# THE PICTURE OF HEALTH?

*Considering Medicaid Expansion in Wisconsin*

WISCONSIN POLICY FORUM

## ABOUT THE WISCONSIN POLICY FORUM

The Wisconsin Policy Forum was created on January 1, 2018, by the merger of the Milwaukee-based Public Policy Forum and the Madison-based Wisconsin Taxpayers Alliance. Throughout their lengthy histories, both organizations engaged in nonpartisan, independent research and civic education on fiscal and policy issues affecting state and local governments and school districts in Wisconsin. WPF is committed to those same activities and that spirit of nonpartisanship.

## PREFACE AND ACKNOWLEDGMENTS

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# INTRODUCTION

Wisconsin has long walked an unusual and even singular path on the issue of health care coverage. In the 1990s and 2000s, the state played a leading role in expanding public health insurance coverage to more individuals who could not otherwise afford it. The state's elected officials also protected Wisconsin's popular state Medicaid prescription drug plan at a time when other such plans around the country were being shut down in the wake of a prescription benefit being added through the federal Medicare Part D plan. In many respects, Wisconsin has been a leader among states in ensuring access to coverage for low-income and vulnerable populations.

With the passage in 2010 of the federal Affordable Care Act (ACA) and the expansion nationally of Medicaid health programs for low-income recipients, Wisconsin has fallen out of the vanguard but remained out of the ordinary. Today, Wisconsin is one of just three states outside of the South that have not fully expanded Medicaid – a source of pride for the opponents of expansion, consternation for its supporters, and perpetual conflict for both.

Given the many national developments on this issue, now is an opportune moment to revisit it in Wisconsin. With support from the American Cancer Society Cancer Action Network, The Leukemia and Lymphoma Society, Community Care Inc., Jewish Family Services, Lutheran Social Services of Wisconsin and Upper Michigan, and the Wisconsin Medical Society, we examine here the history of Medicaid in our state and the possibility of extending the health program to tens of thousands of additional recipients. Our research questions include:

- What has been the history of the Medicaid program in Wisconsin – both before and after the passage of the ACA? What are the characteristics of those already being served by the program?

- Who are the individuals who would benefit from a potential Medicaid expansion? Where do they live and what are their characteristics?

- What are the potential impacts of expansion in Wisconsin and how might they differ from other states? What would be the impact of maintaining the status quo?

- What lessons can we learn from other states and how they have expanded their programs?

- What are options for pursuing an expansion in Wisconsin, if policymakers choose to do so?

As with all our reports, in this study we neither advocate for or against expanding Medicaid. We have striven to do more than simply recapitulate the heated national debate on this topic that often fails to address the unique circumstances here in Wisconsin. Instead, we have sought to approach the topic with a steadfast focus on our state, its particular features, and its full range of stakeholders including patients, health care providers, insurers, and taxpayers. We hope that this study will serve the public and leaders from across the political spectrum as they consider how to proceed.

# HISTORY OF MEDICAID IN WISCONSIN

Wisconsin has a long history of extending state health coverage to its neediest residents and of maintaining a low uninsured rate among all its citizens. The state has done so in part by maintaining a robust private insurance market and making a series of expansions to Medicaid, its main program for insuring those with the lowest incomes as well as many of the elderly and those with disabilities. Yet despite this history, Wisconsin over the past decade has stopped short of fully expanding Medicaid through the federal Affordable Care Act.

Here, we examine the history and details of the program in Wisconsin over the years as well as the problem of the uninsured.

**What is Medicaid?**

Medicaid programs provide health coverage to low-income individuals and families as well as the elderly and disabled and are overseen by the state and federal governments. The federal government and states like Wisconsin set eligibility rules on criteria such as residency and immigration status, income, assets, family size, age, and disability status and decide on certain types of benefits and coverage levels. States can also seek waivers allowing them to depart from federal rules. In general, federal taxpayers in fiscal year 2024 will defray 60.7% of Medicaid costs in Wisconsin and state taxpayers will essentially cover the rest.

Wisconsin's Medicaid programs include BadgerCare Plus, which provides primary and acute care to individuals and families, separate long-term care programs such as nursing home and in-home care, and the SeniorCare prescription drug plan. Over time, Medicaid has largely transitioned from a model of paying fees for individual services to paying a set amount per recipient to managed care organizations, which then pay for all the annual care that the individual might receive.

## Medicaid in Wisconsin over the Decades

In 1997, the federal government approved additional funding for states to expand coverage through the Children's Health Insurance Program. In the wake of that federal legislation, lawmakers and Gov. Tommy Thompson created the BadgerCare program in 1999. Their aim was to expand coverage to more low-income residents as part of a larger effort to transition adults from traditional welfare programs into the workforce. By 2000, Wisconsin was tied with Minnesota for the second-lowest uninsured rate in the nation behind only Rhode Island, according to U.S. Census Bureau data.

The state did not stop there. In 2007, lawmakers and then Gov. Jim Doyle approved BadgerCare Plus. This expansion of the program (subject to certain other criteria such as residency) extended it to all uninsured children and pregnant women with household income up to 300% of the federal poverty level ($77,460 in 2024 for a family of three – see **Table 1**), and parents and other caretaker relatives up to 200%

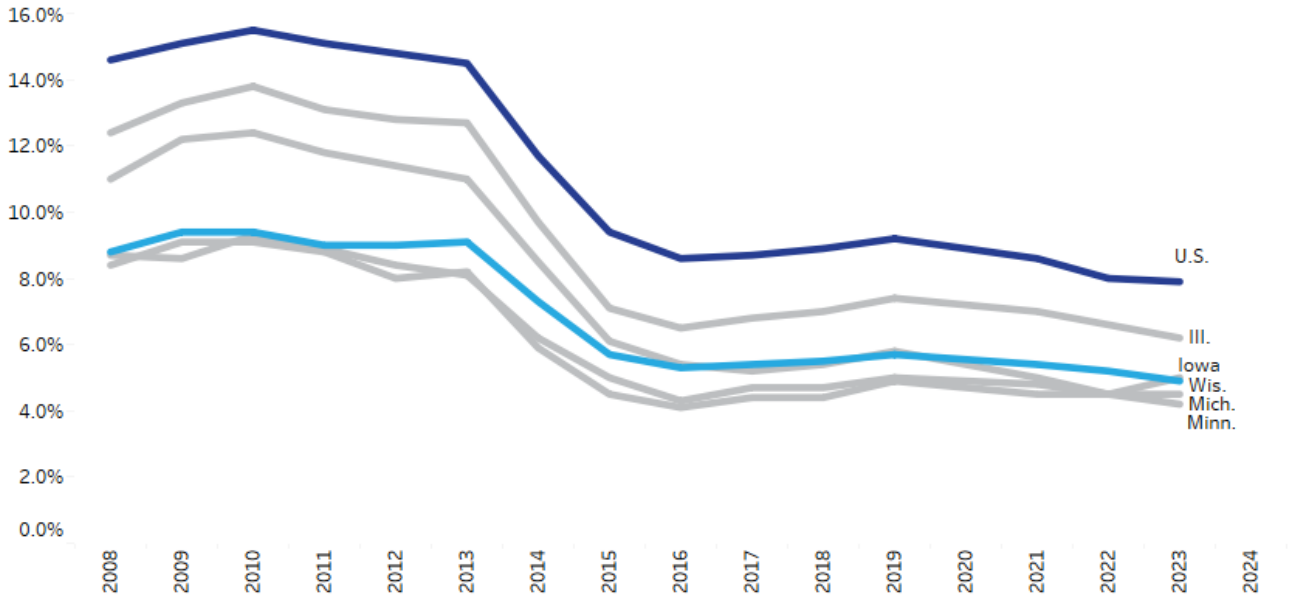
**Table 1: 2024 Federal Poverty Level Guidelines By Family Size**

| | Percent of Federal Poverty Level (FPL) | | | |
|---|---|---|---|---|
| Family Size | 100% | 138% | 200% | 300% |
| Individual | $15,060 | $20,783 | $30,120 | $45,180 |
| Family of 2 | $20,440 | $28,207 | $40,880 | $61,320 |
| Family of 3 | $25,820 | $35,632 | $51,640 | $77,460 |
| Family of 4 | $31,200 | $43,056 | $62,400 | $93,600 |
| Family of 5 | $36,580 | $50,480 | $73,160 | $109,740 |

Source: U.S. Department of Health and Human Services

**Figure 1: Even Without Medicaid Expansion, Uninsured Rate in Wisconsin Remains Relatively Low**

Uninsured rate by state and year*




Source: U.S. Census Bureau American Community Survey One-Year Estimates; *Data for 2020 is missing and has been estimated.

of the poverty level.[1] To create these successive new coverage opportunities, Wisconsin needed to receive waivers of federal rules that now must be renewed from time to time.

As of 2008, Census Bureau data show Wisconsin was tied for the fifth-lowest uninsured rate among states nationally, behind only Massachusetts (which had already passed a major health care overhaul), Hawaii, Minnesota, and Iowa.[2] This was a low rate for Wisconsin given that median household income in the state at the time was well below levels in any of the other states with low rates except Iowa.

As **Figure 1** and data from the U.S. Census Bureau show, Wisconsin's uninsured rate of 8.8% was then much lower than the national rate of 14.6% and the state was close to having one of the lowest rates among its neighbors. For more on the American Community Survey's definition of uninsured, see this Census Bureau brief. In 2009, Wisconsin also extended coverage to adults with household incomes below 200% of FPL and no dependent children (often called childless adults), but enrollment in the more limited coverage known as the Badger Care Plus Core Plan was capped, leading to thousands of people being put on a waiting list.

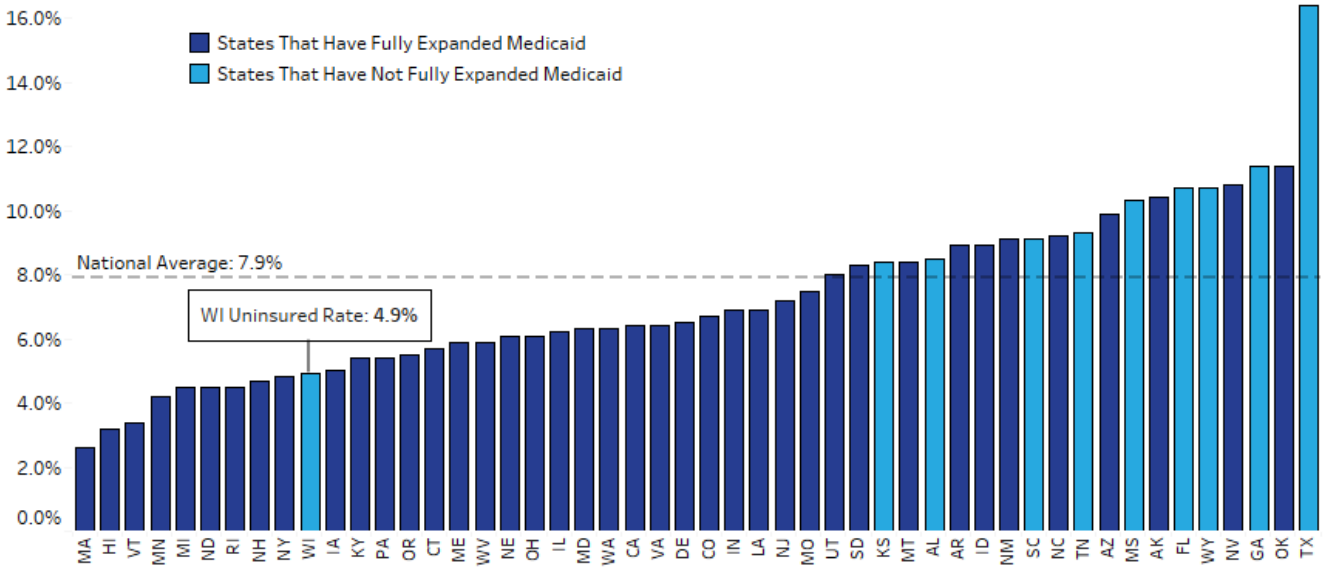
Wisconsin's historically low uninsured rate reflects a variety of factors, including relatively low unemployment and poverty rates, the mix of industries and employers in the state, and a relatively

[1] Under federal law, 6% of income for children and pregnant women in Wisconsin is also excluded from the count, setting the true eligibility limit at 306%. There are also premiums for children above 200% of FPL. Qualifying children, parents, and pregnant women who are enrolled in the program can also have their coverage extended for a period of time if their income rises above the limit for eligibility.

[2] Readers should note that the Census Bureau American Community Survey has a relatively small margin of error for Wisconsin (typically plus or minus 0.2 percentage points in each year) that would not unduly affect the gap in the uninsured rates between Wisconsin and the U.S. average. However, the margin of error could affect Wisconsin's state ranking somewhat in any given year.

**Figure 2: Wisconsin Has Lowest Uninsured Rate by Far Among Non-Expansion States**

Percent of residents without comprehensive health coverage by state at time of survey, 2023




Source: U.S. Census Bureau ACS One-Year Estimates.

strong health care and insurance market and overall social safety net. Yet a major reason was the Medicaid expansions undertaken by the state in 1999 and 2007, which leveraged opportunities under federal programs to extend coverage to more individuals.

Since then, Wisconsin has drawn in part on federal programs to lower its uninsured rate to 4.9% in 2023 but has done so less aggressively than most states. As the chart shows, the gap between Wisconsin's uninsured rate and the national average of 7.9% has narrowed from 5.8 percentage points in 2008 to 3.0 points in 2023. In other words, Wisconsin's uninsured rate was 39.7% below the national average in 2008 but 38.0% lower in 2023. Still, the number of uninsured individuals in Wisconsin fell from 489,000 in 2008 to 284,000 in 2023, Census figures show.

As **Figure 2** shows, Wisconsin's uninsured rate was tenth-lowest in the nation in 2023. That ranking is somewhat worse than in 2008 but still quite positive overall, particularly given Wisconsin is one of just a few states that have not fully expanded Medicaid, as we will see in the next section. All of the other non-expansion states have far higher uninsured rates than Wisconsin and higher rates than the national average as well.

## Wisconsin and the Run-up to the Affordable Care Act

A major reason for the narrowing lead in Wisconsin's uninsured rate relative to the nation's was the decision in this state not to fully embrace a Medicaid expansion as authorized by the federal Affordable Care Act (ACA). With the passage of the ACA in 2010 and a major U.S. Supreme Court decision in 2012, states had to decide

**Affordable Care Act**

In addition to a range of health care policies including funds for Medicaid expansion, the federal Affordable Care Act (ACA) helps lawful U.S. residents purchase private insurance that is subsidized by the federal government. These Qualified Health Plans can be purchased through online marketplaces known as exchanges. They are open to any citizen or legal resident of the United States with income of 100% of the federal poverty level or more who does not have access to health insurance through Medicaid, Medicare, or an affordable plan from their employer.

whether to accept additional federal funds to help extend Medicaid to more of their residents. To incentivize states to expand the programs to 138% of the federal poverty level ($20,783 for an individual and $35,632 for a family of three in 2024) for adults between the ages of 19 and 64, the ACA stipulates that the federal government would pay 90% of the costs of the additional recipients. That is a much higher matching rate than the one typically provided to states.

In Wisconsin, then Gov. Scott Walker and Republican lawmakers chose not to embrace this full expansion, opting instead to obtain a federal waiver to increase access to Medicaid coverage for one group and decrease it for others. In this partial expansion, the state in 2014 lowered the coverage limit for BadgerCare Plus for both parents and adults with no children at home to 100% of the poverty level ($25,820 for a family of three) from the previous 200% level but also eliminated the waiting list for qualifying childless adults. However, some exceptions to this rule do exist such as for children – now young adults – who have aged out of foster care.

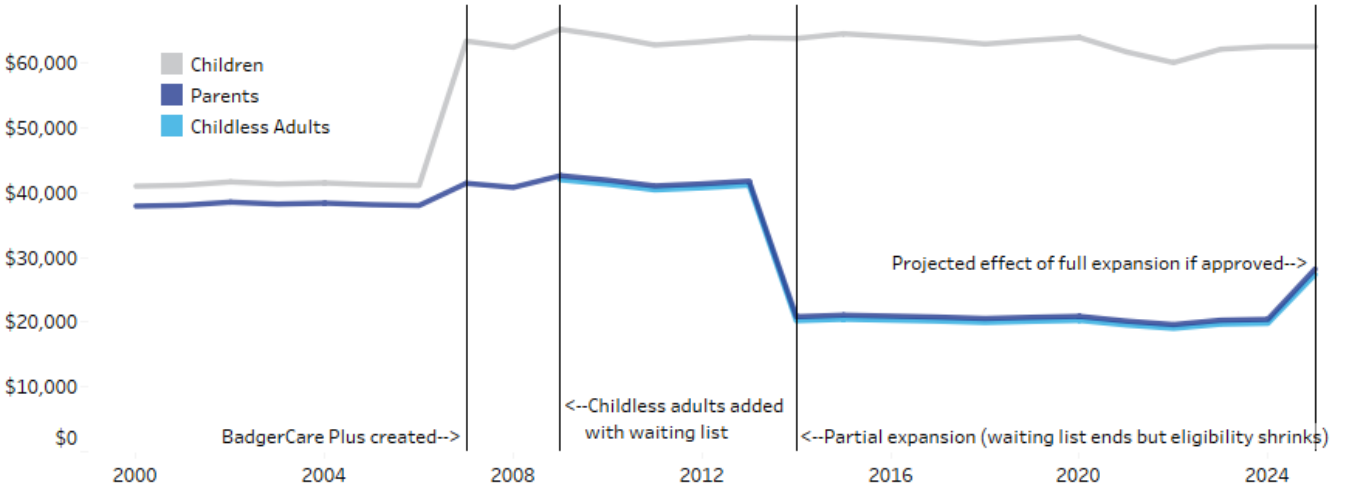
Adults below the poverty level could enroll in Medicaid, and those above it with no employer-sponsored coverage could choose to purchase private coverage through the existing channels or through the insurance exchange created and subsidized through the ACA. On net, these changes increased Medicaid enrollment, so we refer to it as a partial expansion even though many recipients actually lost coverage (for the enrollment changes see Figure 4 on page 8).

Among other arguments, Walker and his colleagues maintained that a Medicaid expansion would prove a disincentive for recipients to work and that the federal government would not sustain the higher reimbursement rate for Medicaid and leave the state footing the bill for the additional enrollees. Democratic lawmakers argued that the expansion represented a chance to extend coverage under favorable financial terms for the state; that there was no sign of any reversal in federal policy; and that the majority of current Medicaid recipients already work.

The ultimate legislation did not fully expand Medicaid but did make Wisconsin the only non-expansion state with at least some public insurance option for all residents of lower income levels. In some non-expansion states, a coverage gap exists between the upper income limit for Medicaid

**Fig 3: Medicaid Eligibility for Adults in Wisconsin Would Remain Below 2014 Levels Even With a Potential Expansion**

Maximum income in a household of two for each type of enrollee to qualify for Medicaid in Wisconsin by year in 2024$




Sources: Legislative Fiscal Bureau and WPF research; chart omits special cases and exceptions such as pregnant women. Coverage not necessarily identical between groups - prior to 2014 childless adults had somewhat restricted benefits as well as a waiting list for coverage and some  invidiuals with greater incomes were required to pay premiums.

eligibility and the poverty level (or 100% of FPL) – the minimum income level at which consumers can purchase plans through the ACA exchanges. Wisconsin's approach eliminates this gap. Since 2014, lawmakers in Wisconsin have considered the question of full Medicaid expansion in every two-year session and rejected it each cycle.

**Figure 3** on page 7 shows the effect of these changes. In 2013, both parents and childless adults were eligible for BadgerCare Plus with incomes of up to 200% of the poverty level, or an inflation-adjusted $41,791 for those living in a household of two people. To qualify today, these adults must have incomes up to 100% of FPL – $20,440 for a household of two. Childless adults currently have better benefits than they did through the previous Core Plan and a much better chance of actually getting enrolled; the previous waiting list in 2013 meant that many qualifying childless adults didn't obtain coverage. Yet to qualify for the enhanced federal matching rate of 90%, these adults would have to be covered up to 138% of FPL, or $28,207 in a household of two. As the chart shows, that would be an increase over the present limit but one that would still leave eligibility in the state well below 2013 levels.

In 2024, the state of Wisconsin is paying 39.3% of the costs of covering the roughly 190,000 childless adults currently in BadgerCare Plus rather than the 10% rate available through a full ACA expansion. As a 2022 *Journal of Health Politics, Policy, and Law* article pointed out, some states such as Idaho, Georgia, and Utah have sought to do a partial expansion similar to Wisconsin's while still receiving the expanded federal matching rate, but the federal Centers for Medicare and Medicaid Services so far has declined these requests.

## From ACA Rollout to Present

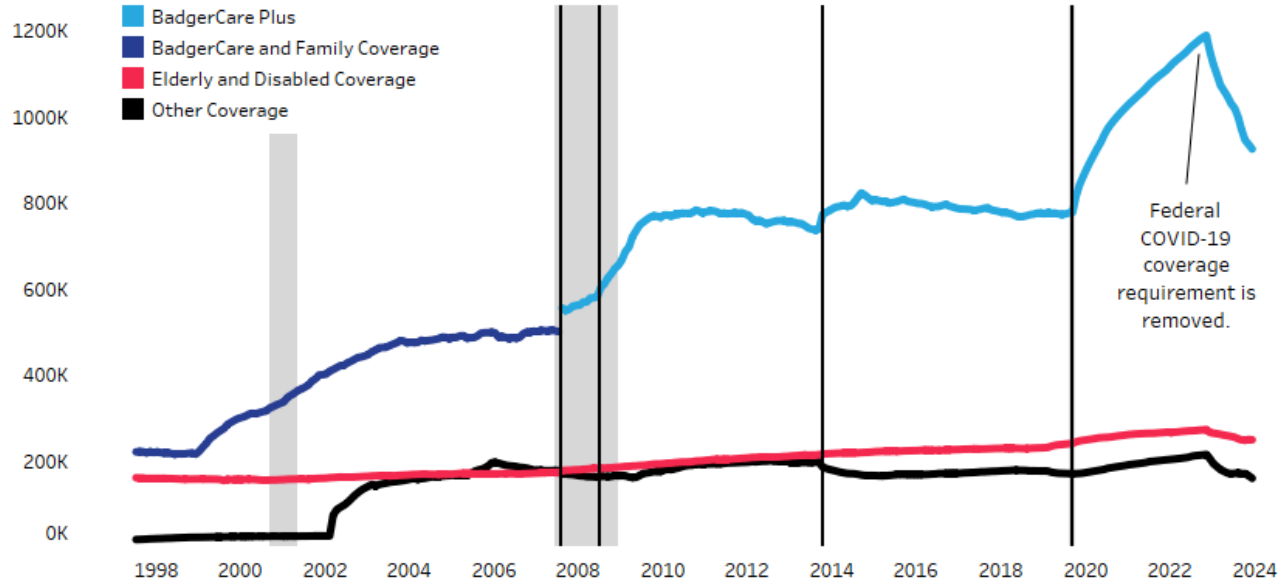
As **Figure 4** on the next page shows, the combined effect of these moves in 2014 – as well as economic forces and other factors affecting the program – was a rise in Medicaid enrollment from 740,768 recipients in December 2013 to 793,003 in December 2014, an increase of 7.1%. As the *Journal of Health Politics, Policy, and Law* article noted, this approach lowered the uninsured rate in Wisconsin less than in states that fully expanded Medicaid around the same time. An analysis of a state insurance claims database also suggested an increase in the uninsured rate among the individuals who lost Medicaid coverage. Under these changes, women were more likely to lose Medicaid coverage and men more likely to gain it, since women are more likely to be parents with custody of their children and men more likely to be childless adults.

From the 2014 expansion until the start of the pandemic, the economy improved and the number of Medicaid recipients in Wisconsin fell slowly, particularly within BadgerCare Plus. As we will discuss later, the state sought through federal waivers to put various restrictions on the program. Those included an ultimately unsuccessful attempt to impose work requirements and a briefly successful attempt to impose premiums and health risk assessments to monitor unhealthy behaviors that was shut down by federal officials at the end of last year. None of these requirements are currently in place.

The arrival of COVID-19, however, shook up this relatively stable situation and brought on changes that have been greater than those expected under an ACA expansion. During the public health emergency, the federal government paid for an additional 6.2% of Medicaid costs starting retroactively on January 1, 2020, but prohibited states from reviewing enrollees' circumstances and

**Figure 4: After Skyrocketing During Pandemic, Medicaid Enrollment Now Falling**

Number of participants in Wisconsin Medicaid programs by month and year




Source: Department of Health Services; Note: Gray bars represent recessions, black lines represent BadgerCare coverage expansions, not shown are certain long-term care expansions.

dropping their coverage because of a rise in income or other changes. As a result, BadgerCare Plus enrollment climbed from 777,312 in March 2020 to a peak of 1.19 million in May 2023, an increase of 53%.

In April 2023, the federal "continuous coverage requirement" lapsed and Wisconsin once again began requiring recipients to report their circumstances, with the state dropping those who failed to submit their documentation or to meet eligibility criteria such as income limits. The additional federal matching rate also was phased out over the final nine months of 2023. As a result, the number of BadgerCare Plus recipients as of June 2024 had fallen to 925,002, more than halfway back to its pre-pandemic level.

Data from the state Department of Health Services shows that 1.4 million state residents had to have some form of Medicaid coverage renewed between April 2023 and June 2024. Of those individuals, 71.4% retained some coverage in a Medicaid program while 10.4% lost their coverage due to a change in their eligibility and an additional 17.7% lost coverage for reasons such as not renewing it or not submitting the required information. The percentages for the subset of nearly 1.1 million BadgerCare Plus recipients who had to renew their coverage were almost identical. In all, just over 399,000 Medicaid recipients lost coverage for various reasons, including more than 321,000 on BadgerCare.

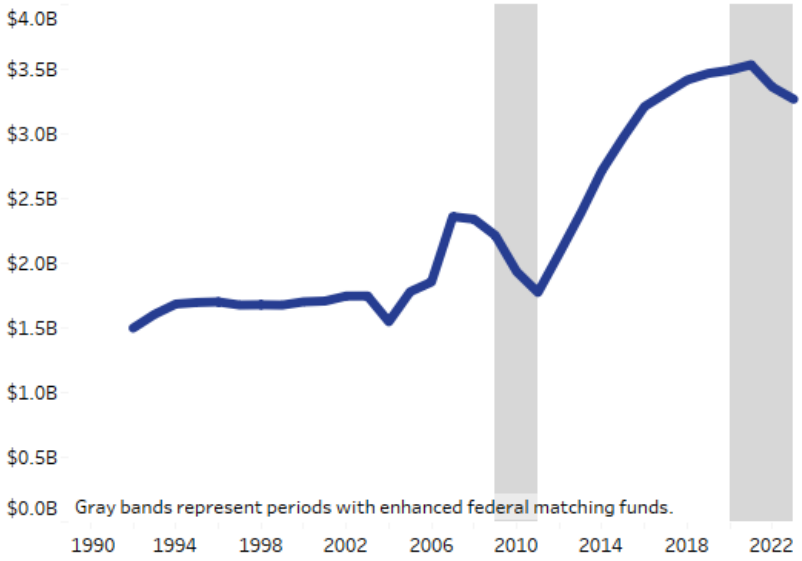
## Medicaid Spending Outpaces Inflation

As in other states, costs within Wisconsin's Medicaid program have outpaced inflation over the past two decades. The rapid increase reflects a combination of growing enrollment, the gradual aging of the population, the increase in the range of benefits and program usage by recipients, and the fact medical costs have risen more quickly than the Consumer Price Index overall. Medicaid expenditures

in Wisconsin rose nearly three times as quickly as this index which tracks the prices for U.S. goods and services and nearly twice as quickly as the portion of that index devoted to medical care.

**Figure 5: State Medicaid Spending Has Outpaced Inflation**

Inflation-adjusted annual* spending of state tax dollars on Medicaid in 2023$




Sources: State Department of Administration and U.S. Bureau of Labor Statistics. *Annual spending volatility smoothed using a three-year rolling average. Expenditures include all Medicaid services including BadgerCare Plus, long-term care, and other programs.

As **Figure 5** shows, the state spent $971 million in state tax funding (general purpose revenue or GPR) on Medicaid coverage including BadgerCare Plus, long-term care for the elderly and disabled, and other programs in fiscal year 2000 (running from July 1999 to June 2000), or about $1.72 billion after adjusting for inflation. That year, Medicaid accounted for 8.6% of the state's overall GPR spending (including transfers out of the state's general fund), according to figures from the state Department of Administration. In fiscal year 2023, the state spent $3.07 billion on Medicaid, an increase of 78.7% even after accounting for inflation. That year, Medicaid accounted for 15.7% of total state GPR spending.

However, readers should remember that BadgerCare Plus is only one among several Medicaid programs. As we note in the next section, the Medicaid long-term care services are the most expensive to deliver.

These spending increases have added to the pressure on other state programs such as higher education and aid to local governments and K-12 schools. One piece of good news is that the additional state spending was held down during the pandemic by the higher federal matching rate that was in place because of the public health emergency. Medicaid spending for both 2022 and 2023 for the state was the lowest it had been on an inflation-adjusted basis since 2014. With the end of those additional federal funds on January 1, the state faces a potential increase in spending in fiscal year 2024 and beyond. The cost pressure will be mitigated by the fact that many thousands of recipients have dropped off the rolls due to the sunset of the federal coverage requirement. Yet policymakers still could look to other ways to reduce spending such as Medicaid expansion.

## Summary

In the 1990s and 2000s, Wisconsin was a national leader in expanding access to health coverage and retains a relatively low uninsured rate despite only partially expanding Medicaid under the federal Affordable Care Act. As in other states, Medicaid rolls here shot upward during the pandemic but have since fallen sharply with the end of a federal requirement that states maintain coverage during the pandemic. The federal government has also withdrawn temporary pandemic funding for Medicaid, which means greater costs for the state if there are no policy changes going forward.

# MEDICAID IN WISCONSIN TODAY

To understand the potential effects of Medicaid expansion, we will examine current participants in the program and then turn to those enrollees who might be added. Our review also looks at what groups make up the uninsured population in the state to see how expansion might affect them.

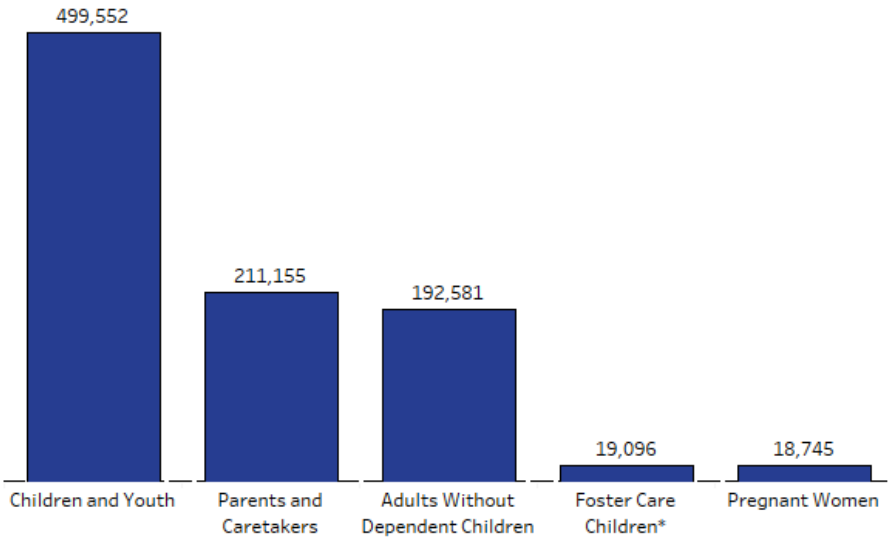
We start with BadgerCare Plus – the program that could be expanded under the ACA – and exclude some other Medicaid programs shown in **Figure 4** on page 9 such as those for the elderly and disabled, family planning services, and the SeniorCare prescription drug benefit.

## BadgerCare Plus Participants

In June 2024, BadgerCare Plus included more than 900,000 enrollees, according to state data. The biggest single group among them was children, with 499,552 enrolled (see **Figure 6**). Yet the state also covers a significant number of parents and adults without children at home. The coverage of childless adults is unusual if not unique among states that have not fully expanded Medicaid, as we will see in the next section of this report.

**Figure 6: Children Single Biggest Group Within BadgerCare**

Number of participants in BadgerCare Plus by group, June 2024




Source: WI Department of Health Services and Legislative Fiscal Bureau. *Also includes children in subsidized adoptions and former foster care youth up to age 26 who are technically not BadgerCare Plus enrollees.

One of the key questions for some lawmakers in Wisconsin is to what extent Medicaid affects whether recipients work. We will discuss that question in more depth later in this report, but include here figures from a study last year by the Kaiser Family Foundation, which looked at employment rates among Medicaid recipients nationally.

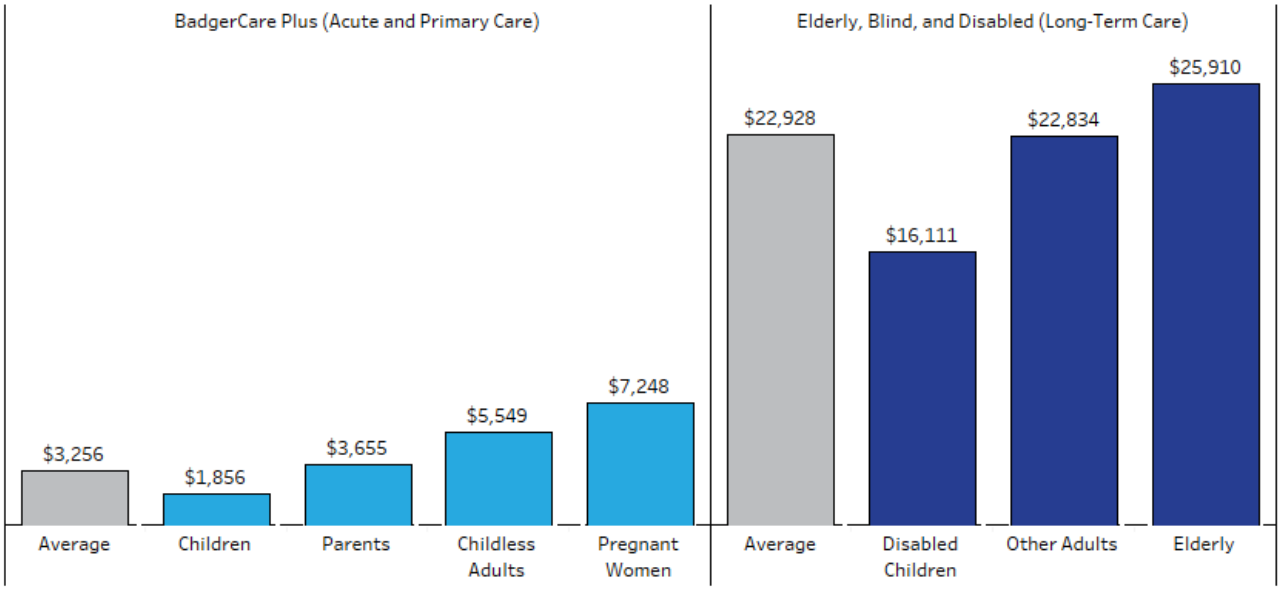
Examining U.S. Census Bureau data on recipients ages 19 to 64 who did not qualify for disability coverage, the study found that in 2021, 68% of Medicaid recipients in Wisconsin were employed, which was greater than the average of 61% nationally. That included 43% of enrollees in the state who were working full-time (at least 35 hours) and an additional 25% who worked part-time. Twelve percent of Medicaid recipients in the state said they were not working because they were ill or disabled and another 12% said they were not working because they had a responsibility to care for another person in their life. Only 17% of the enrollees in 2021 were part of a family in which no one worked.

## Which Groups Within Medicaid Cost the Most?

Medicaid costs vary widely depending on the type of coverage and group receiving it. According to the Wisconsin Legislative Fiscal Bureau, the average elderly Medicaid enrollee receiving nursing home or other types of long-term care in 2021 cost $25,910 per year – 14 times more than the $1,856 annual cost for the average child within BadgerCare Plus (see **Figure 7**).

**Figure 7: Children and BadgerCare Plus Acute Care Cost Less Per Person than Long-Term Care**

Estimated 2021 costs per recipient by Medicaid eligiblity group




Source: Legislative Fiscal Bureau; chart does not include certain programs such as Well Woman, foster children, and family planning and does not include costs that cannot be assigned to one of the recipient types.

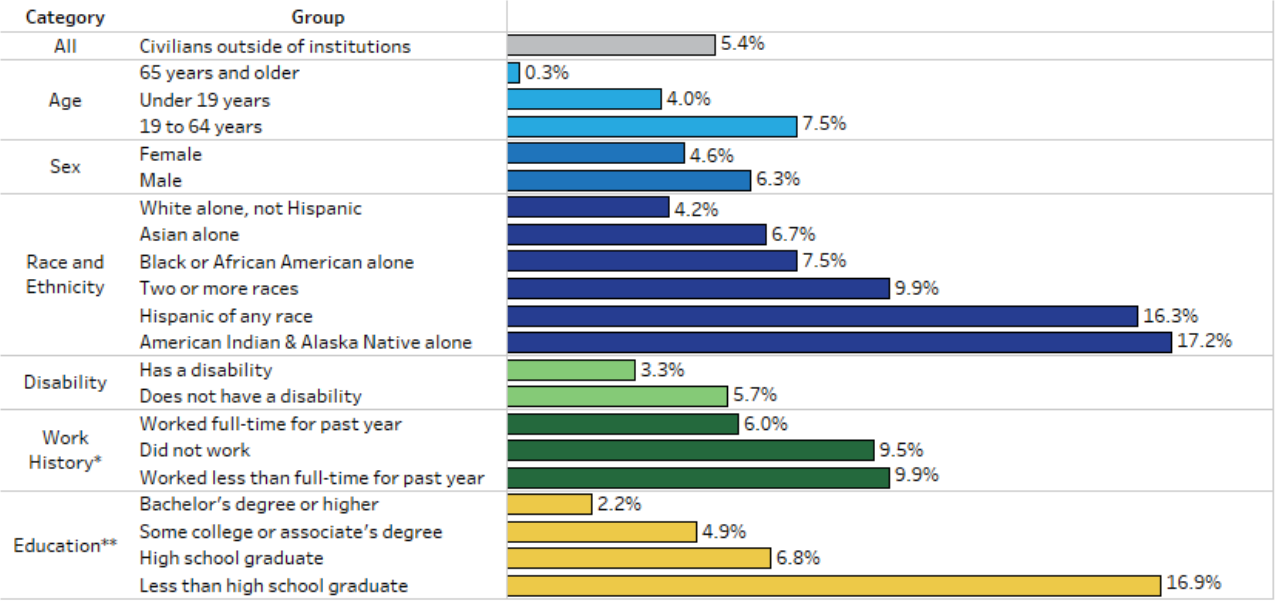
As a general principle within Medicaid and the private market, long-term care such as nursing homes, residential, and home health care costs much more on an annual basis than doctor's visits and other forms of acute care. These differences are logical. Though there are always exceptions, an elderly or disabled man in a nursing home or community-care facility may need frequent, labor-intensive care, but a young girl within BadgerCare Plus may require little more than an annual physical, vaccinations, and care for an occasional illness such as chicken pox.

## Who Makes Up the Uninsured Population?

So far, we have discussed the uninsured rate in Wisconsin only in terms of the overall statewide average of roughly 5%, but there is considerable variation among state residents by age and other characteristics. As **Figure 8** on the next page shows, all state residents who are 65 and older qualify for Medicare as well as Medicaid in some cases and almost none of them lack insurance. The chart uses 2022 U.S. Census data – the most recent available. The uninsured rate is also relatively low (4%) for children and teenagers up to 18 years old – a reflection in part of the fact that children without access to other insurance are eligible for Medicaid in Wisconsin up to 306% of the poverty level. The uninsured rate for Wisconsinites of working age (19 to 64) is higher at 7.5%, in part because public programs do not prioritize this population to the same degree as children and seniors.

**Figure 8: Which Groups Are More Likely to Be Uninsured?**

Uninsured rate by group of Wisconsin residents




Source: U.S. Census Bureau 2022 ACS Five-Year Estimates. *For civilians outside of institutions ages 19-64. **For non-institutionalized civilians ages 26 & older.

The chart shows that uninsured rates are also higher for those with less education, for state residents of color, and for men. Hispanics have notably high uninsured rates because of barriers due to income, occupation, language, education, and immigration status. Native Americans in the state also have high uninsured rates. People with disabilities tend to have much lower uninsured rates, a likely reflection of the fact that they can qualify for public coverage such as Medicaid and Medicare in some cases. It's also worth noting that, though the unemployed are more likely to lack insurance, those who work part-time or part of the year have even higher uninsured rates.

Rural areas have the largest share of the population with no health coverage, with counties like Clark and Menominee having more than one in five residents in 2022 with no insurance, Census Bureau figures show. The debate over health care often overlooks these challenges of the uninsured in rural areas, where there are lower incomes, fewer employers offering coverage, fewer health care facilities, and in some cases fewer insurance options.

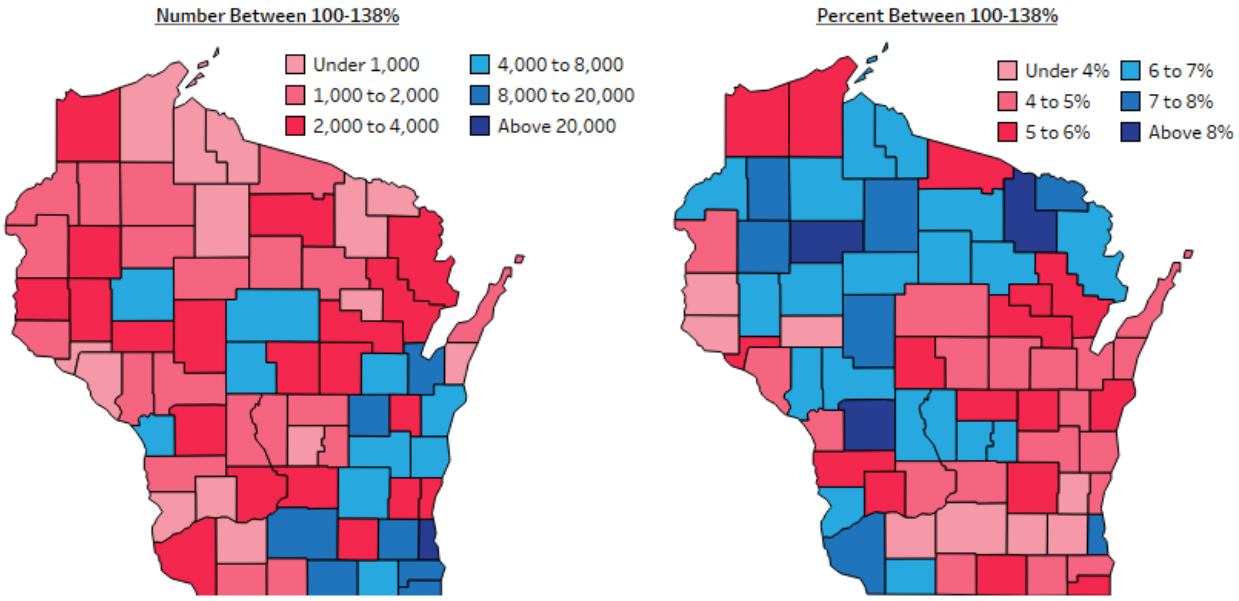
At the same time, the biggest concentrations of the uninsured are found in cities. Just three urban counties – Milwaukee, Dane, and Brown – accounted for just under one-third of all the uninsured in the state in 2022, the Forum analysis found. A 2022 analysis of the state's health insurance market prepared for the Wisconsin Office of the Commissioner of Insurance came to similar conclusions. Though cities do have more hospitals and clinics, some urban neighborhoods can still face some of the same obstacles as their rural peers, including low incomes, high unemployment, and lack of access to providers. For more on the state's uninsured rates by region, see the **Appendix**.

## Where Would Medicaid Expansion Have the Biggest Impact?

The same basic pattern with regard to urban and rural areas is true for Wisconsin residents with incomes between 100% and 138% of the poverty level, who at least potentially could be eligible for Medicaid if the program were fully expanded. As of 2022, roughly 290,000 state residents - about

**Fig 9: Largest Share of Potential Eligibles for Medicaid Expansion Lives in Rural Areas, Largest Number in Cities**

Percentage and number of residents between 100% and 138% of the federal poverty level by county




Source: U.S. Census Bureau 2022 American Community Survey Five-Year Estimates

5% of the state's population – fell into this category, and Milwaukee, Dane, and Brown counties again accounted for roughly one-third of the people in this group, or 97,643 (see **Figure 9**).

However, the share of residents in this category is low in large urban areas in Wisconsin with the exception of Milwaukee County, where 7.3% of residents have incomes between 100% and 138% of the poverty level. By contrast, six rural counties count at least 7% of their residents in this category and more than 8% of residents in Monroe, Rusk, and Forest counties fall into this group. In other words, when one considers the share of the population who might benefit from expansion, it becomes clear that the residents of rural counties would be impacted the most.

## Most Between 100% and 138% of Poverty Level Already Insured

It is important to note that the overwhelming majority of state residents with incomes between 100% and 138% of the poverty level already have some form of health coverage. Even if Wisconsin fully expands Medicaid, most of these state residents would not be signing up for Medicaid for the first time – many already have Medicaid or would remain on other insurance.

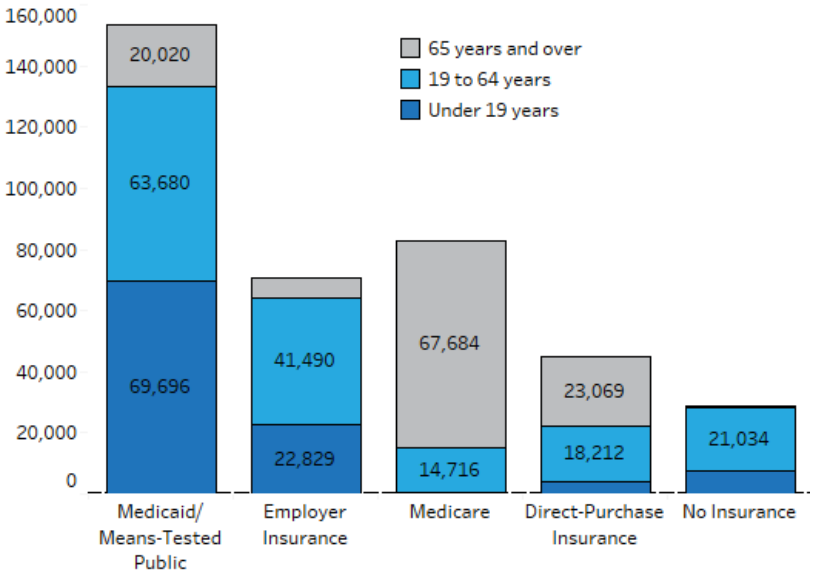
Within this income group in 2023, 271,268 state residents – 90.3% – reported having some form of health insurance coverage, according to Census Bureau American Community Survey One-Year estimates. Only 29,023 individuals, or 9.7%, reported having no health coverage, as shown in **Figure 10** on the next page.

Among those surveyed, 23.6% had coverage from their employer. An additional 27.5% were covered by the federal Medicare program and 15.0%, or 45,134, had insurance that they had purchased themselves.

Perhaps surprisingly to some readers, 51.1% of those in this income category (153,396 people) were already covered through Medicaid or another public program subject to means testing. This does not appear related to the COVID-19 prohibition in effect for part of 2023 against dropping Medicaid recipients from coverage even if their incomes had risen, since Medicaid covered a similar proportion of this income group in 2019.

**Fig. 10: Half of Those Just Over Poverty Level Already on Medicaid**

Number of Wisconsin resident between 100% and 138% of the federal poverty level by type of coverage and age, 2023




Source: U.S. Census Bureau American Community Survey One-Year Estimates

Some of these individuals are likely covered by Medicaid because they are a child or pregnant woman – and therefore eligible even at this income level. They may also have a coverage extension that allows the eligibility of children and parents to continue for 12 months even though their income has risen. DHS data show a monthly average of 290,300 such recipients enrolled in BadgerCare Plus in 2023. A smaller portion of these individuals are over age 65, suggesting they may be covered under Medicaid long-term care programs for the elderly and disabled, perhaps because those programs allow certain deductions from applicants' income.

Even among the uninsured, some might not be eligible to enroll in Medicaid under a full expansion for reasons such as their immigration status. Therefore, the numbers shown in **Figure 9** on the previous page overestimate the number of individuals who might actually enroll in coverage under a full Medicaid expansion.

## Summary

At present, a majority of BadgerCare Plus enrollees in Wisconsin are children but the program also serves a significant number of childless adults – an unusual circumstance for a state that has not fully expanded Medicaid. Most adult recipients of BadgerCare Plus without a disability work at least part-time and the majority of those who are unemployed say they are either ill, have a disability that does not qualify for coverage, or care for another person.

Medicaid expansion would extend eligibility to many residents of urban counties such as Milwaukee, Dane, and Brown. However, it is in rural Wisconsin counties where the largest share of the population would become eligible for BadgerCare Plus if Medicaid is expanded fully. At the same time, most of the population between 100% and 138% of FPL in Wisconsin is already insured and nearly half of them already receive Medicaid. So though Medicaid expansion would decrease the uninsured population in Wisconsin, its impact on coverage levels would be more modest than some might assume.

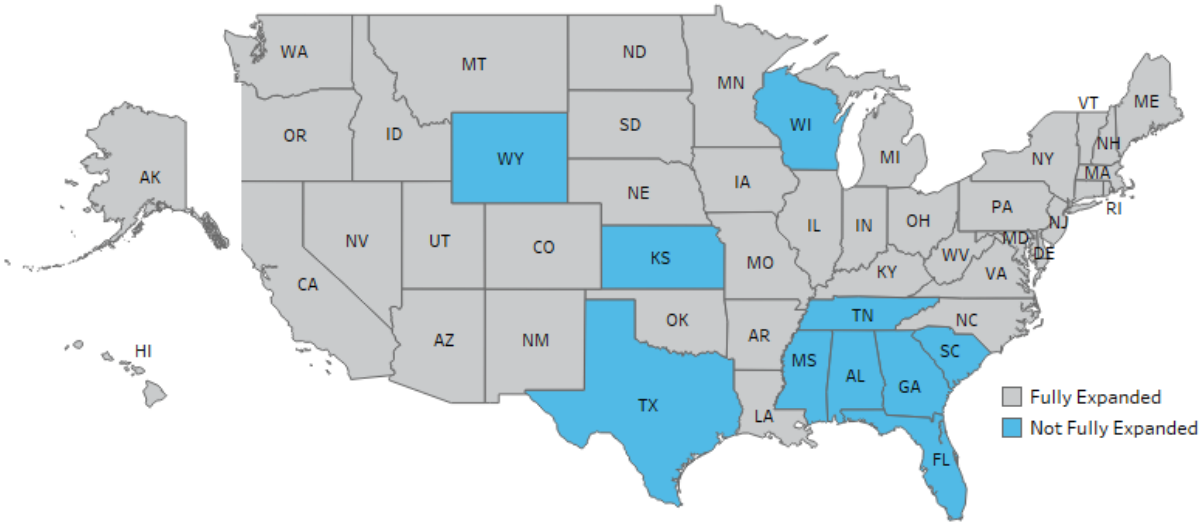
# EXPLORING EXPANSION IN WISCONSIN AND OTHER STATES

As our analysis makes clear, Wisconsin is an outlier among U.S. states for achieving relatively high coverage levels while declining to pursue a full expansion of Medicaid. Though some other states such as South Carolina have considered it, no other state has adopted and implemented Wisconsin's approach of a partial expansion that is heavily self-financed. Wisconsin has stuck with this strategy even as more states have expanded Medicaid using additional ACA funding.

As **Figure 11** shows using data from the Kaiser Family Foundation, Wisconsin is now one of just 10 states that have not expanded the program and is one of just three states outside of the South that have not done so. Among these remaining states, proposals to expand Medicaid have been approved by at least one legislative chamber in Wyoming and Mississippi.

**Figure 11: Wisconsin* One of Ten States That Have Not Fully Expanded Medicaid**

Affordable Care Act Medicaid expansion status by state




Source: Kaiser Family Foundation; *Wisconsin did not fully expand Medicaid but did carry out a partial expansion in 2014.

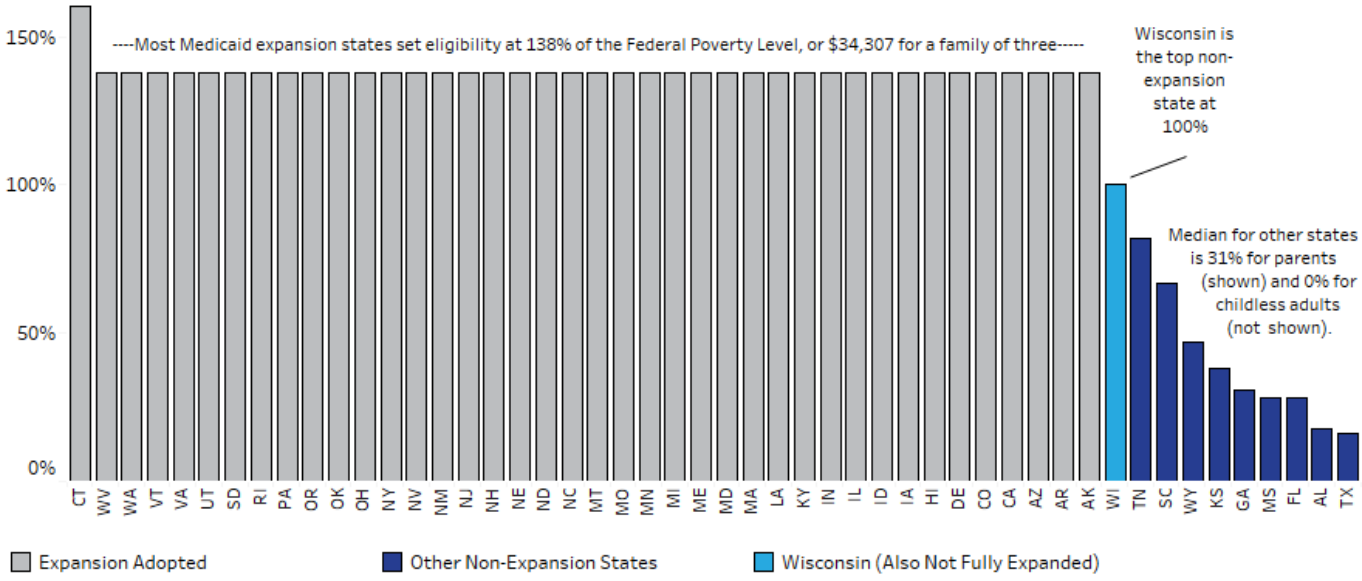
Yet even among this small group of states that have not fully expanded Medicaid, Wisconsin remains distinct. Among the other nine non-expansion states, the median maximum income level for Medicaid eligibility for a parent is 31% of FPL, or $8,004 for a family of three in 2024, according to Kaiser data (see **Figure 12** on the next page). That's less than one-third of the 100% maximum set in Wisconsin. As previously noted, Wisconsin is using more of its own state tax dollars to pay for this expanded coverage since it falls short of the ACA requirements.

The differences are even more stark if one looks at childless adults. As with parents, BadgerCare Plus accepts all childless adults in Wisconsin up to 100% of FPL. Among the other states that have not expanded Medicaid, not one covers childless adults without a qualifying disability at any income level, as the Kaiser Family Foundation has shown. Once again, Wisconsin pays roughly two-fifths of these costs.

As Wisconsin considers whether to fully expand Medicaid, these past decisions put our state on a different footing from the other nine remaining states. Those other largely Southern states have not

**Figure 12: Wisconsin Has Highest Medicaid Income Limits Among States That Have Not Fully Expanded the Program**

State income limits for Medicaid eligibility for parents as a percentage of the federal poverty level



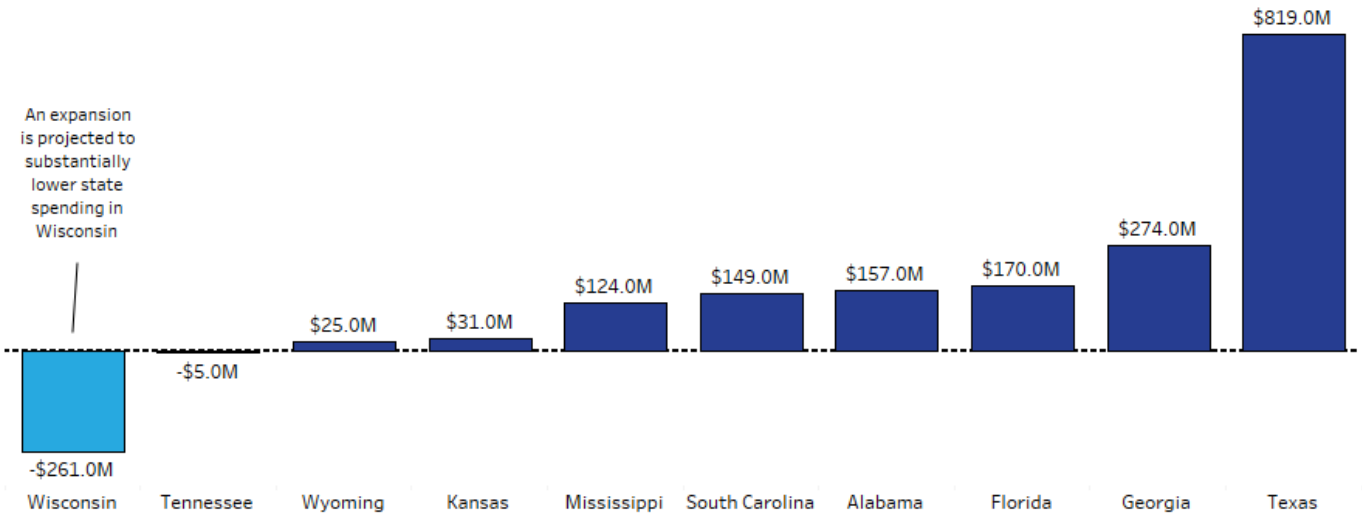

Source: Kaiser Family Foundation

greatly invested their own state tax dollars in expanding coverage and provide Medicaid only to residents with the very lowest incomes. Wisconsin, on the other hand, has already expanded its program much of the way to the ACA target and done so with a sizable state investment.

The upshot is that unlike taxpayers in the other nine states, Wisconsin taxpayers would actually save substantially on Medicaid spending if elected officials expanded the program and drew down additional ACA funding. As **Figure 13** shows using projections from [The Urban Institute and the Robert Wood Johnson Foundation], a full Medicaid expansion would require the other nine states to

**Figure 13: Wisconsin Would Save the Most from Fully Expanding Medicaid Among the States That Have Not Done So**

Projected impact to state Medicaid spending in 2024 from potential expansion under federal Affordable Care Act (in millions)




Source: The Urban Institute and Robert Wood Johnson Foundation

spend an average of $193.7 million more per year for that program in 2024 because they would be covering so many more individuals under an expansion. Wisconsin, on the other hand, would lower its ongoing state Medicaid spending by a projected $261 million in 2024 as part of an expansion, since the state would capture a much higher federal matching rate on the coverage it is already paying to provide to tens of thousands of adults (90% rather than the fiscal year 2025 rate of 60.7%).

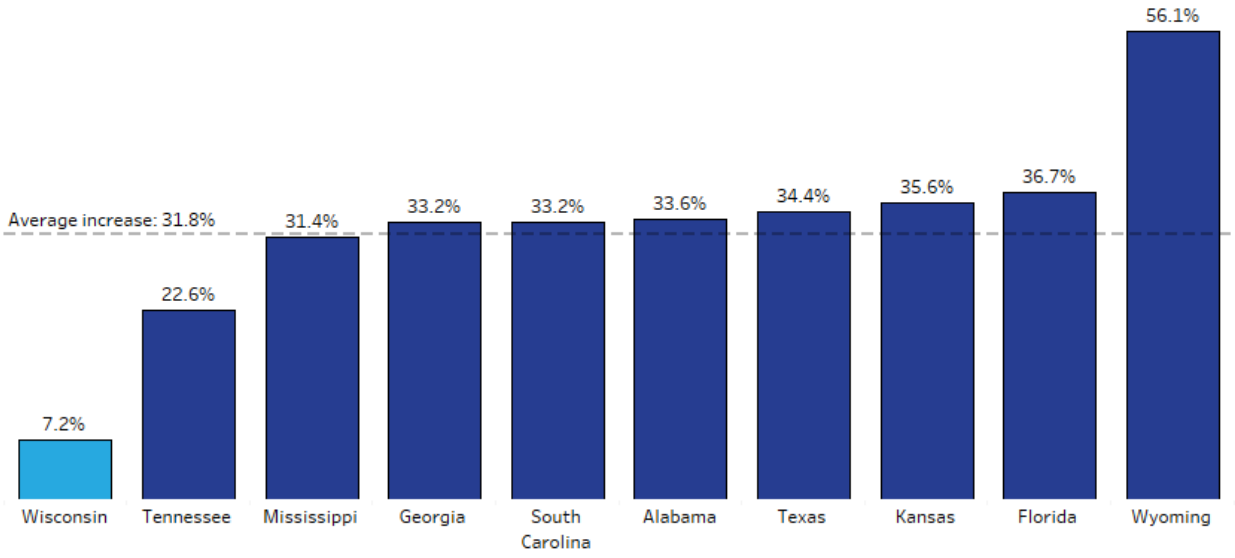
The authors say their estimates represent the impacts to Medicaid spending only – some states may also benefit from some budget savings from expansion because of reduced health care spending outside of Medicaid. Yet either way, it does not change the fact that Wisconsin's situation is unique.

On the other hand, while the financial benefit would be significant, the relative increase in coverage levels would be more modest. As **Figure 14** shows, a full expansion would add a projected 72,000 residents to the Medicaid program in Wisconsin, a 7.2% increase that would be the smallest by far among the remaining states. The reason, once again, is that unlike the other nine states, Wisconsin has already done most of the work of expanding its Medicaid program at more of its own expense.

The projections are admittedly difficult to make, since the authors at the time did not have access to complete data from after the end of the public health emergency, when states began the long process of disenrolling recipients who no longer qualified for Medicaid. The study also assumes that the rate at which newly eligible recipients will enroll in Medicaid in new expansion states will equal the average rate in the states that have already expanded the program. With its unusually high income eligibility, Wisconsin may actually behave differently. The projections also assume a typical expansion with no premium or work requirements on recipients, which matches the current situation in Wisconsin. That was not always the case in the past, however, and might not be true in the future.

**Figure 14: WI Would Increase Medicaid Enrollment the Least of Any Remaining State Under a Full Expansion**

Percentage change in the projected number of Medicaid recipients by state in 2024 under a full expansion




Source: The Urban Institute and Robert Wood Johnson Foundation

The projected drop in Wisconsin's uninsured population also would be modest, with a reduction in the uninsured population of 23,000 people, or 8.1%. That would be by far the smallest percentage decrease of any of the non-expansion states but is relatively consistent with the number of individuals within this income group who are uninsured (as we noted previously, the Census Bureau estimated it at just over 29,000 in 2023). The modest dip reflects the fact that most state residents with incomes between 100% and 138% of the poverty level already have some form of health coverage, including employer coverage, Medicare, and the federally subsidized private insurance available through the ACA.

Whether one embraces or opposes an expansion of Medicaid coverage, the reality is that the bulk of it already has happened in Wisconsin. The main questions left are how the state pays the ongoing cost of maintaining its costlier partial expansion or whether the state wishes to go somewhat further.

## Assessing the Impacts in Wisconsin

### State Residents

When considering a potential Medicaid expansion in Wisconsin, the first impact to consider is the effect on state residents and patients, starting with their overall health care costs including premiums, co-pays, deductibles, and the scope of their benefits. Overall, Medicaid coverage would be cheaper for residents falling into the income gap between 100% and 138% of FPL than obtaining coverage and medical care through the ACA or an employer plan, though the difference with the ACA plans has narrowed over time.

Medicaid coverage in Wisconsin through BadgerCare Plus has no monthly premiums for adults. In the past, that was not necessarily true of ACA plans -- even those for enrollees with relatively low incomes. However, the federal American Rescue Plan Act and subsequently the Inflation Reduction Act have also lowered the premiums for those who obtain insurance through the subsidized ACA exchange. In fact, there is currently no premium for anyone in certain ACA plans with income up to 150% of the poverty level. However, these enhanced subsidies end in 2025, so premium costs could rise once again after that.

Take, for example, the case of a 30-year-old Milwaukee marketplace participant with no children making $17,921 in 2024, or essentially at the midpoint between 100% and 138% of FPL. He or she would receive $357 per month, or $4,284 per year, in federal premium tax credits passed on to the insurer, according to the calculator developed by the Kaiser Family Foundation. This federal subsidy would cover the enrollee's entire monthly premium for a silver plan providing standard coverage, putting him or her on an equal footing with most Medicaid recipients in this respect for now at least.

However, BadgerCare Plus also has few out-of-pocket health care costs – children and pregnant women do not have co-pays, the co-pays for all services typically do not exceed $3, and any premiums and co-pays in a given month cannot exceed 5% of a participant's income. Our hypothetical participant in an ACA silver plan, on the other hand, could incur up to $3,150 in out-of-pocket costs in 2024 – or 17.6% of the participant's total annual income. That's more than three times the limit in BadgerCare Plus.

Notably, however, ACA plan participants can qualify for additional reductions in their payments if they have incomes between 100% and 250% of the poverty level and enroll in a silver plan. These "cost-

sharing reductions" (CSRs) lower the deductibles, co-pays, and other cost-sharing a participant in a marketplace insurance plan might otherwise pay. Just over one-third of Wisconsin participants in the marketplaces, or 72,800 people, received these reductions in 2022, according to an analysis of the individual health insurance market delivered to the Wisconsin Office of the Commissioner of Insurance. The total amount of these reductions is not available, but in some cases, they could amount to several thousand dollars or more for an individual. These reductions also reduce the differences between Medicaid and ACA plans.

However, BadgerCare Plus also generally covers more types of services and health care providers than ACA marketplace plans, including dental, vision, and chiropractic care. ACA marketplace plans must offer dental and vision coverage for children but do not have to do so for adults and may or may not cover visits to a chiropractor. Service providers also point to the more comprehensive benefits available from Medicaid for mental health and substance abuse treatment.

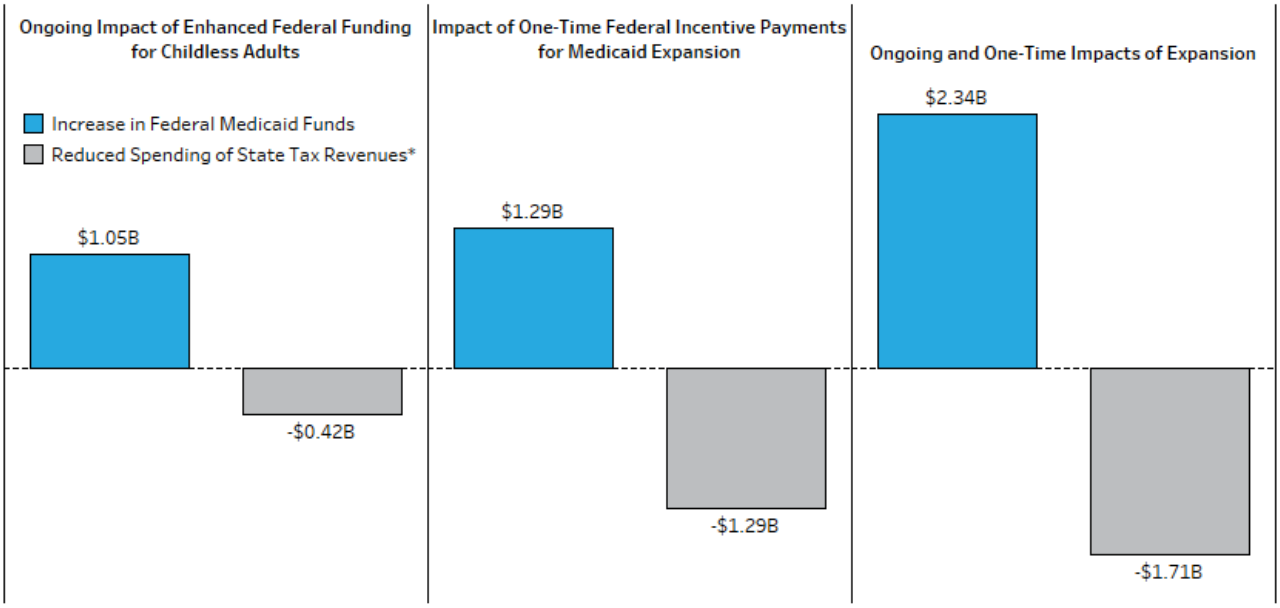
There may be some drawbacks for ACA participants who switch to Medicaid, including the potential task of having to change health care providers in some instances. Consumers and policymakers may also wish to consider the provider networks for various plans. For example, though BadgerCare does provide dental coverage, its relatively low payment rate to dentists means that many of them are not accepting new Medicaid patients, making the coverage difficult to use in practice. At the same time, some ACA plans also have relatively narrow provider networks for consumers.

### State Government and State Taxpayers

Medicaid expansion also would have a major financial effect on state government by drawing down additional federal funding that would pay for the majority of the state's costs to cover the roughly 190,000 childless adults already served by BadgerCare Plus. At the same time, the state would also have to spend some additional funds to cover tens of thousands of additional enrollees.

**Figure 15: Medicaid Expansion Would Draw Down Federal Funds, Lower State Spending**

Projected fiscal effect of a proposed Medicaid expansion over the upcoming 2025-27 state budget




Source: Wisconsin Department of Health Services; *General Purpose Revenue (GPR)

The net result would be a major savings for the state, according to the state Department of Health Services. In its 2025-27 budget request, the agency projects that Medicaid expansion would provide state taxpayers with permanent ongoing savings totaling $423.8 million over the course of fiscal years 2026 and 2027 combined. That averages out to $211.9 million per year, somewhat less than the Urban Institute's independent projections for the earlier year of 2024 that are shown earlier in **Figure 13**. Those funds could be used to lower taxes or increase spending on other priorities. The agency budget request estimates 90,900 state residents would gain Medicaid coverage in fiscal year 2026 over what enrollment would have otherwise been. That is somewhat more than what the Urban Institute projects. The estimates include 61,100 parents and 29,800 childless adults.

In addition to the ongoing annual savings, the state would also receive a one-time federal incentive that would raise the federal reimbursement rate for most Medicaid spending in the state by 5 percentage points for two years, bringing in an estimated $1.29 billion over the period following implementation. Expanding Medicaid during the 2025-27 state budget, therefore, would cover more state residents and provide a total net benefit to state taxpayers of just over $1.7 billion over the two years, as shown in **Figure 15** on the previous page. These additional revenues could be used to pursue a variety of state goals either within or outside the Medicaid program. The impacts of Medicaid expansion on health care providers would depend in part on whether the state used those new funds to improve reimbursement rates or make other health care changes in Wisconsin or used them for other state priorities such as education or lowering taxes.

Last, in some cases county governments may see some savings from expansion for the share of Medicaid costs that they currently fund for substance abuse and mental health services for childless adults. However, these savings would be on a case by case basis and not all counties would receive them. There may be some increased costs as well for counties to sign up the additional enrollees.

### Employers and the Economy

As previously mentioned, one consideration for Medicaid expansion is whether it will lead to fewer workers or fewer hours worked. The unemployment rate in Wisconsin is already near record lows, making this an important concern for employers and the economy. Health insurance represents a major piece of the compensation for some U.S. workers, and some argue that receiving access to health coverage outside of a job could make some workers less likely to seek or retain employment.

Workers considering retirement, for example, may remain employed longer to retain their health coverage if they cannot obtain it cheaply elsewhere and have not reached the age of 65 to qualify for Medicare. It is worth noting, however, that a 2019 Journal of Pension Economics and Finance paper did not find this effect. In addition, many workers lack health coverage and some Medicaid enrollees limit the hours they work to avoid earning enough to lose their public coverage.

The first point to consider with regard to these concerns about expansion is the fact that, as noted previously, the majority of Medicaid recipients in Wisconsin are already employed. Moreover, the enrollees added under an expansion would likely be employed at even higher rates since by definition they have higher incomes than current recipients. Data from the Kaiser Family Foundation support this conclusion, showing that in 2018 the median share of Medicaid recipients who were working was greater in expansion states than in non-expansion states. Raising the income limit to 138% of the poverty level also may allow enrollees to work more hours without losing coverage.

In addition, academic studies have generally found that Medicaid expansion has not negatively affected the labor force in the states that have implemented it. An April 2021 article in the *Journal of Labor Economics* found expanding coverage had no meaningful effect on the unemployed finding a job and did have a modest positive effect of keeping parents and the short-term unemployed from exiting the labor force. That may lend some credence to the idea advanced by expansion proponents that keeping workers in better health may help them remain employed. However, these results would not necessarily apply in Wisconsin since more of the working poor already have access to Medicaid here and expansion may not have as great an effect in this state.

Ultimately, it is worth noting that nearly half of the population between 100% and 138% of FPL already receive Medicaid. A full expansion would affect a projected 72,000 to 90,900 individuals based on the estimates and that most of them would likely already be employed. That represents a relatively modest number in a state with a labor force of 3.14 million. As a result, any marginal effects of expansion on the labor force – whether positive or negative – would likely be small – at least with respect to the Medicaid recipients themselves. (We discuss the Medicaid work requirements that were sought in Wisconsin and other states in the next section of this report.) The gain in federal funding and Medicaid spending from the expansion – and the loss in spending within the ACA exchanges – might have greater effects on employment, as we will discuss below.

### Health Insurers and Consumers

Proponents of Medicaid expansion often point to the benefits of drawing down additional federal aid. However, it is worth noting that federal funding also flows into the state through the federally subsidized ACA insurance marketplaces. These federal funds provide a benefit to marketplace participants as well as indirectly to health insurers, which by extension also helps providers here.

The ACA marketplaces allow individuals to provide their information and select a private health insurance plan through a public website. These individuals can qualify based on their income and household circumstances for federal tax credits that in turn reduce the monthly premium for their coverage. As noted in the previous section, these credits currently completely pay for the premiums for Wisconsin residents with incomes between 100% and 138% of FPL, though that could change.

Data from the Centers for Medicare and Medicaid Services (CMS) allow for estimating the total value of the premium tax credits awarded to the majority of the 266,327 Wisconsin residents enrolled in an ACA marketplace plan. The data for 2024 show that 235,587 enrollees received an average of $572 per month in tax credits, which was somewhat more than the national average of $536. That works out to an estimated $1.62 billion in tax credits this year for all Wisconsin enrollees in marketplace plans and shows that Medicaid expansion is not the only way in which state residents can benefit from federal ACA funding.

The federal tax credit figures include all qualifying participants, not just those with incomes between 100% and 138% of FPL who would be affected by Medicaid expansion. According to the CMS data, the 46,571 marketplace enrollees between 100% and 138% of FPL make up 17.5% of the Wisconsin enrollees. Because of their low incomes, these enrollees would qualify at higher rates for premium tax credits and receive larger credit amounts than enrollees with greater incomes.

For those reasons, we conservatively estimate that these enrollees in the state are benefiting from at least $283 million in federal tax credits in 2024 and likely more.[3] To the extent that expanding

[3] These calculations were made with the assistance and input of UW-Madison researcher emerita Donna Friedsam.



Medicaid in Wisconsin causes these enrollees to shift into BadgerCare Plus, it would reduce the federal tax credits currently flowing to insurers in the state to subsidize health coverage and services here. It is important to factor both the reduced ACA tax credits and the additional federal Medicaid funding into an analysis of the overall net impact of expansion on the residents of Wisconsin.

Marketplace coverage levels and costs are described using metals of increasing value, from bronze to gold. Of all marketplace enrollees in Wisconsin, 129,867 of them signed up for bronze level plans, or 48.8%, making that the biggest single group, according to the CMS data. Bronze level premiums are cheaper and may be available to enrollees for no premium after the tax credits, but these plans come with the highest out-of-pocket costs and may be most suitable for largely healthy individuals and families who do not expect major health care bills or who simply need insurance to protect them against very large bills. Silver plans offer better coverage levels and can still have very low premiums for consumers qualifying for higher amounts of tax credits. However, these plans account for only 38.1% of the marketplace enrollees in the state while gold plans make up 12.2% and platinum and cheaper catastrophic plans for consumers under 30 together account for 0.9%. The selections by marketplace enrollees overall suggest that participants with higher incomes who qualify for fewer tax credits opt for bronze plans, despite their lesser benefits, because of the lower premiums.

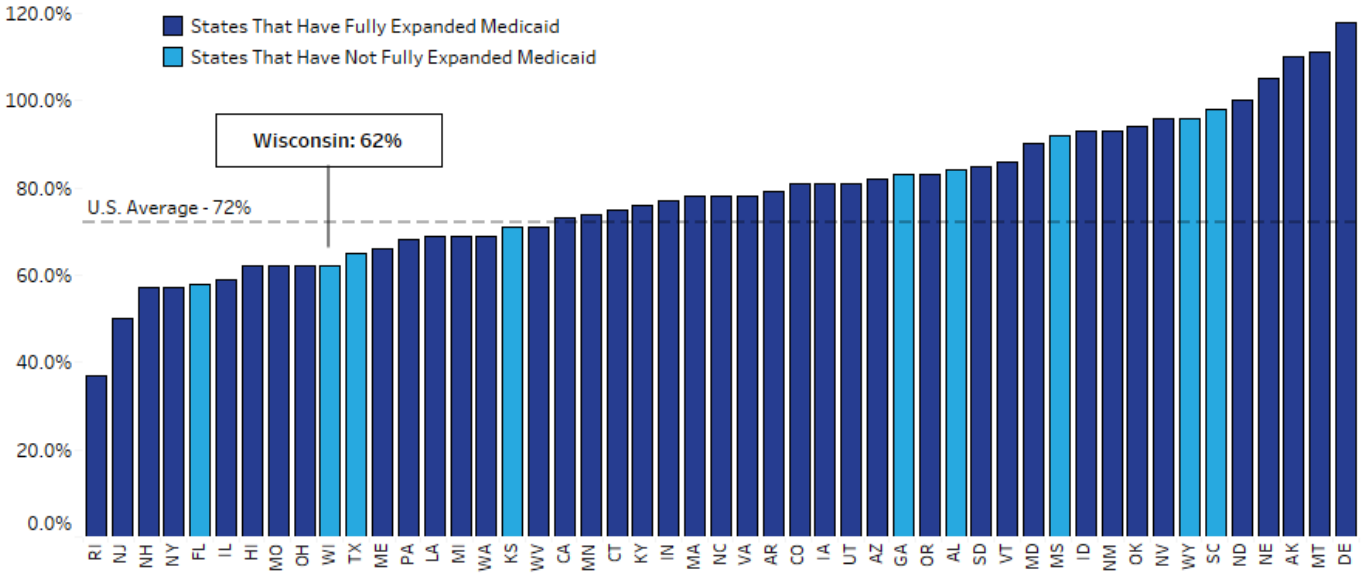
However, additional CMS data show a different story for marketplace enrollees between 100% and 138% of the poverty level. These enrollees qualify for greater federal tax credits that currently fully cover their premiums and the majority of them, or about 39,674, enrolled in silver plans while only 6,493 chose bronze plans and 651 chose gold. Those selections suggest these consumers are seeking to maximize coverage levels based on the available federal subsidies, as briefs by the Covering Wisconsin program have also noted.

### Health Care Providers

An assessment of Medicaid expansion also must consider how much the state's Medicaid program pays health care providers. To the extent that Medicaid does not fully reimburse Wisconsin providers

**Figure 16: Wisconsin Among Bottom 10 States for How Much Medicaid Pays Health Care Providers**

Medicaid reimbursement to providers by state* as a share of what Medicare would pay, 2019




Source: Health Affairs; *Study omitted Tennessee because it does not establish fee for service Medicaid physician fees.

for their reported cost of serving patients, some argue the shortfall may affect provider profits, their acceptance of Medicaid patients, and the rates charged to private insurers and their clients.

A 2021 study in *Health Affairs* looked at the physician fees paid by state Medicaid programs for 27 common procedures including primary care, obstetrical care, and other services. The report compared the fees to federal Medicare program reimbursements for those same services. If a state Medicaid program pays less than the Medicare rate, it is notable for providers since Medicare already is generally seen to pay less than private insurers for the same services.

The study found that in 2019, Wisconsin reimbursed Medicaid providers only 62% of what Medicare paid for the same procedures, which was below the U.S. average of 72% for state Medicaid reimbursement rates nationally (see **Figure 16** on the previous page). Wisconsin was ranked in the bottom ten states nationally and was the second-lowest among the states that have not fully expanded Medicaid.

The study admittedly had some limitations. One significant caveat was that it only looked at the fee for service payments made for different types of individual physician services, rather than at the amount per patient (known as a capitated rate) paid by states like Wisconsin that have largely shifted to a managed care model within Medicaid. The private insurance plans providing managed care coverage within Medicaid negotiate in turn their own payment rates to providers for specific procedures. The authors write that these two payment approaches have typically yielded similar fees across different states, though there are likely at least some differences.

In addition, Wisconsin's 2023-25 state budget included $52.2 million in GPR funding to increase Medicaid payments for primary care medical services such as office visits with family and general practitioners. The increase sought to raise reimbursement rates for these services to 70% of what Medicare pays for them. The state has also increased rates for long-term care services, though those lie largely outside the scope of this report.

The Kaiser Family Foundation also recently examined spending in the program and found that in 2021 Wisconsin ranked 30th nationally for Medicaid spending per enrollee receiving full benefits, with average spending per enrollee of $7,295 that was 3.9% below the national average of $7,593. (Solid data were not available for West Virginia and Mississippi.) The Kaiser data also showed Wisconsin was below the national average in Medicaid spending on adults, children, and seniors respectively, though the state spent more on individuals with disabilities. Average Medicaid spending can vary by state because of many factors, including the demographics of enrollees, the mix of benefits and procedures covered by state, and more. Yet these data again suggest that Wisconsin providers are receiving less on average per patient to care for them.

We can also examine reimbursement rates to hospitals. In Wisconsin, at least one other factor also complicates this sort of comparison, however. The state makes access payments to certain hospitals through Medicaid above base reimbursement rates and disproportionate share hospital payments to institutions that serve relatively high numbers of Medicaid recipients and low-income patients. Though these payments do not go to every hospital, they do further increase the funds that some of the most important institutions in the state receive for serving Medicaid patients. A 2017 study by the Medicaid and CHIP Payment and Access Commission found that factoring in supplemental Medicaid payments eliminates gaps with Medicare rates and can substantially change how states like Wisconsin rank compared to fee for service data.

For its part, the Wisconsin Hospital Association has reported that Medicaid covers 65% of the costs incurred by its members in treating patients. According to its report, the gap in Medicaid reimbursement in 2022 totaled $1.34 billion for Wisconsin hospitals and health systems, up 13% from $1.19 billion the previous year. The association states that Medicaid in 2022 made up 14.7% of the total gross patient revenue among 155 Wisconsin hospitals (a group that does not include veterans hospitals in the state). It is worth noting that since then, the 2023-25 state budget included a $26.6 million increase in GPR funding for hospital reimbursement rate increases and $48.2 million for increases in disproportionate share hospital payments.

Though technical and difficult to grasp, the issue of Medicaid fees matters. Lower Medicaid reimbursement rates may leave some providers less willing to serve Medicaid patients or support legislation to expand the program. The lower rates may also put upward pressure on the rates paid by private insurers and their customers to hospitals and clinics to the extent that the providers have enough market leverage to pass along the unreimbursed Medicaid costs.

The other states that have not expanded Medicaid may find it challenging to increase program spending as part of an expansion while also raising reimbursement rates. In Wisconsin, however, policymakers could choose to use all or part of the state savings from an ACA expansion to address low Medicaid reimbursement rates, as we will discuss in the next section.

### Broader Considerations

We find Medicaid expansion would benefit the state of Wisconsin's finances and likely provide less costly coverage with a greater level of benefits to individuals switching from marketplace plans to BadgerCare Plus, particularly if the current enhanced marketplace subsidies expire. The effect of expansion on the labor market is important to consider but should be relatively modest in Wisconsin given the state's prior partial expansion. As health care providers, the net impact to them would depend in part on whether state government pours the savings from additional federal aid back into the health care system in the form of higher Medicaid reimbursement rates or other strategies.

Health plans within the ACA marketplaces are generally designed to pay providers more for caring for patients than the Medicaid program pays to deliver the same care. In this sense, it might appear to be in the interest of health care providers to have more patients enrolled in marketplace plans rather than BadgerCare Plus.

This analysis, however, assumes that those who qualify for employer or marketplace plans will enroll and use them to select options with adequate coverage and cost-sharing provisions when that is not always the case. So far, the evidence on that question is mixed. On the one hand, the great majority of Wisconsin residents between 100% and 138% of the poverty level have health coverage and the marketplace enrollees in this group have largely selected silver level plans with a balance of cost and coverage – an encouraging sign.

On the other hand, most projections and studies suggest that Medicaid expansion would modestly lower Wisconsin's uninsured population. Consumers enrolled in a marketplace plan may also fail to cover their higher out-of-pocket costs. They may drop coverage, rack up unpaid bills, or forego cheaper preventative care and as a result end up generating greater costs and more expensive emergency room visits.

If a consumer fails to sign up for a marketplace plan, then he or she receives no coverage and no federal subsidies come into the state. That outcome may produce worse results for providers such as hospitals, who may have to provide completely unreimbursed emergency room care, for example.

These scenarios are not merely speculative. As previously noted, the 2022 *Journal of Health Politics, Policy and Law* article found that the 2014 changes in Wisconsin lowered the uninsured rate here less than in states that fully expanded Medicaid around the same time period. In addition, the analysis of the state insurance claims database in that study suggested an increase in the uninsured rate among the individuals who lost Medicaid coverage.

As already noted, The Urban Institute and the Robert Wood Johnson Foundation have projected that expanding Medicaid would lower Wisconsin's uninsured population by 23,000 people, or 8.1%. Though such a reduction would be relatively modest when considering the state as a whole, it is likely to yield at least some benefits beyond those that we have already discussed, such as improved health care for those obtaining coverage and a reduction in unpaid bills for providers.

The Wisconsin Hospital Association reports that its members provided $151.5 million in charity care in 2022 and accrued $226.1 million in bad debt from patients. Those figures underline the substantial costs to providers of delivering care not covered by any health plan. In short, reducing the uninsured or under-insured population in the state could yield tangible benefits to those individuals as well as providers, particularly those serving a low-income population.

## Summary

Wisconsin differs in fundamental ways from the other nine states that have not expanded Medicaid. Those other states offer no Medicaid coverage for childless adults and cover parents up to only a fraction of the federal poverty level. Wisconsin, on the other hand, covers all adults up to 100% of FPL through Medicaid.

For that reason, an expansion is projected to produce the smallest percentage increase to the Medicaid rolls in Wisconsin among the 10 non-expansion states. However, Wisconsin would benefit from a significant decrease in its ongoing state Medicaid spending from an expansion – the only remaining state that would see such a benefit. Together with additional one-time incentive payments, expansion could save state of Wisconsin taxpayers $1.7 billion over two years while adding an estimated up to 90,900 adults to the Medicaid rolls and lowering the uninsured population by a smaller amount.

At the same time, however, Medicaid expansion would reduce the federal premium tax credit subsidies that flow into Wisconsin through the ACA marketplace plans. This reduction would total at least $283 million per year and policymakers may wish to consider its impact to the state's health care system if they pursue Medicaid expansion.

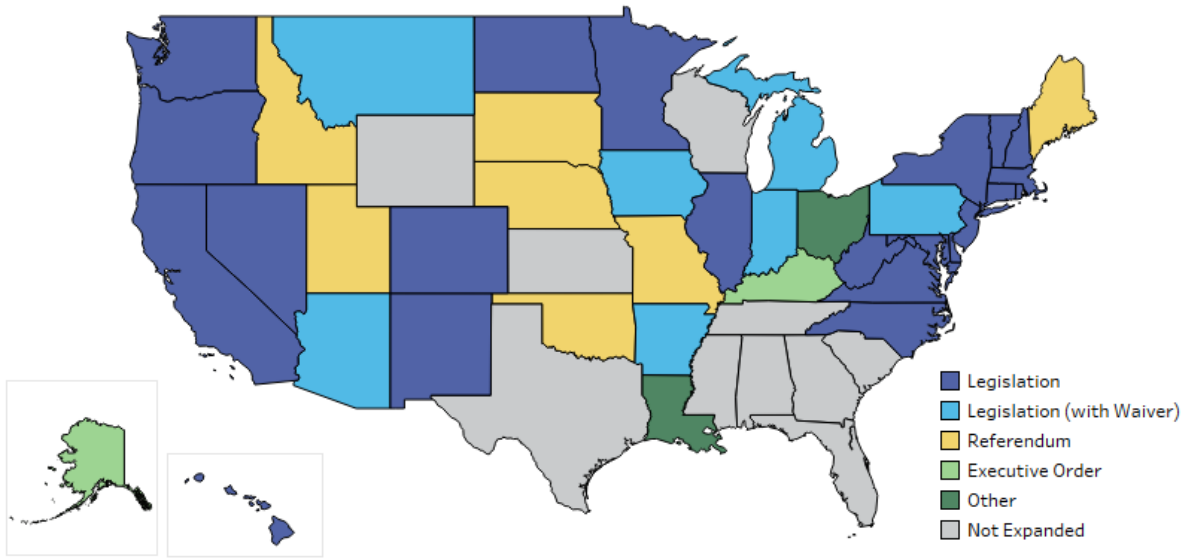
Providers may be negatively affected by shifting more consumers from ACA plans into BadgerCare Plus because of Medicaid's lower reimbursement rates. However, this potential impact needs to be balanced against the possible gain for providers from lowering the number of uninsured residents in the state and the cost of uncompensated care for them.

# A LOOK AT OTHER STATES AND THEIR PATHS TO EXPANSION

In examining how 40 states have implemented Medicaid expansion since 2014, the most striking detail is the different paths they have taken to arrive at this destination. As **Figure 17** shows, a majority of those states – 22 – have expanded the program through state legislative action alone, with many being Democratic-leaning states on both coasts. An additional seven states have done so by approving legislation and also obtaining a federal waiver of some of the standard Medicaid rules. Medicaid has also been expanded by ballot measures in seven states, executive orders by governors in two states, and the action of both legislators and the governor in Ohio and Louisiana.

**Figure 17: States Have Taken Different Paths to Expansion**

Whether and how states have fully expanded Medicaid




Sources: WPF analysis of research from Kaiser Family Foundation, Advisory Board, and others. Louisiana lawmakers first passed a concurrent resolution and the governor then expanded Medicaid via executive order. Ohio expanded Medicaid initially via a Controlling Board.

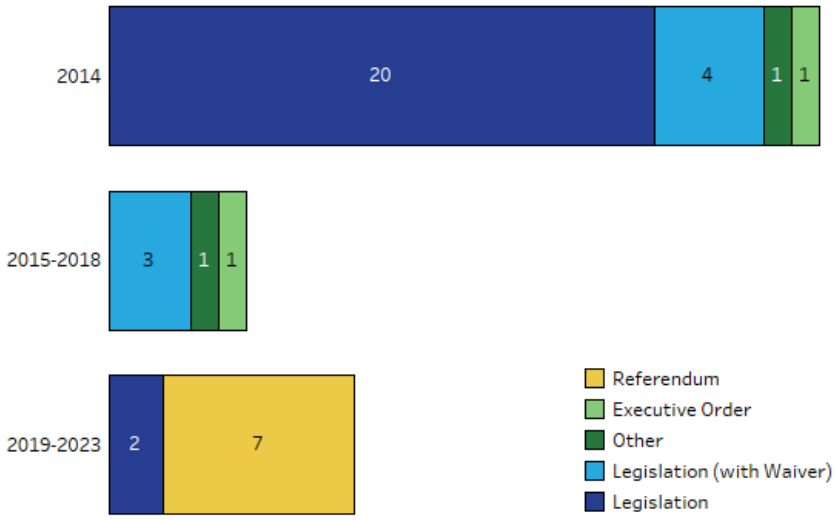
The majority of states implemented Medicaid expansion in 2014, the first year in which states could do so under the ACA. Of the 26 states that implemented an expansion that year, all but two did so primarily through a measure passed by their legislature and signed by their governor (see **Figure 18** on the next page). As already noted, these were primarily blue states where elected officials were immediately receptive to the goal of expanding Medicaid. Since then, elected officials in the remaining states have been more cautious in expanding Medicaid. In 2015 and 2016, five states took this step, and none did so in 2017 or 2018. Since 2019, the pace has quickened somewhat, with nine mostly Republican states approving an expansion.

Most notably, supporters of Medicaid expansion have shifted their efforts away from state legislatures. Since 2015, the majority of expansions have been approved by voters through a ballot initiative or the action of a governor. In particular, seven of the nine most recent expansions have been approved by referendum. Only one binding state referendum related to Medicaid expansion has failed – a funding measure in Montana, where the state ultimately still funded its expansion.

Some of these referendum states still might have expanded the program later through legislation. Still, this trend suggests that approving an expansion will be difficult in Wisconsin, given that lawmakers here have declined to do so and no alternative exists to the legislative process. Unlike some other states – mainly those in the West – Wisconsin citizens cannot place binding legislation onto ballots and then vote on whether to approve it into law. In fact, one of the common characteristics among the 10 remaining states that have not expanded Medicaid is the inability for citizens in most of those states to enact legislation on their own.

**Figure 18: More States Turning to Referenda to Expand Medicaid**

How Medicaid was expanded and the number of states using each method by year




Sources: WPF analysis of research from Kaiser Family Foundation, Advisory Board, and others. Louisiana lawmakers first passed a concurrent resolution and the governor then expanded Medicaid via executive order. Ohio expanded Medicaid initially via a Controlling Board.

Another important facet of Medicaid expansions approved after 2014 has been the use of waivers, in which states have sought exemptions from federal rules that would allow them to take steps such as charging premiums to some recipients. Three of the 14 states that have adopted Medicaid expansion most recently have successfully sought and received a waiver.

Here we look in depth at some of the steps taken by other states as they expanded Medicaid. We include both neighboring states to Wisconsin (Minnesota and Iowa) as well as states that have taken longer or non-traditional routes to expansion (North Carolina and Arkansas). In the next section, we will draw on these other models as we discuss a potential expansion in Wisconsin.

## Minnesota

After the passage of the ACA in 2010, Minnesota was one of a group of states along with California, New Jersey, Connecticut, and Washington, that expanded Medicaid prior to the full implementation of the federal law by shifting individuals on state health insurance programs to Medicaid coverage the following year. As part of the state's budget negotiations, Republican Gov. Tim Pawlenty agreed to consider this expansion and allow the next governor to implement it. Pawlenty decided against expansion, but his successor, Mark Dayton, was elected and expanded Medicaid in Minnesota to this population in January 2011. The Minnesota expansion was estimated at the time to cover an additional 95,000 individuals. The majority of that group was already receiving state-sponsored health insurance either from MinnesotaCare or the now discontinued General Assistance Medical Care program, though around 12,000 were uninsured.

Minnesota expanded Medicaid again in 2014 along with a much larger group of states, raising the eligibility limit for parents and childless adults to 138% of FPL. The state also covers pregnant women at the higher threshold of 283% of FPL and children two and over at 280% and 288% for those under two years old. Parents and childless adults who earn between 138% and 200% of FPL can access coverage via MinnesotaCare – a state coverage plan that receives federal Basic Health Program funding and provides 95% of what each individual would have received in federal subsidies through the ACA marketplace. This expansion passed by the Minnesota legislature by a wide margin, as the state had Democratic majorities in both its House and Senate.

Prior to early expansion in 2009, 9.1% of Minnesota's population was uninsured, according to U.S. Census Bureau data. As of 2023, only 4.2% of Minnesotans were uninsured, giving it the fourth-lowest uninsured rate in the country.

## Iowa

Unlike Minnesota, Iowa did not take a traditional path to Medicaid expansion, opting instead to use waivers from the federal government to implement a two-tiered system to provide health coverage to those at or below 138% of FPL.

In 2013, the state applied for and received two waivers to expand coverage for adults. The first waiver specified that adults at or below the poverty line must enroll in a Medicaid managed care program known as the Iowa Health and Wellness Plan. Iowa did not include a work requirement but did require monthly premiums in certain cases beginning in the second year of enrollment. The second waiver directed adults with incomes between 100% and 138% of the federal poverty line to enroll in the Iowa Marketplace Choice Plan, an ACA health plan that used Medicaid funds to fully pay the premiums. A waiver amendment approved the following year allowed enrollees to these two programs to lower or eliminate their premium in exchange for completing a wellness exam and health risk assessment.

With this approach, Iowa joined Arizona, Arkansas, Indiana, Michigan, Montana, and Pennsylvania as states that initially expanded Medicaid using waivers. However, the initial group of private insurers participating in the Iowa Marketplace Choice Plan were either liquidated due to financial problems or ended up withdrawing. In 2015, Iowa brought its expansion more in line with the ACA and transitioned its Marketplace Choice Plan enrollees to Medicaid managed care. Since April 2016 – when implementation of this transition began – the group of private insurers under contract with the state of Iowa to provide managed care has changed a number of times; when an individual's insurer exits from the group of providers, the recipient is transitioned to another provider either by choice or default.

When initial action on Medicaid expansion was taken in 2013, Iowa Republicans held a narrow majority in the House and Democrats held a similar position in the Senate. Then Republican Gov. Terry Branstad was initially unwilling to accept federal dollars for Medicaid expansion, which was why the final piece of legislation in Iowa required certain premium payments, kept the private insurer system for individuals above the poverty line, and did not allow for Medicaid dollars to pay for non-emergency transportation, among other items. Iowa has traditionally had low uninsured rates, and they have fallen from 8.6% in 2009 to 5.0% in 2023, according to the Census Bureau.

## Arkansas

Before 2013, Arkansas tightly restricted adult eligibility for Medicaid. The income limit for non-disabled adults in the state who were not pregnant was limited to parents at or below 17% of the federal poverty line, and no childless adults qualified.

Arkansas was an early adopter of Medicaid expansion, with Democratic governor Mike Beebe signing the Health Care Independence Act into law on April 23, 2013. The measure passed with Republican majorities in both houses of the legislature because it took a different approach than many other states at the time. The law authorized a waiver to allow the state to use Medicaid expansion dollars to enroll newly covered individuals in a "private option" plan through the state's ACA health care marketplace. Arkansas was the first state to use this kind of waiver and it was followed by Iowa.

The "private option" concept has been a facet of Medicaid expansion in Arkansas since that time. In 2016, lawmakers passed "Arkansas Works," which added premium payments for enrollees with income levels above the federal poverty line.

Arkansas later implemented for a short period the only work requirement in the country for recipients of Medicaid expansion. Proponents said the work requirement helped foster self-sufficiency among low-income populations, and ensured that public benefits were not given to individuals who were choosing not to work. Initially, Arkansas Works simply included job training referrals for unemployed enrollees. But in 2017, Republican Gov. Asa Hutchinson had taken office and Donald Trump became president, clearing a path for new waiver requirements that might not have been otherwise approved. Hutchinson signed Act 6 into law on May 4, 2017, and work requirements were approved by federal CMS officials in March of the following year and phased in starting in June 2018.

**Private Option Plans and Their Cost**

As part of the Affordable Care Act expansion in both states, Arkansas and Iowa won approval from the federal Centers for Medicare and Medicaid Services (CMS) to use Medicaid funds to pay for enrollees' premiums in private plans on the health insurance exchanges. We note these waivers since they may represent a model for a bipartisan compromise on Medicaid expansion. However, an August 2014 memo from the federal Government Accountability Office found that allowing Arkansas to employ this "private option" increased Medicaid costs for federal taxpayers. The memo concluded that the Arkansas waiver was "further evidence of our long-standing concerns that (CMS) is approving demonstrations that may not be budget-neutral" as required by federal law. These concerns could serve as an impediment to CMS approving similar waivers for states such as Wisconsin in the future.

If the state's data sources could not verify an enrollee was employed or met an exception to the work requirement, then enrollees had to verify each month they had worked, volunteered, studied, trained for a job, or performed community service for at least 80 hours. If they did not do so for three straight months, they were removed from Medicaid through the end of the calendar year even if they were otherwise qualified. Over the second half of 2018, 18,000 Arkansans lost coverage. That was about 23% of the recipients subject to the requirement, according to a June 2022 Congressional Budget Office report. The budget office found the requirement increased the number of adults who were uninsured and roughly doubled the portion of those adults reporting serious problems paying their medical bills, but did not have a statistically significant effect on the share of recipients with jobs, perhaps because recipients were unaware of the requirement or had difficulty complying.

In 2019, a federal judge overturned Arkansas' work requirement, and it remained suspended until Joe Biden became president in 2021. Both the 2019 decision and a 2020 appellate court decision found that the state's work requirement and waiver did not further the goals of Medicaid – to provide health insurance to low-income people – and that the federal Health and Human Services Secretary issued the waiver without adequately considering the impact a work requirement would have on coverage. Federal CMS officials withdrew the Arkansas Works waiver soon after, ending the possibility of work requirements in Arkansas as well as other states.

The Arkansas Health and Opportunity for Me (ARHOME) waiver was approved in December 2021 to replace Arkansas Works; ARHOME dropped not only the work requirements but also the premium payments that were part of Arkansas Works. In state fiscal year 2020, just over 350,000 Arkansans were eligible for Arkansas Works, and that number rose to 441,608 in 2021 due to COVID expansion requirements. As of May 2024, just over 244,300 state residents were eligible for ARHOME. The uninsured rate in Arkansas in 2023 was 8.9%, according to Census Bureau American Community Survey data.

## North Carolina

In March 2023, Gov. Roy Cooper signed into law House Bill 76, which made North Carolina the 40th – and most recent – state to expand Medicaid. The process of expansion began when the state's General Assembly, or legislature, passed the state budget in September 2023, and the legislation took effect in December 2023. Prior to this date, only parents at less than 40% of FPL were eligible for Medicaid and childless adults without a qualifying disability were not eligible at all.

Much like Wisconsin, both houses of the North Carolina state legislature had been controlled by Republicans for more than a decade, but Cooper – a Democrat – had sought Medicaid expansion since being elected in 2016. While some legislative Republicans backed expansion for some time, many others became convinced only after President Donald Trump and Republicans in Congress opted in 2017 not to repeal the ACA and then additional financial incentives for expansion were offered through the American Rescue Plan Act. House Bill 76 passed with only a handful of dissenting votes in both houses. The North Carolina expansion was unusual in recent years because it was approved by lawmakers rather than by voters in a statewide referendum. Prior to that, Virginia had been the last state to pass expansion legislatively in 2018, implementing it the next year.

Groups pushing for the expansion highlighted individuals affected by Medicaid coverage gaps and took on other efforts such as letter writing campaigns. Another factor in the push for Medicaid expansion in North Carolina was the state of rural healthcare: from 2005 to 2023, North Carolina was one of just six states to see at least 10 rural hospitals close, according to the National Conference of State Legislatures.

Some North Carolina officials wanted to impose work requirements on Medicaid recipients, but the Biden administration had rejected similar requirements in Arkansas and other states. In response, North Carolina's expansion legislation directed the state to implement work requirements "if there is any indication that (they) may be authorized by the Centers for Medicare and Medicaid Services."

Data from the state of North Carolina shows that as of August 2024, there were 520,667 new enrollees in Medicaid in the statedue to the expansion – or the majority of the 600,000 individuals the state estimated would become eligible under expansion last year. The expansion population has a higher makeup of rural and Black individuals than the state's adult population but the majority of

the enrollees are white, according to the state data. A majority of enrollees are also female. The uninsured rate in North Carolina in 2023 was 9.2%, according to Census Bureau data.

## Exploring Work Requirements and Supports in Greater Depth

As we have seen, the Medicaid expansion debate has often focused on whether it could affect enrollees' willingness to work and whether they should be required to hold a job. A May 2022 brief by the Kaiser Family Foundation noted that federal CMS officials under then President Donald Trump approved Medicaid work and reporting requirements in 13 states on adults of working age with no qualifying disability. Nine more states requested authorization to impose their own requirements.

Proponents of these requirements say that states like Wisconsin should incentivize employment given their very low unemployment rates, aging workforces, and high demand for workers. Yet opponents have successfully argued – first in court and then with the Biden administration – that the rules undermine the fundamental goal of Medicaid to provide health coverage to those in need and lead to many recipients losing coverage as they did in Arkansas. Yet these policies might return in states like North Carolina if there were a change in presidential administration.

Work requirements have been more common in other public assistance programs such as Temporary Assistance for Needy Families (the successor to welfare programs also known as TANF) and in the Supplemental Nutrition Assistance Program (SNAP), the program that was once known as food stamps and is also referred to as FoodShare in Wisconsin. A Congressional Budget Office report from June 2022 found that work requirements within TANF "substantially increased the employment rate" of recipients but that such requirements within SNAP had less effect and within Medicaid had no discernible effect, though the latter conclusion is based on the limited experience in Arkansas.

These work rules can lower the cost of public aid programs by reducing enrollment, but they can also increase costs if states fund work supports to help recipients meet the requirements. In the case of Wisconsin's Medicaid work requirement, the potential cost of the proposal in 2017 was cited as $19.7 million over the following two years, with greater costs in subsequent years. In the place of an outright work requirement, some other states instead seek to make it easier for recipients to gain and keep a job. Those states offer supports such as child care subsidies, assistance in job searches, subsidies to employers to hire these recipients, and job training. In the next section, we discuss the case of Montana, one state that has adopted this approach.

## Summary

The examples of other states underline the challenge for proponents of Medicaid expansion to succeed in Wisconsin. In recent years, most of the states that have approved an expansion have done so either by a referendum initiated by citizens or some other non-legislative means such as an executive order by their governor. None of those options could be pursued in Wisconsin, where the path to expansion must run through the Legislature.

The experience of other states, however, provides options for how Wisconsin could pursue expansion legislatively. They range from Minnesota's efforts to extend public coverage beyond the standard ACA approach and states such as Iowa and Arkansas that implemented Medicaid expansion in part through a use of the ACA insurance marketplaces. These other states feature both successes and cautionary tales, such as the financial challenges faced by the Iowa insurers engaged in that state's non-traditional approach to expansion.

# EXPLORING WHAT EXPANSION WOULD MEAN

In Wisconsin, the question of Medicaid expansion will be decided primarily by lawmakers. In 2018, legislators and then Gov. Scott Walker approved legislation that said the next administration could not expand Medicaid eligibility under the Affordable Care Act "unless the state Legislature has passed legislation to allow the expansion and that legislation is in effect."

With the current composition of the Legislature, expansion supporters would need to assemble a bipartisan coalition to pass legislation. This action has been accomplished in other states, but the difficulty is underlined by the fact that only two states have done so legislatively since 2019. Here we provide a series of options for policymakers to consider. They range from maintaining the status quo to a full expansion of Medicaid under multiple approaches.

## Option One – Make No Change

With the present composition of the Legislature, the most likely near-term scenario for Wisconsin is that elected officials maintain the state's partial expansion of Medicaid – an approach that has now prevailed for a decade. It offers some advantages, including maintaining a system that is familiar to both consumers, insurers, and providers in the state. To the extent that state residents between 100% and 138% of the poverty level are enrolling in health coverage via the ACA exchange or employer coverage, the status quo may also limit the effect of low Medicaid payments on providers.

The state's 4.9 % uninsured rate is below the national average and all other non-expansion states. That fact partly reflects Wisconsin's status as the only non-expansion state in the country to eliminate the gap in health coverage for adults by bringing Medicaid eligibility up to 100% of FPL – the income threshold at which the ACA plans become available. The current approach also leverages at least $283 million in federal tax credits received by those between 100% and 138% of FPL.

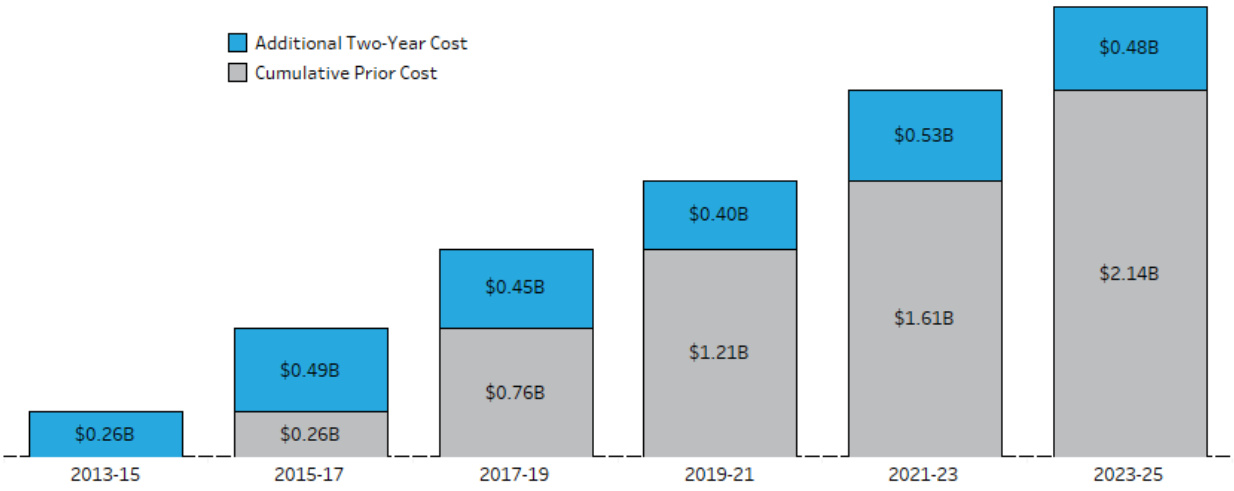
Yet, as this report has noted, the ACA plans can leave these individuals with higher out-of-pocket costs than BadgerCare Plus. At present, Wisconsin is also missing out on the substantial additional federal funding afforded to expansion states, which in turn affects state taxpayers.

In the past, opponents of Medicaid expansion raised doubts about whether the additional federal funding would persist. However, it now has lasted for more than a decade, including periods in which both Democrats and Republicans controlled the federal government. Also, if the funding did end, then Wisconsin officials could still vote to repeal the expansion by changing eligibility requirements as the state has done in the past.

As **Figure 19** on the next page shows, the Legislative Fiscal Bureau estimates state taxpayers covered a total of $2.6 billion in costs that would have been paid by federal taxpayers if Wisconsin had expanded Medicaid at the first opportunity in 2014 and maintained the expansion through the end of the current fiscal year on June 30, 2025. That does not include the $1.2 billion in one-time ARPA funds since Wisconsin would not have qualified for those funds if the state had expanded Medicaid in 2014. These funds could have been used for any legal state purpose, such as strengthening provider reimbursement or other aspects of the health care system, funding education, or reducing tax rates.

**Figure 19: Cumulative Cost of Partial Medicaid Expansion Has Risen Over Time**

Additional cost to the state of WI of partial Medicaid expansion compared to the cost of full expansion by two-year state budget cycle




Source: Legislative Fiscal Bureau

It is worth noting that Democrats in the U.S. Senate and President Biden have proposed expanding coverage in non-expansion states like Wisconsin through federal programs. For now, these plans do not appear likely to pass but if approved might result in Wisconsin's state taxpayers permanently foregoing additional funding and savings if the federal government provided the coverage directly to recipients and as a result did not increase reimbursement rates for Wisconsin's Medicaid program. Policymakers may wish to weigh this possibility as one factor among many to consider.

## Option Two – Expand Medicaid Without Seeking a Federal Waiver

If policymakers in Wisconsin seek to fully expand Medicaid, the simplest path would be to do so by following the existing federal rules and not requesting that any of them be waived. The official projections for Wisconsin suggest expanding Medicaid would extend health insurance to tens of thousands of state residents, lower state Medicaid costs and improve coverage benefits for tens of thousands more enrollees, provide hundreds of millions of dollars in ongoing Medicaid savings to state taxpayers, and draw down a roughly $1 billion infusion of one-time federal Medicaid funds. Medicaid expansion would lower uninsured rates for most groups in Wisconsin, particularly for rural residents, young adults, Black and white residents who are not Hispanic, and women.

Forgoing a federal waiver would mean the state could not impose certain conditions such as requiring recipients to work or undergo health risk assessments. There is no guarantee, however, that federal officials would approve waiver requests. In fact, as we have seen, federal officials in recent years have denied them for Wisconsin and some other states, making it uncertain at best that the state could receive such a waiver in the future. Even without a waiver, state officials still could pursue many of their underlying goals outside of the Medicaid program, as we will discuss next.

In addition, elected officials could still require the state to sunset its Medicaid expansion if the federal government reduced the more generous funding for it. Expansion legislation could also require the state to pursue a Medicaid work requirement or other waivers if a change in presidential administration led federal CMS officials to once again approve such requests and if court decisions were also favorable.

A full expansion could help health care providers by reducing the number of uninsured patients receiving uncompensated emergency room and other types of care. Yet, as we have noted, tens of thousands of affected ACA plan recipients and their health insurers and providers would also lose an estimated $283 million in federal premium tax credits as patients shift from ACA plans to Medicaid.

As part of this transition, some recipients might have to switch health care providers, though some of the same health insurers provide both Medicaid managed care products and ACA plans in Wisconsin. Providers also could have some additional uncompensated costs should large numbers of ACA enrollees be replaced by Medicaid patients in light of the relatively low Medicaid reimbursement rates. Given that Medicaid in Wisconsin already covers many more adults than in other non-expansion states, some providers may choose to see a full expansion as a less urgent priority.

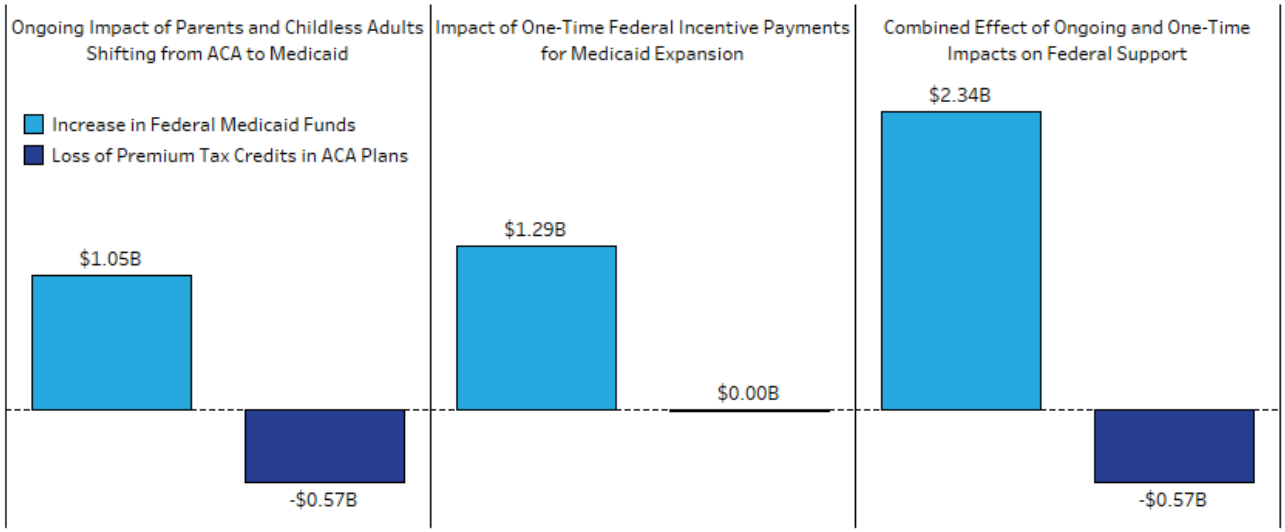
However, as **Figure 20** shows, Medicaid expansion likely would produce a net financial gain for the residents and providers in Wisconsin. That is because the more than $1 billion in ongoing additional federal funding for the Medicaid program over two years plus the nearly $1.3 billion in one-time funding over the same two-year budget would provide enough resources to replace the federal tax credits and co-pays from the current ACA plan recipients, cover the additional patients gaining coverage through Medicaid, and still leave substantial savings.

What could the state do with these additional funds? One answer would be to use a significant portion of them to improve the overall health care system through enhancing coverage, benefits, or Medicaid reimbursement rates in areas such as primary and acute care, behavioral health, dental services, and long-term care. Such an approach might counter the concerns of providers who worry about low reimbursement rates and doubt expansion would substantially improve the quality of health care in Wisconsin. The state could simply provide these higher rates or could do so in exchange for providers hitting certain targets with respect to patient outcomes and health

Providers do have good reason to question whether the state savings from expansion would stay within the health care system. State officials have numerous priorities ranging from education to public safety to low taxes, and would face pressure from some voters and interest groups to use some of the expansion savings for those goals or simply to plug a future budget shortfall.

**Figure 20: Even With Loss of ACA Tax Credits, Medicaid Expansion Would Still Increase Federal Support**

Overall inflows and losses of federal funds to Wisconsin from Medicaid expansion over a two-year period




Sources: Wisconsin Department of Health Services, Centers for Medicare and Medicaid Services, and Policy Forum research

In fact, those who doubt whether the expansion savings will help the health care system can point to a discouraging precedent. In 1998, Wisconsin and other states reached a legal settlement with tobacco companies that resulted in billions of dollars being paid to the state over the succeeding decades. Many hoped these settlement monies would help fund programs to curb tobacco use and address its health impacts. However, most of the funds were ultimately pledged to help resolve state budget shortfalls in the 2001-03 and 2007-09 budgets as part of two complex financial transactions known as tobacco securitization. Under these deals, the state borrowed to receive lump sum payments and the stream of settlement funds was used to make payments on the resulting debt.

## Option Three – Expand Medicaid Through a Waiver or Other Less Traditional Approach

If state officials wish to seek a compromise on Medicaid expansion, they could explore a number of alternatives to the traditional approach. Such options hold out the promise of bipartisan agreement and perhaps even innovation. Among the remaining states that have not done so, Wisconsin would have the greatest financial flexibility in its approach to expanding Medicaid because of the unique state budget savings an expansion would produce here. However, the development and success of any alternative approach would likely call for a greater level of planning, monitoring, and investment than a simple Medicaid expansion and could also require approval from federal CMS officials.

With that caveat, lawmakers could approve Medicaid expansion with requirements that recipients:

- **Receive access to work referrals** – Montana refers Medicaid enrollees to the Health and Economic Livelihood Partnership Link (HELP-Link), a program that provides career counseling, job training, and help in addressing other barriers to work such as child care or a lack of transportation. HELP-Link represents a compromise between requiring Medicaid recipients to work and providing no encouragement or incentive for them to do so. A 2019 report by Montana's labor department found that 32,000 Medicaid recipients received services from HELP-Link and federally funded workforce programs. For those recipients receiving some type of job training, 72% of them were employed within a year and 83% of those with jobs received a wage increase in the year after participation. Such assistance would carry a greater cost than simply requiring recipients to work, but might also produce greater benefits and could potentially be financed through the additional federal funding from expansion. At present, a little more than two-thirds of working-age Medicaid recipients in Wisconsin without a qualifying disability work.

- **Adopt healthy behaviors** – As part of Nebraska's expansion, the state initially required recipients to work and undergo an annual health risk assessment to obtain additional benefits, though the state later rescinded those rules. Wisconsin also imposed this requirement for a limited time on childless adults, though in November 2023 federal officials withdrew the waiver provision allowing it and Wisconsin stopped the practice on Jan. 1, 2024. This decision means the state might be restricted to offering assessments on a voluntary basis going forward. Unlike work requirements, wellness assessments relate to Medicaid's goal of promoting health, and they also could reduce Medicaid spending. However, without adequate support to ensure recipients complete their assessments and take the necessary corrective actions, this requirement could also lead to otherwise qualified recipients losing coverage without substantially improving the health of those who remain in Medicaid. Providing this support could also entail additional costs.

- **Participate in an Affordable Care Act-style plan** – Arkansas and Iowa both used Medicaid expansion funds to help pay for state residents between 100% and 138% of the poverty level to participate in an ACA marketplace plan. On the one hand, this plan might draw down additional federal funding and avoid low Medicaid reimbursement rates for the new enrollees. However, Iowa's decision to end its experiment because of financial difficulties among insurers may inspire caution as much as imitation. The idea was sustainable in Arkansas and might be here, as Wisconsin ACA plans already have experience working with this income group, but this approach does carry some risk.

- **Pay Modest Premiums** – Wisconsin briefly implemented this approach for childless adults within BadgerCare Plus but also had the authority for it withdrawn by federal officials last year. Proponents saying it encourages responsibility on the part of participants and only added a few dollars per month to their costs. Critics, however say the low premiums represented an additional opportunity for recipients to lose their coverage while adding little in the way of direct actual cost savings for taxpayers.

As noted earlier, all of these approaches except the work referrals would require CMS approval. All of them would entail either greater risk or greater cost for the state or both, with no guarantee that they would yield sizable benefits. For that reason, these alternatives would likely require greater foresight and skill to implement successfully than a traditional Medicaid expansion. Yet for now at least, such a middle-of-the-road approach may offer some benefits if it is well executed and for expansion proponents may represent the only pathway to adoption.

## Option Four – Start Small with a More Modest Bipartisan Agreement

In the spring of 2025, lawmakers will likely receive and consider another expansion proposal from Gov. Tony Evers. If both sides reach agreement, the question is resolved, but if they do not, it leaves the prospect of a stalemate for the rest of the two-year legislative session. In such a case, both sides could consider introducing a smaller bill that would demonstrate that they could work together in good faith to achieve mutual benefits. Such a proposal could pair a modest coverage expansion with an accountability measure such as a pilot work referral program in one or more counties.

For example, the governor has proposed – and the Legislature has rejected – a change to extend BadgerCare Plus coverage of pregnant women for a full year after they give birth at a cost of $11.6 million over two years. Wisconsin is currently the only state nationally that has done already done so or started to do so, according to the Kaiser Family Foundation. As part of this hypothetical proposal, lawmakers and the governor could reconsider this or another coverage extension while also considering a program to refer unemployed Medicaid recipients without a qualifying disability to services that would help them gain employment. Such a proposal would not greatly increase federal funding, but the current state surplus would readily absorb the cost of such a bill.

As part of such a compromise, legislators could seek a report or audit that would examine the results and lessons learned from the initiative and then consider those findings as they debate next steps.

## Summary

Legislators and Evers will decide on whether to expand Medicaid in Wisconsin – no other vehicle exists for doing so here. Their options start with retaining the status quo, in which Wisconsin foregoes significant federal aid but retains the lowest uninsured rate among non-expansion states.

If state officials do opt to expand Medicaid, they would likely decrease the uninsured rate modestly and would have greater financial flexibility in doing so than any other remaining state because of the unique benefits of additional federal aid to Wisconsin. For example, they could seek to better reimburse providers in exchange for better health outcomes.

They could also try to boost employment among Medicaid recipients without a qualifying disability above its current level of 68% by spending some of the expansion-related savings on voluntary employment assistance. Meeting this goal would be difficult at best given that two-thirds of Medicaid recipients are already employed and the employment rate would likely be higher among the potential expansion population. State officials may wish to employ a pilot or other method such as a follow-up audit to ensure the target is reached or progress is at least made. Though some states previously pursued this goal through work requirements, this approach is currently prohibited by CMS.

# CONCLUSION

After the passage of the Affordable Care Act, Wisconsin in 2014 adopted a unique response to the prospect of Medicaid expansion, in essence ending coverage for parents and other caretakers above the poverty line but extending it to enough childless adults living in poverty to increase the net number of recipients. Our detailed analysis of whether and how Medicaid could now be expanded in in the state finds:

- Wisconsin's uninsured rate remains below the national average, a product of both our state's demographics and robust private insurance market and its partial Medicaid expansion, giving the state the highest coverage levels among the 10 states that have not fully expanded the program. Most working-age Medicaid enrollees without a disability are also employed.
- Under the state's current approach, it has foregone additional federal aid that would deliver an ongoing state savings of more than $400 million over the next two-year state budget plus additional one-time savings.
- Rural counties would see the largest share of their population becoming eligible for Medicaid under an expansion, though large numbers of residents would still enroll in urban areas.
- An expansion in Wisconsin is projected to produce the smallest percentage increase to the Medicaid rolls among the 10 remaining non-expansion states. However, Wisconsin would be the only state in the group to significantly reduce its Medicaid spending through expansion.
- In recent years, most of the states that have approved an expansion have done so either by a referendum initiated by citizens or an executive order by their governor. In Wisconsin, however, expansion can be accomplished only through the passage of legislation. For the past decade, lawmakers have declined to do so, suggesting that expansion would likely only result from some combination of compromise and change in the Legislature's composition.

Opponents can argue that expanding Medicaid from 100% of the poverty level to 138% would have some offsetting costs. Moving the ACA plan participants in this income group to Medicaid would mean that these individuals and their health insurers and providers would no longer receive at least $283 million in federal tax credits from the ACA. That would reduce the net influx of federal assistance to Wisconsinites from an expansion, though it would remain substantial. Providers might also receive lower reimbursement rates to care for these individuals under BadgerCare Plus than they currently receive from ACA plans.

Supporters note expansion would provide a projected 72,000 to 90,900 individuals with more robust and affordable health coverage and treatment than is currently available to them through the ACA marketplaces. An expansion could reduce the uninsured rate, lower state costs, and potentially limit uncompensated and charity care for providers, which might in turn lower costs for other patients.

Finally, the uncertainty regarding the potential use of the Medicaid expansion savings leaves a large unknown in our analysis. On the one hand, these savings give policymakers unique flexibility to finance various compromises while also pouring more money into health care improvements that could offset financial concerns for providers. On the other hand, there is no guarantee that savings would be invested in that way, which may help to explain the skepticism of some providers.

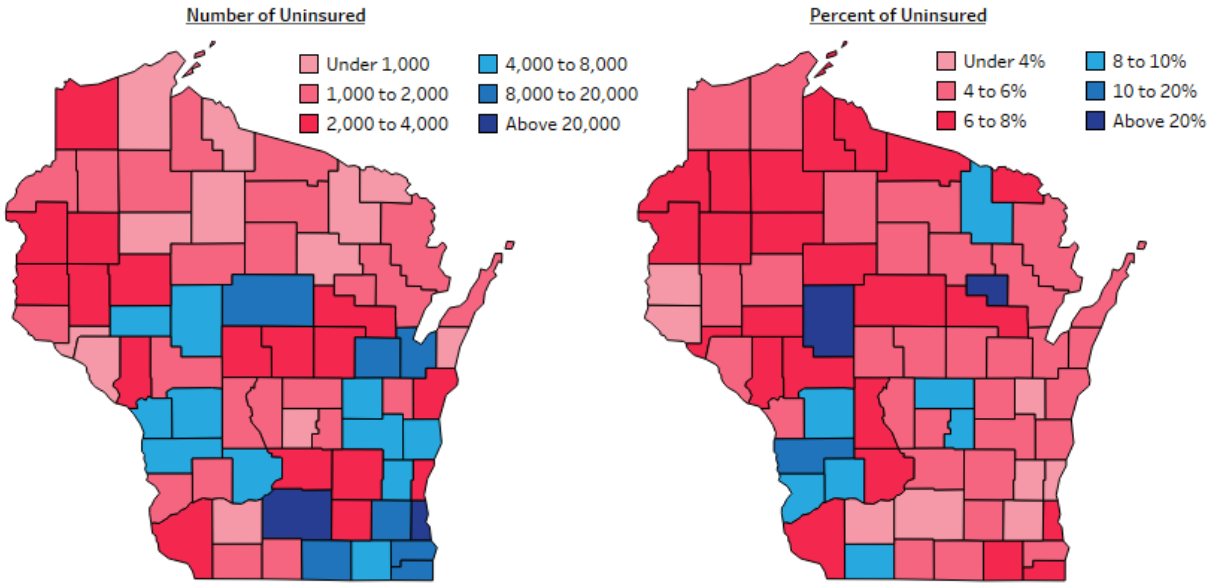
In publishing this report, we ultimately seek neither to promote nor to undermine expansion proposals. Instead, we have simply sought to frame this issue for policymakers and citizens, and we hope our study serves both sides in this debate as they consider the next steps for Wisconsin.

# APPENDIX

As shown in **Figure 21**, maps of the number of uninsured Wisconsin residents by county and their uninsured rate are similar to the maps included on page 14 that show the number and rates of residents by county with incomes falling between 100% and 138% of the federal poverty level.

**Figure 21: Highest Share of Uninsured Live in Rural Areas, Largest Numbers in Cities**

Percentage and number of uninsured residents by county in 2022




Source: U.S. Census Bureau American Community Survey Five-Year Estimates