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The Wisconsin Health Insurance Market and Wisconsin Entitlement Reforms

WISCONSIN'S UNIQUE APPROACH TO OPERATIONALIZING THE AFFORDABLE CARE ACT

EXECUTIVE SUMMARY

Wisconsin has much to be proud of when it comes to the quality and access of health care in our state, including the access to coverage of health care. Wisconsin has had one of the best uninsured rates in the country—well below the national average with an uninsured rate that has been ranked the 6th lowest or better in the country. This coverage includes government programs like Medicaid, but also Wisconsin's highly competitive commercial insurance market. In addition, Wisconsin has been a leader in protecting consumers by having reasonable and prudent regulations, which combined with federal requirements existing well before 2010, created a healthy environment for our health care consumers and taxpayers. In Wisconsin, well before the advent of the Affordable Care Act, consumers could not have their policies dropped or cancelled because of health conditions or pre-existing conditions; Wisconsin has long provided guaranteed access to health insurance coverage through the Health Insurance Risk-Sharing Plan (HIRSP) and guaranteed issue for our small group market; dependent children up to the age of 27 were allowed to stay on their parents insurance plan; and consumers had a free-look option to return a policy and receive a refund of the first month's premium. Additionally, Wisconsin law served as a model for many of the other consumer protections adopted by the National Association of Insurance Commissioners (NAIC) and eventually incorporated into the ACA, including: independent external review, rescission reforms, network adequacy standards, and coverage of certain health care costs related to cancer clinical trials. Wisconsin consumers had a plethora of choices from a vast field of insurance companies of all types (For Profit, Non-Profit, Cooperatives, HMOs, PPOs, Association Plans, local, regional and national insurers, etc.). For those covered by Medicaid, Wisconsin has been a leader in Medicaid and CHIP program innovation for many years. Wisconsin was one of the first states to streamline and simplify our programs for families, pregnant women and children and one of the few states that expanded Medicaid to cover adults without dependent children.

This very sound system of health care coverage access and health care quality resulted in relatively low premium rates, high insured rates and vast choice and was upended with the passage and implementation of the federal law known as The Patient Protection and Affordable Care Act (ACA). In order to protect the health insurance market for our state's consumers while preserving a vital safety net for the neediest, Wisconsin, like some other states, moved forward with innovative reforms and created a Wisconsin-specific solution by working within the limited flexibility allowed by the federal government. These actions allow Wisconsin to be able to provide quality health care services and options for individuals and families living in our state. Wisconsin is now in a position to better manage its finances long-term, while creating a system where every individual and family has access to affordable health insurance either through the federal exchange, our state's existing competitive commercial insurance market, or through Medicaid. The Wisconsin model ensures people in poverty are covered through Medicaid while also realizing the instability that exists with regard to federal funding. The Wisconsin model protects taxpayers because decisions were based on what would be best both now and in the long term. Finally, the Wisconsin model protects consumers by

maximizing consumer choice within the federal constraints.

When Wisconsin, like other states, could have been tempted by the promise of the federal government to foot the full cost for Medicaid coverage for those covered by the ACA for the first three years and no less than 90 percent through 2022; Wisconsin decided to stay the course of bringing financial sustainability to our state government and not gamble on the federal promise of these funds being available. Moving forward, Wisconsin taxpayers will be able to budget for Medicaid and not be susceptible to the financial uncertainty of excessive dependence on federal funding. We need not fearfully wait for the next shutdown or decision from the federal government that it cannot live up to its lofty promises of being able to foot all or most of the bill for paying for the healthcare of our great nation's citizens living in poverty.

The plan to implement the Affordable Care Act, as required under the federal law, while reforming Wisconsin's entitlement programs, and preserving the choice and competition in Wisconsin's insurance market that has existed for consumers for the last decade, is one that was uniquely Wisconsin.

In operationalizing the Affordable Care Act, Wisconsin started at a much different place than other states. Relative to Medicaid, while many other states traditionally implemented the federal minimum coverage levels for Medicaid, Wisconsin expanded its Medicaid program above federal minimum coverage levels for parents, caretaker relatives, children and pregnant women before the federal government implemented the Affordable Care Act. However, this expansion led Wisconsin on a financially unsustainable path which Governor Walker has been working to correct since taking office in January 2011.

Wisconsin's unique solution was to cover all adults living in poverty and allow individuals with incomes above the poverty line to utilize tax credits and cost-sharing assistance to purchase private coverage through the federal exchange. Consumers in states that chose not to commit to the "expansion" solution were able to begin accessing the tax credits and cost-sharing assistance at 100% of the Federal Poverty Level (FPL); whereas consumers in expansion states were able to begin accessing the tax credits and cost-sharing assistance at 138% FPL.

Wisconsin's solution also continued to cover kids and pregnant women up to 300% of the FPL. It is important to note that kids with household incomes above 300% FPL had been able to buy into BadgerCare Plus by paying the full monthly cost. Since coverage was now available through the federal exchange, Wisconsin no longer allows families with household incomes greater than 300% FPL to buy their children into BadgerCare Plus.

Relative to Wisconsin's insurance market, the federal exchange didn't need to create a vast array of insurance options as Wisconsin already enjoyed the most competitive insurance market in the country. In fact, the intent of the federal exchanges and the ACA was to expand consumer choice but Wisconsin's market already offered broad consumer choice and continues to do so today.

It is because of Wisconsin's unique solution that most reports and studies looking at the Affordable Care Act simply don't apply to Wisconsin because they don't accurately account for the different solutions that Wisconsin implemented; one that was neither expansion nor rejection, and didn't fit into the one-size-fits-all methodology which many reports used. (See Appendix 1) The best summary and explanation of Wisconsin's situation is contained in the Kaiser Family Foundation issue brief about The Coverage Gap; however, it only became accurate after clarifying edits requested by the Department of Health Services (DHS) were made.

This report contains Wisconsin's story – a process that began with operationalizing federal law, as well as maintaining regulatory authority over our insurance market, and will result in a financially stable, secure Medicaid program that will be available as a safety net for Wisconsin's poorest citizens for years to come. This report also documents the actions taken by DHS and the Office of the Commissioner of Insurance (OCI) to operationalize the very law that Governor Walker has opposed. These actions demonstrate that even though

there are philosophical disagreements surrounding the Affordable Care Act, Governor Walker, DHS and OCI took Wisconsin's obligation to implement this law very seriously.

- DHS and OCI worked with community partners to establish 11 grassroots, Regional Enrollment Networks across the state with more than 1,500 partners to assist people with learning about and enrolling in health care coverage. There have been more than 40 meetings since July 2013 between DHS personnel and these stakeholders.
- OCI and DHS planned and participated in 16 public town hall meetings and 8 editorial boards throughout the state to inform the public of upcoming changes in health insurance in September and October.
- OCI also worked with DHS to provide free Navigator and Certified Application Counselor (CAC) training to 578 individuals, and online training for 400 insurance agents.
- DHS has sent more than 400,000 letters to those on Medicaid or newly eligible for Medicaid, and made hundreds of thousands of follow up phone calls to individuals receiving the letters to make sure they understood the letter and took appropriate action.
- DHS also sent more than 56,000 paper applications to individuals transitioning from Medicaid to the federal exchange after the failed rollout of HealthCare.gov to ensure they had another way to apply.

The focus at each and every step was creating a fiscally responsible solution meeting the needs of consumers, including taking every action possible to mitigate the disruption of the individuals who were transitioning from receiving health care through BadgerCare Plus to purchasing it in the private market through the federal exchange.

INTRODUCTION

Wisconsin, like every other state in the nation has been faced with a new challenge—operationalizing Medicaid under newly imposed rules contained in the Affordable Care Act (ACA) and regulating the health insurance market operating under this new set of federal rules. Despite Governor Walker’s strong opposition to the Affordable Care Act (ACA), it is the law of the land, and, as such, he directed the Wisconsin Department of Health Services (DHS) and the Wisconsin Office of the Commissioner of Insurance (OCI) to ensure that we are all fulfilling our obligations to protect Wisconsin consumers and taxpayers under the law.

DHS and OCI have worked tirelessly to fulfill our obligations to comply with and regulate the markets impacted by the ACA, including compliance with requirements articulated in federal regulation and guidance that continues to be released, and is not always consistent with the ACA. We believe it is our responsibility to ensure that Wisconsin residents have the information they need to access the new public and private health insurance options available to them.

Commercial Health Insurance Market

OCI remains the primary regulator over Wisconsin’s health insurance market despite additional federal requirements. Insurers are required to obtain a state license as well as meet state marketing and financial standards. OCI continues to review all rate and form filings, conduct financial and market conduct examinations; and respond to consumer complaints.

A key goal as the primary regulator is to protect our competitive health insurance market against adverse impacts resulting from the ACA and federal exchange problems. Unlike most other states, Wisconsin has a very competitive insurance market where the top 10 health insurers in the individual market comprise approximately 67% of the market and the top 10 health insurers in the small group market insure 60% of the market. The competitive nature of our market has been a significant benefit to health insurance consumers, resulting in premiums that more accurately reflect medical costs, demographics and utilization patterns of health care delivery in the state. Our regulatory framework relies on the competitiveness of the market in order to best serve the market’s participants, consumers, insurers, and health care providers.

The Federal Department of Health and Human Services (HHS) has been inconsistent in their issuance of federal regulations and guidance implementing the ACA. Guidance changes weekly and is not always consistent with the statutory language of the ACA. ACA deadlines are a moving target, definitions of who qualifies for an exception to federal penalties for not purchasing coverage continues to grow, and the demands on insurers increases as the problems with HealthCare.gov continue (e.g., requests to accept late premiums and offer coverage back to the first of the month; emphasis on HHS’s preference that when HealthCare.gov displays a plan in an area where the insurer does not offer coverage, that the insurer allow the consumer to keep the plan, etc.). (See Appendix 2) It has been a very challenging regulatory environment over the past couple of years, and OCI has shifted resources in order to keep up with the federal rule changes. OCI worked hard to analyze state law and ensure we accurately communicated to consumers and insurers the requirements of the new health law.

OCI has been at the forefront of ensuring insurers are aware of any flexibility, when it exists, so that consumers can benefit from more options as they determine what type of health insurance plan best suits their needs. OCI allowed for early renewals of non-ACA compliant plans so that consumers could keep their current plans longer and avoid having to purchase a more expensive plan that includes benefits they are not interested in having. OCI also used its state regulatory authority to help consumers when the HealthCare.gov website displayed errors and began to impact the plans they were purchasing. OCI directed insurers to immediately reach out to these consumers and help them enroll in new coverage, rather than wait for the

Center for Consumer Information and Insurance Oversight (CCIIO) to develop a way to handle the back-end data transfers that would need to occur as a result of consumers changing their plans.

OCI and DHS have been very proactive in ensuring consumer access to coverage and in gaining an understanding of their responsibility under the law. Together the two agencies held 16 town hall meetings which served as an opportunity for interested members of the public to receive an explanation of key ACA requirements and have their questions answered. Press attended these events as well, further expanding the information across the state. Separate meetings with editorial boards, presentations to consumer and employer groups, and meetings with state legislators and federal congressional members also were used to educate the public about the ACA.

Public Assistance Changes

Wisconsin has made fiscally responsible decisions to leverage the solutions that the federal government made available to states. Wisconsin is the only state out of the 25 states not expanding their Medicaid programs as part of the ACA that will provide access to health insurance to everyone, ensuring that Wisconsinites will not have a gap in access to health care coverage as of April 1, 2014. (See Appendix X)

The 2013-2015 biennial budget transforms Medicaid to a program that more closely reflects the way the people of Wisconsin live their lives. These reforms re-focus Medicaid on the population that it was created for—people in poverty. The plan ensures long-term sustainability and predictability for a Medicaid program that serves those who are most in need in our state. As of March 1, 2014, approximately 1 in 5 Wisconsin residents receive services through Medicaid.

The Medicaid reforms also addressed the unfairness and inconsistency under the previous Medicaid rules—people in poverty were not eligible for the program because their eligibility was tied to their household structure, not their income. For a long time, adults at twice the federal poverty level were able to access Medicaid because they had a dependent child in their care, whereas many adults without dependent children living at or below the federal poverty level were not able to get Medicaid coverage simply because they did not have a child. In allowing access to Medicaid for all people in poverty, Wisconsin has strengthened its commitment to the poor and has maintained the health care safety net for those who need it most. It is important to note that these were solely for the BadgerCare Plus program and did not make changes to the Medicaid programs for those who are elderly, blind or disabled.

The newly improved Wisconsin model preserves Medicaid as a vital safety net for our state's neediest, supports residents' health so they can live more quality lives, and provides long-term protection for Wisconsin taxpayers. These reforms will continue to move Wisconsin forward.

Some say Wisconsin should have taken the promise of short-term federal money to expand Medicaid. More people dependent on government-run Medicaid should not be our end goal. People who are not living in poverty should be allowed to purchase a plan of their own choosing in the private market and they should remain in the private sector for their health insurance coverage. Our approach is based on what will provide the best outcome for our citizens, not on obtaining short-term financial assistance for the state.

These entitlement reforms and our approach have put Wisconsin in a position to better manage its finances long-term, while creating a system where every Wisconsin individual and family has access to affordable health insurance either through the private market outside of the federal health insurance exchange, the federal exchange, or through Medicaid. The Wisconsin model ensures people in poverty are covered while not putting Wisconsin taxpayers potentially at risk financially due to the instability that exists with regard to the long-term viability of federal funding.

Keep in mind that the Wisconsin approach is about making sure that hundreds of thousands of Wisconsinites now have access to affordable health insurance that they did not have access to before. This is a decision that should be a model for other states across the nation. For the first time in Wisconsin's history, on April 1, 2014, every person in poverty can be covered under the same Medicaid benefits. No limited benefit package. No waitlist. No enrollment cap. These reforms will ensure all Wisconsin residents have access to affordable health insurance coverage and seek to reduce Wisconsin's uninsured rate by half. (See Appendix 3)

Wisconsin will achieve the greatest economic impact for our state by having people who live above the poverty level purchasing their health insurance coverage through the federal health insurance exchange. We have all heard providers' complaints about Medicaid reimbursement rates being too low. In contrast, the traditional commercial market pays providers a higher rate than Medicaid. The more people we have who are purchasing their insurance through the federal exchange and the more providers we have being paid the commercial rates, the greater the overall economic impact.

Ultimately, it is up to each person and each family to decide to purchase this health care coverage, now that all residents in Wisconsin will have access and choices. The federal government has decided what is considered to be "affordable health care coverage" and it will be up to every individual and family to fit this into their monthly budget. While government can make these health care options available, it should not control the choices and decisions that individuals and families make.

Wisconsin has made a significant effort to be involved collaborators and leaders in the effort to build a grassroots infrastructure to assist the public in learning about and applying for public and private health insurance coverage, despite the very minimal federal resources being made available to support such efforts. Instead of spending valuable taxpayer dollars on short-term marketing with television, print, radio advertising and social media campaigns (all with limited reach), Wisconsin has been building a comprehensive network of partners informed about health insurance options for residents that encompasses the entire state. (See Appendix 4) Our public and private partners are now formally united and working together in a coordinated manner that can be sustained for years to come.

Wisconsin's successes in helping individuals and families learn about their health care options is not something that Governor Walker, the DHS or the OCI can solely take credit for—there are literally thousands of individuals across the state—the members of our Regional Enrollment Networks (people from all over the state representing community organizations, county income maintenance and social service personnel, providers, insurance agents, assisters, and navigators) who were there every step of the way with us and did a lot of the heavy lifting. Implementing Wisconsin's entitlement reforms and the ACA would have not have been nearly as successful if it had not been for our community partners.

While Wisconsin government did our part by providing information and trainings—and helped to obtain as much information as we could from the federal government, it was the individuals and organizations on the ground who pounded the pavement and strategized, in some cases down to neighborhood and street, on how to ensure that Wisconsin residents knew about and understood their health care options. Another important role that our partners perform is getting people to make the choice to take action – whether it was applying for BadgerCare Plus at their local county or tribal agency, calling the federal exchange call center, talking with an agent or broker—and not giving up when call times were lengthy, or when the federal government's website failed to work. At the end of the day, it was the hard work and dedication at the local level through our partners that has allowed Wisconsin to achieve success and help us take very important strides towards our shared goal of reducing the uninsured rate. Progress towards achieving this goal is expected throughout the biennium. (See Appendix 3)

DHS and OCI have crafted plans to operationalize the law and the entitlement reforms—including strategies on how to educate our community partners and consumers to plans and on how to monitor the insurance market under the ACA. We have been doing everything possible to ensure a seamless transition, however the federal government has often been unable to assist us. Many of the issues that we have been brought to their attention are often not considered a priority for them and are often not addressed. (See Appendix 5) As of March 26, 2014, they have yet to provide a data match so we can identify those Wisconsin residents who no longer meet BadgerCare Plus program rules and who have not purchased health insurance through the federal health insurance exchange. Our goal is to do more targeted outreach to this population to ensure that they do not have a gap in health care coverage.

Wisconsin has been doing everything that we can do, as you will see throughout this document, to ensure our residents are educated about their health insurance options and enroll in affordable health insurance—whether it is a Medicaid plan through BadgerCare Plus, private health insurance through a Qualified Health Plan in the federal exchange, or a plan they purchase outside of the exchange through an agent or broker. At the end of the day, we have a shared goal of making sure that Wisconsin residents have access to affordable health insurance.

An epilogue will be released in mid-April containing information from DHS and OCI including BadgerCare Plus enrollment data directly through Wisconsin's online application tool, ACCESS.wi.gov; data on members Wisconsin received through the account transfer process from the federal exchange; number of childless adults who were newly eligible and began receiving health insurance coverage through BadgerCare Plus on April 1, 2014; and federal exchange enrollment numbers from the open enrollment period.

The epilogue, along with this report, will be available online at <http://www.dhs.wisconsin.gov/health-care/index.htm> or at www.oci.wi.gov

THE ROLE OF THE WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE AND THE AFFORDABLE CARE ACT

Office of the Commissioner of Insurance (Agency Overview)

OCI was created by the legislature in 1871. The original intent of OCI has not changed drastically over the past 125 years. In 1871, OCI was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

OCI performs a variety of tasks to protect insurance consumers and ensure a competitive insurance environment. OCI's major functions include:

- Reviewing insurance policies that are sold in Wisconsin to make sure they meet the requirements set forth in Wisconsin law;
- Conducting examinations of domestic and foreign insurers to ensure compliance with Wisconsin laws and rules;
- Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;
- Issuing licenses to the various parties involved in selling and marketing insurance products;
- Assisting insurance consumers with their insurance problems;
- Researching special insurance issues to understand and assess their impact on Wisconsin;

- Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws;
- Creating and distributing public information and consumer education pieces to educate people about insurance; and
- Operating a state life insurance fund, a property fund for the property owned by local units of government, and a patients' compensation fund insuring health care providers for medical malpractice.

Effective Rate Review Program

The ACA provides a process for states to seek certification as an effective rate review program (ERRP). ERRP certification allows states to retain their primary enforcement authority over federal and state rate regulations. In July 2011, Wisconsin was certified by the federal government as an ERRP state. Insurers are required to file rates with OCI annually, consistent with the ACA. OCI reviews rate filings to determine whether the rates filed are unreasonable, subject to the standards of the Wisconsin insurance laws and regulations.

Retaining state authority over the rate review process is critical to ensuring Wisconsin is able to maintain a competitive market. OCI understands the state-specific dynamics that impact rates and is able to make review determinations with that information in mind. Federal control over this process would result in a one-size-fits-all approach that would compromise the state's competitive insurance market. Maintaining a competitive market is necessary to ensure both the availability of affordable coverage and a marketplace that offers an abundance of consumer choice. Many states have one or two large insurers dominating a majority of their individual market which results in few consumer options.

Affordable Care Act: Market Changes

The ACA contains a number of significant market changes that impact health insurance plans with effective dates beginning on or after January 1, 2014. These new market rules impact individual and group plans sold on the federal exchange and plans sold off the exchange. Some of the most notable changes are listed below.

- All insurers must sell a health insurance policy to any person who applies for coverage, except in cases where fraudulent information is intentionally provided by the applicant. This is called guaranteed issue. (Prior to the ACA, Wisconsin had guaranteed issue in the small group market and high-risk individuals had guaranteed issue through the Health Insurance Risk-Sharing Plan or HIRSP).
- Insurers are prohibited from excluding or limiting coverage for a preexisting condition. A preexisting condition is a health condition an individual has been treated for or was made aware of within a defined period of time before purchasing a health insurance plan. [Prior to the ACA, the Health Insurance Portability and Accountability Act (HIPAA) excluded the use of preexisting conditions for the majority of all markets.]
- Insurers must set premium rates for their individual and small group market plans based on market-wide claims experience and may only take four items into account when determining the premium a policyholder is charged for coverage under a plan. These are: (1) whether the policy provides individual or family coverage; (2) the area of the state the policy is sold; (3) age; and (4) tobacco use.
- Plans are required to offer "essential health benefits." (Prior to the ACA, a majority of plans covered the essential health benefits, with the exception of pediatric dental, vision and habilitative services.

- Plans are categorized into one of four different levels, which the federal government calls “metal tiers.” Consumers know the level of coverage expected by a plan based on the metal tier assigned to it. The percentages attached to each metal tier represent the average portion of expected costs a plan will cover for the average individual. The metal tiers include: bronze plans covering 60%; silver plans covering 70%; gold plans covering 80%; and platinum plans covering 90%. (Prior to the ACA, consumers had unlimited benefit choices.)
- All plans will limit in-network out-of-pocket expenses to \$6,350 for self-only coverage and \$12,700 for family coverage.
- Insurers have the option to sell their plans through the federal exchange, as well as selling health insurance plans off the federal exchange.

Essential Health Benefits

Also required under the ACA, beginning January 1, 2014, insurers in the individual and small group markets must now offer a minimum level of coverage called “essential health benefits.” The essential health benefits that insurers must minimally cover include the following categories:

- Emergency services
- Ambulatory services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Insurers are not allowed to impose annual or lifetime dollar limits on essential health benefits.

Large group health insurance plans are not required to cover essential health benefits. However, if a large employer chooses to offer a health insurance plan that includes essential health benefits, the plan cannot impose any annual or lifetime dollar limits on those benefits.

Each state had the opportunity to identify their Essential Health Benefit Benchmark plan or default to the plan identified by the federal government. Insurers must offer benefits that are substantially similar to the benchmark plan.

The federal government has identified a plan sold by UnitedHealthcare as Wisconsin’s benchmark. It is their Choice Plus Definity HSA Plan (A92NS). A copy of the Wisconsin EHB Benchmark plan can be found at: http://oci.wi.gov/healthcare_ref/ehb_certificate.pdf (See Appendix 38)

Federal Tax on Consumers for Not Having Coverage

Beginning January 1, 2014, individuals must have health insurance or pay a tax. The federal government refers to this as the “individual shared responsibility payment.” The tax is set to increase each year as follows:

- In 2014 it will be the greater of \$95 per adult or 1% of taxable income.
- In 2015 it will be the greater of \$325 per adult or 2% of taxable income.
- In 2016 it will be the greater of \$695 per adult or 2.5% of taxable income.
- After 2016 the tax penalty increases annually based on a cost-of-living adjustment.

There are certain circumstances under which individuals may be exempt from this federal tax.

Frequently Asked Questions

Beginning in April 2013, OCI began posting health care reform FAQ documents to its website. These are directed toward consumers, employers, agents and insurers. The FAQs are consistently updated to reflect new guidance and regulations that federal agencies have slowly issued throughout the past year. As with most of the health care reform information posted to OCI’s website, the FAQs are easily accessible by clicking the “Health Care Reform” button on the homepage. (See Appendix 6)

http://oci.wi.gov/healthcare_ref/healthcarereform_agentfaq.pdf

http://oci.wi.gov/healthcare_ref/healthcarereform_consumerfaq.pdf

http://oci.wi.gov/healthcare_ref/healthcarereform_employerfaq.pdf

http://oci.wi.gov/healthcare_ref/healthcarereform_insurerfaq.pdf

Working to Identify Fraud and Alert Consumers

Due to concerns among several state agency General Counsels that the initial open enrollment period under the ACA could be a prime opportunity for the occurrence of fraud against Wisconsin consumers, the General Counsels coordinated an anti-fraud multi-agency taskforce comprised of OCI, the Department of Justice (DOJ), the Department of Agriculture, Trade and Consumer Protection (DATCP), and DHS. The task force held bi-weekly calls beginning October 17, 2013, through March 20, 2014. During the calls each participating agency provided updates and shared information about any suspicious activity they had seen. Throughout this period OCI received one referral from DATCP concerning a possible insurance fraud issue that is still under investigation. Also, the reimbursement enrollment network identified two organizations that were holding themselves out as certified assisters but who had not complied with the navigator and non-navigator assister statutes and emergency regulations. The task force will continue to meet as fraud-related issues arise.

The agencies represented on this group issued a press release on March 4, 2014, “State Warns Consumers to be on the Alert When Signing up for the Affordable Care Act.” Late last year, OCI issued its own release, “Scammers Take Advantage of Health Reform Confusion: State Insurance Regulators Warn Consumers to Be on Alert.” (See Appendix 7)

<http://oci.wi.gov/pressrel/0314aca.htm>

<http://oci.wi.gov/pressrel/0913scammers.htm>

OCI Life and Health Advisory Council

The OCI Life and Health Advisory Council met several times over the course of the last three years. The Life and Health Advisory Council is comprised of 11 members who represent industry, small business, agents and consumers. The Council advises the Insurance Commissioner on regulatory matters in the area of Life and Health insurance.

Council meetings are open to the public and can be attended in-person or via teleconference. Meeting agendas are distributed in advance of the meeting via e-mail to interested parties and posted according to state open meetings laws. Council meetings are well attended by consumers, agents, insurers and employers; all of whom have opportunities throughout the meeting to offer feedback, ask questions and raise concerns. OCI staff leading the meetings encourage active participation and dialogue.

OCI provides detailed updates and explanations of healthcare reform related issues at every meeting. Issues discussed include information on newly released federal guidance, HealthCare.gov challenges, agency outreach and educational efforts, etc. (See Appendix 8)

2014 Wisconsin Individual Health Insurance Market and OCI Efforts to Educate Consumers on Insurers Participating in the Market

For the 2014 plan year, there are 13 insurers selling plans in the individual market on the federal exchange. All but one of these plans is actively marketing products in the market outside of the federal exchange as well. With these insurers and 5 additional insurers selling only in the outside market, there are a total of 17 insurers actively selling individual health insurance off the federal exchange. (See Table 1)

On August 6, 2013, OCI released a list of insurers who requested their plans be certified as qualified health plans and be made available on the federal exchange. On September 3, 2013, OCI also released a preliminary analysis of the rates filed by those insurers to caution that rates overall seemed to be on the rise but that consumers would be impacted differently. A follow-up release was issued on September 19, 2013 (in advance of the initial open enrollment period) with a list of insurers who had officially signed an agreement with the federal government to sell their plans on the federal exchange. OCI felt it was important to share this information as soon as possible to keep consumers informed about their options going into 2014. (See Appendix 7)

<http://www.oci.wi.gov/pressrel/0813qhp.htm>

<http://www.oci.wi.gov/pressrel/0913rateinfo.htm>

<http://www.oci.wi.gov/pressrel/0913serviceareas.htm>

Upon OCI's receipt of the insurer's initial filings, OCI discovered that initially there were counties in Wisconsin where no insurers in the individual market were planning to offer qualified health plans on the federal exchange. It was through OCI's efforts in serving as a resource and answering questions that insurers ultimately decided to sell plans on the federal exchange in those areas.

In an effort to help consumers easily find insurers actively selling individual coverage in their area, OCI posted a map with insurer names listed in each county. The map includes insurers selling on the federal exchange and those selling in the market outside of the federal exchange. A table with contact information for each insurer is also provided. County-by-county, there are more insurers selling outside the federal exchange than on the exchange. Here is a link to the map and contact information:

http://www.oci.wi.gov/healthcare_ref/find_health_insurer.pdf (See Appendix 9)

As an additional resource for consumers and insurers, OCI posted a color coded map which identifies the 16 rating areas across the state. Federal law allows insurers to consider geographical location when pricing their products. This map allows a consumer to easily identify the geographical location insurers in their area are taking into account when pricing their products.

http://www.oci.wi.gov/ociforms/comphlth_geographicrating.pdf (See Appendix 10)

Table 1

On Exchange		Off Exchange
Medica Health Plans of WI		Medica Health Plans of WI
Common Ground Health Care Cooperative		Common Ground Health Care Cooperative
Mercy Care HMO, Inc.		Mercy Care HMO, Inc.
WPS Health Plan, Inc. (Arise)		WPS Health Plan, Inc. (Arise)
Dean Health Plan, Inc.		Dean Health Plan, Inc.
Health Tradition		Health Tradition
Group Health Cooperative South Central WI		Group Health Cooperative South Central WI
Gundersen Health Plan, Inc.		Gundersen Health Plan, Inc.
Physicians Plus Insurance Corporation		Physicians Plus Insurance Corporation
Security Health Plan of WI.		Security Health Plan of WI.
Unity Health Plans Insurance Corp.		Unity Health Plans Insurance Corp.
Compcare Health Services Insurance Corp.		Compcare Health Services Insurance Corp.
Molina Healthcare of WI, Inc.		Celtic Insurance Company
		Humana Insurance Company
		Time Insurance Company
		United Healthcare Life Insurance Corporation
		WI Physicians Service Insurance Corporation

New Opportunity to Renew non-ACA Compliant Plans

Beginning in early 2013, OCI became concerned that consumers would soon receive cancellation notices from their insurers indicating that their current coverage was not ACA compliant and would be discontinued. OCI analyzed federal and state law to determine whether there was an opportunity to allow Wisconsin consumers a choice between keeping their plan or moving to a new, ACA-compliant plan. Through this analysis and discussions with insurers to understand what might be feasible from their perspective, OCI used its authority to allow insurers to offer enrollees an early renewal opportunity that would allow consumers to keep their non-ACA compliant plans for one additional plan year. OCI reached out to insurers to make sure they were aware of this and provided additional information to help insurers make the decision to move forward with offering this renewal option.

A majority of consumers exercised their option to keep their pre-ACA coverage. Consumers benefited from OCI's decision to allow renewal of non-compliant ACA plans by increasing their options when considering their health care coverage needs. In many cases, choosing to keep their non-ACA compliant plan will be less expensive than moving to a new ACA compliant plan. Due to OCI's work to allow early renewals, Wisconsin consumers, unlike consumers in most other states, were not inundated with cancellation notices. Pre-ACA cancellation notices were a non-issue in Wisconsin.

As with many requirements in the ACA, the federal government unilaterally and without statutory authority, sent a letter to state insurance commissioners on November 14, 2013, permitting states to allow insurers to extend renewal of non-ACA compliant plans into 2014. For example, a consumer could choose to renew their plan between January 1, 2014 and October 1, 2014, which would give them coverage under their non-ACA compliant plan into 2015. OCI released a bulletin making insurers aware that they could pursue this extended renewal opportunity. On March 5, 2014, additional federal guidance was released allowing states to extend the renewal opportunity through October 1, 2016. On March 20, 2014, OCI released a bulletin to insurers making them aware that OCI is permitting insurers to continue to renew non-ACA compliant plans through October 1, 2016. (See Appendix 11) Here are links to the November 21, 2013 and March 20, 2014 guidance documents:

<http://oci.wi.gov/bulletin/1113healthplans.htm>

<http://oci.wi.gov/bulletin/0314transitionalpol.htm>

2013-2015 WISCONSIN BIENNIAL BUDGET

Entitlement Reforms

In its 2013-15 biennial budget, Wisconsin state government invested in priorities, while continuing to reform government with the goal of creating prosperity for its citizens.

The biennial budget reformed Medicaid through Governor Walker's entitlement reforms. These entitlement reforms provide an estimated 82,000 childless adults living in poverty access to the same Medicaid benefit package for the first time in Wisconsin's history. Adults without dependent children living in poverty traditionally did not have access to Medicaid and the BadgerCare Plus Core Plan coverage that had been offered in 2009 for a few short months was a limited benefit with fewer covered services. The reforms provide Medicaid coverage to all eligible adults living in poverty, with those above the poverty level able to access coverage through the federal health insurance exchange. (See Appendix 3)

The Wisconsin vision and commitment is to ensure that every resident has access to health insurance, to create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it most. We are working towards reducing the number of uninsured, non-elderly adults in our state and encouraging consumers to be active participants in their health care. These reforms simplify the Medicaid program by creating one standard set of comprehensive benefits that will lead to improved health care outcomes.

The biennial budget added roughly \$760 million in state funds to Medicaid; however a large portion of that funding increase was a direct result of federal decisions outside the State's control, including implementation of the Affordable Care Act and reductions in the federal Medicaid matching rate for Wisconsin. Wisconsin's Medicaid program had been expanded repeatedly in recent decades and could not continue to operate on this unsustainable path. Wisconsin expanded its Medicaid program above federal minimum coverage levels for parents, caretaker relatives, children and pregnant women before it was required and before the federal government implemented the Affordable Care Act.

- Enrollment in Medicaid has nearly tripled since BadgerCare's inception in 1999.
- In fiscal year 2000, the state spent \$134 million, All Funds, for coverage of low-income families.
- In Fiscal Year 2014, the state will spend more than \$1.7 billion.
- The overall Medicaid program cost about \$1 billion in 1987. By 2015, it will exceed \$8 billion.

DHS also requested \$75 million in state funds to address the systems changes and projected spike in eligibility workload caused by the Affordable Care Act implementation. Much of this funding (\$55.5 million) went to the County Income Maintenance Consortia, and Milwaukee Enrollment Services (MiES). These are local agencies that administer and manage some of Wisconsin's public assistance benefits. The remaining \$19.7 million was reserved for state-level system changes and other costs.

Part of the Department's biennial budget request included 88 Full Time Equivalent (FTE) positions to address the federally mandated Medicaid administration workload associated with implementing the ACA. Seventy of those 88 positions were slated for the increased workload at MiES for ongoing eligibility determinations and case management. MiES not only administers and manages income maintenance programs for Milwaukee County residents; it also serves to support the consortia.

Eighteen of the positions are project positions. These positions are budgeted for 18 months beginning in 2013-2014 to perform project management tasks, administrative support, training for state and local Income Maintenance staff, policy implementation, systems work (including facilitating the exchange of data between the state systems and health insurance exchange, facilitating the implementation of Modified Adjusted Gross Income, systems and user acceptance testing), communications and outreach, and technical assistance to the Income Maintenance agencies.

Each consortium made decisions on how best to utilize those funds. The ACA-related funding in the biennial budget served to help build the infrastructure so Wisconsin could effectively and efficiently operationalize the Affordable Care Act.

Health Insurance Risk Sharing Plan (HIRSP)

HIRSP is the state's high risk pool, originally created to provide health insurance coverage to individuals who could not obtain coverage in the commercial market; largely due to a serious health condition. HIRSP was an independent authority with its own governing board and was not part of either DHS or OCI.

Prior to the ACA, individuals had guaranteed renewal rights and small employers already had guaranteed issue and renewability rights. With the requirement that insurers accept anyone who applies for coverage beginning with plans effective January 1, 2014, keeping HIRSP operational was not necessary. Individuals have guaranteed access to health insurance in the commercial market and access to federal premium tax credits and cost sharing subsidies to offset their premium costs. Additionally, childless adults under 100% FPL are newly eligible for Medicaid beginning April 1, 2014.

The biennial budget included language to end HIRSP on December 31, 2013; however, with the failed launch of HealthCare.gov, Governor Walker signed a bill extending the program through March 31, 2014 to give HIRSP enrollees additional time to purchase a plan during open enrollment.

However, throughout this timeframe, HIRSP continued to engage in informing their members about upcoming changes. HIRSP included numerous articles about changes in their newsletter, website, and Facebook page. HIRSP engaged a marketing firm to assist with communications and ensure the messaging was clear and concise. The administrator engaged members through their call center and on billing notices.

From an administrative perspective, the HIRSP Authority, the quasi-governmental entity that managed HIRSP, closed its offices at the end of February 2014. OCI assumed responsibility for the dissolution of HIRSP on March 1, 2014. OCI has staff equipped to handle any consumer issues that arise during the wind down of this program.

Navigator and other Assister Regulation

The 2013-2015 budget included a state licensure requirement for navigators and a registration requirement for certified application counselors (CACs) and other assisters. Among other things, state law requires individuals serving in these capacities to do the following before licensure or registration can occur:

- Complete 16 hours of pre-licensing training,
- Receive a passing score on a state examination,
- Submit fingerprints,
- Complete a criminal background check,
- Maintain a \$100,000 bond or other evidence of financial responsibility (navigator entities), and
- Complete 8 hours of continuing education training annually.

OCI developed FAQs to assist interested organizations and individuals in understanding both state and federal requirements related to navigators, CACs and requirements for licensed health insurance agents wishing to serve as either a navigator or CAC. (See Appendix 6) These are posted to the OCI website at:

<http://oci.wi.gov/navigator/navigator-faq.pdf>

<http://oci.wi.gov/navigator/cac-faq.pdf>

<http://oci.wi.gov/navigator/cacentity-faq.pdf>

<http://oci.wi.gov/navigator/navigator-agentfaq.pdf>

BADGERCARE PLUS DEMONSTRATION WAIVER

Waiver Overview

Before DHS could implement the Medicaid reforms included in the biennial budget, the Department needed to obtain federal approval to make these changes to BadgerCare Plus. To accomplish these Medicaid reforms, DHS needed to modify the existing Medicaid State Plan for parents, caretaker relatives, children and pregnant women and request a new waiver for childless adults and those who receive Transitional Medical Assistance. (See Appendix 12 and 13) Wisconsin’s BadgerCare Plus Core Plan for Adults Without Dependent Children Demonstration Project Waiver was slated to expire on December 31, 2013 at the same time the majority of the Affordable Care Act changes were going to be implemented by the federal government. Wisconsin created a new waiver, the BadgerCare Reform Waiver, that would allow Wisconsin to implement the BadgerCare Plus reforms when the new coverage available through the ACA began. (See Appendix 13) The Waiver, as originally proposed, implemented the following changes to BadgerCare Plus:

- All BadgerCare Plus members would receive health care coverage through the BadgerCare Plus Standard Plan,
- The BadgerCare Plus Core Plan annual enrollment fee and monthly premiums would be eliminated,
- The current enrollment cap for childless adults under 100% FPL would be removed, and
- Parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA) would now have to pay a monthly premium.

DHS did extensive outreach on the proposed waiver to stakeholders including media, Income Maintenance consortia/counties, tribes, advocates, members and the Wisconsin Legislature in order to keep them informed of the progress of the Waiver request. (See Appendix 13,14,15,16)

DHS held three town hall meetings in Green Bay, Eau Claire and Milwaukee to discuss the changes and to solicit feedback. (See Appendix 15) The Department also held a consultation with Wisconsin tribes to discuss the changes and solicit feedback.

TABLE 2 – BadgerCare Plus Waiver Town Hall Meetings

Eau Claire	
Wednesday July 10, 2013 11:00 a.m. to 1:00 p.m.	Chippewa Valley Technical College Health Education Center 615 W. Clairemont Avenue Eau Claire, WI
Wausau – Tribal Consultation	
Wednesday, July 10, 2013 9:00 a.m. to 1:00 p.m.	Best Western - Midway 2901 Hummingbird Road Wausau, WI
Milwaukee	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Radisson Milwaukee West 2303 North Mayfair Road Milwaukee, WI
Green Bay	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Green Bay Kroc Center Walnut and Oak Rooms 1315 Lime Kiln Road Green Bay, WI

Individuals who were unable to attend the public information sessions were able to provide comments directly to DHS by mail, fax, e-mail, or online. At the town hall meetings, the Department presented an overview of the waiver and then opened it up for comments from the public. (See Appendix 13)

Each comment that was submitted to the Department was reviewed. Many of the comments that the Department received were in regard to definitions and clarifications of certain terms used in the waiver application, questions on the benefits to be received under the new waiver proposal, questions on differences between the new waiver and existing waivers, and the identification and communication process for those who may need to transition off of BadgerCare Plus to the federal health insurance federal exchange. Several comments relating to outreach and enrollment strategies were extremely informative and helpful in the development of Wisconsin's grassroots Regional Enrollment Network (REN) outreach strategy, which is discussed in greater detail in later sections of this report.

The Department also received several comments that were outside the scope of the waiver proposal. Many commenters expressed disagreement with the decision to forego the full Medicaid expansion, asked questions about what the federal exchange will do for them, and inquired about changes to Medicaid that were unrelated to the waiver proposal.

As part of the final waiver application, the Department made the following changes and clarifications in consideration of those comments received from the public:

- Added presumptive eligibility for childless adults, which is a temporary eligibility for health care benefits if an individual meets certain financial and non-financial rules. Presumptive eligibility is granted for no more than two calendar months and the individual needs to complete a full application during that time period to remain eligible for benefits. Presumptive eligibility is required for parents and caretakers under the Affordable Care Act. Presumptive eligibility for parents, caretaker relatives and childless adults will only be able to be completed by qualified hospitals;
- Clarified that the length of the Transitional Medical Assistance (TMA) extension will be based upon applicable federal law, rather than stating that it will be 12 months in length;
- Clarified that only children, pregnant women and adult parents and caretaker relatives, not childless adults, may qualify for TMA. Currently these are the only populations who are eligible for TMA and this will remain the same moving forward;
- Clarified language related to the 5% disregard to align it with statutory language included in 2013 Wisconsin Act 20, Section 1097;
- Removed headings related to cost-effectiveness within the Budget Neutrality Section;
- Included additional information on the hypotheses and proposed evaluation of the demonstration; and
- Clarified language around the applicable income levels for eligibility to use the phrases "does not exceed 100% FPL" and "exceeds 100% FPL."

All of the comments related to the waiver proposal were compiled and communicated to the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) as part of the final waiver request on August 9, 2013. (See Appendix 13) When submitted, the BadgerCare Plus Demonstration Project Waiver was slated to become effective on January 1, 2014.

Waiver Negotiations with CMS

After the waiver was submitted, it began progressing through the federal approval process. After being reviewed for completeness, certified as complete and posted online for public comment and review, the federal government then reviewed the waiver and asked for clarifications and adjustments. Thus, the Waiver negotiations began.

A continual sticking point of the waiver negotiation process was Wisconsin's proposed plan for uniformly charging premiums to all adults enrolled in BadgerCare Plus through an extension (TMA), along the lines of premiums for extensions that was approved in the previous waiver. (See Appendix X)

In the previous waiver, Wisconsin, with the federal government's approval, received approval to apply certain provisions (monthly premiums) of the ACA to the BadgerCare Plus population beginning July 1, 2012. Wisconsin modeled the premiums after what would be required of individuals to pay through the federal exchange – a figure that is defined by federal law.

Wisconsin requested through the BadgerCare Reform Waiver to continue the premiums for the individuals in an extension that were put in place July 1, 2012 and to begin requiring monthly premiums for parents and caretaker relatives with incomes between 100% and 133% FPL who were on an extension. Again, the sliding scale premiums that Wisconsin would charge align with the federal exchange premiums parents and caretakers with the same income level are paying to get coverage through the federal exchange. (See Appendix 14)

It is the Department's belief that it only makes sense, when looking at this issue in terms of equity, that individuals with incomes above 100% FPL who are getting BadgerCare Plus coverage because of an extension pay the same monthly premium as a proportion of monthly income as an individual with the same income who is not on an extension and purchases health insurance through the private market. (See Appendix 15)

CMS was not supportive of this provision and continually requested that the extension premiums not begin until the individual's income was at or above 133% FPL. Eventually, after months of negotiation, CMS and Wisconsin came to an agreement that parents and caretaker relatives with incomes between 100% and 133% FPL who were on an extension would pay monthly premiums; however, they would not begin until after the sixth month of coverage through the extension. (See Appendix 15)

OPERATIONALIZING BADGERCARE PLUS CHANGES AND THE AFFORDABLE CARE ACT

In late summer 2013, work around the state began to intensify to operationalize the Affordable Care Act and BadgerCare Plus changes included in the biennial budget. In order to successfully implement the ACA and reform of Wisconsin's Medicaid program to minimize impact and disruption to Wisconsin consumers, a system or mechanism was created to help people learn about their health care options and take action.

Regional Enrollment Networks

DHS has a variety of outreach strategies for ACA changes and Medicaid reform; however one of Wisconsin's most significant strategies to assist Wisconsin residents with enrolling in the appropriate public or private health insurance coverage is through the creation of 11 Regional Enrollment Networks (RENs). The RENs are comprised of various community partners, insurance agents and brokers, health care providers, income maintenance consortia, tribal representatives and other key local stakeholders.

The Department has a strong community partner network throughout the state. These partners have worked with the Department on various program launches as well as serving as a point of contact for existing BadgerCare Plus members and the uninsured. We realized that the Department could not take on this undertaking of helping Wisconsin residents understand their health care options alone. We also understand that people may be less likely to listen to government and more likely to learn about their options and listen to trusted individuals in their community—their doctor, pharmacist, neighbor, nurse, or pastor.

DHS staff located in Milwaukee were invited to join efforts of an enrollment network that was created in the Milwaukee area, the Milwaukee Enrollment Network (MKEN). MKEN is a multi-stakeholder collaboration that was established in the summer of 2013. The MKEN is organized by the Milwaukee Health Care Partnership, Covering Kids and Families and DHS to improve consumer outreach and education, strengthen enrollment support resources, and assist Milwaukee County residents in securing adequate and affordable public or private health insurance. MKEN is a group of more than 100 public and private organizations supporting enrollment of eligible residents of Milwaukee County in public or private insurance with a focus on low-income, vulnerable populations. In anticipation of the roll out of the Facilitated federal health insurance exchange and the BadgerCare Plus eligibility changes, the MKEN put together a community-wide plan to help individuals understand, buy and keep health care coverage. The structure was established to have a steering committee, sub-committees focused on various area, and co-host large scale meetings to facilitate community wide approaches. All participants are there on a collaborative basis by incorporating these tasks into their existing roles as there was not notable funding to support facilitation of such mobilization.

Goals of MKEN:

- Support consumer and mobilizer outreach and education.
- Build the capacity and capability of the enrollment assister workforce and infrastructure.
- Support insurance take-up and retention, including alternative, consumer friendly payment options.
- Measure and monitor coverage and enrollment processes and outcomes.

DHS quickly realized the benefits of this type of collaboration and that the MKEN was exactly the type of effort that could be leveraged in other parts of the state. On July 16, 2013, the DHS and OCI presented a proposed model for the RENs at the UW-Population Health Institute's Wisconsin Health Insurance Outreach & Enrollment Summit. The RENs were modeled after the MKEN. (See Appendix 4)

This coordinated public relations and outreach campaign allows for consistent information to be shared in all regions of the state, as well as allow each REN to tailor the message to meet the needs of its residents and decide how to best reach individuals to assist them with enrolling in the appropriate public or private health care coverage. The RENs have been tasked with assisting transitioning BadgerCare Plus members and uninsured Wisconsin residents to enroll in the appropriate health care coverage.

The Department began work with Covering Kids & Families Wisconsin and the Wisconsin Primary Health Care Association to establish 11 Regional Enrollment Networks spanning the state. The RENs are geographically defined using the same regions as the Income Maintenance Consortia. This was advantageous because we believed that the local agencies in the Income Maintenance Consortia would be one of the main points of contact for individuals who had questions about the Affordable Care Act and Medicaid reforms. The Income Maintenance agencies would then have the ability to refer individuals to the in-person assisters in the RENs for help with securing private coverage and the RENs could refer individuals to the Income Maintenance agencies for assistance with Medicaid or other public assistance benefits.

The Department also pulled together and currently facilitates Regional Enrollment Network Strategic Planning Committee, (See Appendix 17) that meets bi-weekly and includes individuals representing the following organizations:

- Department of Health Services
- Office of the Commissioner of Insurance
- Wisconsin Primary Health Care Association
- Covering Kids & Families – Wisconsin
- Milwaukee Health Care Partnership
- Wisconsin Hospital Association
- Forest County Potawatomi Community Insurance
- Alliance of Health Insurers, U.A.
- University of Wisconsin Population Health Institute
- Wisconsin Association of Health Plans

Because DHS had already established a large, statewide network of community advocates and partners, the Department utilized that list to introduce this outreach model and concept as well as to solicit interest for attending REN kick-off meetings to be held in each region.

Each REN held a kick-off meeting in late August or early September. Community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders were invited to attend the REN meeting in their area. Each meeting was hosted and facilitated by a regional host, in partnership with DHS, Covering Kids and Families, and the Wisconsin Primary Health Care Association. (See Appendix 4)

These RENs were developed at the local level and may be different from each other depending on the needs of the local region, but each REN has dedicated facilitators that lead each region's efforts of supporting partners and mobilizers.

The Wisconsin Primary Health Care Association (WPHCA) received a grant from the Corporation for National and Community Service to fund nine AmeriCorps members. Because the Department had been working with the WPHCA on the creation of RENs it was natural that these resources be used to support the RENs. DHS agreed to sponsor these AmeriCorps members and WPHCA agreed to find host sites around the state. These AmeriCorps members, along with staff from the host site and the Department, became the core team that supported each RENs efforts.

AmeriCorps members provided coordination and communication within and across RENs. Each region had a dedicated staff person to serve as the liaison between the Department and the REN. This link has proved critical in keeping local regions informed of the many rapid changes the ensued over the course of the implementation. In addition, the AmeriCorps members were responsible for maintaining the RENs presence on the Enrollment for Health (E4Health) Wisconsin website. This website is a tool for enrollment assistors and mobilizers to share information and for RENs to post events happening in their region. Additional information about Wisconsin's RENs is available on the E4Health Wisconsin website: <http://e4healthwi.org/regional-enrollment-networks/>

The Department's statewide outreach initiative developed materials for and provided information to various stakeholders, including tribes and legislators, regarding the implementation of certain ACA provisions. DHS

staff supported the RENs by attending Regional Enrollment Network Steering Committees, co-hosting larger REN meetings, fielding questions from REN members on an ongoing basis, supporting the regional AmeriCorps member, and participating in smaller subcommittee meetings as needed. DHS staff met with Income Maintenance supervisors and directors prior to the kick-off of the RENs to solicit their participation and explain the vision for RENs. Bi-weekly REN calls with the REN leads and AmeriCorps members have been co-hosted by DHS staff in collaboration with the Wisconsin Primary Care Association. (See Appendix X)

DHS developed a comprehensive web presence to support RENs, stakeholders, and both potential and existing members. All training materials, including archived webinars are available on the DHS website, dhs.wisconsin.gov/health-care.

This website provided a single location for information, including copies of mailings to current BadgerCare Plus members and potential members, links to other helpful sites including HealthCare.gov, and an evolving FAQ section. DHS also set up a dedicated e-mail address to field questions from anyone about the ACA or changes to BadgerCare Plus. In most cases, general responses were provided, but when the Department saw trends in the line of questioning, these questions and answers would be added to the FAQ portion of the website.

The following directories were developed by as guides for individuals looking for in-person assistance to help them navigate their health care coverage options:

Wisconsin Enrollment Directory – Enrollment for Health Wisconsin

http://e4healthwi.org/wp-content/uploads/Enrollment-Directory_11_27_2013.pdf

MKEN Directory

http://mkehcp.org/wp-content/uploads/2014/02/enrollment_Mar2014.pdf

Town Hall Meetings

Recognizing the complexity of the ACA and the need for consumers to understand how this law may impact them, OCI and DHS held 16 informational sessions across the state in the form of town hall meetings. These meetings, held prior to open enrollment, provided a forum for citizens to gather unbiased information about the ACA. Meetings were open to anyone who had an interest and were informal in nature to allow for an open dialog between attendees and OCI/DHS staff. Issues of interest centered on the new rules governing the health insurance products consumers are newly required to purchase, federal taxes consumers will face if they fail to purchase coverage, the opportunity to offset premiums through premium tax credits/cost-sharing subsidies and changes to Medicaid. In addition to members of the public, news outlets also attended the meetings, further spreading the information shared at these meetings to consumers across the state.

Table 3 – OCI/DHS Town Hall Meetings

Date	Location
September 3	Rhineland, Wausau, Eau Claire and La Crosse
September 4	West Allis and Pewaukee
September 5	Kenosha, Green Bay and Appleton
September 6	Madison and Cleveland
September 25	City of Milwaukee (2 sessions)
September 26	Janesville
October 2	Platteville
October 3	Superior

Town hall meeting locations and dates were distributed through press releases. Legislative offices also received the releases so that they could make their constituents aware of the opportunity. (See Appendix 18)

<http://oci.wi.gov/pressrel/0813townhallmtgs.htm>

http://oci.wi.gov/pressrel/0913janesville_townhall.htm

http://oci.wi.gov/pressrel/0913milwaukee_townhall.htm

http://oci.wi.gov/pressrel/0913superior_platteville.htm

OCI/DHS Presentations: <http://www.dhs.wisconsin.gov/health-care/ren/index.htm#ACATownHallMeetings>

Tribal Outreach

OCI and DHS agency leaders met with tribal representatives from all 11 tribes, including tribal health directors, several times over the past couple of years on many issues, including health care reform. The agencies are a resource for tribal leaders as they work to understand how the ACA affects their members. OCI leadership met one-on-one with tribal leaders. There were also two state tribal consultation meetings, one in 2012 and 2013. The Governor and agency Secretaries led a tribal dinner in the summer of 2013. Additionally, OCI’s Educational and Outreach Specialist attends the quarterly Great Lakes Inter-Tribal Council (GLTC) meetings and sent a formal letter on July 3, 2013, to the GLTC Executive Director offering OCI’s assistance in facilitating a discussion with federal representatives regarding the ACA. (See Appendix 14)

In addition, some Wisconsin tribes also administer income maintenance functions for Wisconsin Medicaid programs. DHS regularly met with the tribes to further discuss the ACA and Medicaid reforms. This forum also provided an opportunity for DHS staff and the tribes to discuss and work through the ACA provisions and requirements specific to tribes to ensure Wisconsin was correctly operationalizing and complying with these requirements.

Presentations and Editorial Board Visits

In addition to the town hall meetings, OCI and DHS leadership delivered presentations at numerous events across the state. They educated consumers, and those working with consumers, on key ACA provisions, Medicaid reforms and new opportunities for parents with income over 100% of the FPL who can now use federal dollars to purchase health insurance in the commercial market. Leadership from both agencies also traveled the state to get the word out through eight editorial board visits.

Table 4 - Editorial Board Visits

Date	Location
September 3	Milwaukee
September 4	Appleton
September 5	Janesville and Wausau
September 6	La Crosse and Eau Claire
September 23	Madison
October 2 nd	Platteville (OCI Only)

Educating congressional members on the direct impact of the ACA through one-on-one visits in October was another outreach opportunity OCI and DHS pursued, and viewed as critical to ensuring federal representatives had the information they needed to advocate for Wisconsin consumers at the federal level.

Presentations at various employer events has also helped disseminate information to Wisconsin employers about the ACA provisions that impact them, like the federal SHOP exchange and employer shared responsibility requirements that result in federal employer penalties if a certain minimum level of coverage is not offered to employees.

Leadership from both agencies continue to present on the ACA at events and serve as a resource on countless ACA related issues that have developed, both pre and post October 1, 2013. (See Appendix 19 for examples)

Training for Individuals Assisting Consumers

Navigators and Certified Application Counselors (CACs): Who they are and “permitted and prohibited activities”

A navigator can be an individual or an entity that supervises or employs an individual who performs any activities and duties related to the navigator program on behalf of the federal exchange and who receives funding to perform such functions on behalf of the federal exchange.

On August 15, 2013, HHS announced that six Wisconsin organizations were awarded federal navigator grants totaling approximately \$1.0 million. (See Appendix 20) A list of all the grant recipients and their award amounts are posted on the OCI website at: http://oci.wi.gov/healthcare_ref/grant_recipients.pdf

Wisconsin insurance law defines non-navigator assisters as individuals who have been designated by or are working on behalf of the federal exchange. The state definition includes certified application counselors who

must become authorized by the federal exchange to provide non-navigator assistance to consumers and be registered with OCI.

Both navigators and CACs help individuals determine their eligibility for public assistance programs and help consumers sort through the health insurance plans that display on the federal exchange website, HealthCare.gov. A distinction between the two is that CACs are not federally funded; however they must work for an organization designated by the federal government as a CAC entity.

Under state and federal law, CACs and navigators are not qualified to and cannot legally sell health insurance or provide advice to consumers about which health insurance plan best meets their individual needs. Only state-licensed health insurance agents may sell and provide advice about health insurance. On July 26, 2013 OCI released a bulletin that details the permitted and prohibited activities for navigators and CACs (and other non-navigator assisters). (See Appendix 11) Here is a link to that bulletin:

<http://oci.wi.gov/navigator/navigator-faq.pdf>

Navigators, CACs and other assisters work very closely with vulnerable populations who rely on their expertise when trying to understand public and commercial health care coverage options. Understanding the Wisconsin health insurance market and Wisconsin Medicaid rules is critical for any assister helping individuals secure health care coverage; in particular, to those enrollees who are transitioning from the Medicaid program into the commercial market. As such, OCI/DHS invested significant state resources to ensure the new state training and examination requirements did not pose a barrier to allowing navigators and CACs carry out their responsibilities during the initial open enrollment period, that began October 1, 2013. The two agencies joined efforts to coordinate free training sessions, often held in one location but broadcast to several other areas of the state for greater accessibility. Each session was two days in length. The table below details the free, state sponsored training opportunities that were made available.

Table 5 - Navigator and Certified Application Counselor Training

Date	Location
August 20 – 21	Madison
September 10 - 11	Milwaukee
September 17- 18	<i>Host site:</i> Sauk City <i>Broadcast to:</i> Fennimore, Eau Claire, Waukesha and Marshfield
September 24- 25	<i>Host site:</i> Madison (DHS) <i>Broadcast to:</i> Madison (OCI), Lac du Flambeau, Weston, Iron River
October 9 – 10	<i>Host site:</i> Racine <i>Broadcast to:</i> Menasha, Rice Lake and Green Bay
October 30-31	Medical College of Wisconsin and St. Joseph’s Hospital

Information for pursuing online training through a vendor was posted to the OCI website for any individual or entity interested in that option.

As a result of the free training opportunities, 578 individuals were trained. An additional 212 individuals completed the training requirements through a private vendor, for a total of 790 trained individuals.

516 individuals who completed the training also completed the state examination. 512 out of 516 individuals taking the state examination passed. To help facilitate a targeted understanding of the concepts captured in the state examination, OCI developed an Examination Content Outline, a Navigator Study Guide and a State Public Assistance Programs document, (See Appendix 21) available at:

<http://oci.wi.gov/navigator/examoutline.pdf>

<http://oci.wi.gov/navigator/pi-230.pdf>

<http://oci.wi.gov/navigator/healthcare-assistance.pdf>

Additionally, OCI worked with the vendor administering the examination to ensure testing sites had additional space to accommodate the volume of people expected to sit for the examination. This was important because examination sites are not limited to one state examination; rather, they are shared spaces between individuals sitting for the various other state professional licenses, such as teachers and nurses.

OCI staff dedicated many hours to developing training/examination and additional materials attendees could use as resources during training sessions while also serving in their capacity as a navigator or CAC. (See Appendix 22)

OCI was also charged with developing administrative rules to further detail state navigator and CAC requirements included in 2013-15 biennial budget. OCI initially prepared an emergency rule to provide the detail individuals and entities needed more immediately to prepare for their upcoming roles. This emergency rule was signed by the Governor at the end of August 2013. (See Appendix 22) Since that time, OCI has incorporated input received from interested parties on the emergency rule into the proposed permanent regulation. OCI staff reviewed written comments that were submitted, revised the emergency rule, held two additional public hearings, made further adjustments in response to feedback and submitted a final draft permanent rule to the Governor in March 2014. The permanent rule could be in effect in the summer of 2014.

Here is a link to the emergency rule: <http://oci.wi.gov/rules/0691em13.pdf>

As referenced earlier, the 2013-15 biennial budget included annual training requirements for both CACs and Navigators. To clarify the type of training that can be applied to the CACs annual eight hour training requirement, OCI issued a guidance document. (See Appendix 37) <http://oci.wi.gov/navigator/ce-guidance-memo.pdf>

With such significant change to the health insurance market due to the ACA and the creation of the federal exchange, there is an increased risk of fraud and abuse in the federal exchange. As such, OCI lists all licensed navigator entities and individuals as well as all registered CAC entities and individuals on its website. These lists are a resource for consumers to verify that navigators and CACs they may come into contact with are indeed who they say they are. If a consumer worked with someone using “navigator” or “CAC” in their title but they are not listed on the OCI website, consumers are encouraged to contact OCI by calling 1-800-236-8517 or completing a complaint form online at <https://ociaccess.oci.wi.gov/complaints-public/>. Individuals also have the ability to verify that a health insurance agent is licensed. This functionality was in place well before the ACA.

Links to the navigator and CAC lists are below, along with the link to the agent look-up feature.

<http://oci.wi.gov/navigator/naventities-registered.htm>

<http://oci.wi.gov/navigator/cac-registered.htm>

<https://ociaccess.oci.wi.gov/ProducerInfo/PrdInfo.oci>

Medicaid Training for Agents/Public List

While Income Maintenance employees are newly working with individuals who qualify for the federal assistance to purchase commercial health insurance, many licensed health insurance agents are newly working with individuals just leaving public assistance or who newly qualify for public assistance. To ensure agents working with individuals transitioning between the commercial health insurance market and Medicaid have an understanding of the Medicaid program, OCI asked licensed agents intending to work with this population to complete a four hour Medicaid training course. Nearly 400 licensed health insurance agents across the state completed training. This training provided licensed health insurance agents with continuing education credit hours.

In an effort to provide a resource to county income maintenance employees and other community organizations working with individuals ineligible for Medicaid but who may be eligible for federal premium tax credits and cost-sharing subsidies through the federally facilitated exchange (FFE), OCI posted a list of licensed agents who completed the four hour Medicaid training and who agreed to help this population enroll in private health insurance coverage through the FFE. The list can be found at:

<https://ociaccess.oci.wi.gov/ren/>. The list is user friendly as it is sortable by county.

However, the list is an exhaustive list of licensed agents available to assist individuals interested in purchasing coverage on the FFE. There are many agents not listed who have completed the necessary federal requirements to sell products on the FFE.

Educating Income Maintenance Case Workers

DHS Education Efforts

As part of operationalizing the ACA, DHS also had to make significant changes to its eligibility determination systems to reflect the new BadgerCare Plus and federal policies. As such, DHS needed to train Income Maintenance case workers in the state and ensure they understood the new program rules.

Wisconsin's 10 consortia and MILES are responsible for conducting eligibility determinations and as well as ongoing case management for BadgerCare Plus members. The staff at the consortia and MILES not only need to fully understand BadgerCare Plus policies and procedures in order to accurately and fairly administer the program, but they also have to be able to explain how the program works to members and the general public. Their staff assist individuals and families in completing BadgerCare Plus and Medicaid applications and gather the information and materials that they need to submit a complete and accurate applications on a daily basis.

DHS worked very closely with local agencies. Much of the content on the agenda of two monthly meetings, Income Maintenance Advisory Committee (IMAC) and the IMAC PPACA Sub-Committee, with local agencies was devoted to working through operationalizing the ACA and BadgerCare Plus reforms. (See Appendix 23 and 24)

Implementation of the Affordable Care Act and Entitlement Reforms as specified in the biennial budget meant a complete overhaul of the BadgerCare Plus program rules and policies for case workers. Since the policy and program changes were so extensive, the entire 384-page BadgerCare Plus handbook was completely revised. One of the main ACA changes that impacted many different BadgerCare Plus policies and

procedures was redefining household composition and income in public health care programs to align them with the way the Internal Revenue Service calculates adjusted gross income, called Modified Adjusted Gross Income (MAGI). MAGI is how the federal government is calculating eligibility for premium subsidies as well. In general, it is an individual's adjusted gross income plus any tax-exempt Social Security, interest or foreign income an individual has.

As a result of implementing MAGI rules, Wisconsin's eligibility determination system and the BadgerCare Plus program rules and procedures were updated to include MAGI. BadgerCare Plus members and applicants are now asked some different questions than previously required about their household composition, tax status, tax dependents and tax deductions. There are two key differences between current BadgerCare Plus rules and BadgerCare Plus under MAGI rules:

- Household sizes are determined based on a combination of tax relationships and family relationships instead of just looking at family relationships.
- Certain income types are no longer be counted. The key types that are currently counted but are not counted under MAGI include child support, workers compensation, and veteran's benefits.

These extensive program and policy changes necessitated mandatory training for approximately 1,200 workers at the consortia and MilES that was completed in four different phases. The first phase was a broad overview of the policy changes that was conducted in May 2013. In August and September 2013, DHS conducted 29 in-person training sessions statewide for caseworkers at the consortia. Each session was six-and-a-half hours long. MilES conducted their training through eight sessions in September and October. The purpose of this training was to give in-depth information about the new BadgerCare Plus policies and how to determine eligibility according to the new policies. In October and November 2013, the third phase of training was completed during a three hour training presented to show how the new policies were reflected in Wisconsin's eligibility determination system, Client Assistance for Re-employment and Economic Support (CARES). Phase four of training was a self-paced practice scenario intended to keep the new policies fresh for the workers during the three month delay. This phase of training was released in January 2014. In addition to the required Income Maintenance training, all MilES employees completed the federal Certified Application Counselor training.

OCI "Insurance 101" Training for Income Maintenance Employees

As Income Maintenance agencies across the state prepared to work with individuals who may be transitioning between two markets, many income maintenance employees expressed an interest in obtaining a baseline understanding of the commercial health insurance market. Most did not have much knowledge about how the commercial market operates and knew that under the ACA they would likely have some interface with that market. In response to this demand for training, OCI developed an "Insurance 101" webinar for income maintenance employees. The webinar can be found at:

<http://dhsmedia.wi.gov/main/Play/bf07076993cc4ee2a1298fa60636e52c1d>

Lines of Communication between Wisconsin and the Federal Government

Beginning in January 2013, key DHS staff have been meeting with the CMS State Operations and Technical Assistance (SOTA) team. (See Appendix 25) These calls were monthly until October 2013 and then were held every other week. The SOTA teams were created by CMS to serve as a dedicated group of CMS staff with a variety of background expertise (systems, policy, operations, etc.) to be the established point of contact for each state to coordinate that's state's implementation of the ACA.

The SOTA meetings were also DHS' main conduit and forum for asking questions related to the ACA law; clarifying how Wisconsin should operationalize the requirements and policies, asking questions received from partners and stakeholders on what the online application tool looks like, how an application will be completed, what information members will receive in the notices, how to interpret the notices that members receive, how the special enrollment period will work, etc.

It was during SOTA calls that DHS had the opportunity to work through the implementation of the ACA requirements and optional provisions that states could implement as well as negotiate Wisconsin's BadgerCare Reform Waiver and State Plan Amendments. After the 2013-2015 biennial budget passed, Wisconsin had to obtain federal approval for many of the Medicaid changes included in the budget. It was through the SOTA workgroup that Wisconsin staff and federal staff were able to work together to negotiate and formalize an agreement, and ultimately receive federal approval for the changes in the biennial budget.

In addition, to the SOTA calls DHS has a weekly conference call with CMS to further discuss Wisconsin Medicaid State Plan Amendments.

Additional DHS Preparation and Communication Efforts Leading up to the Federal Exchange Launch: October 1, 2013

Transition Plan

The DHS worked extensively with CMS to develop and finalize a comprehensive plan to identify and ensure a smooth transition for the BadgerCare Plus members that no longer met the program rules because they would have access to affordable health insurance through the federal health insurance exchange in 2014. The Department's transition plan included a comprehensive outreach strategy for working with the RENS, health care providers, and directly to members to help ensure that they were able to successfully purchase private health insurance through the federal exchange and did not face a gap in health insurance coverage. The Department's finalized transition plan was submitted to CMS on September 11, 2013. (See Appendix 26)

Partner Notification and Training

Through the REN infrastructure, as well as utilizing its existing community partner network, DHS communicated information about implementation of the Affordable Care Act and Entitlement Reform, provided policy clarifications, announced training dates, etc. through extensive series of email communications. (See Appendix 15) Throughout this time, DHS also conducted a series of four webcasts, one each in August 2013, September 2013, October 2013, and January 2014 and in-person trainings in October and November 2013 and January and February 2014 to ensure that the partners who would be assisting individuals had the information they needed to successfully assist someone with applying for health care coverage.

Health Care Provider Outreach

DHS also worked with BadgerCare Plus health care providers and HMOs so providers could do direct outreach to members who would be no longer eligible for BadgerCare Plus in 2014 and would need to purchase health insurance through the federal exchange. As Wisconsin had learned during the Medicare Part D launch in 2005, individuals faced with new health care options and needing to make a decision about their health insurance turn to their health care provider to help them make an educated decision. As a result, the Department made a list available to interested health care providers and HMOs of the BadgerCare Plus members that they had served in the last year who would likely need to transition to the federal exchange, empowering the providers and HMOs to work with these specific members and help them transition to purchasing health care through the federal exchange.

Health care providers and HMOs also received a series of provider updates regarding changes to BadgerCare Plus because of the ACA and entitlement reform. In addition, select partner updates were also shared with providers as an alert message on the secure provider portal.

Letters to BadgerCare Plus Members and Individuals on the Core Plan Waitlist

The Department took a multi-faceted approach to notifying current BadgerCare Plus members who needed to transition to the federal exchange to purchase private health insurance as well as to reach out to individuals who may be newly eligible for BadgerCare Plus. (See Appendix 27) In late September 2013 through January 2014, the DHS sent out a number of targeted informational letters notifying current members and individuals on the BadgerCare Plus Core Plan Waitlist about the BadgerCare Plus changes.

The first letter – the one sent to the households likely transitioning from BadgerCare Plus to the federal exchange was mailed to a total of 56,246 households representing 77,472 individual members. The letter sent to the individuals on the Core Plan Waitlist was mailed to 163,808 individuals.

The purpose for sending these informational letters was to allow current BadgerCare Plus members to report a change impacting their eligibility and possibly keep them on the program, as well as to allow members whose incomes are above 100% FPL as much time as possible to research their health care options and apply for coverage through the federal exchange. Individuals who received letters that indicated their income may place them above the limits for BadgerCare Plus were encouraged to visit HealthCare.gov or call 1-800-318-2596 after October 1, 2013. If people had questions about these letters, they were encouraged to contact the Income Maintenance agency at the top of the letter and those workers could help them directly, refer them to a community based enrollment resource, or refer them to an insurance agent or broker if they needed help deciding on a health care plan through the federal exchange.

DHS has sent more than 400,000 letters to those on Medicaid or newly eligible for Medicaid.

Outbound Calls

After the informational letters were mailed in late September and early October, the Department initiated proactive phone calls to all households receiving one of the informational notices mentioned previously to ensure the letter was received, the individual understood the letter, and the individual is taking action by either making sure their information is up to date with their income maintenance agency in order to ensure they remained eligible for BadgerCare Plus; or depending on their household income, applying for coverage through the federal exchange or BadgerCare Plus. The Department continues to make these proactive calls to the individuals who received letters from the Department. At the time of this writing, more than 350,000 calls have been made in an effort to reach individuals who have received letters from DHS.

While the federal government had said in the lead-up to launch of the federal health insurance exchange that there is no wrong door for an individual or family to complete an application, Wisconsin wanted to help people find the best door and give them the information to make the best decision about their health care needs, especially in light of technological challenges with HealthCare.gov.

THE LAUNCH OF HEALTHCARE.GOV: OCTOBER 1, 2013

Problems with the Launch

Despite the extensive preparation that DHS and OCI took to prepare internally as well as externally with Medicaid members, partners, agents, insurers, brokers, consumers and the general public; the best laid plans could not account for the massive systems malfunction of the federal exchange and the ineffective coordination between the federal entities implementing this inordinately large project. Wisconsin's preparation was based on repeated federal assurances—both public and private—that the federal exchange would be fully operational on October 1, 2013.

On October 1, 2013, the federal exchange website, HealthCare.gov, was scheduled to accept enrollments into both public assistance programs and private health insurance plans. However, the website's scheduled launch was plagued by significant technical problems that prevented consumers from having the option to enroll online. Problems persisted for nearly two months, leaving consumers, assisters, agents and insurers frustrated and looking for answers. Federal guidance during this time was inconsistent and often confusing. Consumers were encouraged to submit paper applications to avoid the website problems and then told that if they had filed paper applications, they should instead go ahead and try to enroll online by creating a new account (and abandoning any progress made in a previously created account).

The issues with the federal exchange directly affected tens of thousands of Wisconsin residents. DHS, OCI, Governor's Office, as well as our local counties and partners were contacted directly by many concerned and frustrated individuals who wanted to learn about and purchase the health insurance that was marketed by the federal exchange.

In addition to consumers contacting DHS about needing to reapply several times due to lost applications and others being unable to access the application tool, HealthCare.gov, DHS received many complaints and concerns related to the integrity of the federal exchange.

Concerns included:

- Social Security numbers that an individual enters being linked by the tool to the wrong family member;
- Income not being counted, resulting in a Medicaid determination being made;
- Individuals being found eligible for both Medicaid and tax credits;
- Individuals being found ineligible for both Medicaid and tax credits;
- Individuals being found incorrectly eligible for Medicaid but unable to purchase private health insurance because their application could not be moved;
- Families who were eligible for private health insurance (parents) and children eligible for BadgerCare Plus (children) being only found eligible for private health insurance and paying for private health insurance for children who should be covered by Medicaid;
- Individuals whose only recourse to an incorrect determination because of a malfunction of the logic, programming and systems of the federal exchange was to submit an appeal that had a 90 day window to be resolved; and

- Partners who had begun the process to become a certified application counselor before the launch of the federal exchange who waited weeks for the federal government to deem them certified and allow them to begin assisting the public.

In addition, there were other problems with the Wisconsin information that the federal government was putting in notices sent to Wisconsin residents. All of the notices from the federal exchange were directing all Wisconsin residents to contact **one** of 11 income maintenance entities in Wisconsin, instead of providing information that would serve all Wisconsin residents. After identifying this issue in early November, an entire month went by with no action taken by the federal Government to address this issue. Wisconsin clearly communicated the issue with CMS using the Bay Lakes Consortium phone number in an email on November 5, 2013.

After CMS responded that they would work to make the necessary changes, the Department found out that on December 2, 2013 the Bay Lakes Consortium was still getting calls from notices being generated on December 1, 2013 to call the Consortium's phone number. Due to systems and staffing limitations on their end, CMS was not able to accommodate Wisconsin's request to modify language from their one-size-fits-all solution to something that would best serve our citizens.

As CMS has still not been able to update the notice language because of higher priority systems changes they need to make, DHS has worked with the consortia to accommodate the limitations to the notice text and to ensure that consumers are able to talk to the correct consortium.

As a result of the many inquiries from individuals having a problem submitting an application online at HealthCare.gov or not wanting to wait on hold for a long amount of time to do an application over the phone, in November DHS mailed out an additional letter to the 77,472 BadgerCare Plus members anticipated to transition to the federal exchange. This letter contained a reminder that the individual will likely be no longer eligible for BadgerCare Plus under the new program rules and as a result needs to apply for and purchase private health insurance through the federal exchange. The letter also contained the paper federal health insurance exchange application and instructions. (See Appendix 27)

Prior to October 1, 2013 media outlets were publishing articles citing a lack of coordinated testing of the federal exchange. After the problematic launch of the online application tool on October 1, 2013 and as this implementation continued to unfold, more press articles were written about the technical issues with the federal exchange as well as the systemic issues with the implementation. (See Appendix 28)

Wisconsin's Work to Help Improve Access

Despite Wisconsin being a federally facilitated exchange state, Wisconsin needed to problem solve and help find "out of the box" solutions to improving access during the failed launch of HealthCare.gov. For example, Governor Walker sent a letter to HHS asking that consumers have access to federal subsidies for coverage purchased in the market outside of the federal exchange. This would have allowed individuals who did not want to risk being uninsured on January 1, 2014 due to HealthCare.gov delays, to benefit from the federal government's promise that individuals with income between 100 and 400 percent of the federal poverty level could access federal tax credits and cost sharing subsidies to offset premium costs. The federal Department of Treasury (DOT) and HHS sent a joint response indicating that tax credits are available only to taxpayers who enroll in coverage through the federal exchange. OCI sent a similar letter and received a similar response. (See Appendix 29) A week later, on February 27, HHS released guidance allowing for an "exceptional circumstance" for individuals who were unable to enroll in a Qualified Health Plan (QHP) through the federal exchange due to technical issues. The "exceptional circumstance" allows these individuals to access the federal premium tax credits and cost sharing subsidies for coverage purchased outside of the

federal exchange on a retroactive basis after the federal exchange determines they are eligible for assistance and have enrolled in a QHP through the federal exchange. On March 26, 2014, Insurance Commissioner Nickel sent a letter to the federal DOT and HHS pointing out the conflicting information contained in the agencies' initial response and requesting that the federal government provide the same flexibility and increased options to all Wisconsin consumers, regardless of whether they have yet attempted to purchase plans on the federal exchange. (See Appendix 37)

The OCI letter addressing the premium tax credits also asked that HHS include Wisconsin insurers in its pilot project to operationalize direct enrollment. Direct enrollment allows consumers to enroll in a qualified health plan offered on the federal exchange directly through the insurer. Wisconsin was not given an opportunity to participate in the pilot. (See Appendix 37)

Healthcare.gov Display Errors/"Back-End" Issues and OCI Efforts to Help Consumers

By early December 2013, some of the more significant technical issues relating to account creation, the ability to compare plans and ability to move forward in the enrollment process were improved. However, beginning in early 2014, serious display errors and "back-end" issues began to surface. "Back-end" refers to the transfer of enrollment information between insurers and the federal exchange using 834 enrollment forms, which are the federally required forms used to track enrollment between the federal exchange and insurers.

Wisconsin insurers reported to OCI that plan information was displayed incorrectly on HealthCare.gov resulting in consumers purchasing plans with features that did not match the information posted to the federal website. For example, one insurer's plan was described as having no deductible when in fact a deductible was tied to the plan. HHS was slow and overwhelmed with all the technical issues with the HealthCare.gov website. Consumers were confused and received limited assistance with their questions. OCI, as the primary regulator, refused to allow such a delay in responding to this issue and directed the affected insurer to make consumers aware of the HealthCare.gov error and provide them with an option to keep their plan, purchase a different plan from the insurer or purchase a plan from another insurer. OCI did not want "back-end" issues to stymie action necessary to make sure consumers were aware of the HealthCare.gov errors and their opportunity to change plans.

Similar display issues related to incorrect cost-sharing information and consumers having access to plans that should not have displayed as available in their service area continued through February and March 2014. OCI took a proactive role in all cases where problems were identified and proactively surveyed insurers to find out how widespread some of these issues were. If not for OCI's action on this, many more consumers may have been negatively impacted. Asserting its state regulatory authority over health insurers doing business in Wisconsin enabled insurers to quickly respond to consumers and help them find a plan that best suits their needs.

In addition to HealthCare.gov display issues, there are problems with the 834 enrollment forms that are sent between the federal exchange and the insurers. In some cases there are inaccuracies and in others there is no CCIO accountability as to what happened to enrollment forms once received from the insurers and enrollment forms that were never sent to insurers. If an insurer does not receive the 834 enrollment form, it does not know to enroll the consumer. The consumer, on the other hand, thinks they have coverage and waits for their identification cards and to be charged for their first month's premium.

Some insurers are also seeing enrollment forms come back with inaccurate effective dates. At OCI's direction, the Wisconsin insurer that brought this issue to our attention is honoring the correct effective dates and working out the inaccuracies with CCIO on the back-end.

OCI continues to use its primary regulatory authority to protect consumers. It is our job to ensure timely correspondence and options for consumers when HealthCare.gov misleads consumers into purchasing a product that either does not exist or is not available to them based on their location. OCI's proactive role in addressing these issues spares consumers from further confusion and delay. Because insurers are comfortable working with their local regulator and find it difficult to get timely responses from HHS on federal exchange issues, OCI is able to gather information on the problems at hand and quickly give insurers direction on consumer outreach and options. OCI is also communicating these problems on behalf of consumers and insurers to HHS in an effort to get technical problems resolved.

OCI issued two consumer alerts to make people aware of the display issues and offered suggested steps they should take to ensure they are enrolled in the plan they think they are. (See Appendix 7)

Links to OCI Consumer Alerts:

<http://oci.wi.gov/pressrel/0114exchange.htm>

<http://oci.wi.gov/pressrel/0314healthins.htm>

OCI posted a FAQ document specific to enrollment issues to its website. OCI sent the document to all state legislative offices and Wisconsin Congressional members to assist them in responding to constituent concerns and questions. (See Appendix 6)

http://oci.wi.gov/healthcare_ref/healthcarereform_enrollmentfaq.pdf

A third consumer alert was released reminding consumers that the open enrollment period ends March 31, 2014 and depending on individual circumstances, a consumer who does not enroll in coverage by March 31, 2014 may not have another opportunity to enroll until the next open enrollment period starting November 15, 2014. (See Appendix 7)

<http://oci.wi.gov/pressrel/0314openenroll.htm>

State Based Exchanges did not Successfully Launch

Similar to the decision made to reform Medicaid, Governor Walker sought to protect both consumers and taxpayers with the decision to allow the federal government to operate the exchange in Wisconsin. States similar to Wisconsin—like Minnesota, Ohio, and Indiana—estimated the operational costs of the exchange to cost consumers and taxpayers from \$35-60 million annually.

Despite stories that those states operating their own exchange fared better than the federal exchange, this turned out not to be the case. States that developed their own exchanges, such as Oregon, Minnesota, Maryland and Vermont, also experienced a problematic rollout and continue to experience technology challenges that are limiting enrollment.

Oregon received \$300 million in federal grants to establish its exchange and was viewed as a leader in its development of a state based exchange. Despite the resources dedicated to their effort, Cover Oregon failed to launch and, according to a March 20 Washington Post article, "How Oregon wound up with the nation's worst Obamacare website," Oregon still has not launched an online enrollment portal. The article also points out that, "Oregon is still weighing whether to rescue its exchange technology, use technology from

another state or even join the federal exchange before the enrollment period starting in November.” (See Appendix 2) A March 20 New York Times article, “Health Care Exchange in Oregon Not Meeting High Hopes,” also highlights the state’s enrollment problems and states, “With a March 31 deadline for first year enrollment looming, the online exchange, Cover Oregon, is still unable to process an applicant from start to finish without help or paperwork.” (See Appendix 30)

In January 2014, Oregon, similar to the request made by Governor Walker, asked for HHS approval to give federal premium tax credits to consumers unable to purchase coverage through Cover Oregon due to the technical problems the state based exchange experienced.

Wisconsin Concern for Transitioning Members Results in Entitlement Reform Delay: November 14, 2013

Wisconsin elected officials as well as other partners and stakeholders continued to contact Governor Walker, DHS and OCI expressing their concerns about the systemic problems with the federal exchange. (See Appendix 38) Due to the many problems individuals and families were having with submitting an application and enrolling in private health insurance, many individuals began expressing concern regarding whether the transitioning BadgerCare Plus members would be able to secure private health insurance coverage before December 31, 2013. These concerns were shared by Governor Walker as well as the DHS and OCI.

As was mentioned in previous sections of this report, the DHS and OCI initiated a comprehensive communication plan including hosting town hall meetings, meeting with editorial boards, and providing training for in-person assisters and insurance agents. DHS also communicated with thousands of Wisconsin residents who will have access to Medicaid for the first time and those who have the opportunity to purchase private health insurance through the federal exchange.

Due to significant technical issues that made it difficult for Wisconsin individuals to access HealthCare.gov, Wisconsin faced a challenging situation by November 2013. Because the Wisconsin Medicaid reforms included in the biennial budget were scheduled to take effect on January 1, 2014, many of the individuals who were transitioning from Medicaid into the insurance products offered through HealthCare.gov would have had less than one month to apply, select and pay for an insurance plan. Rather than allow these 77,000 individuals to fall through the cracks and experience a gap in coverage, on November 14, 2013, Governor Walker announced a three-month delay in the implementation of the Wisconsin Medicaid reforms and a three-month extension of the Health Insurance Risk-Sharing Plan (HIRSP) in order to provide a safety net during the transition for some of the state’s most vulnerable residents.

On November 22, Governor Walker issued Executive Order #123 calling a special session of the Legislature to address the implications of the failed federal launch of the Affordable Care Act. (See Appendix 31) The special session began on December 2, 2013.

DHS then began working with staff at the federal Centers for Medicare and Medicaid Services to address the programmatic and system changes needed to meet the three month delay while waiver negotiations continued to focus on policies related to premium payments. Between November 14, 2013 and December 19, 2013, DHS met and corresponded with CMS frequently regarding the exact terms of the delay.

In addition, during these critical weeks, DHS had to plan simultaneously for at least three or four different implementation dates because we did not know the status of the final CMS negotiations.

In late December, CMS wrote to Wisconsin confirming an agreement between the two entities related to the

state's delay of entitlement reforms until April 1, 2014. (See Appendix 32) The agreement, outlined by CMS, meets the key objectives of the state, while providing both the state and federal governments with systems flexibility to ensure a smooth transition. Under the agreement, CMS agreed to the state's delay in implementing the entitlement reforms originally approved in the 2013-15 state budget and subsequently delayed under 2013 Wisconsin Act 116.

Under the agreement, all enrolled BadgerCare parents and caretakers who had incomes between 100% and 200% of the Federal Poverty Level (FPL) remain eligible for Wisconsin Medicaid until March 31, 2014. DHS continues communication and outreach efforts to provide these individuals with the most up-to-date information about HealthCare.gov. In addition, DHS continues to remind all populations that access to insurance coverage through the federal exchange's open enrollment period ends March 31, 2014 and that premiums are due March 15, 2014.

At the request of CMS, the agreement did make one modification to new parents and caretakers between 100% and 200% FPL. Under this provision, any new parent or caretaker who applied for Medicaid before February 1, 2014 will be eligible for Wisconsin Medicaid until March 31, 2014. While these individuals will be covered under Wisconsin Medicaid, the Department continues to provide information on the federal exchange since Medicaid eligibility for these individuals will end March 31, 2014. Eligibility for new parents and caretakers who applied for Medicaid coverage after February 1, 2014 were tested for eligibility under the new Modified Adjusted Gross Income (MAGI) rules and new income eligibility standards.

As a result of CMS's request, this technical modification was needed to allow Wisconsin to implement the Governor's entitlement reforms envisioned by the state budget on February 1, 2014 instead of April 1, 2014. As such, a technical bill was required to bring Wisconsin statutes and the agreement between Wisconsin and CMS into compliance. (See Appendix 31)

Governor Scott Walker signed Special Session Assembly Bill 1, 2013 Wisconsin Act 116, into law on December 20, 2013. (See Appendix 31)

OPERATIONALIZING THE DELAY

DHS Outreach during the Delay

During the delay process and special sessions, similar to fall 2013, DHS continued to keep the RENs, community partners, health care providers, tribes, and other stakeholders informed of the changes through a series of notification emails, meetings, webcasts and in-person trainings. (See Appendix 15)

In addition, the Department continued the outbound calls to the transitioning members and individuals on the BadgerCare Plus Core Plan waitlist that had begun in October 2013. Scripting for these calls was frequently updated to reflect the adjusted dates, and policy changes with the waiver agreement; however the key message and directive to members did not change. These proactive phone calls were made to ensure the members or individuals on the waitlist received the letters and notices from DHS, that the individual understood the letter, and that the individual was taking action by either making sure their information is up to date with their local agency in order to ensure they remained eligible for BadgerCare Plus; or depending on their household income, applying for coverage through the federal health insurance exchange or BadgerCare Plus. (See Appendix 27)

In early 2014, the Department took these efforts to another level when we began using these outreach calls as an opportunity to do more targeted outreach and offer more direct assistance to current BadgerCare Plus

members with moderate and high-risk health conditions. DHS wants to ensure these transitioning members (i.e. those with chronic illnesses) are successful in securing ongoing coverage. We accomplished this by having care coordinators call these identified members to provide additional assistance such as which of their current providers are offered in the qualified health plans, or which qualified health plans treat their chronic illness well, etc. In addition, the care coordinators also assisted with connecting the members to a navigator, agent, broker, certified application counselor, or in-person assister to assist with completing a federal exchange application and purchasing private health insurance.

Communication to HIRSP Members

HIRSP members were among the most vulnerable population when the federal website's problems persisted and HIRSP took a number of important steps. They worked to communicate with their members through e-mail, website, mailings, Facebook page, and billing notices. The administrative call center staff were trained to assist HIRSP members. For most HIRSP members, the exchange plans offered lower premium payments—if the member was eligible for subsidy. However, the federal website problems added to the confusion, especially for those currently receiving medical care.

Updating Wisconsin's BadgerCare Plus Application and Program Policies

Coming to an agreement with the federal government regarding Wisconsin's implementation of the Affordable Care Act, including implementing MAGI rules, and the policy changes to BadgerCare Plus as well as having the legislative approval reflecting the agreement with the federal government and codifying the delay, allowed Wisconsin to move forward with planned systems changes and operationalizing the new policies in early 2014.

The BadgerCare Reform Waiver agreement with CMS sped up the date in which Wisconsin had intended to implement the new MAGI rules. The application of the MAGI rules was included in the program changes that the Wisconsin Legislature agreed to delay to April 1, 2014 as part of the special session in December 2013. As CMS required Wisconsin to implement these changes earlier than planned and enacted into law by the Legislature, the second special session was needed in January 2014 to make the technical modification needed to implement the MAGI rules for new applicants beginning February 1, 2014. (See Appendix 39)

As such this created a situation in which beginning February 1, 2014, all new BadgerCare Plus applicants have the new MAGI rules, including the new income limit for parents and caretaker relatives applied, to their application. At the same time, from February 1, 2014 through March 31, 2014, existing parent, caretaker relative, and childless adult BadgerCare Plus members with household incomes between 100 % FPL and 200% FPL were able to remain enrolled through March 31, 2014.

Although the new BadgerCare Plus income limit (100% FPL) was applied to parents and caretakers that applied on or after February 1, 2014, newly eligible childless adults were not able to begin BadgerCare Plus coverage until April 1, 2014.

In order to comply with the February 1, 2014 requirement for MAGI implementation, updating the online application to contain the new MAGI questions was completed on February 1, 2014 so individuals could fill out and submit their applications. This was especially significant for childless adults living in poverty. Being able to complete the application was a long-awaited step in being able to apply directly for affordable health care coverage beginning April 1, 2014. Also included in the systems updates the weekend of February 1, 2014 was an update to the "Am I Eligible" screening tool to include the new BadgerCare Plus program rules. By entering a few pieces of information their household, an individual or family can get an overview of the Wisconsin public assistance programs they may be eligible for. It also lets the individual or

family know if they appear to be eligible for BadgerCare Plus or if they should apply for and purchase private health insurance through the federal exchange.

Updating Wisconsin's eligibility determination system and delaying the implementation of the Affordable Care Act and BadgerCare Plus changes by three months had significant systems implications.

Even prior to the formally approved delay of the BadgerCare Plus changes, Wisconsin was put in a challenging position in terms of system modifications. Due to CMS's timeline for releasing the final eligibility rules, Wisconsin did not have enough time to make the complex system changes to implement MAGI and thoroughly test them by October 1, 2013. It is our understanding that other states were operating under timeframes other than October 1, 2013 for implementing the MAGI rules as well, and CMS has been flexible with regard to DHS's timelines for implementation of many of the ACA related systems changes.

Wisconsin had been planning to implement the MAGI changes in mid-November. However, when the decision was made on November 14, 2013 to delay the BadgerCare Plus changes by three months, these systems changes needed to be delayed as well because the 2013 BadgerCare Plus program rules and logic programed in the eligibility determination system had to remain in place for three additional months.

Making changes to the eligibility determination system isn't as easy as flipping the switch or simply entering a new piece of code or rule. In order to delay the BadgerCare Plus policy changes by three months, DHS had to also delay all of the systems changes that were intended to be made on November 18, 2013 and reschedule them for February 1, 2014.

The delay and resulting schedule change not only impacted the systems changes that were supposed to be made in November 2013, but also impacted future systems changes that were scheduled from December 2013 through April 2014. In a matter of days and weeks, DHS and vendor staff had to reorganize and reconfigure major systems changes to meet the needs of the three month delay as well as make additional changes to policies to reflect the final agreement that CMS and DHS made to approve the BadgerCare Reform Waiver. This has included articulating thousands of detailed business requirements for systems functionality and testing and re-testing the code continuously from October 2013 through February 1, 2014. State staff worked additional hours and overtime throughout the 2013 holiday season to accommodate the additional changes necessitated by the 90 day delay as a result of the technical problems with HealthCare.gov.

Workload Adjustments at the Local Level

Delaying the ACA and BadgerCare Plus changes by three months also had very unique implications for the workload of the Income Maintenance consortia and Miles.

Delaying the ACA and BadgerCare Plus changes by three months modified the dates in which the systems would be ready for case workers to begin processing new applications (childless adults applying for BadgerCare Plus coverage beginning April 1, 2014 under the new program rules and account transfers for individuals determined and assessed eligible for BadgerCare Plus by the federal health insurance exchange).

As a result, case processing (new BadgerCare Plus applications for coverage through the new program rules and account transfers from the federal exchange) that was planned to begin in late November was rescheduled for February 2014. This meant that the consortia and Miles had to make workload and caseload adjustments to case workers, especially the ones who had recently been hired and trained to assist with implementation of the Affordable Care Act, to reflect the shift in processing dates. However, it's important to

note that the consortia and MilES were still processing new applications according to the 2013 BadgerCare Plus program rules and managing ongoing cases for the more than 1 million Wisconsin residents receiving health and nutrition benefits.

From November 2013 to February 14, 2014, the focus at the consortia, and MilES shifted to answering consumer questions and addressing consumer frustrations related to problems learning about and getting coverage at HealthCare.gov as well as the three month delay. Consortia staff also assisted the public with paper federal exchange applications.

When the changes were made to the eligibility determination system on February 1, 2014, local agencies were left with the unique challenge of processing four month backlog of account transfers from the federal Health Insurance exchange (as those applications needed to be processed with the MAGI rules) as well as process the new BadgerCare Plus applications that thousands of previously uninsured childless adults were submitting so they could have BadgerCare Plus coverage beginning April 1, 2014.

TFI Form

In coming to an agreement with CMS regarding the BadgerCare Reform Waiver, DHS agreed to do additional outreach to the transitioning members to allow them to request to have their case processed under the new MAGI rules to see if they could remain enrolled in BadgerCare Plus after April 1, 2014. In order for a member to get be processed under the new rules, they had to provide tax filer information to the Department. In late December, DHS sent the tax filing information (TFI) form to the members who will likely need to transition to purchasing private health insurance through the federal exchange. (See Appendix 27) If members filled out the TFI form and it was determined that they will remain eligible under the new program rules, their enrollment will continue after April 1, 2014, as long as they continue to meet current program rules.

If the member filled out the TFI form and they were determined to not be eligible under the new program rules or if the member did not return the TFI form, the new BadgerCare Plus income limits were applied to their case on February 15, 2014 when the eligibility conversion was run. If any of the members in the household were no longer eligible for BadgerCare Plus after March 31, 2014, then they received a notice of decision that was mailed on Feb. 17, 2014 letting them know that they needed to apply for and purchase private health insurance through the federal exchange.

Individuals who filled out and returned the TFI form and were determined to not be able to stay enrolled in BadgerCare Plus under the new MAGI rules still had their accounts transferred to the federal exchange. However, since at the time of mailing the notice of decision in mid-February the Department did not know if the federal exchange had begun processing the account transfers, the notice of decision directed the individuals to apply for and purchase private health insurance directly at the federal exchange so they would not have a gap in health care coverage.

Wisconsin is an Assessment State

The agreement with CMS that allowed for the three month delay in implementing the BadgerCare Plus changes also allowed Wisconsin to become an assessment state as of January 1, 2014. Wisconsin was a determination state for applications that were submitted to the federal exchange between October 1, 2013 and December 31, 2013; meaning that for applications submitted to the federal exchange between October 1, 2013 and December 31, 2013, the federal exchange determines BadgerCare Plus and Medicaid eligibility for applications that Wisconsin residents submit. Those applications were still processed by

Wisconsin, but Wisconsin needed to accept the eligibility determination made by the federal exchange during this timeframe. (See Appendix 33)

Wisconsin is an assessment state for applications that were submitted to the federal exchange beginning January 1, 2014. For applications submitted to the federal exchange beginning January 1, 2014, the federal exchange will transfer applications of Wisconsin residents who appear to be eligible for BadgerCare Plus and Wisconsin IM workers process the application and determine BadgerCare Plus eligibility. (See Appendix 33)

Becoming an assessment state was a very important step for Wisconsin because this meant that applications submitted through the federal health insurance exchange after January 1, 2014 were truly allowed to be treated the same way as a BadgerCare Plus application submitted directly to a local agency in Wisconsin. As was seen during the implementation of HealthCare.gov in fall 2013 and as the Department heard from members, applicants, partners, legislators and the media, there were issues with the functionality of HealthCare.gov that led to incorrect determinations being made, to application data being incorrectly submitted (i.e. someone entering that they had income but the application tool registered the individual have \$0 income), etc. This led to the federal government determining individuals eligible for Medicaid in October through December 2013 that truly were not eligible. Had Wisconsin already been an assessment state, we would have been able to process the application according to our BadgerCare Plus application processing rules, including requesting any needed proof of information. However, for the period in which Wisconsin was a determination state, Wisconsin is required by the federal government to accept the determination made by HealthCare.gov and enroll the individual in BadgerCare Plus even if the determination was incorrect. (See Appendix 34)

Incorrect Determinations

CMS notified states in January 2014 that there had been issues with the data that they collected from applicants on HealthCare.gov and defects in the process by which they completed some determinations and provided guidance regarding timeframes in which states are allowed to re-process determinations made by HealthCare.gov. (See Appendix 34) Families were enrolled for at least one month depending on their application date and childless adults will be enrolled for at least April 2014. Wisconsin is allowed to re-process the applications after enrolling the member to determine if the member meets the BadgerCare Plus program rules and can continue to be enrolled in BadgerCare Plus.

Wisconsin re-ran eligibility for individuals determined eligible for BadgerCare Plus by the federal exchange the weekend of March 22, 2014. Members found to be no longer eligible for BadgerCare Plus, received a notice of decision the week of March 24, 2014 that let them know that they are no longer eligible for BadgerCare Plus as of May 1, 2014. This loss of insurance qualifies them for a special enrollment period allowing them to still enroll through the federal exchange. The member also received the standard notice of decision in the mail that includes a short message about why they are not eligible and what they should do (i.e., apply for and purchase private health insurance through the federal exchange). The notice also includes their hearing and appeal rights and the information used to make the determination. (See Appendix 274)

There are two primary reasons why individuals determined eligible for BadgerCare Plus by the federal exchange could be found to no longer be eligible for BadgerCare Plus:

- The federal exchange incorrectly applied MAGI rules. For example, the federal exchange used household sizes that were too big or income amounts that were too low, or both.

- The member already has an open case with current income information, but they did not report that income to the federal exchange.

When eligibility was re-run on March 22, 2014, CARES correctly applied MAGI rules and considered all current income information known to the case.

In addition, as the individuals who were determined eligible for BadgerCare Plus by the federal exchange incorrectly have received many different notices and letters over the past number of months after initially applying through the federal exchange, the consortia and MiES will be making proactive outbound calls to these individuals. The calls are intend to:

- Help make sure they understand why they received a notice saying they are no longer eligible for BadgerCare Plus;
- Check and see if there have been any changes (income, household size, etc.) since they first applied at the federal exchange to see if they may affect their eligibility for BadgerCare Plus;
- Let the individual know that because they were enrolled in BadgerCare Plus and lost coverage, they have a 60-day Special Enrollment Period after the BadgerCare Plus coverage ends to purchase a health plan through the federal exchange, even though the initial open enrollment period has closed;
- Encourage the member to contact the federal exchange to complete the application process or file a new application if needed; and
- Refer the member to a certified navigator, certified application counselor, insurance agent or broker, or other assister if they need additional assistance completing a federal exchange application.

Identifying and Notifying Members Who Will Be Transitioning from BadgerCare Plus to the Federal Exchange

On February 15, 2014, the new BadgerCare Plus income limits were applied to the individuals who will likely be transitioning from BadgerCare Plus to the federal exchange (the members who received Letters 1, 1A, 9). As a result, members who no longer meet BadgerCare Plus program rules were mailed a notice of decision the week of February 22, 2014 letting them know that they will need to apply for and purchase private health insurance through the federal health insurance exchange. (See Appendix 27)

Individuals who were determined to not be able to stay enrolled in BadgerCare Plus under the new MAGI rules had their accounts transferred to the federal exchange. However, since at the time of mailing the notice of decision in mid-February the Department did not know if the federal exchange had begun processing the account transfers, the notice of decision will direct the individuals to apply for and purchase private health insurance directly at the federal exchange so they would not have a gap in health care coverage.

Account Transfers – Federal Exchange to Wisconsin

CMS had originally planned for the account transfer functionality to be ready and available on October 1, 2013. However, in September 2013, CMS delayed the account transfers until November 1, 2013 and in October 2013 again delayed the account transfers until an unspecified date. (See Appendix 28)

Wisconsin had planned on being able to begin accepting account transfers beginning mid-November 2013 as part of the extensive systems implementation that included the new program rules. When the delay was announced, implementation of this functionality was also delayed until February 2014.

Wisconsin began receiving the Account Transfers from the federal government in mid-December and the eligibility determination system was updated February 1, 2014 to allow local agencies to begin processing the account transfers. As of Friday, March 21, DHS has received 71,065 account transfers. Note that this figure includes individuals and families who applied at the federal exchange between October 1, 2013 and December 31, 2013 and were determined eligible for BadgerCare Plus; individuals and families who applied on or after January 1, 2014 and were assessed by the federal exchange to likely be eligible for BadgerCare Plus; as well as individuals who were referred to Wisconsin because they may be eligible for services because they have special health care needs like needing help with daily living or having a disability.

As this was a very new process, one which DHS has never previously done with the federal government, DHS worked very closely with the local agencies to ensure the process went as smoothly as possible as well as to test and validate the data Wisconsin received through the account transfers. DHS also needed to conduct extensive testing and validation because CMS had changed their base logic at least two times for how states needed to program their systems to accept the account transfers. This process was made even more challenging due to staffing issues with the CMS vendor who worked with states because different staff were assigned during different parts of the account transfer planning and implementation. There were several instances of meetings where Wisconsin was ready and available to discuss the account transfer process, but due to confusion on the part of the vendor, needed staff were not in attendance, requiring these calls to be rescheduled.

As a result of all of these factors, the account transfers were sent to the agencies in a series of batches over the course of February and March 2014. Once the agency successfully processed an account, the applicant was notified about their enrollment status through the mail via a notice of decision or a verification checklist.

Account Transfers – Wisconsin to the Federal Exchange

Wisconsin confirmed with HealthCare.gov in January 2014 that DHS is able to successfully transfer the accounts of people who are no longer eligible for BadgerCare Plus back to the federal exchange. (See Appendix 35) As of March 21, 2014, DHS has transferred 48,630 accounts to the federal exchange. In late February 2013, CMS indicated that they had begun processing the account transfers that they have received from states according to the order in which they received the account transfers from states. As some states began sending account transfers in October 2013 and Wisconsin was not able to begin sending the account transfers until February 3, 2014. Until the Department knows that CMS is processing Wisconsin's account transfers, the Department will be directing individuals whose applications have been transferred to the federal exchange to follow up directly with the federal exchange to complete the application process or file a new application if needed. (See Appendix 27)

WISCONSIN OUTREACH: END OF OPEN ENROLLMENT

Wisconsin has been repeatedly criticized for being ranked as the state with the lowest amount of advertising funding spent per capita—funding that was allocated by the federal government for purposes of sharing information about the ACA. However, despite the lack of federal taxpayer dollars being spent on marketing the ACA in Wisconsin, our grass-root enrollment efforts to inform individuals of their health care options appear to be working. (See Appendix 28)

Wisconsin's RENs and partners statewide continued to work with Wisconsin residents in March 2014 to hold more than 200 local enrollment events statewide where CACs and in-person assisters are available to help them complete an application. (See Appendix 15) Proof of the success of such effort is demonstrated by the

fact that only 17 states have enrolled more of their citizens in an exchange (state or federal) than Wisconsin at this time. When comparing all state's uninsured populations, Wisconsin ranked 8th best.

Additional Outreach to Individuals Transitioning to the Federal Exchange

In April, the Department will send one final letter to the BadgerCare Plus members who no longer met the program rules as of April 1, 2014 because they now have access to affordable health insurance through the federal health insurance exchange. The letter will remind them that they need to take action to apply for and purchase health insurance through the federal exchange since they no longer have BadgerCare Plus coverage. These individuals will have until May 30, 2014 to apply for and purchase private health insurance through the federal exchange because losing their BadgerCare Plus coverage is a qualifying event that allows individuals to purchase health insurance through the federal exchange outside of the open enrollment through a special enrollment period (SEP).

The Department will also be conducting one final round of outbound calls to these individuals once the letter has been mailed to make sure that they received the letter, that they understood the letter, and that they are taking action to purchase private health insurance through the federal exchange.

Special Enrollment Period

The individuals who were enrolled in BadgerCare Plus and HIRSP in February and/or March 2014 and are transitioning to the federal exchange are experiencing a qualifying event that makes them subject to a special enrollment period. (See Appendix 36)

As a result, these individuals have 60 days from the date of the qualifying event to purchase health insurance through the federal exchange. While additional information about the special enrollment period through the federal exchange is available on the HealthCare.gov website, the information is only focused on a broad summary of what a special enrollment period is and has some examples of what kinds of qualifying events would make someone eligible for a special enrollment period. HealthCare.gov, however, does not have any specific information for individuals regarding how they should apply for coverage during this special enrollment period. DHS has asked CMS for additional clarifying information about SEPs, including screenshots of the process that individuals should follow to request coverage through a SEP; however, as of the time of publication, this guidance and additional information has not been received. As the Department has had to throughout the process of operationalizing the Affordable Care Act, it is directing individuals to call the federal exchange so the individual can be walked through the process by the HealthCare.gov call center.

In addition, DHS has also been communicating with CMS in mid-March 2014 regarding Special Enrollment Periods and how this directly relates to the BadgerCare Plus members who are no longer eligible under the new policy rules as the procedural documents released by CMS in mid-February made it very difficult for both partners and health insurers to ascertain whether or not the transitioning members are eligible for a SEP. After discussing the policy with CMS, it was determined that the BadgerCare Plus members are, in fact, eligible for a SEP since BadgerCare Plus benefits met the threshold for minimal essential coverage.

Federal Adjustments to ACA

Throughout 2014 the federal government has continued to release new guidance related to ACA provisions and rules. In March 2014 a proposed rule was released to update policy based on experience with initial open enrollment. Updates may include clarifying federally-managed services available for states in the second year of operations, expanding the use of data for efficient operations of the federal exchange instead of minimum exchange functions, developing privacy standards in the exchange for the federal

exchange and non-exchange entities, implementing penalties related to false, fraudulent, or improper use of information, clarifying eligibility and appeals coordination responsibilities with state Medicaid agencies, and addressing treatment of retroactive eligibility from an appeal. This proposed rule would also establish requirements for exchanges and QHPs to implement specific quality-related provisions of the Affordable Care Act. The 279 page proposed rule is available on the CMS website at

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf>

In early March 2014, the federal government also announced a number of regulatory changes, including that it was going to be extending the 2015 open enrollment period for one month longer than originally intended. It will now occur from November 15, 2015 until February 15, 2015. (See Appendix 28)

Ongoing Issues

There have been a couple of ongoing issues and lingering questions that DHS has asked of CMS but has not received any additional guidance and feedback. These issues include the status of paper applications that were submitted to the federal exchange and the Department's request for outcome data that lets us know how many of the individuals who transitioned to the federal exchange actually successfully purchased private health insurance. (See Appendix 5)

The Department, as well as consumers, advocates, partners and stakeholders, has asked CMS for an update regarding what is happening with the thousands of federal health insurance exchange paper applications that have been submitted. What we know is that they are sent to one operations center in Kentucky, but CMS has never provided a clear update or status on paper application processing. It is our understanding that due to the issues with HealthCare.gov CMS began discouraging people from sending in a paper application in December because the operations center was having problems entering the applications due to technical issues. We hope that these applications are being processed and as of publication we are still waiting for CMS to provide a status update.

Our agreement with the federal government to delay implementation of the Governor's entitlement reforms by three months stated that, "CMS will continue to work with the state to establish acceptable mechanisms for tracking who do and do not successfully make the transition to coverage through the federal exchange, including the strategies discussed below." This text is taken from page 3 of a letter sent to Brett Davis on December 20, 2013 by Eliot Fishman from CMS. (See Appendix 16)

DHS first submitted our request to CMS to do a data match in October 2013 for the individuals who are transitioning from BadgerCare Plus to the federal exchange to determine if they purchased private health insurance through a QHP and began receiving benefits. DHS submitted the request through the federal State Operations Technical Assistance Group (SOTA). CMS has responded that our data match request is on their to-do list; however, due to many different priorities they do not know when they will be able to complete our request. CMS did reach out to DHS on March 14, 2014 to begin this process, but a timeframe has not yet been set for when this data will be provided.

Since October 2013, when DHS made the data match request, the data match request has been an agenda item on every one of our SOTA calls. CMS has not yet been able to provide the requested data match nor have they indicated when it will be available. (See Appendix 5)

We do not have access to information regarding individuals that have purchased health insurance through the federal exchange – only CMS does. We, as well as our state legislators, congressional delegation, local media, and Wisconsin citizens are eagerly waiting for this data.

WISCONSIN'S LANDSCAPE MOVING FORWARD

The DHS and the OCI will continue to fulfill our obligations to operationalize Medicaid under ACA rules and will protect Wisconsin consumers and taxpayers under the law.

April 1, 2014 marks a very significant day for Wisconsin. It is the first day of a new era for Wisconsin's Medicaid program, one in which all adults in poverty have access to the same benefits regardless of their household composition. More importantly it is the first day of a new Wisconsin – one in which health care entitlement programs have been redefined to serve the people they were created for – individuals and families living in poverty – and one in which these programs will be on a financially sustainable path.

Moving forward, Wisconsin taxpayers will be able to budget for Medicaid and not be susceptible to financial uncertainty of excessive dependence on federal funding. Wisconsin will not need to fearfully wait for the next shutdown or worry about receiving news from the federal government that it cannot keep its lofty promises of being able to foot all or most of the bill for paying for the health care of our state's citizens living in poverty. Wisconsin is living up to and embracing its long reputation of taking care of our own and has taken the appropriate and necessary steps to make our Medicaid program stable and sustainable so we can ensure that all of our residents have access to the comprehensive health care we all need to stay healthy, strong, and continue to move Wisconsin forward.

OCI will monitor and protect our competitive adverse insurance market against adverse impacts resulting from the ACA. Looking forward, we anticipate consumers in the commercial health insurance market will choose to stay with their pre-ACA compliant plan, since that opportunity will extend until at least 2016. We also anticipate that Wisconsin will continue to have a robust market outside of the federal exchange, despite challenges faced by insurers as a result of the ACA. OCI will continue to be the primary regulator of the insurance market and be nimble enough to address problems so that Wisconsin consumers do not need to rely on the federal government for assistance.

Our agencies will continue to fulfill our responsibilities to ensure that Wisconsin residents have the information they need to access public and private health insurance options available to them.