BadgerCare: A Case Study Of The Elusive New Federalism

Wisconsin officials raise questions about federal barriers that now stand in the way of a new state program to help poor families.

by Peggy L. Bartels and Pris Boroniec

Bruce Spitz contends that the guiding premise of new federalism is neither a new set of principles devolving responsibility to the states nor a new unified vision or set of policy goals. Rather, even with new federalism, the federal government continues to dictate what states may do and how they may do it.

Wisconsin designed BadgerCare to assure an integrated system of health care coverage for low-income families with children. Wisconsin has a ten-year history of success with welfare reform. As a complement to these reforms, BadgerCare is an innovative health care program to bridge the gap between Medicaid and private insurance for the working poor. BadgerCare builds upon the intent of Title XXI, the new State Children’s Health Insurance Program (CHIP).

Wisconsin has moved beyond the planning process to seek federal approvals for implementation. Although state legislation passed with overwhelming bipartisan support, and federal officials originally indicated that key provisions of BadgerCare were “approvable,” more than a year of negotiations with the federal government recently ended in an impasse.

The Context: Welfare Reform

For more than ten years Wisconsin has successfully implemented numerous welfare reform initiatives to strengthen families by promoting self-sufficiency and independence through employment. From 1987 to 1997 the number of Aid to Families with Dependent Children (AFDC) recipients declined 67 percent. Over that same period low-income children, families, and pregnant women qualifying for Medicaid under AFDC and Healthy Start guidelines fell 26.5 percent. This decline was significantly less than the decline in AFDC in part because of Wisconsin’s broad-based expansions of Medicaid eligibility.

On 1 September 1997 Wisconsin implemented Wisconsin Works (W-2), its Temporary Assistance to Needy Families (TANF) program, which replaced AFDC. Our goal is to assure that a family that moves from welfare to work will not join the ranks of the uninsured.

Even in advance of W-2, the success of programs that reward work and self-sufficiency resulted in a significant and sustained decline in the state’s AFDC caseload. Along with this decrease, however, came a dramatic reduction in Medicaid eligibility for low-income families and children. Since 1995 the enrollment of low-income children and adults in Medicaid has decreased by more than 92,000 persons.

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In the wake of welfare reform, many families do not have access to affordable, employer-sponsored health insurance. Medicaid does not cover all members of intact families. Other families do not understand that they may be eligible for Medicaid. In short, the safety net fails to protect some of the most vulnerable citizens: children.

**BadgerCare At A Glance**

BadgerCare is designed to provide access to health care for all children and adults in uninsured families with incomes below 185 percent of the federal poverty level. Once enrolled, families may remain in the program until family income exceeds 200 percent of poverty. Under BadgerCare, Wisconsin’s current Medicaid program remains an entitlement, including generous categorical and medically needy eligibility criteria. BadgerCare also extends Medicaid eligibility to certain parents whose children have been temporarily removed from the home by child welfare agencies, to allow treatment to support family reunification.

Major components of BadgerCare include (1) monthly premiums of 3–3.5 percent of family income for families at or above 150 percent of poverty; (2) provisions to prevent the “crowding out” of private insurance, including the denial of coverage for individuals with insurance or with access to family insurance for which an employer pays 80 percent or more of the cost; (3) a buy-in of employer-based group health coverage, where cost-effective, with coverage provided up to the Medicaid benefit, if the employer plan is more restrictive than Wisconsin Medicaid; and (4) benefits identical to the comprehensive package covered by Wisconsin Medicaid, with care delivered through Wisconsin’s existing managed care program.

The single most important goal of BadgerCare is to provide health care to uninsured children. We believe that family-based coverage will be more effective than child-only coverage in achieving this goal. Kenneth Thorpe has estimated that, on average, Medicaid child-only expansions enroll about 45 percent of those potentially eligible, while family-based expansions bring in 75 percent of potential eligibles. Another, more recent, study reinforced this finding.

By expanding Medicaid eligibility under Title XIX and by implementing a state block grant program under Title XXI, BadgerCare is designed to help families that do not qualify for Medicaid and that do not have private insurance. In particular, BadgerCare (1) provides a safeguard against unintentionally increasing the number of uninsured children and parents through welfare reform; (2) complements W-2 by providing access to health care, thereby eliminating a barrier to successful employment; (3) assures access to health care for all low-income families without employer insurance; (4) integrates employer insurance with Medicaid, while building on the health care system that is a reality to working families; (5) promotes personal responsibility through cost sharing; (6) improves health outcomes and reduces uncompensated care by establishing a “medical home” for all low-income families with children; (7) preserves the accessibility and integrity of Wisconsin’s current Medicaid program by simplifying income, asset, and eligibility requirements for all family members, not just selected children; and (8) streamlines eligibility procedures and health maintenance organization (HMO) enrollment for health care.

**How Earlier Approaches Fell Short**

- **Medicaid’s weaknesses.** To preserve access to care for low-income families with children, state programs must recognize that most low-income families now work, that AFDC income standards required for Medicaid are significantly less than the minimum wage, and that health care is not always accessible or affordable through employment. Even with more generous categorical and medically needy income and resource standards in Wisconsin, the patchwork quilt of Medicaid coverage is confusing for families, eligibility workers, health care providers, and advocates.
Empowering families to navigate this system is difficult, given the separate eligibility criteria for Medicaid and welfare and given Medicaid's ties to old AFDC rules that use income disregards, time-limited extensions, deductibles and spending-down, and family fiscal units. Federal law that requires Medicaid eligibility to be determined before CHIP eligibility hampers state initiatives to simplify and coordinate access to care.

■ **CHIP shortcomings.** Press reports from several states appear to indicate disappointing initial results of the enrollment of children in CHIP. Some reports cite the need for increased outreach, while others question whether program changes may be needed to address the needs of low-income families with working parents. Long-run implications on the effectiveness of enrollment also may emerge from the lack of coordination between CHIP and Medicaid in several states. Although many states have streamlined the eligibility-determination process for CHIP through the use of mail- and phone-in applications, if a child is potentially Medicaid eligible rather than CHIP eligible, referral is made to a separate agency. The lack of processes to guarantee immediate enrollment of Medicaid-eligible children and the detailed information still required by the Health Care Financing Administration (HCFA) to assure compliance with obsolete AFDC rules continue to create enrollment barriers for Medicaid.

■ **Federal/state balancing acts.** The unwavering federal commitment solely to the Medicaid entitlement fails to recognize the balanced budget requirements of state constitutions and the political realities of rolling back Medicaid coverage. Unlike the federal government, which can incur large deficits, state legislatures must ensure that expenditures do not exceed revenues and must match program expansions to revenues available. State legislatures also must face the political dilemma of ratcheting back eligibility for optional Medicaid coverage or of allowing waiting lists until funds can be appropriated.

In exerting leadership to craft new and innovative health care reform initiatives, state legislatures must balance benefits and risks. Although new programs may be budgeted as fully funded, changes in program participation, supplanting of private insurance, and changes in the economy may lead to higher program costs. New federalism's promise to foster innovation by the states can succeed only if realistic choices are made to allow state legislatures to address the needs of their citizens while balancing state fiscal constraints and avoiding rash cuts in program eligibility.

**The Federal Approval Process**

In seeking federal approval for BadgerCare, the state of Wisconsin submitted a concept paper in September 1997, and ongoing discussions on structuring the state's waiver were held with HCFA staff and officials before the state's waiver request was submitted to HCFA in January 1998. Based on guidance from HCFA, all waivers necessary to implement BadgerCare were requested under Medicaid, and none were requested under Title XXI. As a result, implementation of BadgerCare requires federal approvals for a Title XXI (CHIP) state plan and a Title XIX (Medicaid) waiver.

Although Wisconsin has followed HCFA's process and guidelines to assure that the state submitted an “approvable” waiver, HCFA staff subsequently raised fundamental concerns with BadgerCare. Of particular concern were the cost-effectiveness test of our proposed family-based coverage and the integration of Medicaid and CHIP through a state block grant program under Title XXI. Although the discussion of issues has continued over the past year, key objections and issues raised by HCFA include the following.

1. Requirement to cover parents and children under a Medicaid entitlement: According to HCFA policy, an adult cannot be covered under a federal entitlement program (Medicaid) if the child is covered under a state optional program (CHIP). 2. Cost-effectiveness of covering families under CHIP: HCFA guidance on the coverage of parents...
under CHIP began with advice to compare BadgerCare costs with those of commercial coverage. Subsequently, HCFA advised that Title XXI is limited to children, except for the purchase of employer-based family coverage for parents and children if cost-effective. (3) Allocation of cost-sharing to Medicaid and CHIP: HCFA has indicated that only Title XIX federal matching funds may be provided for the portion of family premium costs associated with parents. (4) Budget-neutrality for child welfare extension: HCFA has questioned the cost-neutrality test for mothers whose children are temporarily removed from the home by child welfare agencies under Title XIX.

**Wisconsin’s Response**

Wisconsin contends that Titles XIX and XXI provide flexibility to HCFA to approve BadgerCare and that federal administrative policies, not federal law, prevent approval of BadgerCare. The underlying goals and statutory provisions for CHIP, along with existing Title XIX provisions, both anticipate and allow HCFA’s approval of innovative state health care plans, including BadgerCare.

■ **Title XXI.** Title XXI (CHIP) includes provisions to assure state flexibility to identify and design effective programs; require states to specify strategic objectives to meet their unique needs; and allow states to purchase family-based coverage. New opportunities created in Title XXI, along with the approval of many existing Medicaid waivers for state health care reform initiatives, provide a basis to support and foster state innovation and reform.

As enacted, Title XXI anticipates alternative program designs, recognizing that a myriad of goals, issues, and opportunities confront each state in implementing CHIP. Title XXI also requires states to describe strategic objectives, performance goals, and performance measures in providing access to health insurance for targeted low-income children. Under CHIP, states may purchase family coverage that includes targeted low-income children if the coverage is cost-effective and does not substitute for other insurance coverage.

During the past year HCFA has suggested at least three different alternatives to document cost-effectiveness, the most recent of which, based on our state employee benefits package, has been neither accepted nor rejected. HCFA has commented that the cost-effectiveness provisions in Title XXI do not make sense. As HCFA administers Title XXI, reasonable tests of cost-effectiveness for family coverage need to be developed, and HCFA needs to work cooperatively to assist states that wish to pursue family-based coverage as the most effective way to reach and enroll their low-income children in health insurance. Also, the CHIP legislation specifically provides HCFA the authority to grant waivers of Title XXI.

■ **Title XIX.** In addressing concerns with the authority to grant Medicaid waivers for BadgerCare, current federal law and waivers granted in other states support approval of BadgerCare. Neither federal law, regulation, nor any published advisory material specifies that an adult caretaker relative of a dependent child can be eligible only if the child is Medicaid eligible. In fact, under current Medicaid policy a parent can choose to exclude a child from Medicaid eligibility and still become (or remain) Medicaid eligible. Examples of this include parents of children receiving child support or survivor or disability payments, when their children are not eligible because of excess income. Further, Medicaid contains no inherent prohibition on covering adults as long as they are part of families with children who meet required income and asset tests.

In prior Medicaid waivers for Wisconsin and other states, HCFA has allowed states to project budget-neutrality based on actuarially equivalent populations. In determining budget-neutrality for the extension of Medicaid coverage to parents whose children have been removed from the home by a child welfare agency, HCFA objected to the calculation of base-year case management costs using this methodology. As of this writing HCFA had not yet responded to additional information
submitted to address this issue.

Wisconsin has continued to negotiate with HCFA to secure federal approval for BadgerCare. Based on HCFA guidance, a compromise was proposed to restructure BadgerCare’s cost sharing and federal funding as a Medicaid program. As part of the compromise, the state requested a capped Medicaid entitlement. (State statutes preclude implementation of BadgerCare as an entitlement program.) In spite of similar provisions approved in Tennessee, HCFA denied this request as a “new precedent.”

With a year since the passage of CHIP, Wisconsin also has requested that HCFA begin to approve waivers under Title XXI, an alternative that has been available since the law was enacted in the summer of 1997. Thirty states have approved Title XXI plans, and twenty states have submitted plans. Many of those states are operating expansions of programs already in place rather than starting new child health programs. The deliberate pace of state plan approvals and the ever-increasing need for affordable health insurance for working families make it imperative that HCFA grant waivers of Title XXI now.

Finally, with our current experience regarding the prospects for new federalism, Wisconsin is now seeking congressional action to establish clear authority for HCFA to approve BadgerCare as originally proposed. In the absence of action by HCFA to clearly state and stand by its guidance, even if that guidance sets a “precedent” not formerly granted but clearly allowed under federal law, a remaining option is to seek passage of federal legislation to secure approval of BadgerCare.

Wisconsin has experienced the success and the reality of welfare reform. We have moved families from welfare to work, but the state’s working families need to be assured of health care. BadgerCare would assure access to health care for all low-income children and the adults who support them.

Wisconsin believes that approval of BadgerCare, as originally proposed, is critical to the continued success of families who move from welfare to work. With our decade-long success in implementing programs that foster the independence of families, we believe that states should be trusted to test health care reform initiatives just as they were allowed to experiment with welfare reform.

With different issues and opportunities in each state, now is the time to truly test the new federalism. States must be free to establish programs that work and respond to the needs of their citizens. To complement successful welfare reform, states, with the support and assistance of the federal government, need to reach out to families, not just to children.

As Wisconsin’s experience details, it will be difficult for a state alone to keep pace with the continuum of services needed under welfare reform, if new federalism remains an elusive goal. Once a state and the federal government begin to share a common vision and build on our collective wisdom and resources, the needs of our citizens will be better met.

The authors thank Wisconsin Governor Tommy G. Thompson and Secretary Joe Lee an of Wisconsin’s Department of Health and Family Services for their support, commitment, and vision in providing access to health care for Wisconsin’s citizens.

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