Shifting Administrative Burden to the State:

A Case Study of Medicaid Take-Up

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Forthcoming in *Public Administration Review,* DOI: 10.1111/puar.12114

Abstract

Administrative burden is an individual's experience of policy implementation as onerous. These burdens may be created because of a desire to limit payments to ineligible claimants, but also serve to limit take-up of benefits by eligible claimants. For citizens, this burden may occur through learning about a program; complying with rules and discretionary bureaucratic behavior to participate; and, stigma costs in participating in an unpopular program. Using a mixed-method approach, we explain process changes that reduced individual burden, and demonstrate how this resulted in increased take-up in Medicaid in the state of Wisconsin. The findings inform the planned expansion of Medicaid under the Affordable Care Act. A key design principle for Medicaid and other means tested programs, is that it is possible to increase program take-up while maintaining program integrity via strict and detailed eligibility rules by shifting administrative burdens from the citizen to the state.

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Acknowledgements: This research was supported by funding from the Institute for Research on Poverty and the Graduate School at the University of Wisconsin-Madison

Administrative burden is an individual's experience of policy implementation as onerous (Burden et al. 2012). In some cases, little may be demanded of citizens as they access public resources. In other cases, citizens may have to search for information about a program, invest time and effort to satisfy procedural requirements, and experience psychological self-esteem costs in participating. Administrative burden is consequential, exerting a material influence on whether citizens are successful in making their claims before the state. We argue that the state can reduce burdens on citizens and shift burdens onto the state, and illustrate this claim by examining reforms designed to increase take-up (i.e. the proportion of eligible claimants who access a service or benefit) of Medicaid in the state of Wisconsin.

All social welfare programs for which only certain citizens are eligible have administrative burden. Every public program with categorical eligibility (i.e., eligibility is restricted to those with low income, to workers, to children, etc.) requires administrative procedures to ensure only those eligible actually receive benefits. But there is considerable variation across programs in terms of how those burdens are placed on citizens versus the state. For example, Social Security is a program with significant administrative complexity, almost all of which falls on the state. Individuals do not need to collect and provide verification of their earnings over their lifetimes; the state collects and maintains this information for them. To receive benefits, all one needs to do is fill out a simple form, either on-line or at a local Social Security Administration office, of which there are thousands throughout the country. Not surprisingly, take-up of Social Security benefits among eligible recipients is nearly 100 percent.

By contrast, programs that place a large fraction of the administrative burden on individuals have significant problems in terms of take-up. For example, requiring claimants to provide verification of income, rather than drawing on administrative tax data, decreases

participation (Sommers et al. 2012). Providing hands-on assistance to complete applications also increases take-up (Aizer 2007). Finally, as we will discuss in the case of Medicaid in Wisconsin, states can automatically enroll individuals who are eligible based on state administrative data on individuals' participation in other programs that would indicate Medicaid eligibility. Auto-enrollment fully transfers administrative burden for determining eligibility from the individual to the state.

The primary goal of the article is to demonstrate the relevance of the administrative burden to outcomes experienced by citizens, with a particular focus on Medicaid. A key lesson from this case study is that programs that limit eligibility to certain groups, especially means tested programs like Medicaid, can increase enrollment, while still maintaining detailed eligibility rules that help ensure only those eligible receive benefit, by shifting the burden of proof back to the state, instead of on individuals citizens.

Expanding Medicaid is a key means by which the 2010 Patient Protection and Affordable Care Act (ACA) seeks to expand health-care access. The potential to significantly increase health care access depends upon understanding how the administrative state can capture eligible non-participants, and estimates of the impact of the ACA depend a good deal on assumptions about take-up (Somers et al. 2012; Thompson 2012). The first section of the paper describes examples of administrative burden in the welfare state, and summarizes existing empirical evidence that this burden matters for access to benefits among eligible beneficiaries.

To illustrate the relevance of administrative burden, the remainder of the article undertakes an in-depth case-study examination of Medicaid burden in the state of Wisconsin. We study Wisconsin because it significantly reduced the administrative burden applicants face in

applying for Medicaid under both Republican and Democratic governors, culminating with the BadgerCare Plus program in 2008. The case study employs a mixed-method approach. The quantitative component of the article uses state administrative data to demonstrate the effects of reducing burden at the time of the implementation of BadgerCare Plus. We estimate the effects of reductions of burden (program and application simplification, greater outreach and aid to eligible populations, the state taking responsibility for verifying applicant information on access to insurance, providing presumptive eligibility of applicants, and using online tools to provide information and submit applications) in capturing additional enrollees. The qualitative component of the article explains these changes, incorporating the views of policymakers and stakeholders.

Administrative Burden in Social Insurance Programs

Research by welfare scholars has built a compelling case that administrative burden affects the take-up of public programs. Relative to universal welfare programs, means-tested programs feature higher levels of burden (Korpi and Palme 1998). Compared to the near 100 percent take-up for universal programs, estimates of take-up rates by eligible beneficiaries of means-tested programs are much lower (Hernanz, Franck, and Pellizzari 2004). There is also substantial evidence from natural experiments that administrative changes that reduce or increase compliance application burden matters to program take-up in social insurance programs. This can come in the form of simplified reporting procedures and less frequent certification (Klerman and Danielson 2009), eliminating face-to-face interview requirements (Wolfe and Scrivner 2005), or allowing online applications (Schwabish 2012). Simply offering individuals help to complete forms has a large effect on applications (Schanzenbach 2009). Other changes increase

burden and reduce take-up, such as the introduction of requirements for income documentation (Brien and Swann 1999).

We consider burden in the context of social insurance programs to be composed of three components. First, and perhaps most obviously to students of administration, there is what we call compliance application burden. The research on red tape emphasizes formal rules as a source of delay and burden (Bozeman 2000). Research from street-level bureaucracy further emphasizes the potential for front-line bureaucrats to use their interpretation of rules and other forms of discretion to make the application process more or less difficult, leading to what Lipsky describes as "bureaucratic disentitlement" (1984). This mixture of formal rules and discretionary behavior creates burdens in the application and reenrollment process. But even before an application is submitted, the individual must find out about the program, determine their eligibility status, and identify what information they must provide. These learning costs provide a second component of administrative burden. Third, there are also psychological costs. Stigma costs are the self-esteem costs of receiving benefits that are associated with widely-held negative perceptions (Moffit 1983). Stigma costs may discourage some eligible participants from applying in the first place, and may be reinforced in the receipt of benefits (Soss 2005), encouraging participants to drop out.

The Case: Medicaid in Wisconsin

Medicaid offers an excellent program on which to focus, given its size and relatively low take-up rate. It provides health insurance coverage for nearly 26 percent of all children and 37 percent of all pregnant women (Kaiser Commission on Medicaid and the Uninsured 2010a). Broadly, Medicaid provides health insurance coverage for low-income pregnant women, parents,

and children, and also serves the elderly and disabled. Indeed, 65 percent of Medicaid spending is on long-term care costs for the elderly and the disabled (Kaiser Family Foundation 2013). However, the focus of this analysis is on Medicaid for low-income pregnant women, parents and children. Eligibility for the program varies considerably by state, though there are minimum eligibility standards. For example, every state must insure pregnant women up to 133% of the poverty level. And while the ACA mandated that states provide coverage for all individuals, including single adults, up to 138% of the poverty level, the Supreme Court ruled that states would not have to abide by this eligibility change (Kaiser Family Foundation 2013). Wisconsin, historically, has been among the most generous states in terms of eligibility for the Medicaid program.

The access of those with low incomes to health care via Medicaid is generally framed in terms of the eligibility levels and generosity of state policies (for exceptions, see Fossett and Thompson 2006; Stuber and Kronebusch 2004). But eligibility guidelines are not the only factors that affect access to the Medicaid program. Estimates of take-up of program benefits vary a good deal, but typically suggest that anywhere from 30-50 percent of eligible beneficiaries do not access Medicaid (Kaiser Family Foundation 2010a; Shore-Shepard 2008; Somers et al. 2012, who also discuss the methods and challenges in estimating take-up rates).

While there is a growing body of work examining how specific procedures affect enrollment, there has been little work that has closely examined how a state has systematically attempted to improve take-up of a program via a package of administrative reforms—and simultaneously measured the impact of those reforms. As we note, many of these reforms hinge upon each other, so it is a meaningful advantage to consider the reforms collectively rather than

as isolated interventions. Indeed, this systematic approach helped us to develop a schema for thinking about administrative burden, specifically the categories of burden (compliance costs, learning costs, and psychological costs) discussed above.

It is important to consider both enrollment and retention in programs such as Medicaid and similar programs, because of a phenomena known as "churning," i.e., individuals or families who enroll in a program when a specific need arises, exit when they face a redetermination, and then re-enroll at a later point. Such churning is costly to administer. It is possible that reductions in different types of administrative burdens could affect churning on contrary ways. On the one hand, easy enrollment processes might encourage participants to drop out because they do not perceive it as difficult to return to the program. On the other hand, less burdensome redetermination processes might reduce churning by reducing exits.

We narrate the evolution of administrative rules and practices during the expansion of the Medicaid program in the state of Wisconsin into BadgerCare Plus in 2008. We focus on the Wisconsin case because it has been identified as a leader in reducing administrative burden in Medicaid and, more broadly, of shifting administrative burden away from citizens and towards the state (Kaiser Commission on Medicaid and the Uninsured 2010b). The case provides insights into the way the adoption of "smart practices" can reduce administrative burden on citizens. In seeking to develop case-based insights about innovations, Barzelay (2007) recommends selecting instrumental cases—that is, cases where it is possible to relate to other comparable phenomena. The Wisconsin case fits that category, being one of 50 states dealing with Medicaid and other intergovernmental social policies. We employ a narrative explanation of the case (Kiser 1996),

focusing primarily on changes in administrative rules that made Medicaid applications more or less burdensome.

We focus on the extension of BadgerCare into BadgerCare Plus under Jim Doyle, Governor of Wisconsin from 2003-2011. BadgerCare was established under Doyle's Republican predecessor Governor Tommy Thompson, expanding access to public health insurance to the working poor using a mixture of funds from federal Medicaid and the Children's Health Insurance Program. In 2007, Wisconsin Act 20 expanded BadgerCare and consolidated it with Medicaid and Healthy Start effective February 2008, creating BadgerCare Plus.

BadgerCare Plus dramatically expanded eligibility to all children and pregnant women up to 300 percent of the federal poverty level (FPL), and all other covered groups up to 200 percent of FPL, which included a large expansion to "caretaker adults", which includes either parents or relatives of the child.[1] In addition to expansions in eligibility, however, BadgerCare Plus also led to the implementation of a range of changes to administrative procedures in the program that were intended to reduce administrative burden and increase enrollment.

Data and Methods

This is a mixed-method study. The qualitative component of the case narrates the changes in administrative burden that contributed to the increases in enrollment presented in the quantitative analyses. Qualitative data were collected from three primary sources. First, 15 interviews (in the form of transcripts and recordings) with 17 informants were provided by the authors of a prior report of the policy changes (Hynes and Oliver 2010). These interviews were completed between December 2008 and January 2009. Invitations to interview were sent to 34

people selected by DHS and project leaders, and 17 of these completed interviews. Interviewees included current and past state Department of Health Service (DHS)[2] employees who oversaw the design of the program, legislative policy staff who oversaw implementation of the programs, county income maintenance office managers who implemented changes, representatives of health care associations affected by policy changes, and leaders of advocacy groups who represented beneficiaries. Second, an additional seven in-depth interviews of nine informants were undertaken by the authors between December 2011 and March 2012. The second set of interviews included respondents who could provide additional information on efforts by the Thompson administration not covered in the Hynes and Oliver study. These interviews were recorded, with authors generating detailed notes from listening to the recordings. The authors used a snowball approach to sampling respondents, starting with contacts based on staff that had worked on the topic in the Thompson and Doyle administrations. No one we contacted declined an invitation to be interviewed, but the snowball approach may have generated some selection bias. Interviews were semi-structured, with general questions about a series of policy changes (where ideas originated, how were they motivated, patterns of implementation, attention to effects of policy changes) supplemented by follow-ups and questions tailored to the interviewee's particular role in the policy process.

A third source of information was documentation about the program. This documentation helped to establish a timeline of changes, and triangulated the interview data. We analyzed over 100 DHS operations memos from 1999 to 2012 that referred to Medicaid, BadgerCare, and BadgerCare Plus eligibility procedures; a collection of all available Medicaid, BadgerCare, and BadgerCare Plus application forms from 1999 to 2011; DHS eligibility handbooks; and DHS internal documents archived at the Wisconsin Historical Society. We also examined

informational papers on Wisconsin Medical Assistance Programs produced by the Wisconsin Legislative Fiscal Bureau, audits of Medical Assistance Programs published by the Wisconsin Legislative Audit Bureau, and external evaluations of BadgerCare and BadgerCare Plus contracted by the state. Finally, we looked at waiver requests submitted to the federal Centers for Medicare and Medicaid Services by the state and federal responses to these waiver requests. We used these documents to identify program changes that appeared to affect participants' interactions with the programs, and we noted any official reasons given for these changes. When primary sources were collected the authors created a detailed narrative of the case that followed a chronological history with detailed documentation of sources. From this document, the authors developed a more analytical theme-based summary of the case, which forms the basis of the case description in the current article. The original source document is available from the authors upon request.

The quantitative part of the analysis explicitly focuses on the impact of the reduction of administrative burden on child enrollment in Medicaid in Wisconsin. The creation of BadgerCare Plus in 2008 saw efforts to expand eligibility as well as reduce burden, but we wanted to capture the impact of changes in administrative reforms on enrollment in the program rather than changes in eligibility guidelines for the program. Consequently, we examined enrollment changes only for children below 185 percent of the poverty line, who were already eligible for the program prior to creation of BadgerCare Plus. We estimate how many additional previously income eligible children entered the program (above and beyond the number that would have entered due to changes in eligibility criteria). In short, *we separate out the effects of eligibility changes in BadgerCare Plus by focusing only on those previously eligible for BadgerCare*. For the population that was previously eligible, the level of enrollment changes

cannot be attributed to policy changes that expanded eligibility for the program. Instead, the main change they experienced is a reduction in the administrative burden in applying for benefits That said, it is possible that increases in the numbers eligible led to some additional enrollment among those already eligible. Those previously eligible may have seen those with higher incomes become eligible and thus realize their own potential eligibility. Given this requires individuals to be intimately aware of others income, however, it seems unlikely it had a major impact. The scale of the enrollment change in this population therefore allows us to infer the size of the effect of the previous level of administrative burden, as well as offer some insights into how changes in application processes reduce burden on individual applicants. In short, we conduct a simulation by comparing enrollment in the program for those below 185% of the poverty level in the years prior to the implementation of BadgerCare Plus as compared to the years following the implementation of BadgerCare Plus. The simulation models (discussed in more detail in Appendix A) control for factors such as unemployment that might confound the differences we find, and exclude the effect of the one-time auto-enrollment that took place on February 1, 2008 on enrollment increases, the effects of which are discussed below based on prior analyses of this one-time effort. The analyses presented here solely focus on the subsequent enrollment increases that were a product of the other administrative reforms.

The Results of Shifting Burden from Citizen to State

As we detail below, the host of administrative changes and reforms implemented under BadgerCare Plus, which shifted more of the administrative burden from citizens to the state, resulted in a significant enrollment increase in Medicaid in the state of Wisconsin. Table 1

summarizes the key process changes, described in greater detail below, what they did, and how they reduced administrative burden for applicants. Many of the changes align with a summary by the Kaiser Commission on Medicaid and the Uninsured (2012) of practices employed by other states that have significantly increased Medicaid enrollment rates.

Insert table 1 here

Auto-Enrollment. In the month prior to the implementation of BadgerCare Plus, DHS instituted a one-time auto-enrollment effort. The effort was not initially planned, but when gearing up for the implementation of BadgerCare Plus, DHS reviewed its own administrative files and discovered a large group of individuals – about 42,000 – who were eligible for the program. This included individuals who had been eligible for the BadgerCare, as well as individuals who would be eligible for under the new more generous eligibility guidelines established by BadgerCare Plus.

While this was the first experience of auto-enrollment in Wisconsin, it has been done in other states. Broadly, auto-enrollment is a technique that makes use of information technology and administrative data to more efficiently capture eligible beneficiaries. Auto-enrollment draws on existing administrative data to identify if individuals meet eligibility criteria for a public program, and enrolls them in that program. If appropriate, the state may undertake additional verification or eligibility, or make the individual responsible for doing so. Massachusetts used this technique to enroll a pool of uninsured individuals into a state-run insurance program. This group represented one quarter of newly-insured residents after the state passed its health insurance mandate, and was instrumental in allowing the state to claim the lowest uninsured rate in the country (Dorn, Hill and Hogan 2009).

Administrative data, therefore, can be actively used to shift the administrative burden for completing applications from the citizen to the state. With auto-enrollment, the state takes the initiative, altering the default choice for citizens toward health insurance coverage, rather than non-coverage. In non-health related programs and in the private sector, auto-enrollment has been found to effectively reduce application burden and increase enrollment (Remler and Glied 2003). This finding has been extensively documented at firms where new workers establish retirement accounts – when the default is enrollment, participation is substantially higher (Choi et al. 2004). Individuals can always opt-out of a program, and some may be enrolled inappropriately (as the administrative data used to enroll them may be out of date). But for a great many citizens auto-enrollment will eliminate the problem of under-enrollment due to doubts about eligibility or the difficult application processes.

The one-time auto-enrollment took place on February 1, 2008. The state applied new eligibility criteria to individuals who were in the state's administrative database, some of whom were previously ineligible (the vast majority of whom were family members of enrollees; see DeLeire et al. 2012). Essentially, the state decided to enroll all citizens if it had credible information about their eligibility. This conversion included anyone who had at least one family member already enrolled in state health programs and anyone who had had a case closed 30 days before the implementation (DeLeire and Friedsam 2010). Individuals were automatically enrolled in BadgerCare Plus, and case-workers followed up with verification notices if needed. A total of 44,264 individuals were enrolled as a result of this one time auto-enrollment (Deleire and Friedsam 2010).

To give a sense of the size of these effects, it is worth noting that almost three-quarters of those auto-enrolled had incomes under 150 percent of the federal poverty level, and therefore

were income-eligible before the changes (DeLeire et al. 2012). Auto-enrollees looked similar to non-auto-enrollees in terms of income. Further, auto-enrolled individuals in the BadgerCare Plus Standard Plan, the plan available for lower-income people who are not required to pay premiums, exited the program at about the same rates over the next 15 months as those who were not auto-enrolled. This "strongly suggests that auto-enrolled populations may need and value public coverage to the same degree as other enrollees" (DeLeire et al. 2012, 5).

The remainder of this section narrates other changes in administrative burden that took place and attempts to estimate the overall size of these effects on enrollment in addition to the auto-enrollment effects.

Shifting Insurance/ID Verification Checks to the State. One concern regarding BadgerCare, which was implemented in 1999 to provide health insurance coverage for the working poor, was that the state might "crowd-out" private insurance by enrolling families that had access to employer-sponsored health insurance. As we detail below, administrative procedures instituted to address this concern in 2005 substantially increased burden on applicants and beneficiaries and led to large declines in enrollment. Consequently, with the implementation of BadgerCare Plus in February 2008, the state assumed responsibility for verifying applicant access to affordable employer-sponsored health insurance. DHS developed a new database that tracked which employers offered insurance, which employees were eligible for the employer-sponsored insurance, and what percentage of the premium the employer paid.

The issue of employment verification is insightful because it illustrates how administrative burdens placed on applicants hinder access, while the state bearing this burden increases access. After May 2004, BadgerCare applicants were newly required to verify income

and health insurance status before they enrolled and again at every renewal (or when their employment changed). Each applicant's family member had to provide verification of income and health insurance status. DHS created two new forms, the Employer Verification of Earnings form and the Employer Verification of Health Insurance form, which were mailed to applicants. Applicants were responsible for having their employer complete the forms and for mailing them to a central processing center. They also had the option of verifying income information through pay stubs or a letter from the employer. The application or renewal was denied if the verifications were not completed.

These employment verification procedures had a profoundly negative effect on enrollment. Before implementation, DHS estimated that the new verification requirement would reduce enrollment by two to three percent, and state officials "thought it was just an innocuous change," according to a stakeholder. After the new requirements were put in place, enrollment dropped dramatically. Between June 2004 and June 2005, enrollment of children dropped 20 percent and enrollment of parents fell 17.6 percent. This episode occurred in a relatively short time period, when there were not other significant changes, and so it is reasonable to accept that these unusually high enrollment declines are largely attributable to the new verification requirement.

There is also evidence to suggest that the new requirement generally affected eligible claimants, rather than serving to weed out truly ineligible claimants. DHS surveyed BadgerCare applicants who were denied and recipients whose eligibility had been terminated to evaluate why verification materials were not returned. This evaluation found that procedural ineligibility was far more often due to failure to verify health insurance status than failure to verify earnings and

that the main reasons for failure to return the verification included insufficient time, misunderstandings about the instructions and process by both applicants and employers, and employers' inability to complete the form in a timely manner (DHS 2006). It is possible that some enrollees, who received many notices not directly relevant to them, simply ignored the new requirements. Even clients who understood the change may have been embarrassed to approach their employer to allow them to seek public benefits, and sought to avoid stigma costs. Employers also had little incentive to complete forms.

In response, DHS first sought to simplify the form, adding instructions, revising questions, and clarifying when and how the form would be accepted. DHS also began accepting verification materials from employers via fax, and, when working with eligibility workers, it began emphasizing the policy to accept alternate forms of verification (such as paystubs). But enrollment problems remained. Next, the state sought to shift the burden of form completion to employers, who had to complete verification forms or face a fine (DHFS 2006). But insurance verification forms continued to be completed at low rates.

Ultimately, the implementation of BadgerCare Plus in 2008 fully shifted the burden associated with earnings and employment verification from the applicants and beneficiaries to the state. The new database eliminated the need for paper verification forms that had placed significant burden on the applicant and had caused large decreases in enrollment.

This process illustrates the general desire on the part of the Doyle administration to reduce administrative burden on applicants. Interestingly, this experience informed not just how the DHS approached employer verification with BadgerCare Plus, but also how it responded to a 2005 federal mandate to verify the citizenship of beneficiaries. DHS worked to ensure that this

did not become a significant burden on applicants by taking responsibility for verifying citizenship. DHS instructed workers to use matches with administrative databases to reduce the number of clients that had to provide paper verification of their citizenship and identity. When documentation was needed, DHS gave clients 30 days, or more if they were seen as making good faith efforts to retrieve documents. Operations memos also instructed case-workers to assist clients with obtaining documentation if help was requested.

Program and Form Simplification. Other states have increased enrollment by integrating Medicaid and the Children's Health Insurance Program (Kaiser Commission on Medicaid and the Uninsured 2012). This was a central goal of BadgerCare Plus. BadgerCare Plus incorporated many different Family Medicaid programs under one program name with one set of rules, making it easier for people to understand if they were eligible and reducing the need to apply for multiple programs with multiple sets of documentation.

Many of the changes in eligibility rules were intended to simplify the program and make it more consistent and easier to understand. As the result of decades of adding programs on top of one another – from Aid to Families with Dependent Children to Medicaid to Healthy Start to BadgerCare – "we had this very organic, but very disorganized, chaotic system" according to one state employee, while another noted that "we were conscious that the system that had evolved had complexity in it which we wanted to streamline. We weren't deliberately trying to make the system difficult, but as you build system and add pieces, that happens." Each program had different eligibility criteria, so members of the same family were often subjected to different rules. "We literally had at least three sets of rules," said DHS staff, "and even in those three rules, there with little exceptions for different groups. Like different [income] definitions."

Another noted: “Before we did BadgerCare Plus, a family could be on Medicaid and BadgerCare and different members of the family were subject to different eligibility, different criteria, different benefit packages. So under BadgerCare Plus, we were trying to simplify that.”

Program simplification made the application process easier in tangible ways. The “Wisconsin Family Medicaid, BadgerCare and Family Planning Waiver Program Application and Review Packet” became the “BadgerCare+ Application Packet.” This meant that individuals could fill out just one form to apply for multiple programs. The application did become somewhat longer, but was made user-friendly with larger font, clearer formatting, and more space for applicants’ responses. Several groups of questions that were only relevant for some applicants – such as questions about employment, pregnancy, and absent parents – were moved out of the basic form and into attachments at the end of the packet. The state later added information and attachments to the BadgerCare Plus form to allow users to also apply for food stamps and Medicare Premium Assistance.

The unification also allowed DHS to simplify its communications with beneficiaries. For example, rather than informing enrollees when their cases switched one funding source to another, such as Healthy Start, Family Medicaid, or BadgerCare, the department tried to provide only relevant information to enrollees. “We were working on notices at the time and we realized we were telling them things that didn’t matter to them,” said a DHS manager, “So we decided to take all of that stuff and sweep it behind a curtain and say we have one program, BadgerCare Plus.” By simplifying the rules and explanations, DHS made BadgerCare Plus easier for applicants and enrollees to understand.

Marketing and "All-Kids" Branding. By putting the many state medical assistance programs and funding sources under the umbrella of a single program with one name, the state was also able to streamline the marketing message. This mattered in two ways. First, it communicated broad eligibility for the program. Second, the marketing moved the framing of the program further away from classic and negative conceptions of welfare for the poor and toward a broadly accessible health-insurance program, thereby reducing stigma costs for participation.

Governor Thompson had arguably started this shift by framing the original and smaller BadgerCare program as a reward for working, rather than a welfare benefit. He had been a leader in the movement to tie welfare benefits to work, having passed a version of welfare reform prior to national reform, with a guiding emphasis on "making work pay." Governor Thompson saw health insurance as a support for families as they entered the workforce, and a basic matter of fairness (Bartels and Boroniec 1998). One state official noted: "They wanted it not to be an entitlement. They wanted it more like an employer plan, and they really wanted to cover families."

Governor Doyle took it further both in terms of the scope of the program and its messaging. Medicaid now fell under the BadgerCare brand, which was presented as a free-standing program. Wisconsin's framing of the message of "all kids" further communicated that this was a broad benefit, not just for the poor. One parent in a suburban school district said, "I've always been under the impression that it was for a certain income group. When I was newly divorced and I had my son, and even then when I was not making much money, I was still under the impression that I had to be receiving some other state benefit. Which may not be the case, but it was at the time what I was thinking" (Wisconsin Council on Children and Families 2010, 14).

This marketing may have therefore created a "welcome mat" effect by expanding applicant understanding of eligibility, and reducing stigma costs that have limited take-up of Medicaid (Stuber and Kronebusch 2006).

Presumptive Eligibility. BadgerCare Plus expanded "express enrollment" (also known as presumptive eligibility) to children below 150 percent of FPL and pregnant women below 300 percent of FPL. Presumptive eligibility provides immediate access to Medicaid to those deemed eligible by qualified enrollment organizations (i.e. DHS, medical providers). This ensures that individuals have immediate access to health care. These beneficiaries then receive assistance from the state to finish the application process in the month following enrollment.

Online Access. Prior to the passage of BadgerCare Plus the state sought to significantly streamline the application process via a new website named ACCESS. Launched in 2004, the website included information about food stamps, Medicaid, and BadgerCare in English and Spanish. While implemented prior to BadgerCare Plus, it served to reduce information and search processes for previously eligible individuals who may have elected to apply when BadgerCare Plus was introduced.

An innovative aspect of ACCESS is that it allowed potential applicants to do a preliminary check of their eligibility. After users entered information about their household, income, and expenses, the electronic screener informed them about health and nutrition programs for which the household appeared to qualify as well as information on how to apply for these programs. In an operations memo, DHS wrote that the screener tool would give applicants greater confidence of their eligibility: "They may choose not to apply because of incorrect assumptions about their potential level of benefits or specific policies –such as the vehicle asset

rule – that have changed over time. Many people believe the application process would involve too much time and effort unless they feel reasonably confident that they will be eligible for benefits."

The second phase of ACCESS implementation started in September 2005, with the launch of the "check my benefits" feature. This function allowed users to find the date their benefits began; the date of their next review; information on cost-sharing; reasons for denials of benefits; items needed by their caseworker, such as verification documents; contact information for their case worker; the address and phone number on file for the user; a history of changes in benefits; and answers to frequently asked questions. "Check my benefits" supplemented, but did not replace, notices and other communication with caseworkers.

In June 2006, applicants started to be able to fill out an application online for food stamps and BadgerCare. The online application could also be combined with a phone interview with an eligibility worker to complete the application. Like the mail-in application, the online application required clients to send in verification before they could be deemed eligible. ACCESS provided a list of the items needed based on the applicant's answers and instructed applicants to mail or bring the items to their local income maintenance office. Case-workers mailed a follow-up verification checklist for missing items. If the applicant completed the online form correctly, an applicant could complete the entire application process for BadgerCare without ever speaking to an eligibility worker. An eligibility worker would call to request more information when there were inconsistencies in the application.

Over time, DHS sought to make the ACCESS website more user-friendly, simplifying the language in the online screener and application to a fourth grade reading level. Operations

memos record that the DHS also conducted 25 focus groups with eligibility workers, supervisors, service providers, and low-income residents to survey what type of questions recipients had about their benefits and to make the design of the feature as user-friendly as possible. ACCESS also became a mechanism by which participants could report changes that had material relevance to their benefits, including employment status, contact information, or change in family status.

By 2010, the online system had become the most popular method of applying for the program. Walk-in applications make up just 20 percent of applications in rural areas and 14 percent in urban counties (DeLeire and Friedsam 2010). ACCESS clearly eased the application process. While it likely contributed to a longer-term trend of greater enrollment, it is worth noting that ACCESS changed little during the implementation of BadgerCare Plus, and so we are cautious about directly attributing any notable effect on enrollment numbers for this period. But it may have mattered by facilitating the outreach efforts described below. One eligibility worker described the process, "Now, it's much faster – I'm doing 3-4 applications a week. I use the application so much now that I can kick out an application in 15 minutes versus somebody doing it on their own it could take them an hour. In the beginning it was more like 30-50 minutes. It's much less time than it was before BadgerCare Plus which I attribute to the online ACCESS program. It's so convenient and it doesn't matter where you're at…So tonight when I leave here, I'm taking my printer, copier and scanner- I'm going tonight to meet with a pregnant woman and I'll be able to give her the application and do her express enrollment all at once with her" (Hynes and Oliver 2010, 17).

Boots on the Ground: Community Outreach and Enrollment. The lessons of community outreach from BadgerCare Plus emphasize the importance of utilizing a diverse mix of on-the-

ground actors who have robust incentives to enroll participants, while still providing strong oversight by the state. In Wisconsin, the state contracted out with county Income Maintenance or Tribal Offices to process Medicaid enrollment forms and in general help individuals apply for the program. These offices largely processed these applications through the ACCESS system, easing the administrative process. By and large the collaboration has been successful, but the state also kept a tight reign on these agencies. Indeed, in 2010 the state actually took over the processing of Medicaid applications in Milwaukee county after it found that county offices were not processing applications in a timely manner, had high eligibility error rates, and were only answering 5 percent of calls coming in to their help center.

While income maintenance offices continued to play a central role, a major shift as a result of BadgerCare Plus was broadening the number of agencies on the ground to help people apply for the program, and even allowing them to do presumptive enrollment. Indeed, states that have increased enrollment of Medicaid beneficiaries engaged in active outreach with partners in the non-profit and health-care community (Kaiser Commission on Medicaid and the Uninsured 2012). Outreach matters in three ways. First, if done well, it targets non-profits and health care providers who are known and trusted by the target population and can reach this population. Second, these actors can provide information to beneficiaries, helping to overcome the lack of knowledge that many claimants have about eligibility, reducing information costs. Finally, most Medicaid-eligible individuals prefer in-person applications (Robert Wood Johnson Foundation 2011), and the ability of outreach efforts to directly provide a helping hand to individuals completing application form can greatly impact form completion rates (Schanzenbach 2009). Such changes most clearly reduce the information and learning costs applicants face and the application compliance burden. We might also speculate that they reduce stigma costs. Outreach

workers are more likely to be recognized as an advocate for the individual, and applicants are likely to encounter peers also seeking to receive benefits.

Wisconsin had a long tradition of engaging in active community outreach to increase enrollment, dating back to the implementation of BadgerCare under Governor Thompson. The Robert Wood Johnson Foundation's "Covering Kids Expansion" project in Wisconsin, supplemented by additional funding from DHS, worked with community organizations, health care providers, and translators. Taken together, these outreach efforts trained hundreds of workers from schools, public health agencies, dental providers, utility companies, legal service agencies, food pantries, and homeless shelters in BadgerCare and Medicaid eligibility (Swart, Troia and Ellegard 2004).

The implementation of BadgerCare Plus built on this tradition of outreach. The state relied heavily on community-based organizations to assist enrollment efforts. In these strategic partnerships, the DHS provided community organizations monetary incentives and training, as well as bilingual and culturally specific marketing materials. DHS encouraged cooperation by offering a $50 "finder's fee" for organizations and providers for every person they enrolled in BadgerCare Plus. In addition, it awarded "mini-grants" of up to $25,000 to 32 organizations to help finance locally based outreach efforts. Approximately 3,000 people from almost 200 community organizations and health care providers were trained by state officials to help to provide outreach about the new program and express-enroll eligible individuals (Center for Healthcare Research and Transformation 2011; Hynes and Oliver 2010). These included community groups likely to have direct interaction with eligible applicants, such as groups providing Head Start, and Women, Infant and Children programs, as well as community health

clinics, schools, and faith-based groups. These partnerships with community groups reflect DHS's broader efforts to use local partners to locate and help solve problems.

Both the mini-grants and the training appear to have contributed to high levels of enrollment in BadgerCare Plus. The mini-grant funds allowed county eligibility workers to accommodate the large number of applicants received after the transition to BadgerCare Plus. One said, "The mini-grants were really effective. We're getting referrals from everywhere and if we didn't have that mini-grant, I don't know how much time we would be able to allow or allot for that. But because of that funding, we are doing as much as we can as soon as we can based on the needs of the community" (Hynes and Oliver 2010, 27). Another county eligibility expert said of the community partnerships, "I would say that media attention has been good but I don't think that's the most significant factor, I think it's the involvement of so many external partners that has generated a level of buzz that is unprecedented."

Community groups involved in outreach efforts not only were able to help people apply for BadgerCare Plus, but also had the opportunity to improve their own knowledge about the program more generally, allowing them to advocate more effectively for their clients. One county eligibility expert said, "I think the democratization of that process has been a good thing. It has really opened up the process for advocates to know what is really going on in the formal eligibility process and before."

The Effects of Reductions in Burden on Previously Eligible Applicants

What was the cumulative impact of these changes in administrative procedures on enrollment, which came about with the implementation of BadgerCare Plus in 2008? The enrollment analyses detailed below *do not* include those who were enrolled via the one time auto-enrollment on February 1, 2008. But even excluding this group, Figure 1 demonstrates that there was a substantial gross increase in new enrollment of children with incomes below 185 percent of FPL (these are the individuals who were already eligible for BadgerCare) in the months following the implementation of the new BadgerCare Plus program. Basic descriptive statistics, based on Figure 1, demonstrate with a basic fitted model that there were approximately 2300 additional enrollees per month after the implementation of BadgerCare Plus. However, after controlling for a range of differences (such as state unemployment rates and changes in the poverty rate), we estimate an additional 1,371 child enrollees per month from March 2008 through November 2009, when BadgerCare Plus was implemented, as compared to typical enrollment in BadgerCare in years prior. To help ensure that these increases reflect the impact of administrative changes rather than other factors, these numbers are adjusted to account for seasonal effects, for changes in the state unemployment rate and percent of families above/below 185% of the poverty level, and for individual characteristics: whether English is spoken at home, whether there are other children in the household, and residency in an urban area (see Appendix 1 for more detail on the specification of the model and detailed regression analyses).

Insert Figure 1 here

We noted earlier the potential for reductions in administrative burden to alter the churning on and off the program in different ways. The BadgerCare Plus program reduced

churning partly by increasing eligibility, shrinking the proportion of cases where individuals would be forced to exit the program because of marginal changes in income. It is possible that by reducing administration burdens in enrollment, the program made the decision to exit appear less costly. But if such an affect exists, it was more than offset in the Wisconsin case by reductions in burden in redetermination processes, including extended periods before redetermination of status had to be made. Indeed, previously published analyses focused on children below 100 percent of the poverty level (i.e. those not affected by changes in eligibility) found a net reduction of disenrollment by 35 percent under BadgerCare Plus (Leininger et al. 2011b).

Discussion

Wisconsin's implementation of BadgerCare Plus in 2008 was the culmination of a steady pattern of innovations that used state action to reduce learning and stigma costs, and take on more of the eligibility, enrollment, and verification responsibilities. The size of jumps in enrollments with BadgerCare Plus is all the more striking because both Governor Doyle and his Republican predecessor consistently worked to reduce burden on applicants, meaning that, historically, Wisconsin is a state with relatively low burden for applicants.

The policies discussed here were adopted or expanded when BadgerCare Plus was put in place, with the exception of on-line access, which underwent constant improvements since its inception in 2004. While we can separate the effect of the one time auto-enrollment conducted on February 1, 2008, we cannot separate how each of the other specific changes in administrative burden affected the enrollment of beneficiaries in the immediate months following

implementation. We are able only to demonstrate the total effect of these additional administrative changes.

But our primary purpose here is to offer evidence that burden did matter to enrollment, and that relatively simple administrative changes can reduce burden, resulting in positive and substantive increases on enrollment. An obvious goal for future research would be to separate the relative effects of different reductions in administration burden. One insight from our case study is that there are likely interactive effects between different forms of reduction of burden. For example, the potential of outreach becomes much greater if it is combined with an express-enrollment capability that allows third-parties to actively enroll individuals rather than simply inform them of their eligibility, or online-application processes that allow outreach workers to enroll individuals outside of traditional settings. In addition, program simplification around the brand of BadgerCare not only lessened burden by reducing the number of forms an applicant had to complete, but by facilitating marketing and outreach efforts around a single easily-identified program.

The concept of administrative burden and the research presented here points to a rich potential research agenda. One question is the degree to which burden reflects a deliberate political choice (Moynihan and Herd 2010). While the case shows a growing awareness of the impacts of burden among state officials, the topic of administrative burden is not one frequently addressed by elected officials, at least in the area of social policy. To better understand the use of burden as a policy tool requires an ability to examine how the political intent behind a program or how the broader political philosophy of elected officials is reflected in adjustments to policies and rules expected to affect burden. It also incorporates an understanding of the incentives and

goals of policy stakeholders. For example, if hospitals receive federal funds, they are required to provide care for individuals even if they cannot pay. This creates an incentive for hospitals to support Medicaid reforms that raise enrollment by expanding eligibility and reducing burdens, thereby reducing charitable care. This incentive is also reflected in implementation, where hospitals actively seek to enroll patients at the point of service, taking advantage of policies, such as express enrollment, allowing them to receive payment for care for which they would not otherwise be reimbursed.

Any discussion of the politics of administrative burden in an intergovernmental program such as Medicaid must also consider the role of the federal government (Thompson 2012). In the Wisconsin case, the creation and expansion of BadgerCare occurred under federal waivers from standard rules. Federal regulators pushed Governor Thompson to reduce burden with the creation of BadgerCare and were largely supportive of Governor Doyle's reforms. Indeed, aspects of the Wisconsin plan are mirrored in policy changes that took place at the federal level at the end of the Doyle administration. The 2009 Children's Health Insurance Program Reauthorization Act offered performance bonuses to states that modified administrative procedures to reduce burden and increase enrollment. Many of the criteria for bonuses were ones already employed in Wisconsin, including continuous 12-month eligibility for children, liberalization of asset requirements, having the same application for Medicaid and the Children's Health Insurance Program, elimination of in-person interviews, presumptive eligibility for children, and express eligibility. The Act also encouraged auto-enrollment, rewarding states that used data from other programs (such as tax data, or school lunch programs) to enroll individuals.

Over the coming years it will also be critical to consider the role of private actors, specifically managed care, in enrollment in Medicaid (Thompson 2012). Around 64 percent of Medicaid recipients in Wisconsin are enrolled in a managed care plan, though this is lower than the national average (CMS 2012). What are the implications? There is evidence that high managed care penetration is correlated with higher take-up, possibly because states attempt to expand eligibility and increase enrollment utilize managed care to control costs (Sommers et al. 2012). In theory, their close contact with recipients could provide contractors with a unique opportunity to facilitate both enrollment and re-enrollment in the program. But there is a fundamental incentive problem with involving these organizations in facilitating take-up. In short, because managed care companies receive a capitated payment for each beneficiary, they have very strong incentives to only enroll the healthiest beneficiaries. Indeed, this is a central problem with managed care organizations participating in Medicare Advantage (Herd 2005). Consequently, most states, including Wisconsin, severely limit the ability of these organizations to advertise or participate in processes that advertise enrollment (Center for Health Care Strategies 2011).

With the 2010 ACA, the federal government created a policy environment that makes the lessons learned in Wisconsin regarding administrative burden critically important if the legislation is to achieve its central goal: reducing the number of uninsured. One major challenge the ACA implementation will face is the number of individuals who fall on the cusp of eligibility for Medicaid versus receiving subsidies to buy private insurance in health insurance exchanges. To the extent that individuals have to shift back and forth between these programs will pose a significant risk to experience administrative burdens, and therefore fail to take-up benefits.

There are provisions in the ACA, however, that likely reflect some of the administrative innovations implemented in Wisconsin. States will be required to simplify how income is counted to determine Medicaid eligibility. States must also generate a universal application to apply for Medicaid, the State Children's Health Insurance Program (what is essentially Medicaid for children who qualify at higher income levels), and for the subsidies to buy private health insurance in the exchanges. Individuals must also be allowed to apply online, by telephone, fax, mail and in person. Finally, states must eliminate in-person interviews, utilize administrative records, where possible, to verify eligibility, and provide application assistance.

More broadly, the ACA prohibited states from making Medicaid eligibility standards, methodologies, or procedures more restrictive at the risk of losing federal matching funds until 2014 for adults and 2019 for children. This restriction effectively blocked Governor Doyle's successor, Republican Scott Walker, from using administrative burdens to reduce the scope of BadgerCare. Walker proposed a federal waiver that would have removed presumptive eligibility for children, redefined household income to include all adults, and required verification of residency status. These provisions were rejected by the Obama administration, but other changes were allowed, such as income scaled premiums for adults with income above 133% of the poverty level and $60 processing fee for reenrollment. Evidence suggests that cost sharing leads to large reductions in Medicaid take-up among individuals with low incomes (Wright et al. 2005). However, the Supreme Court decision on the National Federal of Independent Businesses vs. Sibelius case returned to Walker substantial discretion in eligibility issues in implementing the ACA. At the time of writing, the state passed a 2013-15 budget which reduced maximum income eligibility levels for BadgerCare Plus to 100 percent of the poverty level for parents (approximately 88,500 parents would lose coverage) and would not expand the Medicaid

program to cover childless adults above 100 percent of the poverty level. While Wisconsin had been an exemplar in expanding health insurance coverage for the time period discussed, in the future it seems set to offer much more limited options to publicly-funded health insurance.

Conclusion

The implementation of BadgerCare Plus topped a series of changes over the preceding 15 years that not only expanded the pool of Medicaid beneficiaries via more generous eligibility guidelines, but also reduced administrative burdens. Successive administrations did so by creating a unified and simplified program that was targeted at "all kids" rather than a complex array of programs that elicited considerable confusion on the part of potential enrollees; auto-enrolling eligible citizens; allowing express-enrollment of presumptively eligible enrollees; training and incentivizing community partners to inform and enroll applicants via outreach, thus providing considerable one-on-one assistance to applicants; streamlining the application process with online tools; and, moving the responsibility for primary verification of employer insurance and citizenship to the state using databases. All of these changes required more work on the part of the state, but led to reduced administrative burden for applicants and beneficiaries.

The Wisconsin case shows not only that administrative burdens matter to take-up, but that there are a variety of ways the state can actually reduce this burden on citizens to enroll more citizens, including auto-enrollment, simpler forms, online information and application systems, and better outreach. In sum, if states want to maximize enrollment, they need to find way to take on the majority of the burden associated with determining who is eligible and the actual enrollment procedures.

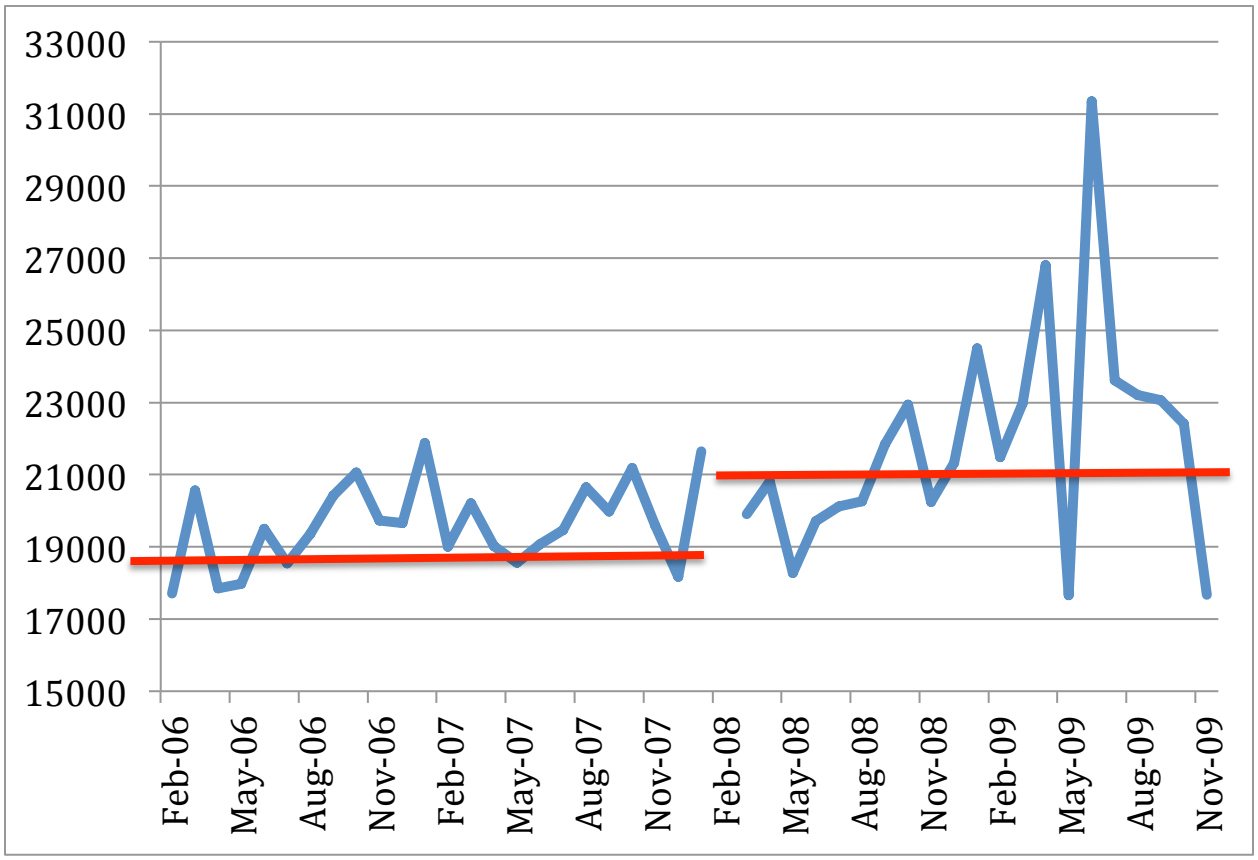
Endnotes

1. Other covered groups include farm families and families of other self-employed workers and families whose children are in foster care. It did not include single childless adults who are key beneficiaries of the ACA.
2. The DHS was formerly part of the Department of Health and Family Services, which was split into two agencies during the Doyle administration. For the sake of simplicity, we use only the acronym DHS, though in some cases we are referring to the former Department.

Table 1: Reductions in Administrative Burden with BadgerCare Plus		
Process change	What it did	How it helped
Auto-enrollment	State automatically enrolled individuals it could determine were eligible based on state administrative data (one time)	Eliminated information and learning costs and application compliance burden
Employer Verification	State, rather than applicant or employer, took responsibility for verifying that applicants did not have access to employer-provided insurance	Eliminated one aspect of application compliance burden
Program and Form Simplification	Allowed the use of a single, simpler form for multiple programs, reduced confusion about program eligibility	Reduced information and learning costs; reduced application compliance burden
Marketing and Branding	Facilitated use of simple "all kids" message, reducing stigma costs	Reduced information and learning costs; reduced stigma costs
Presumptive Eligibility	Allowed individuals to be enrolled pending additional verification, facilitated the use of third parties including health care workers to enroll	Reduced application compliance burden
Online Access*	Made it easier for potential applicants to determine whether they were likely to be eligible, and what eligibility information they needed to provide; made it easier for outreach workers to enroll; facilitated the ability of individuals to apply for multiple programs.	Reduced information and learning costs; reduced application compliance burden
Community Outreach	Community partners could provide information on the new program to eligible population, aid completion of applications, and enroll participants	Reduced information and learning costs; reduced application compliance burden, and possibly reduced stigma costs

* occurred prior to the implementation of BadgerCare Plus

Figure 1. Unadjusted Increase in Previously Eligible New Child Enrollees after the Implementation of BadgerCare Plus*



*The red line is based on fitted estimates.

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Appendix A: Estimating the effects of administrative simplification on child enrollment

To estimate the effect of administrative simplification (other than autoenrollment) on the number of entrants into the program we employ administrative data from the state of Wisconsin's CARES eligibility and enrollment system that covers the period from February 2006 though November of 2009. These data include family income, date of enrollment, category of eligibility (i.e. pregnant women, child), number of children in the household, English language first language spoken in the household, and whether or not participants live in a metro area. We also collected state level monthly unemployment data for the period covered by the data. As we noted, we do not include the effects of the onetime auto-enrollment in February of 2008. This was possible because the administrative data accounts for whether individuals were enrolled under this onetime auto-enrollment.

To generate the enrollment increase estimate, we performed a simulation by focusing on enrollment before and after the implementation of BadgerCare Plus. We focus on children below 185% of the poverty line because this group was eligible for both BadgerCare and BadgerCare Plus. Additional enrollment from this group after the implementation of BadgerCare Plus, thus, cannot be a function of changes in eligibility, but is likely instead a function of changes in administrative procedures. We then accounted for a range of other factors that could account for pre and post differences in enrollment including state level unemployment data (unemployment levels are strongly correlated with enrollment) and changes in the percent of families above/below 185% of the poverty line, in addition to individual level factors such as whether individuals lived in a metro area, whether there is more than one child in the household, and whether English is the primary language spoken in the household. All of these individual level factors are positively correlated with enrollment in Medicaid.

Thus, we estimate the following model:

$$new\_child_j = \beta_0 + \sum_{k=1}^{12} \beta_k m_k + \gamma U_j + \lambda Post_j + \varepsilon_j ,$$

where:

new_child_j is the number of child enrollees into BC+;

m_j is a categorical variable indicating the first month of enrollment; and

U_j is the state unemployment rate in month j; and

$Post_j$ is an indicator for whether the month is March 2008 or after (the post-reform period). The model also accounts for monthly changes in the percent of individuals above/both 185% of the poverty line and individual level factors including whether English was spoke at home, whether there was only one child in the household, and whether or not they lived in a metro area. The coefficient on Post indicates by how much new monthly child enrollment increased in the post-reform period.

Table A1 presents the detailed results from the regression analysis. Even after controlling for individual level factors and state level factors including changes in the state unemployment rate and the percent of families above/below 185% of the poverty line, the number of individual children enrolled in BadgerCare Plus remains statistically significant with an estimated additional 1371 enrollees per month.

Table A1.

Estimated increase in child new enrollment due to the administrative simplification

	(1)	(2)	(3)	(4)	(5)
Post-simplification period	1315.15	1298.82	1279.52	1356.24	1371.17
	(269.91)**	(297.59)**	(304.95)**	(370.22)**	(367.19)**
Unemployment Rate	224.07	231.06	239.15	239.33	234.08
	(87.77)*	(107.52)*	(109.69)*	(110.09)*	(111.05)*
Income > 185% Federal Poverty Level	-19700.00	-19740.38	-19546.47	-19648.06	-19531.14
	(331.00)**	(319.30)**	(419.51)**	(568.13)**	(595.55)**
February		-1403.32	-1429.74	-1409.95	-1401.82
		(584.89)*	(592.29)*	(597.41)*	(601.63)*
March		-719.40	-738.53	-719.04	-709.71
		(610.11)	(610.66)	(621.09)	(622.60)
April		-571.38	-565.27	-590.45	-613.07
		(866.26)	(875.20)	(878.94)	(890.20)
May		-2256.21	-2270.76	-2257.17	-2332.79
		(829.56)**	(827.43)**	(848.69)**	(848.46)**
June		-27.06	-22.63	1.98	18.66
		(1373.47)	(1383.49)	(1425.04)	(1440.97)
July		-1077.34	-1120.21	-1140.06	-1127.51
		(590.61)	(598.21)	(597.17)	(600.99)
August		-1139.96	-1130.61	-1110.97	-1089.51
		(552.23)*	(553.35)*	(555.20)*	(560.84)
September		-917.41	-939.26	-962.45	-1009.31
		(522.65)	(530.04)	(546.45)	(553.70)
October		-599.59	-623.70	-612.81	-600.44
		(565.26)	(573.74)	(575.44)	(579.72)
November		-2013.22	-2027.79	-2034.53	-2056.61
		(734.79)**	(740.04)**	(749.43)**	(753.41)**
December		-1496.45	-1529.56	-1516.20	-1470.46
		(557.58)**	(565.29)**	(567.64)**	(578.84)*
English spoken at home			-5819.17	-6489.25	-3132.00
			(9184.44)	(9565.54)	(9368.46)
Only one child in the household				1433.47	1350.93
				(3666.24)	(3750.58)
Lives in metro area					-2593.31
					(2504.80)
Constant	18924.15	19917.79	25312.52	25469.20	23300.86
	(302.08)**	(663.14)**	(8527.78)**	(8545.10)**	(8172.25)**
Observations	90	90	90	90	90
R-squared	0.98	0.98	0.98	0.98	0.98

Robust standard errors in parentheses. * = p-value <0.05; ** = p-value < 0.01