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The "Access" Problem: How Employee and Employer Issues May Increase Badgercare Participation by Impeding the Verification Process

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THE "ACCESS" PROBLEM: HOW EMPLOYEE AND EMPLOYER ISSUES MAY INCREASE BADGERCARE PARTICIPATION BY IMPEDING THE VERIFICATION PROCESS

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INTRODUCTION

In its effort to be a welfare reform pioneer, Wisconsin has led the nation in adopting one of the most expansive public health insurance programs, "BadgerCare," to address the health care needs of working families in the post-welfare reform era. One year after BadgerCare implementation, Wisconsin is experiencing the fiscal impact of the program due to unexpectedly high enrollment in BadgerCare. While some Wisconsin leaders praise this growth rate for reducing the number of uninsured, others raise a concern that the enrollment figures may be rising due to employees opting for BadgerCare rather than employer-sponsored insurance. Consequently, this "crowd-out" effect may spoil the success of the BadgerCare program.[1]

The crowd-out effect hinges upon the success of the BadgerCare verification process, a process that ultimately decides who is eligible for the program based on an applicant's access to employer-sponsored family health insurance. However, under current labor and health care market conditions, employees and employers may diminish the effectiveness of the verification process. As a result, BadgerCare may be insuring people who would otherwise be insured through their employer.

After a brief description of the BadgerCare program and related concerns in Part I, Part II of this article explores the BadgerCare verification process to determine whether the Wisconsin Department of Health and Family Services (DHFS) can adequately access health insurance policy information from employees and employers through

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1. Referring to the crowd-out possibility, DHFS Secretary Joe Leean recently stated that crowd-out "would be the fastest thing that could destroy the BadgerCare program." Patricia Simms, *Fewer Insured by Employers – A Major Drop Could be Threat to BadgerCare,* WIS. STATE J., Sept. 26, 2000, at 1B.

the current process. In Part III, this article details how the potential failure of employees to comply with the verification process may be due to the labor market, the comprehensiveness of BadgerCare benefits, and BadgerCare marketing. Then, Part IV contends that employers may be able to avoid complying with the verification process through ERISA preemption, implementation of longer waiting periods, or reduction in family coverage. Finally, based upon the arguments in Parts III and IV, Part V concludes with suggestions on how to improve the BadgerCare verification process and maintain the program's viability.

PART I: BADGERCARE ESSENTIALS

A. *Brief History*

The concept of BadgerCare began in the mid-1990's during the flurry of activity at both the state and national levels to reform the welfare system.[2] The efforts to change the welfare system made BadgerCare possible.[3] Indeed, welfare did change in 1996 under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which eliminated the Aid to Families with Dependent Children (AFDC) program and replaced it with a block grant program called Temporary Assistance to Needy Families (TANF) to help needy parents end their dependence on government benefits by promoting job training, work, and marriage.[4]

On the heels of the federal legislation under PRWORA, Wisconsin used the opportunities provided by TANF block grant monies to enact its own legislation replacing Wisconsin's AFDC program with Wisconsin Works (W-2) under 1995 Act 289.[5] W-2 has been characterized as "an employment and training program, rather than a means of providing income support."[6] To help make work pay,[7] Wisconsin created the BadgerCare program,[8] which was intended to provide health insurance to low-income working families,[9] in 1997 Act 27 (the bien-

2. Louise G. Trubek, *The Health Care Puzzle, in* HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA 148-49 (Joel F. Handler & Lucie White eds., 1999).

3. Some claim Bill Clinton originated this activity in his 1991 campaign speech at Georgetown University, in which he stated: "In a Clinton Administration, we're going to put an end to welfare as we know it." RUTH SIDEL, KEEPING WOMEN AND CHILDREN LAST: AMERICA'S WAR ON THE POOR 4 (1998).

4. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, §401, 110 Stat. 2105, 2113 (1996).

5. 1995 Wis. Laws 289.

6. TERESA A. COUGHLIN ET AL., THE URBAN INST. STATE REP., HEALTH POLICY FOR LOW-INCOME PEOPLE IN WISCONSIN 23 (1998).

7. Trubek, *supra* note 2, at 149 ("[W]elfare reformers realized that changes in health insurance for low-income families were essential in order to have a work-based strategy succeed.").

8. 1997 Wis. Laws 27 (Biennial Budget Act).

9. Interview with Angela Dombrowicki, Director, Bureau of Managed Health Care Programs, DHFS, in Madison, Wis. (Nov. 3, 2000).

nial budget act). This was possible due to the availability of the federal State Children's Health Insurance Program (SCHIP) funding, which was included in the federal Balanced Budget Act of 1997.[10] The enactment of SCHIP amended the Social Security Act by adding Title XXI funding that allows states to either adopt a separate program or expand their existing Medicaid (MA) program to assist uninsured, low-income children.[11] Wisconsin took advantage of this additional federal funding and passed legislation to expand MA services to low-income working families.[12]

Although BadgerCare is meant to benefit all impoverished families without employer-sponsored health insurance, the program is primarily intended to encourage low-income mothers to enter the workforce without the fear of losing health insurance coverage as their income increases.[13] In a September 29, 1998 press release, Governor Thompson stated that he would not "rest until everyone is provided [health insurance] . . . particularly *poor women* and families . . . . We want to make sure that hard-working families don't have to go without health care for their children as they climb the economic ladder."[14] In fact, since the enactment of W-2, approximately 96% of those who left welfare were female,[15] and the majority of the adult population enrolled in BadgerCare is female.[16]

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10. Balanced Budget, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 275 (1997).

11. 42 U.S.C.A. § 1397aa (West 2000).

12. 1997 Wis. Laws 27. 1997 Wis. Act 27 created Wis. Stat. § 49.665, "BadgerCare." Wisconsin Statute § 49.665(2) requires the Wisconsin Department of Health and Family Services (DHFS) to submit a waiver to the federal Department of Health and Human Services to implement the BadgerCare program. WIS. STAT. § 49.665(2) (1999). This waiver was approved on January 22, 1999. LEGISLATIVE FISCAL BUREAU s. 13.10 REQUEST PAPER TO THE JOINT COMMITTEE ON FINANCE, HEALTH AND FAMILY SERVICES—SECTION 13.10 REQUEST FOR TRANSFER OF FUNDS TO SUPPORT BADGERCARE—AGENDA ITEM IV-A (Sept. 16, 1999). *See also* COUGHLIN ET AL., *supra* note 6, at 26-27; Trubek, *supra* note 2, at 149 (noting that many childrens' advocates were opposed to using SCHIP funds to provide MA services to adults because they feared that fewer children would receive benefits and coverage, which was the intent of SCHIP). However, Wisconsin submitted the waiver arguing that "high-quality health care for children will emerge from health care coverage for the working family." Trubek, *supra* note 2, at 150.

13. Trubek, *supra* note 2, at 147 (stating that "job stability for poor women is linked to the availability of health care coverage.").

14. JON PEACOCK, WIS. COUNCIL ON CHILDREN AND FAMILIES, WISCONSIN BUDGET PROJECT BADGERCARE COMING OF AGE: PROMISE AND REALITY 1 (2000) (emphasis added), *available at* http://www.wccf.org/BC.pdf (last visited April 20, 2001).

15. WIS. DEP'T OF WORKFORCE DEV., SURVEY OF THOSE LEAVING AFDC OR W-2, JANUARY TO MARCH 1998, PRELIMINARY REPORT 3 (Jan. 13, 1999) [hereinafter DWD SURVEY].

16. Interview with Angela Dombrowicki, *supra* note 9.

B. *The Design of the BadgerCare Program – Eligibility and Coverage*

To be eligible for BadgerCare, a family[17] must meet three general criteria. First, the family must be currently uninsured.[18] Second, the family's income must not exceed 185% of the federal poverty level (FPL), unless the family is already in the BadgerCare program, in which case the family may continue receiving coverage until they reach 200% FPL.[19] The third criterion, discussed more in depth below, is that the family must not have access to "employer-subsidized health care coverage."[20] If families meet these three general criteria, they may be eligible for BadgerCare.[21] However, if a family earns above 150% of the FPL, the family must contribute toward the cost of its health care by paying a premium.[22] This premium may never exceed 3.5% of the family's income.[23] According to the current schedule established by DHFS, the state would require a family of three earning 185% of the FPL to pay a monthly premium of $60.[24] To a limited extent, these premiums help defray the cost of BadgerCare to

17. WIS. STAT. § 49.665(1)(d) (1999) (defining "family" as "a unit that consists of at least one child and his or her parent or parents, all of whom reside in the same household. 'Family' includes the spouse of an individual who is a parent if the spouse resides in the same household as the individual."). Under HFS § 103.03(1)f)(1), the child must be under age 19. WIS. ADMIN. CODE § 103.03(1)f)(1) (2000).

18. WIS. ADMIN. CODE § 103.03(1)(f)(2) (2000) (making the provision that the family currently not have health insurance and that the family did not have health insurance coverage in the three months prior to becoming eligible for BadgerCare).

19. WIS. STAT. § 49.665(4). For example, according to the DHFS website, the annual income for a family of three at 185% FPL is $26,177.52. DHFS, Programs and Services, Eligibility – Wisconsin BadgerCare, Financial Eligibility Requirements (March 22, 2001), *at* http://www.dhfs.state.wi.us/badgercare/html/eligreequire_2.htm (last visited Apr. 20, 2001). At the 200% FPL, the same family's income would be $28,299.96. *Id.* It should be noted that there is no asset test for BadgerCare eligibility. *Id.*

20. WIS. STAT. § 49.665(4). This is clarified to mean employer-subsidized "family" health insurance. WIS. ADMIN. CODE § 103.03(1)(f)(3) (2000). If an employee does have access to employer-subsidized family health insurance, the employee and his or her family may still be eligible for BadgerCare if the employer pays less than 80% of the offered group health insurance plan. *Id.* Furthermore, the BadgerCare applicant must not "at any time in the 18 months immediately preceding application for BadgerCare have access to employer-subsidized health care coverage, or a state employe's health plan." WIS. ADMIN. CODE § 103.03(1)(f)(4).

21. There are additional criteria that must be met, such as U.S. citizenship or legal permanent resident, WIS. ADMIN. CODE § 103.03(2), Wisconsin residency, WIS. ADMIN. CODE § 103.03(3), furnishing a social security number, HFS § 103.03(4), assignment of medical support, WIS. ADMIN. CODE § 103.03(5), or not being any of the following: incarcerated, in a mental institution, an ineligible caretaker relative, or a striker, WIS. ADMIN. CODE § 103.03(6)-(9).

22. WIS. ADMIN. CODE § 103.085(1)(b)(2); *see also* WIS. STAT. § 49.665(5)(a)-(b).

23. WIS. STAT. § 49.665(5).

24. DHFS, *Fact Sheet, BadgerCare Eligibility and BadgerCare Premiums* (March 22, 2001), *at* http://www.dhfs.state.wi.us/badgercare/factsheets/bcpremium.htm (last visited April 20, 2001) [hereinafter *BadgerCare Premium Fact Sheet*]. This assumes a family of 3 at 185% FPL earns $2,139.83 per month. *Id.*

the state.[25] However, federal funds pay the bulk of the program costs, covering approximately 71% of children's health costs and 59% of adult health costs.[26]

Those that qualify for BadgerCare receive care under one of the most expansive public health insurance programs in the nation.[27] This coverage incorporates the same benefits included in the Medicaid program, including services for physicians, chiropractors, medical social workers, podiatrists, nurse midwives, optometrists and dentists.[28] BadgerCare also covers "prescription drugs, some over-the-counter drugs, hospice care, emergency ambulance transport, personal care and addiction treatment."[29]

C. *The Popularity of the BadgerCare Program – A One-Year Status Report*

Since its inception on July 1, 1999,[30] BadgerCare attracted more eligible people than expected.[31] After one year, 66,545 people enrolled in BadgerCare, including 18,535 children and 48,010 adults.[32] The number of enrolled adults compared to the number of enrolled children has exceeded budget projections.[33] As a result, the program exceeded its current budget authority and required the State Legislature to appropriate additional money in state fiscal year 2000-01.[34] In order to fund an estimated 84,000 individuals in BadgerCare over the

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25. Peacock, *supra* note 14, at 1.

26. *Id.* At the time of this writing, DHFS submitted a waiver to the federal Department of Health and Human Services requesting to use federal "SCHIP" (Child Health Insurance Program) funding for coverage of parents, rather than just using Title XIX (MA) funds. Press Release, Thompson Administration Submits Amended BadgerCare Waiver Request to Feds (Mar. 10, 2000) (on file with author).

27. *BadgerCare Coverage is Among Nation's Broadest*, WIS. STATE J., Aug.27, 2000, at 3A ("Wisconsin is one of only 10 states that pay for medical social workers' services; Wisconsin is one of 28 states that pay for chiropractors' services; Wisconsin is one of 38 states that pay for dentures; and Wisconsin is one of 14 states that pay for respiratory care services.") [hereinafter *BadgerCare Coverage Nations Boradest*]. For a comprehensive list of BadgerCare services, see WIS. STAT. § 49.46(2) (1999).

28. *BadgerCare Coverage Nations Broadest*, *supra* note 27.

29. *Id.*

30. Peacock, *supra* note 14, at 1.

31. *Id.* at 2.

32. DHFS, BadgerCare Enrollment by Category (Aug. 14, 2000) (on file with author).

33. Peacock, *supra* note 14, at 2. Specifically, "original projections anticipated a ratio of 1.7 parents in BadgerCare for each child enrolled, but the current ratio is 2.6 adults to each child." *Id.* This higher ratio of parents to children results in higher costs for the state because the state is reimbursed for 71% of its costs for covering children under the federal SCHIP program, but only 59% of its costs are reimbursed for covering adults under the federal Medicaid program. *Id.* Furthermore, adults are generally more expensive to cover in an health insurance program, when compared to children. *Id.*

34. 2001 Wis. Laws 1 (appropriating an additional $11,512,200 for state fiscal year 2000-01 for the BadgerCare program).

next biennium (2001-03), DHFS asked for an additional $93.3 million in its biennial budget request to the Governor and Legislature.[35]

D. *The Private Insurance Crowd-Out Debate and its Importance to BadgerCare*

It is the combination of the ever-increasing BadgerCare expenditures, enrollees, and extensive benefits that raise the question of employer-sponsored or private insurance crowd-out. If BadgerCare is encouraging private insurance crowd-out, the program's sustainability may be at risk due to limited public funding. More importantly, the overall number of uninsured families in Wisconsin may not drop and thereby defeats BadgerCare's goal. According to one researcher, crowd-out causes two potential unintended consequences as a result of Medicaid expansion programs, such as BadgerCare: "(1) persons with private coverage drop it in order to take advantage of the public subsidy being offered; and (2) some who are uninsured enroll in Medicaid rather than obtain private coverage (as they would have under the more stringent Medicaid eligibility conditions)."[36] Crowd-out may also include employers who discontinue (or do not begin) offering health insurance to their employees because government programs are available.[37]

The recent focus on crowd-out, as it relates to Medicaid expansion, began several years ago. Between 1988 and 1993, researchers found that 2% to approximately 50% of the increase in Medicaid coverage was attributed to private insurance crowd-out.[38] The two major policy implications of crowd-out for states are: (1) the displacement of private insurance for public insurance may not reduce the overall

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35. *Leean Asks for Healthy Billion – Request Includes More Funds for BadgerCare*, WIS. STATE J., Sept. 23, 2000, at 3B [hereinafter *Leean Budget Request*].

36. Linda J. Blumberg, et al., *Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP*, 19 J. OF HEALTH ECON. 33, 34 (2000).

37. *Id.*

38. John C. Ham & Lara Shore-Sheppard, *The Effect of Medicaid Expansions for Low-Income Children on Medicaid Participation and Insurance Coverage: Evidence from the SIPP* 5-7 (March 2000), *available at* http://www.jcpr.org/wpfiles/ham.shore-sheppard.pdf (last visited April 20, 2001). It should be noted that this range is due to varying study populations, data sources and assumptions used by the researchers. For example, some researchers limited their study to certain groups of eligible children; some studies assumed parents would drop their own private insurance coverage under Medicaid expansions, others did not. *Id.* The 50% crowd-out estimate derives from the 1996 study by Cutler and Gruber using Current Population Survey data from 1987 to 1992. *Id.; see also* David M. Cutler & Jonathon Gruber, *Medicaid and Private Insurance: Evidence and Implications*, HEALTH AFF., Jan./Feb. 1997, at 194, 197. However, the crowd-out effect is not unique to Medicaid expansion programs. Center for Health Sys. Change, *Medicaid Eligibility Policy and the Crowding-Out Effect: Did Women and Children Drop Private Health Insurance to Enroll in Medicaid?* 3 (Oct. 1996), *at* http://www.hschange.org/CONTENT/78/?topic=topic13 (last visited April 20, 2001). For example, substitution of private benefits for public benefits can also occur in retirement income (i.e., Social Security displacing private savings). *Id.*

number of uninsured people; and (2) a greater increase in state expenditures for public health insurance.[39] Consequently, if Wisconsin employees and employers are opting for BadgerCare rather than employer-sponsored health insurance, this crowd-out effect may weaken the BadgerCare program by absorbing too much of the state budget while not reducing the state's uninsurance rate.[40]

Although there is currently no solid evidence of crowd-out occurring in Wisconsin due to BadgerCare, a debate about its occurrence is beginning to ensue. Some legislators have voiced concern that employers are dropping health insurance coverage in favor of BadgerCare.[41] Others have noted that current statistics do not support the occurrence of crowd-out.[42] Regardless of which position is correct, the BadgerCare verification process holds the key to ensuring an efficient use of limited public funds and an adequate balance between government and employer-sponsored family coverage.

E. *Important Differences Between BadgerCare and Medical Assistance (MA)*

Before discussing the BadgerCare verification process, it is important to highlight some of the differences between BadgerCare and MA, especially as those differences relate to the increasing participation rate in BadgerCare. The first difference is that unlike MA, BadgerCare is not an entitlement program.[43] This is significant because if the number of people enrolled in the program exceeds the available funding for the program, the state will either have to increase funds to support the extra enrollees or institute the "enrollment trigger," which would cut back on the number of eligible people

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39. Blumberg et al., *supra* note 36, at 34.

40. According to the most recent Census Bureau report, 11% of Wisconsin residents were uninsured for the entire calendar year in 1999, a decrease from 11.8% in 1998. Sarah Wyatt, *State Rank High in Health Insurance*, WIS. STATE J., Sept. 29, 2000, at 1E. However, this percentage is much higher than the percent uninsured reported by the Census Bureau in 1996 and 1997, which was 8.4% and 8.0%, respectively. Memorandum from Barbara Zabawa and Charles Morgan, Legislative Fiscal Bureau to Senator Robert Cowles, *Estimated Percentage of Wisconsin Residents Without Health Insurance: A Comparison of the DHFS Family Health Survey and the U.S. Census Bureau Estimates* (Nov. 11, 1999) (on file with author).

41. In response to whether BadgerCare is becoming "government-run health care for everybody," Representative John Gard (R-Peshtigo), co-chair of the Joint Committee on Finance, said he believed that is happening. Simms, *supra* note 1. He further stated "I don't have proof in front of me, but I think people have been very creative in making sure their tracks are covered." *Id.*

42. PEACOCK, *supra* note 14, at 3 (referring to the relatively small number of people above 150% FPL who are enrolled in BadgerCare). Mr. Peacock believes that if crowd-out were actually occurring, more people above 150% FPL would be enrolled in BadgerCare, rather than private insurance. *Id.*

43. WIS. STAT. § 49.665(4)(b)(1999); *see also* AMIE GOLDMAN & RICHARD MEGNA, LEGIS. FISCAL BUREAU, MEDICAL ASSISTANCE PROGRAM – INFORMATIONAL PAPER #44 1 (1999).

for the program.[44] Either option threatens BadgerCare's viability and goal of reducing the number of uninsured working families. Increased BadgerCare spending due to crowd-out may demonstrate employer and employee preferences for the public program over private employer-sponsored insurance. However, one issue is whether the public funds being used to cover these families is occurring at the cost of not providing any insurance to families with no employer-sponsored insurance alternative. Similarly, if Wisconsin implements the enrollment trigger because the program is unable to afford covering additional families, then fewer uninsured families will have access to health insurance. As a result, the occurrence of private insurance crowd-out limits the ability of BadgerCare to provide health insurance to all the families who may need it and therefore presents a threat to the program's long-term survival.[45]

A second and perhaps more important difference is that unlike MA, people are ineligible for BadgerCare if they have access to employer-sponsored family health insurance.[46] Specifically, if the employer of a BadgerCare applicant pays for at least 80% of the cost of a group health insurance plan, the applicant is not eligible for BadgerCare.[47] If the applicant's employer pays between 60% and 80% of the cost of a group health insurance plan, the applicant is eligible for BadgerCare, but may be required to participate in the Health Insurance Premium Payment (HIPP) or "buy-in" program.[48] The buy-in program allows DHFS to purchase the coverage offered by the applicant's employer if the purchase is more cost effective than providing coverage under BadgerCare.[49] The purpose of the buy-in program is two-fold: (a) it offers an opportunity to save BadgerCare funds by allowing the employer-sponsored health insurance program to pay a portion of the BadgerCare enrollee's coverage; and (b) it accustoms working families to the idea that employers are the primary source of health coverage, not the government.[50] If people who have access to employer-sponsored family health insurance receive BadgerCare

44. WIS. STAT. § 49.665(4)(at) (discussing the "enrollment trigger"). This mechanism can be implemented if there are insufficient funds to support enrollment projections. *Leean Budget Request, supra* note 35. Although it has not yet been used, state officials have discussed implementing the enrollment trigger as one solution for the increased BadgerCare costs. *Id.*

45. Simms, *supra* note 1.

46. WIS. ADMIN. CODE §§ 103.03(f)(3), (4) (2000). Under MA, access to employer-sponsored health insurance will not preclude program eligibility. Vickie Baker, Health Benefits Counselor, ABC for Health, BadgerCare Training (Nov. 8, 2000) (on file with author) [hereinafter BadgerCare Training].

47. WIS. ADMIN. CODE § 103.03(f)(3).

48. WIS. ADMIN. CODE § 108.02(13) (2000).

49. WIS. ADMIN. CODE § 108.02(13).

50. Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, in Madison, Wis. (Feb. 23, 2001).

rather than participating in the employer or buy-in program, BadgerCare expenditures may be unnecessarily high.

Due to these important differences between MA and BadgerCare, the state relies on a verification process to ensure that only those eligible for BadgerCare are ultimately enrolled in the program. However, this process may have difficulty detecting all employees who have access to employer-sponsored family health insurance.

PART II: THE BADGERCARE VERIFICATION PROCESS

Verification of a BadgerCare applicant's health insurance status is essential to determine whether the person is eligible to enroll in BadgerCare or participate in the buy-in program. All eligibility information is entered into a database system called the Client Assistance for Reemployment and Economic Support (CARES) system.[51] To determine whether a person has access to employer-sponsored family health insurance, a caseworker assesses a BadgerCare applicant's employment status.[52] If the applicant is unemployed and meets the other eligibility requirements, the person is immediately enrolled in the BadgerCare program.[53] If the applicant is employed, the applicant is still enrolled in the BadgerCare program (providing he or she meets the other eligibility requirements), but DHFS sends out an Employer Verification of Insurance Coverage (EVIC) form to the employer to determine whether the appropriate employer-sponsored family coverage is available.[54] According to DHFS officials, approximately 66% of the employers return the EVIC form to DHFS.[55] Employers may also be contacted by telephone if the form is not returned within four weeks.[56]

Regardless of whether the employer returns the EVIC form, after 56 days from the initial eligibility determination, DHFS must make a final decision about a person's eligibility.[57] If the EVIC form is not

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51. *Id.*

52. Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, in Madison, Wis. (Nov. 15, 2000).

53. *Id.*

54. *Id.*; *see also* Telephone Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, (Nov. 10, 2000); DHFS, *DHFS BadgerCare Fact Sheet, Essential Information for Employers* (Mar. 22, 2001), *at* http://www.dhfs.state.wi.us/badgercare/factsheets/employers.htm (last visited April 20, 2001) [hereinafter *Employer Fact Sheet*].

55. Telephone Interview with Don Schneider, *supra* note 54; *see also DHFS BadgerCare Fact Sheet, Wisconsin Health Insurance Premium Payment (HIPP) Overview* 2 (March 22, 2001), *at* http://www.dhfs.state.wi.us/badgercare/factsheets/hipp.htm (last visited Apr. 20, 2001) [hereinafter *HIPP Fact Sheet*].

56. *Employer Fact Sheet, supra* note 54.

57. Telephone Interview with Don Schneider, *supra* note 54. Mr. Schneider stated that the 56-day limit is an internal limit set by DHFS. *Id.* The limit is not established by any law or rule. *Id.* However, it is based on DHFS' best time estimate to receive the EVIC form from the employer as well as the time needed to enroll

returned, the BadgerCare applicant remains in the program, even though the person may have access to employer-sponsored family coverage that would make the person otherwise ineligible for BadgerCare. If the employer returns the EVIC form and indicates the BadgerCare applicant has access to employer-sponsored family coverage, one of two actions may be taken. If the employer pays for at least 80% of the cost, the BadgerCare applicant is no longer eligible for the program and is notified by DHFS of this fact even though the person could have received BadgerCare benefits for up to 56 days, though they were not eligible.[58] If the employer-sponsored coverage pays between 60-80% of the cost, DHFS will determine whether the buy-in program would be more cost effective than providing services under BadgerCare.[59]

Even if an employer returns the EVIC form, the information provided on the form is often inapplicable because the employee no longer works for the employer, or the provided information disqualifies the employer-sponsored plan from consideration. For example, of the returned EVIC forms, 28% indicate that the employer no longer employs the BadgerCare recipient.[60] According to one DHFS official, this problem may be due to BadgerCare recipients frequently changing jobs.[61] In such a case, employees remain enrolled in BadgerCare unless they inform their caseworkers of their new job and the job provides access to family coverage that pays for at least 80% of the cost, in which case the BadgerCare recipient would lose program eligibility. If the employer returns the EVIC form and indicates that they do not offer "family" coverage or that the employer is self-insured, DHFS ends the verification process and keeps the BadgerCare recipient in the program.[62] Fifty-two percent of the returned EVIC forms indicate that the employer does not offer family health insurance, the plan offered does not qualify for the buy-in program (i.e., the employer pays less than 60% of the cost), or the employer is self-insured.[63] Therefore, due to a number of factors affecting the verifi-

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BadgerCare recipients into an HMO, which is the preferred mechanism to provide services (the fee for service mechanism is much more expensive). *Id.*

58. *Id.*

59. *Id.* Angela Dombrowicki, Director of the Bureau of Managed Health Care, indicated that only seven families are participating in the buy-in program because the 60% threshold is very limiting as to the number of eligible employer-sponsored programs. Interview with Angela Dombrowicki, *supra* note 9. In addition, the wrap-around service requirement (allowing the services covered under the employer-sponsored program to match those services covered under BadgerCare) makes the buy-in program expensive for the provider and the state. *Id.* According to Ms. Dombrowicki, at the time of this article DHFS has requested another waiver from HCFA to lower the buy-in threshold to 50% employer-sponsored coverage. *Id.*

60. *HIPP Fact Sheet*, *supra* note 55, at 2.

61. Interview with Angela Dombrowicki, *supra* note 9.

62. Telephone Interview with Don Schneider, *supra* note 52.

63. *HIPP Fact Sheet*, *supra* note 55, at 2. According to Don Schneider, the employee may have access to individual coverage, but the EVIC form only asks whether

cation process, DHFS may be unable to discontinue an employee's benefits under BadgerCare or take advantage of the buy-in option.[64]

If a BadgerCare recipient enrolls in an employer-sponsored plan that is not self-insured, DHFS can identify such dual coverage through monthly "tape matches" between the information stored in the CARES system and the Medicaid Management Information System (MMIS).[65] The MMIS system, among other things, stores private insurance information.[66] The tape match is made possible through data provided by insurers about who is covered under their plans.[67] The information on the MMIS tapes is matched to the information stored on the CARES system.[68] If a person shows up as having health insurance on the MMIS tapes, this information is sent to the BadgerCare caseworker via the CARES system to resolve the discrepancy.[69] If the BadgerCare enrollee is also enrolled in employer-sponsored health insurance, DHFS notifies him or her of their ineligibility if the employer pays for at least 80% of the insurance cost, or will try to implement the buy-in program if the employer pays between 60% and 80% of the cost. However, the tape match process does not address whether an employee has *access* to employer-sponsored family coverage; the tape matches can only identify those employees who are *covered* by both their employer and BadgerCare.[70] Consequently, the tape match process is of little value in situations where an employer offers family health insurance but a BadgerCare recipient chooses not to enroll.

Therefore, there are a number of instances where BadgerCare recipients may be ineligible for benefits because they have access to employer-sponsored health insurance, but DHFS is unable to detect that ineligibility through the verification process. Specifically, these loopholes in the verification process may occur in the following circumstances: (1) an employee fails to give correct insurance informa-

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the employer provides "family" coverage. Nov. 15 Don Schneider Interview, *supra* note 52. In addition, approximately 15-16% of the returned EVIC forms indicate the employer is self-insured. Telephone Interview with Don Schneider, *supra* note 54. Self-insured plans do not contract with an insurer to bear the risk of loss, but rather bear the risk of loss themselves. *See infra,* Part IV. According to a DHFS official, DHFS does not pursue further information from self-insured plans because it is not cost-effective to coordinate the buy-in option with those plans. Telephone Interview with Don Schneider, *supra* note 54.

64. Interview with Angela Dombrowicki, *supra* note 9; *see also* Telephone Interview with Don Schneider, *supra* note 54. DHFS noted "It is difficult and time consuming to obtain demographic information about employers and their payroll/benefits staff necessary to follow up on information provided on the EVIC to complete the HIPP process." *HIPP Fact Sheet, supra* note 55, at 2.

65. Telephone Interview with Susan Wood, Director, Bureau of Health Care Eligibility, DHFS (Nov. 7, 2000); *see also* Nov. 15 Don Schneider Interview, *supra* note 52.

66. Telephone Interview with Susan Wood, *supra* note 65.

67. Telephone Interview with Don Schneider, *supra* note 54.

68. *Id.*

69. *Id.*

70. Telephone Interview with Don Schneider, *supra* note 52.

tion; (2) an employer fails to return the EVIC form; (3) an employer returns the EVIC form but the employee no longer works for the employer; (4) an employer returns the EVIC form and indicates that the employer does not offer "family" coverage; and (5) an employer returns the EVIC form and indicates the employer is self-insured. This Comment examines each of these loopholes below in the context of reasons for employee and employer noncompliance with the verification process.

PART III: IMPEDIMENTS TO THE BADGERCARE VERIFICATION PROCESS – THE EMPLOYEE PERSPECTIVE

Although employees who apply for BadgerCare must provide "full, correct and truthful information necessary for eligibility determination,"[71] employees, for various reasons, may be unable to provide information relating to access to employer-sponsored family coverage during the verification process. For example, verifying access to employer-sponsored family coverage may be impossible due to current labor market conditions of low wages and high turnover. High turnover may encourage employees to continue BadgerCare coverage for continuity of care reasons. Furthermore, if a low-wage employer offers health insurance at all, the low cost and comprehensiveness of BadgerCare benefits may be preferred to employer-sponsored family coverage. Finally, DHFS markets BadgerCare as a health insurance program rather than public assistance, which may encourage more people to opt for BadgerCare rather than employer-sponsored family coverage.

A. *The Current Conditions of the Low-Wage Labor Market*

Employees who are eligible for BadgerCare by definition are in the low-wage labor market.[72] Over the past 50 years, the low-wage labor market has moved from large-employer, manufacturing jobs to small employer, service jobs.[73] As a result, today's low-wage workers find themselves in "dead-end jobs," rather than acquiring a permanent job with upward mobility possibilities.[74] These jobs are found, for example, in the service, clerical, hospitality and health care sectors.[75] Dead-end jobs are characterized as low-wage with no upward

71. WIS. ADMIN. CODE § 102.01(6) (2000).

72. WIS. STAT. § 49.665(4).

73. LAURA DRESSER & JOEL ROGERS, CTR. ON WIS. STRATEGY BRIEFING PAPER, REBUILDING JOB ACCESS AND CAREER ADVANCEMENT SYSTEMS IN THE NEW ECONOMY 1-2 (1997).

74. *Id.* at 3.

75. *Id.* at 2-10; Jennifer Middleton, *Contingent Workers in a Changing Economy: Endure, Adapt, or Organize?*, 22 N.Y.U. REV. L. & SOC. CHANGE 557, 565 (1996).

mobility and few if any fringe benefits.[76] Furthermore, these jobs are often temporary, leased or part-time, and are prone to a high rate of turnover.[77] According to Wisconsin's Welfare Leavers Study, 45% of those who left welfare and were employed stayed only a few days to three months at their *best* job.[78] Another study found that significant percentages of newly hired welfare recipients left their jobs after three to four months.[79]

Women are most likely to be trapped in dead-end jobs.[80] In fact, the contingent worker population consists of the same population base as welfare recipients: women with children, and minorities.[81] Furthermore, many women do not choose contingent employment; rather their participation in those jobs is involuntary.[82] Temporary employment firms increasingly establish exclusive relationships with businesses to supply temporary and contract workers for jobs that used to be in-house,[83] thereby cutting off any opportunity for advancement and exacerbating the already-high turnover rate.[84]

According to the Wisconsin Welfare Leavers Study, a large percentage of jobs that former welfare recipients acquire fall into the dead-end job category. The largest percentage of welfare leavers worked in the service sector, including hospitality, business services, and health care.[85] As a result, many former welfare recipients and other low-wage workers who would be eligible for BadgerCare are

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76. DRESSER & ROGERS, *supra* note 73, at 3; Stewart J. Schwab, *The Diversity of Contingent Workers and the Need for Nuanced Policy*, 52 WASH. & LEE. L. REV. 915, 919 (1995).

77. DRESSER & ROGERS, *supra* note 73, at 3 (providing an example of one employer, in the hotel business, as having a turnover rate of 100%. The employees view this employer's jobs as "something to do for a couple of months and they're gone"); Sharon Dietrich et al., *Work Reform: The Other Side of Welfare Reform*, 9 STAN. L. & POL'Y REV. 53, 57 (1998).

78. DWD SURVEY, *supra* note 15, at 7.

79. Robert Jacobson & Gary Green, *Who's Hiring Whom for What? A Report on Employer Practices and Perceptions in Wisconsin and Their Implications for the Future of Welfare Reform* 1, 2 (Nov. 2000), http://www.wccf.org/whohire2.pdf (last visited April 20, 2001) [hereinafter *WCCF Study*].

80. DRESSER & ROGERS, *supra* note 73, at 3; Dietrich, *supra* note 77, at 58.

81. Dietrich et al., *supra* note 77, at 58. According to one study, "women hold 60% of contingent jobs." *Id.* at 58 n.88.

82. Patricia Schroeder, *Does the Growth in the Contingent Work Force Demand a Change in Federal Policy?*, 52 WASH. & LEE L. REV. 731, 733 (1995) ("The female rate of involuntary part-time work is 44% greater than that of men.").

83. Middleton, *supra* note 75, at 565. Interestingly, Wisconsin is home to one of the largest temporary employment agencies – Manpower, Inc. – based in Milwaukee. *Id.*

84. DRESSER & ROGERS, *supra* note 73, at 3; *see also* WCCF Study, *supra* note 79, at 3 (indicating that since entry-level positions offer no opportunity for advancement, workers only benefit from the tight labor market by taking a job elsewhere, increasing the turnover rate).

85. DWD SURVEY, *supra* note 15, at 8 (indicating that 48% of welfare leavers worked in the service sector).

stuck in dead-end jobs that offer few benefits and little incentive for a long-term commitment.

Most important for this analysis, however, is that dead-end jobs generally offer inadequate health insurance. Although Wisconsin's unemployment rate has been steadily decreasing since 1990 and is below that of the United States as a whole,[86] many low-wage employers may still find it difficult or unappealing to offer health insurance to attract low-wage workers.[87] "Many employers of part-time and temporary workers either cannot afford to pay insurance for their employees or simply do not want to invest in these workers who will not be around for the long term."[88] According to a U.S. General Accounting Office report, employers are less likely to offer health insurance coverage if they are in industries with high labor turnover rates and a large portion of temporary and part-time workers.[89]

However, even if a low-wage employer offers health insurance, the cost of that insurance may be prohibitively high or the benefits comparatively low to those offered in public programs such as BadgerCare.[90] For example, one temporary worker who earned $11.50 per hour paid $300 per month for health insurance to cover both herself and her children, absorbing a significant amount from each paycheck.[91] However, to receive the comprehensive benefits offered under BadgerCare, the most a family of three earning between 185%

86. Bureau of Labor Statistics, *State at a Glance – Wisconsin* (April-Sept. 2000), *at* http://stats.bls.gov/eag/eag.wi.htm (last visited Apr. 22, 2000); Bureau of Labor Statistics, *Local Area Unemployment Statistics – Wisconsin 1990-2000, at* http://stats.bls.gov/eag/eag.wi.htm (last visited Apr. 20, 2001); *see also* Bureau of Labor Statistics, *Labor Force Statistics from the Current Population Survey, Series Catalog, Civilian Labor Force 1990-2000, at* http://stats.bls.gov/eag/eag.us.htm (last visited Apr. 20, 2001). From this series of data, one discovers that Wisconsin's unemployment rate in September 2000 was 3.6%, compared to the national rate of 3.9%. According to the statistics, Wisconsin's unemployment rate fell from 4.6% in January 1990 to 3.3% in January 2000. Nationally, for the same time period, the unemployment rate fell from 5.4% to 4.0%.

87. According to one small business group in Wisconsin, 81% of the group's members indicate that health insurance is needed to attract employees. But, because of cost pressure, small businesses are struggling to continue with health insurance benefits. Interview with Bill Smith, State Director, National Federation of Independent Businesses, in Madison, Wis. (Nov. 14, 2000).

88. Schroeder, *supra* note 82, at 735.

89. U.S. Gen. Acct. Off., *Employment-Based Health Insurance: Medium and Large Employers Can Purchase Coverage, but Some Workers are not Eligible* 7 (1998), *available at* http://www.gao.gov (last visited Apr. 20, 2001).

90. According to one study, "low-wage firms tend to pay a smaller percentage of premium costs and to offer policies with fewer benefits." Nancy S. Jecker, *Can an Employer-Based Health Insurance System Be Just?, in* THE POLITICS OF HEALTH CARE REFORM: LESSONS FROM THE PAST, PROSPECTS FOR THE FUTURE 259, 262 (James A. Morone & Gary S. Belkin eds., 1994).

91. Julia R. Henly, *Barriers to Finding and Maintaining Jobs – The Perspectives of Workers and Employers in the Low-Wage Labor Market, in* HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA 48, 66 (Joel F. Handler & Lucie White eds., 1999).

and 200% of the FPL would have to pay is $60 per month.[92] Therefore, the benefits low-wage workers receive in employer-sponsored plans pale in comparison to the benefits offered in BadgerCare, especially considering the cost to the employee.[93] Consequently, many low-wage workers do not "take-up" employer-sponsored family health insurance, even if it is offered. One researcher notes that "for many workers, the costs of health insurance are greater than the benefits. These workers would prefer higher wages to the benefits, and presumably the employer is indifferent between paying compensation in the form of insurance premiums or wages."[94]

As health insurance premiums increase, fewer employees are likely to take-up employer health insurance. In recent years, Wisconsin employers have faced record increases in their health insurance costs.[95] In 2001, employers could face an average 30% increase in the cost of providing employee health insurance in Wisconsin.[96] Furthermore, Wisconsin's health care costs are higher than the national average, with Milwaukee and Madison outpacing other metropolitan areas such as New York City, Boston, South Florida, Houston, Detroit, and Chicago.[97] Such increases will force some employers to increase employee out-of-pocket costs through co-payments and deductibles in the year 2001.[98] According to responses from 730 Wisconsin small businesses, 83.33% experienced increased health insurance costs in 1999.[99] As a result, 26.75% of those employers increased their deductible and 10.03% increased employee premiums.[100] Another study found that employees in small firms (fewer than 200 workers) faced an increase in the average monthly contribution to family health insurance premiums from $34 to $175 between 1988 and 1996.[101]

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92. *BadgerCare Premium Fact Sheet, supra* note 24. BadgerCare monthly income limits for a family of three earning between 185% and 200% FPL range from $2,139.83 and $2,313.33. *Id.*

93. Interview with Angela Dombrowicki, *supra* note 9; Interview with Bill Smith, *supra* note 87.

94. Schwab, *supra* note 76, at 930.

95. Joe Manning, *Health Premiums May Leap 30%*, MILWAUKEE J. SENTINEL, Sept. 24, 2000, *available at* http://www.jsonline.com/bym/news/sep00/insure25092400a.asp (last visited April 20, 2001).

96. *Id.; see also* Interview with Bill Smith, *supra* note 87 (indicating that some businesses faced 85-100% health insurance increases in 2000).

97. Joe Manning, *Medical Costs Top Average – Area Surpasses New York in Health Care Expenses*, MILWAUKEE J. SENTINEL, Oct. 25, 2000, *available at* http://www.jsonline.com/bym/news/oct00/health26102500a.asp (last visited April 20, 2001).

98. *Id.* ("Approximately 25% of employers will increase workers' co-payments and deductibles.").

99. Preliminary Report, Wis. Indep. Bus., Inc. 1999 Health Insurance Survey (March 1999).

100. *Id.*

101. Paul B. Ginsburg et al., *Tracking Small-Firm Coverage, 1989-1996*, HEALTH AFF., Jan.-Feb. 1998, at 167, 170.

Thus, increased cost sharing and declining real incomes contribute to low take-up rates of employer-sponsored family coverage by low-wage employees. Accordingly, when it comes to health insurance, low-wage workers face several challenges: (1) their employers are less likely to offer health coverage; (2) if the employer offers health coverage, low-wage workers typically must pay more for it; and (3) low-wage workers have the least money to spend on health coverage.[102]

B. *How Low-Wage Labor Market Conditions May Impede the BadgerCare Verification Process*

Due to the low-wage labor market conditions of high turnover and inadequate and high cost employer-sponsored family health insurance, employees may not comply with the BadgerCare verification process. As a result of the high rate of turnover in the low-wage market, employees may seek continuity in their health care coverage. According to Representative John Gard, a program such as BadgerCare helps people move from job to job.[103] One recent study found that of the adults and children who lost insurance for at least one month between 1991 and 1993, 25% experienced this loss "when a family member changed jobs or occupations."[104] Thus, rather than signing up for employer-sponsored coverage (if offered) each time an employee changes jobs, the employee may continue receiving benefits through BadgerCare. By continuing BadgerCare coverage, the employee can avoid the paperwork involved with enrolling in a new plan and perhaps changing providers.[105] Consequently, when an employee changes jobs, he or she may not report that information to the caseworker.[106] Therefore, DHFS may be unable to verify whether employees have access to employer-sponsored family coverage, resulting in more ineligible BadgerCare recipients and fewer participants in the buy-in program.

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102. Charles N. Kahn III & Ronald F. Pollack, *Building A Consensus For Expanding Health Coverage,* HEALTH AFF. Jan.-Feb. 2001, at 40, 44.

103. Interview with John Gard, Wis. State Representative, in Madison, Wis. (Nov. 16, 2000).

104. U.S. Gen. Acct. Off., *Employment Based Health Insurance: Costs Increase and Family Coverage Decreases* 20 (1997), *available at* http://www.gao.gov (last visited April 20, 2001) [hereinafter *GAO Family Study*].

105. Richard Curtis et al., *Finding Practical Solutions to "Crowding Out,"* HEALTH AFF., Jan.-Feb. 1997, at 201, 201 ("The shift from employer coverage to Medicaid often forces a change in providers, which may reduce continuity of care."). It is assumed that the reverse situation is also true.

106. Interview with Don Schneider, *supra* note 52 (admitting that even though an employee should report a job change to their caseworker, it is difficult to track a mobile population).

C. *The Impact of BadgerCare's Comprehensive Benefits on the Verification Process*

In addition to continuity of care reasons, low-wage employees may not comply with the BadgerCare verification process because BadgerCare benefits are typically more comprehensive than employer-sponsored health plans. According to DHFS, this fact is one of the most appealing aspects of BadgerCare.[107] The comprehensiveness of benefits may discourage employees from taking up employer-sponsored family plans, especially at the low costs at which they can receive such coverage. According to one small business leader, the benefits in BadgerCare are much more generous than the typical benefits small business owners purchase.[108] Consequently, BadgerCare is a good deal[109] and may discourage employees from complying with the verification process. In fact, some caseworkers may assist such noncompliance by encouraging people to take BadgerCare rather than employer-sponsored family coverage. One health plan worker indicated that some caseworkers advise clients not to enroll in private insurance but wait three months to become eligible for BadgerCare because the benefits are more comprehensive than employer-sponsored family coverage.[110] This attempt to enroll as many people in BadgerCare as possible may reflect a desire to make the program a success at the expense of uniform application of the eligibility rules and controllable growth. This strategy also disrupts the effectiveness of the verification process. As a result, some health insurance companies and legislators have voiced concern that BadgerCare needs to be studied and uniformly controlled before it can continue to expand.[111]

D. *How BadgerCare Marketing may Reduce Stigma and Impede the Verification Process*

BadgerCare marketing may also disrupt the verification process for low-wage employees. Wisconsin has strategically marketed BadgerCare as an insurance program rather than public assistance. Re-

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107. Interview with Angela Dombrowicki, *supra* note 9.

108. Interview with Bill Smith, *supra* note 87.

109. *Id.*

110. Interview with Carola Gaines, Cmty. Health Outreach Mgr., Unity Health Plans, in Madison, Wis. (Nov. 14, 2000).

111. Telephone Interview with Tom Hefty, President, Blue Cross Blue Shield of Wis. (Nov. 3, 2000) (stating that the BadgerCare population is nonstandard and unpredictable, and that enrolling people in BadgerCare is often done by ignoring a person's eligibility information (i.e., "clean-sheeting")). Mr. Hefty also states that BadgerCare needs a common enrollment mechanism. *Id.*; Interview with John Gard, *supra* note 103 (indicating that the state may be encouraging skyrocketing costs in BadgerCare and would like to cap enrollment and make sure that the program is working effectively); Interview with Wayne Corey, Executive Director, Wisconsin Independent Businesses, in Madison, Wis. (Nov. 14, 2000) (indicating that the BadgerCare issue for Health Maintenance Organizations (HMOs) is that they are losing business from BadgerCare and that ineligible people are being enrolled in the program).

searchers suspect that the stigma related to enrolling in public assistance programs such as MA deters people from applying for coverage.[112] Particularly in the wake of welfare reform, studies attributed some of decline in MA enrollees to the stigma attached to the program.[113] According to one DHFS official, "no one in the general public thinks of BadgerCare as welfare Medicaid. They think of it as an insurance program without the welfare stigma."[114] A Wisconsin legislator partially attributed BadgerCare's large enrollment to the program's "cute name" and disassociation from welfare.[115] The brochures that advertise BadgerCare describe the program as "Health Insurance for Working Families," and convey no connection to MA.[116] Consequently, more low-wage employees may be willing to participate in BadgerCare in lieu of employer-sponsored family coverage, since the program is a much better deal and is not viewed as welfare. Thus, if employees are ineligible for the program because they have access to employer-sponsored family coverage, there is less incentive for them to comply with the verification process, which may discontinue their benefits under BadgerCare.

It is already known that "Medicaid applicants may not always disclose the availability of coverage from their employer."[117] Since BadgerCare offers the same comprehensive benefits as Medicaid, but carries less stigma, expands eligibility, and is less costly than employer-sponsored family coverage, low-wage employees may have little incentive to comply with the BadgerCare verification process. As a result, BadgerCare's success may be attributable to ineligible employees escaping detection under the verification process. However, employee issues may only be partially to blame.

PART IV: IMPEDIMENTS TO THE BADGERCARE VERIFICATION PROCESS – THE EMPLOYER PERSPECTIVE

Although they are not required to provide health benefits to their employees,[118] employers carry the primary burden of providing health insurance coverage to citizens.[119] According to one small business

112. Bowen Garrett & John Holahan, *Health Insurance Coverage After Welfare*, HEALTH AFF., Jan.-Feb. 2000, at 175, 181.

113. *Id.*

114. Interview with Angela Dombrowicki, *supra* note 9.

115. Interview with Judy Robson, Wis. State Senator, in Madison, Wis. (Nov. 15, 2000).

116. DHFS, DHFS BADGERCARE BROCHURE (June 1999) [hereinafter BADGERCARE BROCHURE].

117. Curtis, *supra* note 105, at 202.

118. Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1042 (1996).

119. *Id.* (noting that of the 84% of people who were covered by health insurance in 1999, 62.8% of those had coverage through their employer as opposed to 24.1% of insured people who were covered by a government program).

representative, providing health insurance to employees is the number one concern for small businesses in Wisconsin.[120] Before discussing how employer concerns may thwart the verification process, it is important to first understand the tax incentives behind employer-sponsored health insurance in the United States. Employer tax incentives are at least partially responsible for creating our nation's fragmented health care system[121] and contribute to the threat of private health insurance crowd-out.

A. *Tax Incentives Behind the Employer-Sponsored Health Insurance System*

To encourage employer-sponsored health insurance, sections 105 and 106 of the Internal Revenue Code (IRC) allow tax incentives to those employers who choose to offer health insurance to their employees.[122] Specifically, section 105 of the IRC excludes from taxable gross income those amounts "paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him [or his family]" for medical care.[123] Section 106 of the IRC excludes from an employee's taxable gross income "employer-provided coverage under an accident or health plan."[124] As a result, these tax incentives allow employers to deduct health insurance contributions from their profits, and allow employees who receive employer-sponsored health insurance to receive a nontaxable benefit.[125]

However, not all employers, particularly smaller and nonunionized firms,[126] are able to take advantage of these tax incentives, especially as the costs of providing employee health insurance continue to escalate. In particular, "if the cost of health premiums rises faster than wage rates, eventually the number of pretax dollars needed to buy health insurance, less the applicable tax savings, will exceed the number of after-tax dollars required to purchase the same amount of labor with straight wages."[127] As a result, employers must find ways to

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120. Interview with Bill Smith, *supra* note 87.

121. U.S. Census Bureau, *Health Insurance Detailed Table: 1999, Table 1 – Type of Health Insurance and Coverage Status, All People: 1998 and 1999, at* http://www.census.gov/prod/2000pubs/p60-211.pdf (last April 20, 2001) (indicating that health insurance coverage consists of private (employer-based and individual) as well as government-sponsored programs, such as Medicare, Medicaid, and military programs).

122. I.R.C. §§ 105(b), 106(a) (2000).

123. I.R.C. § 105(b).

124. I.R.C. § 106(a).

125. Jecker, *supra* note 90, at 261. *But see* Jay A. Soled, *Taxation of Employer-Provided Health Coverage: Inclusion, Timing, and Policy Issues*, 15 VA. TAX REV. 447, 448 (1996) (noting that the present cost of I.R.C. § 106 exclusions result "[i]n an estimated annual revenue loss to the federal government of $74 billion, which is projected to grow.").

126. Jecker, *supra* note 90, at 262.

127. Matthew, *supra* note 118, at 1044.

still offer health insurance to attract workers in a tight labor market[128] and maintain the tax benefits, but reduce premium costs. One way to reduce health insurance costs is to take advantage of the Employee Retirement Income Security Act of 1974 (ERISA) preemption. However, ERISA preemption may create difficulties for the BadgerCare verification process.

B. *ERISA Preemption and the BadgerCare Verification Process*

ERISA complicates state regulation of employer-sponsored health plans, including the gathering of employer health plan information, which is the primary purpose of the BadgerCare verification process. With more coordination between DHFS, the Office of the Commissioner of Insurance (OCI), and the Department of Workforce Development (DWD), Wisconsin may be able to avoid at least some of the issues ERISA presents.

Generally, ERISA preempts "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan,"[129] which includes group health plans offered by employers.[130] This "relate to" clause creates difficulty for the BadgerCare verification process because a state law requiring employers to return the EVIC form would likely "relate to" the employer benefit plan.[131] Specifically, a state law may "relate to" an employer-sponsored health plan if it "directly refers to ERISA plans . . . by imposing obligations on them," or "regulates the same areas as ERISA (such as reporting, disclosure, or remedies)," or "regulates an ERISA plan's benefits, structure, or administration."[132] Under the current BadgerCare verification process, when the State sends the EVIC form to employers, the State directly asks employers to report or disclose information to the state, which is arguably preempted by ERISA.[133] Furthermore, if one purpose of the EVIC form is to involve the employee and employer in the buy-in option, the State is arguably intervening in the employer plan's "benefits" and "administration."[134] Consequently, even though 66% of

128. *Id.* at 1063 ("In the end, the simple fact that the employer is offering a health insurance plan at all is usually sufficient to attract workers to apply for, and accept, a position.").

129. 29 U.S.C. § 1144(a) (2000) (emphasis added).

130. 29 U.S.C. § 1167(1) (2000).

131. Patricia A. Butler, *The Commonwealth Fund Rep., ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* 4 (Oct. 2000), *at* http://www.epn.org/whatsnew/full_cite/613.html (last visited Apr. 20, 2001).

132. *Id.*

133. *Id.* at 7 ("ERISA is likely to preempt state attempts to require that employers report information to states about health plan coverage and contributions, inform employees about buy-in opportunities, modify payroll tax deductions, or remit public funds to insurers.").

134. *Id.* at 7 ("Although no court has considered such a state reporting requirement, it would arguably relate to employer-sponsored plans by imposing an adminis-

employers voluntarily return the EVIC form,[135] it is likely that ERISA prevents a state from compelling employers to return such forms.[136]

Therefore, ERISA may preempt the State from determining *directly* from employers whether a BadgerCare recipient has access to employer-sponsored family coverage or is eligible for the buy-in program. This preemption issue is particularly important to self-insured employers. Unlike insured employer health plans, where an employer contracts with an insurance company or health plan to bear the risk of loss, self-insured employer plans do not contract with insurers,[137] paying health insurance claims directly and thus bear at least some of the risk of loss.[138] If an employer indicates on the EVIC form that they are "fully or partially self-funded," DHFS terminates the inquiry into an employee's access to employer-sponsored family health insurance, avoiding even stronger ERISA preemption arguments than is presented with just a one-time request for health plan information.

However, ERISA, combined with other federal mandates, may provide a loophole for states to gather health coverage information directly from employers. Although a full discussion is beyond the scope of this comment, there is agreement from national scholars in ERISA law that preemption exceptions concerning Title XIX and Qualified Medical Child Support Orders (QMCSO's) are a valid starting point for making such arguments.[139] In practice, direct access to employer health coverage information would require greater coordination between the state agency that administers MA and BadgerCare

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trative obligation already required by ERISA—that ERISA plans report certain data to the DOL.").

135. *HIPP Fact Sheet*, *supra* note 55 and accompanying text.

136. Butler, *supra* note 131, at 7.

137. Except perhaps with Administrative Services Only (ASO) or a Third Party Administrator (TPA) to administer claims only. State of Wis., Off. of the Comm'r of Ins., *Health Insurance Coverage in Wisconsin* 1, *at* http://badger.state.wi.us/agencies/oci/pub_list/pi-094.htm (last visited Apr. 20, 2001) [hereinafter OCI Survey].

138. Rebecca Lewin, *Job Lock: Will HIPAA Solve the Job Mobility Problem?*, 2 U. PA. J. LAB. & EMPLOYMENT L. 507, 509-10 (2000). It should also be noted that sometimes self-insured plans are referred to as "uninsured" plans.

139. E-mail from Patricia Butler, J.D., Ph.D., to Barbara Zabawa (Nov. 29, 2000, 9:57 AM CST) (on file with author) (verifying this author's view that the general purpose of ERISA's § 514(b)(8) amendment is consistent with an obligation of employee plans to provide data to the State, and that *Wisconsin Department of Health and Social Services v. Upholsterers International Union Health and Welfare Fund* case in conjunction with ERISA § 502(a) bolsters that argument with respect to the summary plan document or other individual participant data). Wis. Dept. of Health and Soc. Serv. v. Upholsterer's Int'l Union Health and Welfare Fund, 686 F.Supp. 708 (U.S. D. Ct., W.D. Wis. 1988); *see also* E-mail from Susan Lahne, Attorney, U.S. Dept. of Labor, to Barbara Zabawa (Jan. 16, 2001, 11:05 AM CST) (on file with author) (noting the ERISA preemption exception under §§ 514(b)(7) and 609(a)(2)(B)(ii) for laws enacted under § 1908 of the Social Security Act, which requires "state child support agencies, as [a] condition of receiving federal money, to secure employer-provided [health] coverage for noncustodial children who are receiving aid funds from the state.").

(DHFS), with the state agency that handles child support orders and labor issues (DWD). Consequently, the State could explore preemption exception options to help in obtaining employer-sponsored health insurance information directly from employers.

Furthermore, states may be able to access health plan information *indirectly* from insured employers using ERISA's savings and deemer clauses. Most employer-sponsored plans fall under an insured arrangement.[140] ERISA preserves the historical state function of regulating insurance[141] through the "savings clause," which states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking, or securities."[142] To fall within the savings clause, the state law must be specifically directed toward the insurance industry and must regulate the "business of insurance."[143] However, ERISA's "deemer clause," which specifies that an employee benefit plan is not "deemed to be an insurance company or other insurer,"[144] precludes states from regulating employer-sponsored plans by directing laws at those plans.[145] Therefore, states are more likely to avoid ERISA preemption issues by directing reporting requirement laws at the plan's insurer.[146] As a result, to improve the verification process with respect to insured employer plans, the State may wish to require more coordination between DHFS and OCI, the latter of which is responsible for regulating the insurance industry in Wisconsin, to collect necessary plan information.[147]

C. *Extension of Waiting Periods*

Another method employers may use to decrease the costs of providing health insurance to their employees and impede the Badger-

140. Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L. J. 29, 32 (1999).

141. *Id.* at 33.

142. 29 U.S.C. § 1144(b)(2)(A) (2000) (emphasis added).

143. Strain & Kinney, *supra* note 140, at 49. The "business of insurance" is that which is contemplated by the McCarran-Ferguson Act. *Id.* Specifically, a law regulates the "business of insurance when it meets these criteria: 'first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.' A state law must meet all three of these criteria to fall within the scope of the savings clause and thus avoid preemption by ERISA." *Id.* at 49-50.

144. 29 U.S.C. § 1144(b)(2)(B).

145. Strain & Kinney, *supra* note 140, at 48-49.

146. *Id.* at 52 (quoting the Supreme Court's holding in *FMC Corp. v. Holliday*, 498 U.S. 52, 53 (1990), where the Court noted "if a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts.").

147. Wis. Off. of the Comm'r of Ins., *Departmental Overview, at* http://badger.state.wi.us/agencies/oci/dpt_over.htm (last visited Apr. 20, 2001) (indicating that OCI is responsible for regulating the insurance industry in Wisconsin).

Care verification process is extension of waiting periods. Wisconsin statutes define "waiting period" as "the period that must pass with respect to the individual before the individual is eligible for benefits under the terms of the plan or coverage."[148] Generally, employers who provide health insurance through commercial insurers are not restricted in discriminating against new employees with respect to offering health insurance coverage.[149] However, to benefit from the tax deduction of offering health insurance, self-insured employers may not discriminate against employees who have completed three or more years of service.[150] Yet, to comply with the discrimination rules, self-insured employers may exclude from consideration those employees who have not completed at least three years of service.[151] As a result, a self-insured employer could conceivably impose up to a three-year waiting period and still benefit from the health insurance tax deductions. According to one Wisconsin health care advocate, typical waiting periods range from three months to one year.[152] Thus, whenever an employee starts a new job, even though the employer offers family health insurance, the employee may not be eligible for coverage until several months after he or she starts his or her job.

This waiting period is particularly important given the current low-wage market characteristics of high turnover and the BadgerCare eligibility requirements, which prohibit applicants from having "access" to employer-sponsored family coverage to be eligible for the program.[153] DHFS administrative rules define "access," for purposes of BadgerCare, as a family member living in the household having "the ability to sign up and be covered by an employer's group health plan in the *current* month."[154] Consequently, if an employer has a waiting period of three to six months the employee could enroll in BadgerCare during that waiting period until he or she is eligible for employer-sponsored family coverage.[155] However, if an employee changes jobs frequently, then the employee may never satisfy the employer's waiting period to be eligible for employer-sponsored family

148. WIS. STAT. § 632.745(27) (1999).

149. Henry S. Farber & Helen Levy, *Recent Trends in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?*, 19 J. HEALTH ECON., 93, 115-117 (2000). Prior to the repeal of I.R.C. § 89 in 1989, employers who contracted with commercial insurers could still benefit from the tax breaks by excluding workers with less than six months of tenure with respect to offering health insurance coverage. *Id.* After the repeal of I.R.C. § 89, such employers are not limited in who they can exclude when offering health insurance, with a few exceptions (e.g., provisions under the 1996 Health Insurance Portability and Accountability Act (HIPAA) as well as provisions regarding cafeteria plans)). *Id.* at 115-17, n.15.

150. I.R.C. § 105(h)(3)(B)(i) (2000).

151. I.R.C. § 105(h)(3)(B)(i).

152. BadgerCare Training, *supra* note 46.

153. WIS. ADMIN. CODE § 103.03(1)(f)(3) (2000).

154. WIS. ADMIN. CODE § 101.03(1) (2000) (emphasis added).

155. BadgerCare Training, *supra* note 46.

coverage.[156] In fact, the employee may prefer to stay enrolled in BadgerCare to maintain continuity of care.[157]

Waiting periods may disrupt the current BadgerCare verification process because the process is based on a definition of "access" to employer-sponsored family coverage that fails to account for high turnover in the low-wage market. Even if a BadgerCare recipient informs his or her caseworker of a change in jobs, which he or she may not have incentive to do, the returned EVIC form from the new employer is usually outdated because the employee has left the company.[158] Therefore, the verification process is currently unable to capture BadgerCare recipients who may have future access to employer-sponsored family coverage but change jobs so frequently that they are never eligible for such coverage. Consequently, employers can synchronize their waiting periods with the turnover rate of BadgerCare eligible employees, thereby avoiding health insurance costs for those employees and staying well within the IRC nondiscrimination rules.

D. *Reduction in "Family" Coverage*

A third and final way an employer may impede the BadgerCare verification process is by failing to offer family coverage to the employee. Offering family coverage is becoming increasingly expensive and therefore places employers at a competitive disadvantage.[159] In Wisconsin, as of July, 2000, a Milwaukee employer with 75 employees pays an average premium of $244.41 for single coverage, compared to an average premium of $660.98 per employee for family coverage.[160] According to one study, "employers that provide generous family health insurance packages, in effect, pay employees with family coverage more than they pay employees without family coverage – considering the value of benefits."[161] As a result, many employers see a decreasing incentive to offer family benefits.[162] In fact, a Wisconsin

156. *See generally* Kenneth G. Dau-Schmidt, *The Labor Market Transformed: Adapting Labor and Employment Law to the Rise of the Contingent Workforce*, 52 WASH. & LEE L. REV. 879, 885 (1995) ("Temporary workers are less likely to meet waiting periods or vesting periods for private benefits and, therefore, are less likely to qualify for private benefits such as sick leave, vacation time, and pensions.").

157. Interview with John Gard, *supra* note 103.

158. *HIPP Fact Sheet*, *supra* note 55, at 2.

159. *GAO Family Study*, *supra* note 104, at 6-8 (stating that between 1989 and 1996, "premium costs for health maintenance organization (HMO) coverage for families increased 59%, while premium costs for employee-only HMO coverage increased only 36%.").

160. Wis. Off. of the Comm'r of Ins., *Group Health Insurance Index July 1, 2000, at* http://badger.state.wi.us/agencies/oci/pub_list/pi-081/htm (last visited Apr. 20, 2001).

161. *GAO Family Study*, *supra* note 104, at 8.

162. *Id.* at 7; *see also* Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J. L. REF. 899, 905 (1999).

health advocate noted seeing more employers offering employee-coverage only, not family coverage.[163]

Under the BadgerCare verification process, if an employer indicates on the EVIC form that the employee does not have access to family coverage under the employer-sponsored plan, DHFS keeps the BadgerCare recipient and his or her family enrolled in the program.[164] The current verification process is not able to detect those BadgerCare recipients whose employer may offer employee-only coverage.[165] The current rules regulating BadgerCare are only concerned with employer-sponsored family coverage.[166] Thus, even though more employers are offering health insurance coverage,[167] they may offer employee-only coverage. This information escapes the current BadgerCare verification process. As a result, DHFS may be enrolling employees in BadgerCare who have access to employee-only employer-sponsored coverage. To avoid these unnecessary costs, the rules could be amended to reflect employee access to employee-only sponsored coverage. Alternatively, legislation could be enacted to encourage more employers to offer employer-sponsored family coverage.

PART V: CONCLUSION

In Wisconsin, BadgerCare attempts to bridge a gap in our fragmented health insurance system by providing health insurance to low-income working families. However, unlike Medicaid, BadgerCare faces the unique challenge of integrating a public program with private health insurance as eligibility is linked directly to access to employer-sponsored family coverage. The BadgerCare verification process is the backbone of determining access to employer health insurance and balancing public and private insurance offerings, yet there are many issues surrounding its effectiveness. To improve the process, the state could coordinate the efforts of DHFS with DWD, the latter of which administers the W-2 program, to understand the low-wage labor market in Wisconsin and how that market relates to BadgerCare versus employer-sponsored health insurance take-up.[168] Such studies should consider employee behavior as it relates to benefits and costs of health insurance, continuity of care, and BadgerCare marketing. Armed with a better understanding of the low-wage labor market, the state may be able to modify the verification process to increase employee and caseworker compliance with this process. It is

163. BadgerCare Training, *supra* note 46.

164. *See* Interview with Don Schneider, *supra* note 52.

165. *Id.*

166. WIS. ADMIN. CODE § 103.03(1)(f)(3) (2000).

167. Farber & Levy, *supra* note 149, at 94.

168. Interview with Angela Dombrowicki, *supra* note 9 (noting that BadgerCare must work in connection with the labor market, which was never a concern under AFDC).

likely that such increased compliance would require more education of the buy-in option so that employees and caseworkers would be more comfortable with enrollment in the employer-sponsored plan.

Second, the state may benefit from a better understanding of employer issues that may impede the verification process. Specifically, the state should explore the possibility of requiring employers to disclose health plan information. One method of requiring such disclosure would be to explore ERISA preemption exceptions concerning Title XIX and QMCSO's. Again, state agencies such as DHFS and DWD should work together to explore using these exceptions to obtain necessary health plan information. Furthermore, through the "savings clause," ERISA would not likely preempt states from accessing insured employer health plan information through the insurer. Thus, by coordinating OCI insurer regulation with the BadgerCare verification process, the state could likely gather more information from insured employers. The IRC could also be amended to require shorter waiting periods, increasing take-up of employer-sponsored family coverage by low-wage employees and avoiding employer synchronization of such coverage with the turnover rate. In addition, the verification process could be modified to identify employees who have access to employee-only, employer-sponsored coverage. Finally, legislation that provides employer incentives to offer family coverage may help increase the effectiveness of the verification process.

The purpose of ensuring the success of the BadgerCare verification process is to ensure the viability of the BadgerCare program. Wisconsin, like all other states, does not have unlimited funds. Under the current political climate, which is emphasizing the need for public-private partnerships in health coverage,[169] the only way to cast the widest net of health insurance coverage and to ensure BadgerCare's long-term survival is to operate the program efficiently and not permit it to replace employer-sponsored health insurance. Refusing to consider all the factors that prohibit the state from identifying those with access to employer-sponsored health insurance may invite financial woes without gaining any ground in increasing the number of families with health insurance. Although the state should be proud of its enrollment accomplishments under BadgerCare, the state must act now to eliminate the kinks in the verification process and secure the program's future.

169. Nat'l Governor's Ass'n Policy Position, *HR-37: Private Sector Health Care Reform Policy, § 37.1 Preamble* (2000), *at* http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_555,00.html (last visited April 20, 2001) (indicating that states must have the flexibility to work with the private sector health care delivery system to explore strategies to help control costs and ensure quality of care).