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WISCONSIN: ROUND 1

State-Level Field Network Study
of the Implementation of the
Affordable Care Act

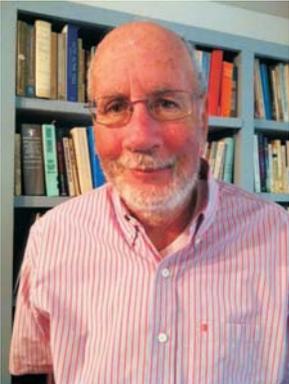
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WISCONSIN: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1 Decisions to Date

Health Insurance Exchange: Wisconsin's leadership opted out of creating a state-based health insurance marketplace after initially expressing interest and exploring options for developing an exchange.

In fall 2010, under former Governor Jim Doyle, Wisconsin received a \$1 million federal planning grant for exchange development. In February 2011, Wisconsin was one of seven government entities (six states and one multistate consortium) to receive \$37.8 million in early innovator funds. Before leaving office, Doyle's administration set up an Office of Health Care Reform and released an exchange prototype of enrollment technology. Democratic leaders in the legislature also favored a state-run exchange. In spring 2010, a bipartisan study committee on health care reform, staffed by the Legislature Council, a nonpartisan service agency that staffs study committees, was convened. The committee then met several times through the rest of 2010.

The November 2010 elections turned over both the executive and legislative branches to Republican control. The new leadership of the legislature cancelled all scheduled meetings of the study committee on health care reform and then disbanded the committee. One of Governor Scott Walker's first moves upon taking office was to issue an Executive Order that changed the Wisconsin Office of Health Care Reform into the Office of Free Market Health Care.¹ In fall 2011, this office conducted some early stakeholder engagement efforts, such as fielding a survey about exchange development² and formed stakeholder work groups run by the Office of the Commissioner of Insurance (OCI).³

The legislature and the Walker administration then proceeded to consider a series of issues surrounding implementation of a Wisconsin exchange. In fall 2011, the state's insurance commissioner — an appointee of the governor — issued draft administrative rules and proposed legislation to bring some aspects of state law in line with the Affordable Care Act (ACA) and prepared for implementation of a Wisconsin insurance exchange. The Assembly Insurance Committee passed, on a bipartisan basis, Assembly Bill 210, which codified state law with certain provisions in the ACA. The bill specified that the legislature oversees establishing a health insurance exchange in the state and exempted insurers from federal ACA requirements if the law was found unconstitutional.⁴

Although a bipartisan insurance bill had passed in the assembly, Senator Frank Lasee, Republican chair of the Senate Insurance and Housing Committee, said he would not bring the assembly-passed insurance regulations before his Senate committee for a vote.⁵ With this, the insurance commissioner's proposed regulations were ultimately withdrawn.⁶ This placed Wisconsin out of compliance with the ACA's external review requirements for health plans, placing them instead under a federally administered review process.⁷

On October 31, 2011, Insurance Commissioner Ted Nickel and former Department of Health Services (DHS) Secretary Dennis Smith sent a joint letter to Department of Health and Human Services (HHS) Secretary Kathleen Sebelius expressing concerns pertaining to the Centers for Medicare & Medicaid Services (CMS) proposed rules on the establishment of exchanges and Qualified Health Plans.⁸ Their letter stated that the proposed regulations lack flexibility and create a "once size fits all" system. Several weeks later, on January 18, 2012, Walker announced that he was dissolving, by Executive Order, the Wisconsin Office of Free Market Health Care and ordering his agencies to cease all activities related to implementation of the ACA.⁹ He also turned down further funding from the federal early innovator grant program.

In subsequent months, many organizations — including business, insurance, and health care industry organizations, along with consumer advocates — publicly called for the governor to proceed with a state-based exchange for Wisconsin.^{10,11} The governor announced his decision to not establish a Wisconsin exchange in November 2012 after the presidential election,¹² although Smith, the former health services secretary, stated in a February 22, 2013, interview that "The governor made the decision more than a year ago."¹³ The governor said that Wisconsin would default to a federally facilitated marketplace (FFM) because of concerns over taxpayer liabilities in a state-run marketplace and his belief that the federal program did not offer sufficient or meaningful flexibility to states.¹⁴

Medicaid Expansion: The governor and state legislature in Wisconsin also decided not to adopt Medicaid expansion as

envisioned and funded by the ACA. Wisconsin's Medicaid decision was probably shaped, in part, by the policy perspective of the state's DHS secretary, who runs the Medicaid program.

When Walker took office, he recruited Smith to lead the DHS. Smith came to Wisconsin from his post as a senior fellow at the Heritage Foundation in Washington, DC, where he had written extensively in opposition to the ACA and about the need to restructure Medicaid as a block grant or for states to abandon Medicaid entirely.¹⁵ Prior to that, Smith served as a CMS official under President George W. Bush. Smith was Wisconsin's DHS secretary from January 2011 through March 2013.

At the time of Smith's appointment, the state's Medicaid and Children's Health Insurance Program (CHIP) (called BadgerCare) provided broader coverage than programs in most states. Children at all income levels could be enrolled, and those in families with incomes up to 300 percent of the federal poverty level (FPL) were eligible to receive subsidies, as were parents/caretakers up to 200 percent of the FPL. A capped, limited benefit program was available for adults without dependent children ("childless adults") up to 200 percent of the FPL.¹⁶

In February 2011, Walker made clear his intentions to limit the state Medicaid program through a range of provisions in his first state budget proposal for the 2011-13 biennium. The administration requested approval from the federal government to make a wide variety of changes, particularly related to the premium cost-sharing structure and provisions related to the affordability of employer-sponsored insurance. Many of these proposed changes were framed as a "test" of the provisions of the ACA.¹⁷ The CMS, in July 2012, granted Wisconsin permission to make selected changes. The federally approved changes included: charging scaled premiums that reflect the premium contributions required in the federal health insurance marketplace for adults with income over 133 percent of the poverty level; charging similar premiums for adults on transitional Medicaid; increasing the restrictive reenrollment period from six months to one year if adults fail to pay a premium; ending coverage for adults with income over 133 percent of the FPL if they have access to employer-sponsored coverage that would not cost more than 9.5 percent of family income; and ending retroactive eligibility for adults with income over 133 percent of the poverty level.¹⁸ The formal evaluation of the impact of these changes is currently being conducted by the University of Wisconsin – Madison Population Health Institute.

The governor announced plans for additional Medicaid reform two years later in his 2013-15 biennial budget proposal.¹⁹ The modifications were passed by the state legislature and, pending approval of a new CMS waiver, will go into effect on January 1, 2014. The reforms did not include expansion of Medicaid as written in the ACA. The most significant changes included reducing income eligibility for parents and caretakers enrolled in the

BadgerCare program from 200 percent of the FPL to 100 percent of the FPL and reopening coverage for childless adults up to 100 percent of the FPL. These changes were estimated to remove coverage for 97,000 parents and caretaker adults, directing them to find subsidized private coverage through the federal exchange. At the same time, the opening of Medicaid to childless adults up to 100 percent of the FPL was expected to increase enrollment by about 92,000. So, the overall net drop in the number of Medicaid recipients would be about 5,000 people.

Walker projects that his plan, plus the operation of the ACA in Wisconsin, would lead to a nearly 50 percent reduction in the number of uninsured in the state. This estimate includes uninsured persons who qualify for coverage through the exchange. The Wisconsin Legislative Fiscal Bureau (LFB), a nonpartisan service agency of the state legislature, questioned the governor's insurance enrollment assumptions for persons leaving Medicaid, suggesting that the take-up rate for private coverage is "unreasonably optimistic" and that the enrollment in private health insurance of former Medicaid recipients would likely fall short of the governor's projection.²⁰

The Medicaid changes that Walker proposed and the legislature enacted expand coverage for childless adults under Medicaid. However, the policy reduces public coverage for parents and caretakers, as all adults' coverage is limited to those under 100 percent of the FPL. This does not qualify as an ACA Medicaid expansion that allows for increased federal matching funding for newly eligible adults up to 133 percent of the FPL. The LFB estimated that the governor's policy would require more expenditures of state general revenue and cover fewer people than would a full ACA expansion.²¹

Throughout the 2013 budget process, state health care and business leaders (including the Wisconsin Hospital Association and Wisconsin Medical Society),^{22,23} consumer advocates,²⁴ and major media outlets advocated for full adoption of the ACA Medicaid expansion to take advantage of enhanced federal funding and provide more coverage. Several Republican legislators publicly voiced concerns about the plan to remove people from Medicaid coverage, considering uncertainty about the launch of ACA exchanges. They called for a one year delay in the governor's plans in order to allow time for an orderly transition.^{25,26}

Nonetheless, the state legislature approved the governor's Medicaid reform plan as part of the final state budget in June 2013. The legislature's Joint Committee on Finance amended Walker's original proposal slightly, adding \$30 million in state funds (to be matched with federal funds) for disproportionate share hospital funding over the next two fiscal years to account for anticipated increases in uncompensated care.²⁷ This appeared to be tacit recognition that people being moved off of Medicaid coverage may, in fact, become uninsured rather than move to

exchange-based coverage. Otherwise, Walker's plan remained unchanged from the original proposal.

The state DHS worked throughout 2013 to implement these changes and requested an 1115 Medicaid Waiver from the federal government.²⁸ The waiver accounts for the fact that the proposed income limit of 100 percent of the FPL for all BadgerCare adults means that Wisconsin will not receive the federal enhanced funding from the ACA. Additionally, the waiver requested changes affecting adults on transitional Medicaid — a longstanding program whereby Medicaid-covered adults who experience increased income that would disqualify them from coverage may remain on the program for one year. The waiver requested that transitional Medicaid adults — those with incomes over the poverty level — be charged premiums for their continued Medicaid participation. The waiver also proposed increasing the restrictive reenrollment period for nonpayment of premiums for transitional Medicaid adults from the previous six months to a twelve month lock-out period.

On January 9, 2014, CMS approved the waiver for Wisconsin's new Medicaid/BadgerCare policy.²⁹ The state prepared to implement various elements on February 1, 2014, and fully implement the new policies by April 1, 2014.

The sections below describe the efforts by the DHS to ensure that current BadgerCare enrollees make the transition to subsidized marketplace coverage in 2014. This includes creating regional enrollment networks,³⁰ staffing county income maintenance consortia to help with enrollment, and working to align enrollment systems and technology with the federal government.

1.2. Goal Alignment

As noted in the discussion around implementation questions 1.1, Wisconsin's approach has changed over time. Soon after passage of the ACA, Wisconsin under Governor Doyle, a Democrat, took an affirming response. After a change to Republican governor and Republican control of the state legislature, Wisconsin took a much more oppositional response, refusing to work on any part of implementation until after the 2012 Supreme Court decision about the ACA and, then, until after the presidential election.

As open enrollment approached and the major decisions around marketplace development and Medicaid had been made, the state DHS worked with the federal government in aligning the ACA's goals of providing coverage through the health insurance marketplaces for people who will lose Medicaid coverage. The Office of the Insurance Commissioner has been less supportive of the ACA.

Walker's Medicaid policy created a bifurcated approach to the ACA. Wisconsin's plan to reject federal Medicaid funding and cut Medicaid eligibility for some adults with children relies on the ACA exchange as an alternative destination for coverage. This

was described early by *Politico* in the headline “In Wisconsin, Obamacare with a twist.”³¹ *Politico* explains: “Walker packaged his plan as a responsible effort to cut into the ranks of the state’s uninsured while weaning low-income residents off a reliance on entitlement programs. He took credit for expanding coverage to about 225,000 more people — though the net gain would come through the federal program.”

With his Medicaid policy in place, Walker has a large investment in assuring that the estimated 80,000 adults facing removal from Medicaid would not end up uninsured in the months leading up to the November 2014 vote on his reelection. The governor’s appointed leadership at the DHS has been fully engaged with the advocacy community in conducting outreach and in promoting and preparing for enrollment into the federal marketplace.³² It links on its website to the federal ACA’s HealthCare.gov portal. And it has run town hall meetings throughout the state to organize regional enrollment networks that work toward connecting the state’s residents with ACA exchange-based coverage.³³

At the same time, the OCI, which regulates insurance companies, agents and brokers, has been less enthusiastic about the ACA. OCI worked with the state legislature to set up regulatory, training, and certification requirements that went beyond those required in federal law for navigators and certified application counselors (CACs).³⁴ Some perceived these requirements as barriers to the development of a robust enrollment workforce and an effort by the OCI to protect the competitive domain of licensed insurance agents and brokers. Indeed, OCI’s fact sheet for consumers makes several references to the benefits of consulting with insurance agents and brokers outside of the exchange.³⁵

OCI was later accused of using “scare tactics” when, in a September 3, 2013, press release, it estimated that costs for health insurance on the exchange would rise substantially from current costs in all areas of the state.³⁶ “While there is no question that some consumers will have subsidies and will not pay the higher rates,” the release said, “someone will pay the increased premiums whether it is the consumer or the federal government.”

OCI also has adopted a practice of not referring to the ACA exchange as the “marketplace,” thereby resisting federal efforts toward consistent branding and messaging. OCI maintains that the private “off-exchange” products represent the free marketplace; the exchange represents a place to acquire government “public assistance” products.³⁷

Despite this lack of enthusiasm for the ACA, Walker’s entitlement reform policy depends heavily on the ACA exchange/marketplace to meet his Medicaid reduction and coverage goals. The DHS reflects this reality through its practical and task-oriented engagement with the ACA. On the national stage, however, Walker continues to speak out in opposition to the ACA, recently opining in the *Wall Street Journal* about “Unworkable ObamaCare.”³⁸

Part 2 — Implementation Tasks

2.1. Exchange Priorities

Wisconsin is participating in the federally facilitated marketplace, so the federal government conducts many of the major implementation tasks.

One major task for the state system was to implement the Modified Adjusted Gross Income (MAGI) standards for Medicaid's income eligibility determination. This required significant reworking of the state's information technology systems. A delay in Wisconsin's attainment of MAGI assessment capability presented a significant challenge. The federally facilitated marketplace, prior to offering an applicant subsidized exchange-based products, first assesses the applicant for likely Medicaid eligibility. If the applicant appears Medicaid eligible, he or she is to be sent to the state Medicaid agency, rather than continuing an FFM enrollment process. Wisconsin, however, was not able to conduct MAGI-based assessments until February 2014 and, until then, applicants were placed on temporary hold.

Once this was resolved, Wisconsin's Medicaid agency then turned its attention to its plan to develop a single streamlined application process between the FFM and the state Medicaid program. This will eliminate the need for applicants to go through two systems — HealthCare.gov and Wisconsin's ACCESS application portal. The state had intended to have such a combined process in place by spring 2014 and now expects full implementation by 2015.

Wisconsin's insurance commissioner's office retains its traditional functions of regulating health insurance plans. As such, it is responsible for reviewing health plan filings and rates when insurance companies propose to offer products on the exchange as Qualified Health Plans (QHPs) to assure compliance with state laws.³⁹ It is also responsible for enforcing the ACA's standards with regard to Medical Loss Ratio (MLR).

In October 2011, the Walker administration requested a temporary waiver of MLR standards from the federal government, arguing that the market needed more time to phase in these provisions. Consumer advocates objected,⁴⁰ and the Obama administration rejected the request in February 2012.⁴¹ Later, in June 2012, the commissioner's office announced that the MLR rebates were below national average, which suggested that, contrary to OCI's early predictions, Wisconsin's insurance companies were doing well in meeting federal standards.⁴² In the most recent MLR rebates, only one Wisconsin insurance company failed to meet the required MLRs.

The OCI conducted its review of the QHP filings and submitted rates. It announced on August 6, 2013, that it had completed its rate filing reviews for insurers planning to participate in the federally facilitated marketplace.⁴³ On September 3, 2013, OCI released limited information on the rate filings along with its

own analysis and a range of caveats. It shared this information with the public through a press release that asserted a somewhat negative message about the ACA: “From our analysis, it appears premiums will increase for most consumers. And, while there is no question that some consumers will have subsidies and may not pay these higher rates, someone will pay for the increased premiums whether it is the consumer or the federal government.”⁴⁴ In response, several groups requested that OCI release the actual rates underlying its analysis. OCI asserted that the data were proprietary and would not be readily understood by the general public, leading one advocacy group to file an open records request.⁴⁵

The federal government released rates for Wisconsin health plans on September 24, 2013, showing that the average premiums for health plans sold through the marketplace for Wisconsin may increase less than may have been anticipated. Wisconsin’s OCI continued to assert that the federally reported rates did not effectively compare to current rates.⁴⁶

Apart from this, OCI has taken an active role in alerting the public about potential scammers who could take advantage of health insurance confusion. It sent out a press release and created a web page warning consumers about common red flags and providing tips on how to avoid being the victim of a scam.⁴⁷

Most of the functions related to outreach, education, training, field support, and navigational and other enrollment assistance have fallen to private sector partners, as described in the following sections. Six navigator entities for Wisconsin received grants from the federal government and are in the process of being trained. In addition, Community Health Centers have received funding to perform enrollment assistance. Many other organizations are in the process of becoming certified application counselors. The state goes beyond the federal requirements, mandating additional training, testing, and registration of enrollment assistants in Wisconsin.⁴⁸ The OCI is providing the state-required training for a fee.

2.2. Leadership – Who Governs?

The federal Centers for Medicare & Medicaid Services provide the primary leadership in Wisconsin, with its federally facilitated marketplace. Until 2013, Wisconsin stakeholders did not have a designated contact person in the federal HHS for issues regarding the ACA. Recently, the contact person for Wisconsin had been the acting regional director, Jackie Garner, of the HHS Region V Office, based in Chicago. In September 2013, Kathleen Falk was appointed to that position. Falk comes from Madison, WI, and brings to this position significant political and governmental experience in Wisconsin. She served as the Dane County executive for fourteen years and prior to that as an assistant attorney general at the Wisconsin Department of Justice for fourteen years. Falk was also a gubernatorial candidate in Wisconsin’s 2010 election,

running in the Democratic primary but not advancing to the general election.

Federal officials work with state officials at the DHS and OCI. DHS takes a leadership role in the connection between Medicaid and the health insurance marketplace, and OCI continues to regulate health insurance plans sold in Wisconsin, including those that will be sold on the ACA exchange. OCI also regulates insurance agents and brokers and now ACA navigators and certified application counselors.

Designated staff at the HHS regional office interact regularly with staff at state agencies and with private sector organizations in Wisconsin. These regional office staff travel to Wisconsin to give talks at conferences and community forums. However, the most significant relationships between state and federal officials occur with leadership at the CMS and its Center for Consumer Information and Insurance Oversight Center (CCIIO), not at the regional office. That is where negotiations occur on Medicaid and BadgerCare waivers, which have been a major focus for Walker's administration.

State Agency Leadership

As noted above, Walker appointed Dennis Smith to serve as DHS secretary from January 2011 through March 2013.⁴⁹ When Smith left Wisconsin, Walker appointed Deputy Secretary Kitty Rhodes to serve as secretary. Rhoades served in the Wisconsin State Assembly from 1999 to 2011. As a member of the Assembly, she was a leader on long-term care issues.⁵⁰ Wisconsin's Medicaid director, Brett Davis, also came to his position from his former service as an elected representative in the Wisconsin State Assembly, where he served from 2004 to 2010. Davis joined the Walker administration in January 2011 upon Walker's inauguration. Davis resigned from his position as Medicaid director in May 2014, taking a position with a private insurance carrier, and the Medicaid agency is currently led by an interim staff director.

Ted Nickel, the insurance commissioner,⁵¹ served in various positions for the National Association of Insurance Commissioners, including the Executive Committee, the Health Reform Regulatory Alternatives Working Group, and the Health Insurance and Managed Care Committee. Prior to his appointment in January 2011, Nickel worked for nearly eighteen years as the director of governmental and regulatory affairs for Church Mutual Insurance Company. Much of the leadership on health care reform implementation in OCI comes from Deputy Commissioner Dan Schwartz and Legislative Liaison/Public Information Officer J.P. Wieske, who were also appointed by Walker in January 2011. Schwartz owned his own government relations and association management firm prior to his appointment and is a licensed insurance intermediary. Prior to his appointment, Wieske served as executive director for an association of insurance carriers and worked in government affairs for a Wisconsin insurer.

2.3. Staffing

Wisconsin's exchange functions are staffed by the federal government through the federally facilitate marketplace. The federal government is strongly promoting HealthCare.gov and the federal call center for consumer information and enrollment assistance in Wisconsin. No local offices for the exchange operate in Wisconsin. Points of contact for the marketplace are at the Chicago HHS Region V Office.

State staffing might be construed to include the Wisconsin information technology interactivity and upgrades needed to coordinate between Medicaid and the federal marketplace. The DHS has contracted this work out to Deloitte Consulting.

2.4. Outreach and Consumer Education

Federal resources for outreach and enrollment in Wisconsin have been limited. Six organizations⁵² received federal navigator funding: Partners for Community Development, Inc., \$314,720; Northwest Wisconsin Concentrated Employment Program, \$285,035; Legal Action of Wisconsin, Inc./SeniorLAW, \$70,000; National Council of Urban Indian Health, \$35,000; National Health Start Association, \$191,667; and R&B Receivables Management Corporation, \$104,520.

The navigator organizations' work is also to include consumer outreach and education, but the navigators focus on enrolling individuals in coverage. The federal CMS also has two national contractors – Cognosante and SRA – that have been designated as federal nonnavigator assisters with responsibility in Wisconsin. State-based organizations were unfamiliar with these organizations and unaware of their expected role. The CMS did not inform state agencies or stakeholders about its funding or assignment of these outside organizations until after state-based stakeholders began to receive inquiries about their presence and questions about their legitimacy. The two organizations began in December 2013 to become acquainted with the existing stakeholders and to appear at various community functions.

The federal government has engaged in online and social media advertising in Wisconsin and eventually expanded to radio and TV during the open enrollment period. However, the federal government has designated Wisconsin a secondary market for its television advertising, which limited its exposure here.

State administration outreach and consumer assistance is being done by both DHS⁵³ and OCI.⁵⁴ The Wisconsin biennial budget included funding for DHS to increase staff at county enrollment sites (income maintenance consortia) in anticipation of higher volume due to the ACA and the state's Medicaid reform plan.

DHS is providing online training on the Medicaid policy changes. Mail and telephone outreach were underway in October through January 2014, notifying current Medicaid enrollees who faced removal from the program and informing them about new health insurance options through the ACA marketplace.⁵⁵

OCI also provides consumer education. It has conducted town hall meetings throughout the state in conjunction with DHS. OCI has worked closely with insurance agents and brokers to get them certified to sell coverage through the exchange and also to educate consumers about purchasing coverage “off exchange.” OCI also contracted with a private organization to develop and conduct the state-required enrollment assistor training, which participants can take for a \$75 fee.

These state efforts notwithstanding, most of the outreach and education occurs through private sector organizations, generally health care, social service, and advocacy organizations. Wisconsin stakeholders groups, led by the Wisconsin Primary Health Care Association, Covering Kids & Families Wisconsin, and the Milwaukee Health Care Partnership, worked with DHS to develop regional enrollment networks (RENs) in an effort to coordinate outreach and consumer assistance throughout the state.⁵⁶ Twelve RENs convened, with local entities working on reaching out and enrolling consumers in health coverage. RENs allow organizations to interact and coordinate with one another, provide peer support and manage hand-offs. The Wisconsin Primary Health Care Association secured federal AmeriCorps members to staff the RENs, with DHS providing the matching support. DHS staff support the RENs with training, coordination, and information, but not with direct funding.

The Milwaukee Enrollment Network has served as the model for the other RENs and has developed the most robust infrastructure. It has garnered city, county, and foundation funding for its members to provide outreach, training, and technical assistance.

Beyond the regional enrollment networks, no single statewide agency is in charge of creating or coordinating an outreach strategy. Over seventy groups in Wisconsin came together to support the development of Enrollment for Health Wisconsin (E4Health),⁵⁷ a subsidiary of the Wisconsin Primary Health Care Association, that applied for federal navigator funding.⁵⁸ Though E4Health did not receive federal funding,⁵⁹ the organization continues as a collaboration with the state’s Covering Kids & Families (CKF) program. The two agencies, along with the private Milwaukee Health Care Partnership, are leading efforts to coordinate enrollment in Wisconsin and support for the regional enrollment networks.⁶⁰ These groups, among others, are doing public education trainings and outreach across the state, much of it on an ad hoc basis and with some designated funding.

State media report regularly on ACA developments and Medicaid. Private partners also contribute to the outreach and education through paid media campaigns. One nonprofit health maintenance organization (HMO) in particular, Group Health Cooperative of South Central Wisconsin, aggressively promoted the ACA marketplace through paid television and radio advertising as part of its overall campaign to attract customers to its new plans.⁶¹

2.5. Navigational Assistance

Federal grants fund official navigators in six agencies throughout Wisconsin.⁶² The funds, however, total only about \$830,000 to serve a statewide population of 5.6 million, 10 percent of whom are uninsured. As of early January 2014, only four of the navigator grantees had been licensed by the OCI as navigator entities, with twenty-two individuals designated to serve as affiliated licensed navigators.⁶³

There has been debate about the degree to which federal glitches and state regulations have interfered with the navigation and application assistance system in Wisconsin. Some have suggested that state regulations on navigator and certified application counselors pose barriers to organizations and individuals wishing to serve in these roles.⁶⁴ Others blame federal delays in funding, training, and certification and the selection of unfamiliar or novice organizations for navigator grants. As noted in Section 2.4 above, the federal CMS also tasked two national contractors — Cognosante and SRA — with designated responsibility as federal nonnavigator assisters with responsibility in Wisconsin. State-based organizations were unfamiliar with these organizations and unaware of their expected role.

Existing nonprofits in Wisconsin place more confidence in investments made with Community Health Centers, which have received nearly \$1.8 million in federal funding to provide consumer assistance in Wisconsin.⁶⁵ Much of their work focuses on enrollment assistance, though they also conduct outreach and consumer education. Community Health Centers have longstanding experience in this arena, having provided eligibility services for Medicaid for two decades.

Wisconsin received less per capita in federal support for outreach and education than is any other state. Outreach funding for Wisconsin totals \$2.6 million, but the state receives no funding for marketing and advertising. This results in about \$0.46 per capita for outreach and education. The U.S. national average is \$2.37 per capita.⁶⁶

Wisconsin has not allocated any funding to outreach education, but it is supporting an expansion in its Medicaid enrollment capacity through its income maintenance offices. The provisions for funding this capacity lie within the budget provisions related to BadgerCare eligibility changes.⁶⁷ The 2013-15 biennial budget authorizes approximately \$53 million to support seventy-one additional positions to perform eligibility determinations and manage cases.

Milwaukee County government has allocated \$379,000, with \$350,000 placed in contingency, for outreach, education, and enrollment efforts.⁶⁸ Some of this money is earmarked for specific community-based organizations with the intent of reaching high need and special populations.

Most of the responsibility statewide for consumer assistance has been assumed by unfunded private and nonprofit

organizations acting as certified application counselors, along with licensed insurance agents and brokers. CAC entities include hospitals, consumer groups, and others that have completed required federal and state training and certification. Many of these organizations have background in conducting enrollment assistance related to Medicaid and BadgerCare and are also engaged in broader consumer outreach and education activities. As of early January 2014, eighty-eight entities had been registered by the OCI as certified application counselor organizations, with 465 individuals meeting the requirements to serve as CACs.⁶⁹

Many organizations have also taken on ACA-related outreach and education responsibilities, acting as “mobilizers” or “Champions of Coverage.” This represents a workforce of in-person assistants emerging on an ad hoc basis without dedicated resources. Enrollment for Health Wisconsin has created a directory of enrollment assistants by county to direct individuals to in-person help.⁷⁰ Wisconsin’s general information telephone line, 211-Wisconsin, also provides information to callers about the ACA and enrollment assistance.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. This is discussed under Section 1.2 – Goal Alignment.

2.6(b) Intergovernmental Relations. The state DHS works closely with the CMS on implementing the federal marketplace in Wisconsin, particularly because the state is relying on the marketplace to provide insurance coverage to the nearly 80,000 individuals losing Medicaid coverage.⁷¹ The state’s Medicaid/BadgerCare changes require a waiver from the CMS to reduce eligibility for parents and caretakers and increase eligibility for childless adults. The state is also working closely with the CMS on the data transfers and coordination between the state Medicaid eligibility system and the new marketplace portal.

The state DHS also works closely with county income maintenance agencies where people actually apply for Medicaid. The agencies also are responsible for review of continuing Medicaid cases. For Medicaid enrollees who lose eligibility, county income maintenance staff will help clients apply for ACA exchange-based coverage.

The state OCI works with the federal government on regulation of health insurance plans, particularly those offering coverage in the marketplace. Though HHS and CCIIO are ultimately in charge of the federal marketplace operation in Wisconsin, the state OCI maintains many traditional state regulatory functions of the private insurance market. OCI conducts rate review and reviews the proposals by Qualified Health Plans prior to federal review.

2.6(c) Federal Coordination. The federally facilitated marketplace is a collaborative effort among HHS, the Internal Revenue Service, the Department of the Treasury, the Social Security

Administration, the White House, and others. Wisconsin's federally facilitated marketplace stakeholders have a federal point of contact in the HHS Region V Office, though many decisions are made and questions are answered by other federal agencies. This single point of contact approach within HHS is intended to smooth coordination and communication from state stakeholders, but the process has not provided for expedient responses to questions and communication from divisions of HHS or other federal coordinating agencies. Wisconsin's state Medicaid agency has assigned to it a federal desk officer within the HHS Region V office who differs from the point of contact for nonstate agency stakeholders.

The regional office staff do not have authority over program or policy matters, so often do not have answers. At times, they may be unaware of matters that have arisen with the state that emerged out of the central HHS and CMS offices.

Thus far, even within HHS, the coordination necessary among several jurisdictions proves complicated and challenging.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). Wisconsin has one of the most competitive health insurance markets in the country,⁷² with multiple insurance carriers present in each county;⁷³ no single carrier dominating the state market; and several smaller, domestic, regional, and national carriers. Managed care models dominate the state, through HMOs or Preferred Provider Organizations. Wisconsin also has many strong local insurance carriers, most of which operate in regional, rather than statewide, service areas.

The National Committee on Quality Assurance (NCQA) has recognized two state-based plans in its top fifty quality rankings of national commercial plans; one has been recognized among the top nationally in all three categories – commercial, Medicaid, and Medicare.⁷⁴

Thirteen health insurance companies, five of which are nonprofit, offer ninety-seven products through the individual marketplace in Wisconsin, and nine offer products through the Small Business Health Options Program (SHOP) marketplace in Wisconsin. Residents of most of Wisconsin's seventy-two counties have a choice of at least two insurance carriers. Four counties have six competing insurers and the state's largest counties, Milwaukee and Dane, have four competing insurers. Thirteen counties have only one plan available, and five northern counties have no plans offered.⁷⁵ (Detail of plans in each county are available on the Insurance Commissioner's website.⁷⁶) The state has accepted the maximum of sixteen geographic rating areas permitted by the CMS,⁷⁷ and each of these rating areas has several health plans, with most offering several choices in each metal tier.⁷⁸

Plan prices vary widely across the state, counties, and geographic regions. In addition, Wisconsin's average premiums rank

higher than the national average.⁷⁹ Prior to the ACA, 14 percent of Wisconsin's insured — over a half-million residents — had premiums that exceeded ACA Marketplace affordability guidelines under the ACA.⁸⁰ Wisconsin's employer-sponsored health insurance premiums ranked among the highest nationally.^{81,82,83} Even with the ACA, Wisconsin's rural areas are among the insurance price zones on the most-expensive list, based on rates for the lowest-priced "silver" plan under the Affordable Care Act.⁸⁴

Much debate centers on the substantially higher rates in Wisconsin relative to those in neighboring Minnesota.^{85,86,87,88} Liberal advocates have attributed Wisconsin's higher premiums to the state's plan to transfer previously Medicaid-covered adults over 100 percent of the FPL to ACA coverage, rather than expanding Medicaid, thereby adding what some considered a higher need population to the exchange pool. These advocates also suggested that the state insurance commissioner was not aggressively leveraging potential price reductions when reviewing QHP premium bids. Others, however, explained several complicated factors that contribute to such rate differences, and cautioned against drawing early conclusions based on these first year rates.

It does appear that Wisconsin's average premium prices stand about 30 percent higher than those in Minnesota. The factors that contribute to such a difference may include Minnesota's decision to keep its high risk pool operational for an additional year, while Wisconsin's pool members became part of the QHP's actuarial model in this first year. Rates also depend on the number and penetration of plans in each market, broad versus narrow networks, and the ability to negotiate rates and discounts with providers. Analysts and Wisconsin state government officials also pointed out the large variation in prices within Wisconsin, suggesting the importance of other factors beyond the state-level policy decisions.⁸⁹

With regard to rate review, analysts and administration officials pointed out that Wisconsin had among the lowest average Medical Loss Ratio (MLR) rebates in the country, with Wisconsin individual market rebates of \$26 per family in 2012, Minnesota of \$241 per family, and the national average of \$94 per family.⁹⁰ This suggests that the rates submitted by Wisconsin carriers do not far exceed their actual costs to include excessive profit or overhead. Rather, the pricing variation between Wisconsin and other states may more likely relate to underlying cost and price factors in the delivery system, along with the actuarial pool.

The price of premiums in the exchange ultimately affects the amount of subsidy the federal government will have to pay in order to meet the ACA's affordability standards for those who qualify for subsidies. The Kaiser Family Foundation has estimated that out of a total potential exchange market in Wisconsin of 482,000 persons, 62 percent (301,000 residents) would be eligible for premium tax credits.⁹¹ Another report by a national consulting firm showed that 25-35 percent of uninsured individuals in Wisconsin

will qualify for zero-net-premium bronze plans (i.e., their federal subsidy exceeds the premium required).⁹²

The silver metal tier is, of course, of most concern for lower-income residents, as it provides them access beyond the premium subsidy to cost-sharing subsidies. For this reason, residents will depend on access to not only a QHP, but specifically to a silver tier plan with an adequate network in each county. Rural advocates have raised some concern that, while QHPs are providing products in each metal tier in each of the sixteen rate regions, the silver tier does not have a product in each county of the region.⁹³ In at least one rural region of the state, low-income residents will need to go out of county for care if they enroll in a silver plan.

Another challenge: The premium subsidy amount is pegged to the second lowest cost silver plan in each region. For large rural rate regions that include several counties, the second lowest cost silver plan may not offer a network in or near some counties. In those cases, residents may enroll in their own county’s lowest cost silver plan, which may have a premium, as Table 1 shows, higher than the rate region’s second lowest silver plan. In that case, the federal subsidy may prove insufficient to meet the ACA’s affordability standards (2-9.5 percent of income). It is not clear how many people might actually face this challenge.

Many in Wisconsin also remain concerned that persons from 100-133 percent of the FPL who are moving from Medicaid to marketplace will not be able to meet the premium cost-sharing of the QHPs, even with the federal subsidy. The local United Way in Dane County, Wisconsin’s second most populous county, developed a fund to assist with the cost of insurance premiums for plans purchased through the marketplace.⁹⁴ The HealthConnect program was made possible through a special \$2 million contribution from a local integrated delivery system.

In Wisconsin, by the end of the 2014 open-enrollment period, 91 percent of individuals who selected a Marketplace plan were eligible for tax credits, higher than the 87 percent average in Federally Facilitated Marketplace states. Those Wisconsinites pay an average of \$112 per month in their individual premium, supported by an average \$316 monthly premium tax credit. This means that the premium tax credit in Wisconsin covers approximately 74 percent of premium costs.⁹⁵

2.7(b) Clearinghouse or Active Purchaser Exchange. Wisconsin participates in the federal facilitated marketplace, a clearinghouse model exchange. The OCI carriers out regulatory

Table 1. Percent of Income Devoted to Premium Under the ACA

	<i>27-Year-Old Individual</i>	<i>50-Year-Old Individual</i>	<i>64-Year-Old Individual</i>	<i>64-Year-Old Couple</i>
Lowest Cost Silver Plan	5.38%	7.66%	11.4%	15.9%
2nd Lowest Cost Silver Plan in Rate Region	2.14%	2.14%	2.14%	2.14%

responsibilities related to premium rate review and network adequacy, but does not actively negotiate to leverage lower prices from the QHP proposals.

2.7(c) Program Articulation. The federally facilitated marketplace will communicate and share data with the Wisconsin Medicaid enrollment system, the ACCESS portal. Wisconsin started out the open enrollment period in October 2013 as a “determination state,” meaning that it was required to accept and automatically enroll any person whom the federal exchange deemed eligible and sent through its system. This raised serious program integrity concerns during the troubled roll-out of the ACA website, with fear that applicants were being misinformed about their potential eligibility status. By January 2014, Wisconsin converted to an “assessment state.” It has the ultimate authority to assess any applicants for eligibility once the federal exchange sends along a potentially eligible person.

Previously, the federal exchange would transfer data to the state agency while informing an applicant that he/she has been determined eligible for Medicaid. Wisconsin’s new “assessment state” status alters this process: The federal exchange notifies a potentially Medicaid-eligible exchange applicant of this status and, at that point, the application is turned over for assessment by the Medicaid agency within the state DHS.

The state now is working to merge the two different portals of entry for consumers: the federal marketplace (HealthCare.gov) and the state Medicaid application process (ACCESS.wisconsin.gov). At this point, a consumer can apply via ACCESS for Wisconsin Medicaid, along with Supplemental Nutrition Assistance Program (formerly food stamp) benefits and other economic supports. But ACCESS does not connect to the federal online exchange application process. Similarly, consumers may enter through HealthCare.gov to apply for marketplace coverage and have their file sent to the Medicaid agency for assessment. But that consumer does not receive the ACCESS function of being prompted to apply for other economic support programs for which they may be eligible.

2.7(d) States That Did Not Expand Medicaid. Though Wisconsin did not expand Medicaid as intended in the ACA, and thus is not receiving the ACA’s financial support for newly covered Medicaid members, the state did expand Medicaid as an entitlement to all individuals with income up to 100 percent of the federal poverty level. This effectively eliminated the coverage gap, in that all persons, including childless adults, below 100 percent of the FPL are Medicaid eligible, while those above 100 percent of the FPL are expected to utilize the ACA marketplace. Wisconsin has been recognized as the only state in the country that, while not participating in the ACA’s Medicaid expansion, does not have a “coverage gap.”⁹⁶

Wisconsin’s Medicaid approach will continue to receive much interest and scrutiny, particularly with regard to how Wisconsin’s

enrollment will perform relative to similar states. The *Washington Post* reported in April 2014 how the neighbor states of “Michigan and Wisconsin highlight the divide on Medicaid expansion,” with Wisconsin’s Republican Governor Walker paring back Medicaid eligibility while opening up the program to more lowest-income adults, and Michigan’s Republican Governor Snyder using a federal waiver to implement the ACA’s expansion.⁹⁷

Governor Walker announced in May 2014 that 81,731 childless adults had enrolled in new Medicaid coverage.⁹⁸ U.S. CMS released the Medicaid and CHIP eligibility activity for the month of April 2014, showing Wisconsin with the ninth lowest rise in Medicaid and CHIP enrollment nationally.⁹⁹ Wisconsin’s Medicaid membership increased only 1.1 percent since the period before open enrollment began.

Wisconsin’s U.S. Senator Tammy Baldwin then sent a letter to Governor Walker inquiring about the status of the 62,776 individuals with incomes above the federal poverty level that no longer met the program rules on April 1, 2014 and were disenrolled from the program.¹⁰⁰ Governor Walker responded that persons above the poverty level should be able to access health care through the marketplace and, given that the exchange is under federal purview, “it only seems logical that concerns about [the former BadgerCare members’] ultimate status be directed to HHS.”¹⁰¹

CMS in May 2014 reported that, as of the end of the first open enrollment period for the Health Insurance Marketplaces, 139,815 Wisconsin individuals had selected a Marketplace plan and over 81,000 who went to the federal Marketplace were found eligible for Medicaid.^{102,103} One report comparing FFM to state-based Marketplace states in meeting federal enrollment targets ranked Wisconsin relatively high, enrolling nearly 30 percent of “potential enrollees.”¹⁰⁴ But these reports do not account for Wisconsin’s simultaneous changes in state Medicaid eligibility levels (concurrent with ACA open-enrollment). The nationally reported enrollment performance for Wisconsin has been bolstered by the movement of the transitioning Medicaid/BadgerCare members to ACA coverage beyond enrollment of previously uninsured ACA-eligible enrollees – those who would have been “potential enrollees” actually targeted by the ACA.

The Wisconsin Department of Health Service reported that, as of June 30, 2014, the enrollment status had been tracked for 62,776 persons who had been transitioned from former BadgerCare eligibility.¹⁰⁵ The tracking found that 18,801 (30%) had selected an ACA Qualified Health Plan through the Marketplace as of June 13, 2014, and 4,867 (8%) were redetermined eligible for BadgerCare. DHS does note that 34,915 of the former BadgerCare members had incomes above 133 percent FPL – and “would have had to transition to the Marketplace regardless of whether or not Wisconsin had accepted the Medicaid expansion.” But it does not report how many of the 27,861 with income between 100-133 percent FPL had enrolled in QHPs.

2.7(e) Government and Markets. There are no private insurance exchanges in Wisconsin. Changes in the private insurance markets, in terms of market entry and exit of carriers, has not happened on a significant scale. The few examples that have occurred are not clearly attributable to the ACA and may reflect normal market transitions and industry evolution. For example, Anthem Blue Cross and Blue Shield announced that it would no longer offer its individual insurance policies in forty-one counties, while remaining in thirty-one counties. It called this “an effort to refine our networks” and to achieve “the right balance between access, cost of care, and high quality.” It asserted that it will offer “a lower-cost product utilizing a focused network” in order to “balance access with affordability.”¹⁰⁶ The conservative MacIver Institute, however, distributed a press release asking, “Is Obamacare to Blame?”¹⁰⁷

Insurance carriers have more clearly adjusted their staffing in ways that reflect ACA implementation and health system transformation. Some insurance carriers in Wisconsin have implemented or announced imminent reductions in force, particularly from within their insurance underwriting units.¹⁰⁸ This would seem to relate to the ACA’s removal of preexisting condition exclusions and other market rating reforms.

As well, delivery system changes take a high profile: One large integrated delivery system in southeastern Wisconsin announced workforce cutbacks that it attributed to reductions in Medicare payments and ACA-related factors.¹⁰⁹ A major hospital system in Madison similarly attributed its layoffs to the same factors.¹¹⁰

2.8. Data Systems and Reporting

The state is working to implement an upgrade of Medicaid eligibility information technology with enhanced federal matching funds available under the Affordable Care Act. Wisconsin’s capability to use Modified Adjusted Gross Income standards to assess income eligibility did not become effective until February 2014, and the data-matching capabilities between the state and federal systems have been further complicated by the troubled roll-out of the HealthCare.gov website.

The state has its existing longstanding Family Health Survey¹¹¹ and other public health and vital statistics capacity that will continue to report on health insurance coverage. The state Medicaid agency provides monthly reports on its program enrollment. But no plans or further data reporting have been developed or budgeted at this point.

Private sector organizations and advocacy groups have initiated efforts to attain data from federal sources to monitor the performance of the federal exchange with regard to Wisconsin’s residents. Such groups also have undertaken various ad hoc efforts at mapping for strategic targeting of their consumer outreach and education activities.¹¹² A coalition of organizations hosted a

meeting with representatives from Enroll America in July 2013 in order to learn about its best practices in this arena.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

The SHOP marketplace in Wisconsin is also being run by the federal government and is not merged with the individual marketplace. However, consumers navigate to both the SHOP and individual marketplace through HealthCare.gov. The health plan options are specific to the SHOP marketplace, and fewer insurers are providing SHOP plans than are providing individual market plans in Wisconsin.

The federal Small Business Administration has an active education and outreach component, with an assigned representative for Wisconsin.¹¹³ But for the most part, Wisconsin businesses rely on agents and brokers to consider their SHOP options. Local groups have invited speakers from the national Small Business Majority to help provide education and outreach. The Wisconsin Business Alliance, a state-based advocacy group focused on small-businesses, also has an active ACA-related outreach program.¹¹⁴

This component of the ACA has been relatively low-profile in the first year, given that the federal government has postponed several elements related to the SHOP until 2015.

Part 4 – Summary Analysis

4.1 Policy Implications

The drive to enroll consumers in private health insurance coverage has fostered new alignment among consumer advocates, insurance agents and brokers, community-based organizations, the Wisconsin Department of Health Services, and the health care and insurance sectors. The unique policy position on Medicaid expansion in Wisconsin brings collaboration between those who support the ACA and those who may not support the ACA, but recognize that the governor's entitlement reform plan depends on effective outreach and enrollment into the federally facilitated marketplace. The limited federal funding available for outreach and enrollment has also required public/private partnerships and unlikely alliances.

Wisconsin's decision against full Medicaid expansion and instead to cover all adults up to 100 percent of the FPL, but remove adults above that level, provides a boost for the commercial insurance sector. Nearly 80,000 adults will transfer from Medicaid to marketplace coverage and be sent to purchase subsidized coverage on the exchange.

The health care provider sector can gain from this policy if those who were on Medicaid actually end up taking up commercial coverage through the ACA. These providers will be paid commercial insurance rates rather than Medicaid rates. On the other

hand, providers will lose if those previously eligible for Medicaid instead become uninsured. This has been a significant concern by advocates and providers, as noted in Section 1.1 above.

These formerly eligible Medicaid members immediately lose a substantial benefit package that came with little or no financial burden. This could turn into a win if they find affordable coverage through the marketplace, in that the commercial coverage might improve their access to providers. Providers have, however, voiced great concern about the ability of lower-income enrollees to sustain regular and timely premium payments and about the availability of the ninety-day grace period for nonpayment of premiums. Insurers are required to pay claims arising only in the first month after an enrollee fails to meet a required premium payment. If enrolled members fail to meet their premiums by the end of the grace period, the providers will be left with uncompensated bills for services rendered in the remaining sixty-day time period.¹¹⁵

The ACA itself, to the extent that it brings in the anticipated number of newly insured from the ranks of the uninsured, brings hundreds of thousands of new insurance customers through the marketplace. It also provides more compensated care for providers.

From a political perspective, the balance of wins and losses remains to be seen. The troubled rollout of the ACA led to a delay in implementing Wisconsin's planned Medicaid transitions. The effects of both the ACA and the changes in Medicaid and BadgerCare may become evident after the first year, once the data emerge about plan take-up, insurance status of the state's population, and the actuarial experience of those that enrolled in the QHPs.

4.2. Possible Management Changes and Their Policy Consequences

Wisconsin and the federally facilitated marketplace faced a large challenge in ensuring a fully functional, streamlined, and coordinated enrollment process that could handle both the ACA launch and the substantial transitions in Medicaid/BadgerCare. The state budget includes language specifying that if the federal exchange was not "fully operational" by January 1, 2014, the current eligibility levels for Medicaid would remain. Though the federal marketplace opened on October 1, its launch was marked by poor functionality. This led the state to seek a delay in implementation of its Medicaid and BadgerCare waiver, so that they take full effect on April 1, 2014, rather than January 1.

Messaging had already been underway for several months informing the public about the change in the conversion date from January 1 to March 1. The state legislature approved the delay in a special session convened in December 2013. This produced a period of great confusion in the messaging for BadgerCare members, who had been informed of their imminent loss of coverage, and

for childless adults below 100 percent of the FPL who had received prior notice that they might have access to Medicaid coverage as of January 1, 2014. A new series of letters and phone calls were initiated in late December and early January.¹¹⁶ On January 9, 2014, the CMS approved the waiver for Wisconsin's new Medicaid/BadgerCare policy.¹¹⁷ The state prepared to implement various elements on February 1, 2014, and fully implement the new policies by April 1, 2014.

Once these challenges were resolved, Wisconsin turned its attention to its plan to develop a single streamlined application process between the federal exchange and the state Medicaid program. This will eliminate the need for applicants to go through two systems – HealthCare.gov and Wisconsin's ACCESS application portal. The state's system also provides the substantial benefit of conducting simultaneous screening for other economic support programs, such as the Supplemental Nutrition Assistance Program (SNAP) and child care subsidies. The state is implementing this in phases, with plans for a single streamlined application fully in place by 2015.

On a larger scale, Governor Walker faces reelection in November 2014, and much has been written about his potential aspirations to launch a presidential campaign.¹¹⁸ His likely Democratic challenger, Mary Burke, has stated that Wisconsin should have participated in the ACA's Medicaid expansion.¹¹⁹ Wisconsin's two U.S. senators have polar opposite positions on the ACA.¹²⁰ Senator Tammy Baldwin stands as a liberal Democrat who fully supports its implementation and has publicly called on Walker to expand Medicaid.¹²¹ Senator Ron Johnson, a conservative Republican, staunchly opposes the ACA and, in January 2014, filed a federal lawsuit related to subsidies for ACA marketplace participation of congressional staff.¹²²

Wisconsin's OCI and DHS released an over-1,500 page report in March 2014 reviewing the Wisconsin insurance market prior to the ACA, the roles of OCI and DHS, the biennial budget decisions and impact on BadgerCare and ACA implementation.¹²³ The report details the work done by both agencies during open enrollment, a look ahead, and copies of outreach and education materials from various sources.

The ACA, along with the Walker administration's Medicaid policy, is likely to be a significant issue leading up to the November elections, as will the impact of the ACA on Wisconsin residents, health care delivery system, and the economy.

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