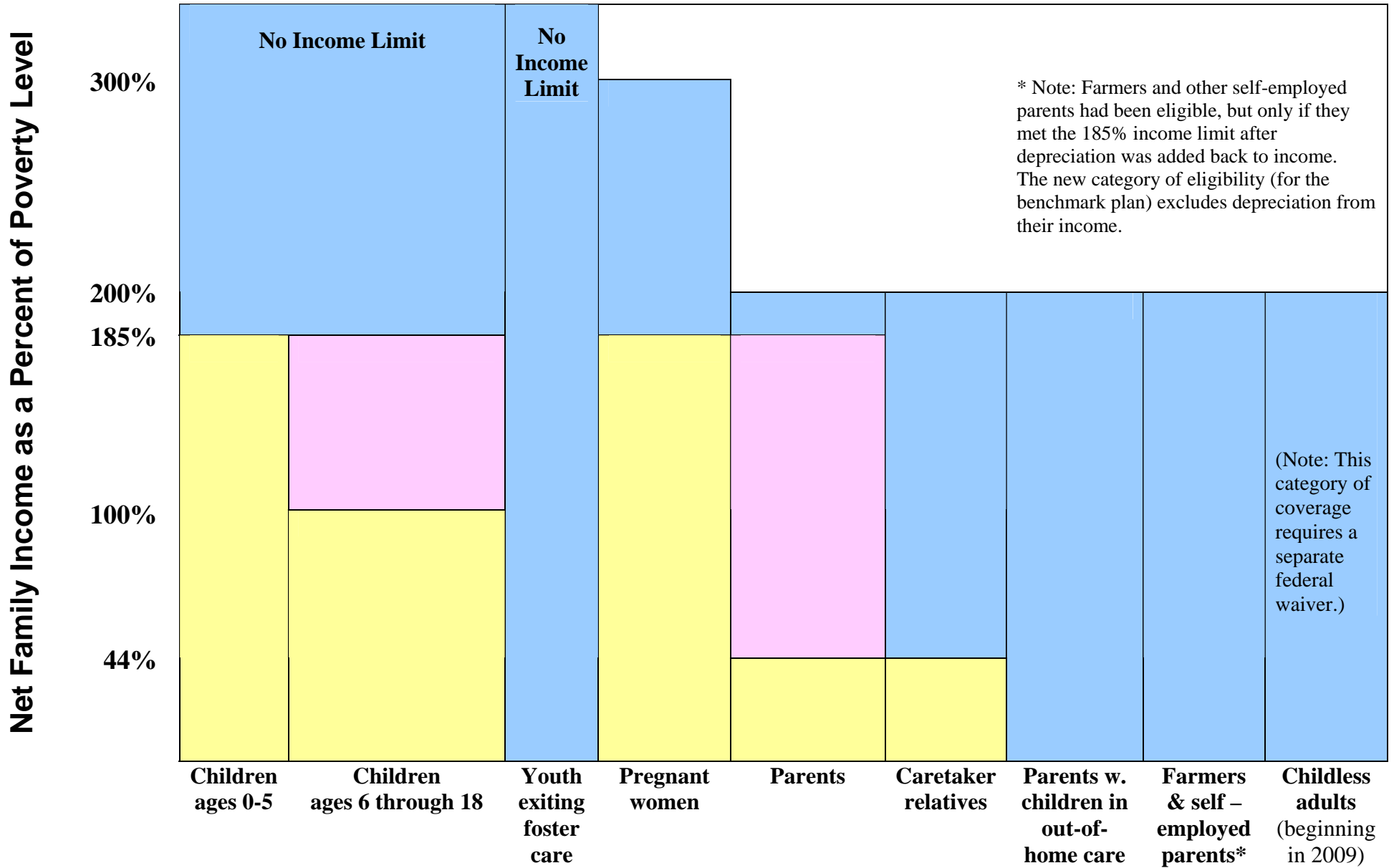
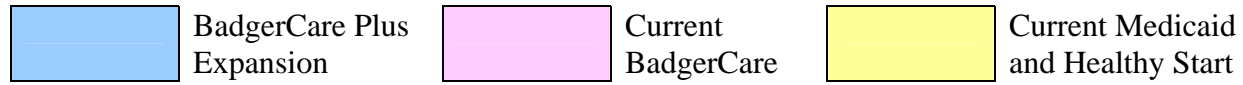
Premiums for children enrolled in BC+ begin at 200 percent of FPL and are \$10 per child per month for families up to 230 percent of FPL. They gradually rise to \$68.25 per child (full cost) for kids above 300 percent of FPL.

As the chart on the next page illustrates, coverage of parents stops at 200 percent of FPL. Premiums for parents begin at \$10 per parent per month for families from 151-160 percent of FPL, and they gradually rise to a maximum of 5 percent of family income (for coverage of either one or both parents).

Kids and parents at or below 200 percent of FPL are eligible for the same comprehensive benefits package that the state previously provided under Medicaid and BadgerCare (known as the Standard Plan). Children above that income level will receive a somewhat narrower benefits package, which is known as the Benchmark Plan because it is comparable to Wisconsin’s largest commercial, low-cost health care plan.

Additional information about BadgerCare Plus can be found on the DHFS website at: www.BadgerCarePlus.org and on the WCCF website at: http://www.wccf.org/health_pub.php.

Appendix 1 (continued) -- Family Health Coverage -- Before and After BadgerCare Plus



(Prepared by WCCF, with assistance from the WI Department of Health and Family Services)