FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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EXPLAINING HEALTH REFORM: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act

Introduction

Under the new federal health reform law, the Patient Protection and Affordable Care Act (ACA), most U.S. citizens and legal residents will be required to have health insurance beginning in 2014, and the law establishes a state-based system of health insurance Exchanges and expands Medicaid to make coverage readily available to millions of uninsured people who need it. Congress included strong provisions in ACA designed to ensure that state enrollment policies and procedures and supporting technology systems genuinely help individuals and families enroll and stay covered, and also foster efficient administration. The success of the ACA in achieving near-universal health coverage will depend to a great extent on the effectiveness of the enrollment and renewal processes that states put in place. As states move forward, the experience in other states and contexts can help guide them in designing an integrated, consumer-friendly enrollment structure that incorporates Medicaid, CHIP, the Exchange, and any other available state or local public health programs.

What are the key enrollment-related provisions of health reform?

The ACA establishes numerous requirements regarding eligibility and enrollment processes, with the goal of creating a streamlined system for connecting people with the appropriate health program, and maximizing reliance on electronic data exchanges and other technology applications to reduce burdens on consumers and enhance continuity of coverage. The law requires the new system to enroll people applying for health subsidy programs — including Medicaid, CHIP, premium tax credits or cost-sharing reductions in the Exchange, and §1331 state qualified basic health plans — into the proper program, and to facilitate seamless transitions between programs when individuals' and families' circumstances change.

In particular, the ACA:

- Directs the Secretary of Health and Human Services to operate an information portal (**www.healthcare.gov**) to help consumers identify and compare their coverage options and assess their eligibility for health subsidy programs, to develop a model template for Exchange-level portals, and to assist states in developing and maintaining such portals;
- Requires the Secretary to develop a single, streamlined application that states may use to allow individuals to apply for all health subsidy programs, and that may be filed online as well as in person, by mail, or by telephone;[1]
- Requires states to create a "no wrong door" system, supported by an Internet website that allows for enrollment and reenrollment, ensuring that individuals seeking coverage are screened for all health subsidy programs and processed through to enrollment without requiring additional application forms or multiple eligibility determinations;
- Modifies and standardizes income and other eligibility rules to promote uniformity across all health subsidy programs and simplify the eligibility process; and
- Requires states to develop and use secure electronic interfaces to exchange available data "to the maximum extent practicable" to establish, verify, and update eligibility for health subsidy programs; the law specifically identifies tax data for this purpose.

For further details about the ACA's enrollment provisions, see **Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges** (**http://www.kff.org/healthreform/upload/8090.pdf**).

What enrollment system features are needed to meet health reform's expectations?

To comply with the ACA, states will need to develop policies, procedures, and information technology (IT) systems that achieve multiple important purposes. To support states in this work, the Secretary of HHS has adopted standards and protocols for interoperable electronic enrollment systems that were developed by a stakeholder Enrollment Workgroup[2] and the ACA provides grants to states to develop and implement such systems. States' enrollment systems under the ACA must have the following attributes[3] (See Appendix 1 for a crosswalk to the relevant sections of the ACA):

- Provide individuals and families the option of an online, self-service process to apply for and renew coverage;
- Provide meaningful application support and alternatives to the online application for those who want them;
- Retrieve and exchange relevant eligibility data from available databases to the maximum extent practicable ;
- Replace paper-based procedures with electronic ones;
- Ensure smooth transitions between all health programs;
- Use secure interfaces and safeguard shared data;
- Facilitate cross-program enrollment initiatives, such as Express Lane Eligibility;
- Function as a doorway to other critical safety-net programs, including available state or local public programs, in addition to all health subsidy programs and other human services;
- Provide presumptive eligibility;
- Allow for timely, cost-effective IT systems updates and modifications; and
- Ensure that all new systems and features are built using technology that can be scaled larger and that promotes integration system-wide.

What is an ACA-ready enrollment system and how does it operate?

The ACA's eligibility and enrollment provisions direct HHS and the states to build coordinated, consumer-friendly enrollment systems that successfully help individuals navigate their options and obtain and maintain coverage and that make use of already-available data whenever feasible. Reaching that ideal will require the use of modernized enrollment systems, which will necessitate systems changes and improved IT in most states.

To attain a modernized, ACA-ready enrollment system, states need not start from scratch, nor are they required to "rip and replace" all of their existing technology. Instead, states can take a "system of systems" approach that incorporates, links, improves, and builds upon existing technology, including legacy systems. To be truly modernized, an enrollment system must have "front-end" capability (such as accepting applications online) and, more importantly, "back-end" data-brokering capabilities (such as identifying, retrieving, and organizing relevant eligibility information from available databases). The concept is that the system's interface with the consumer should be as simple and user-friendly as possible, with the complex activities necessary for eligibility determination and enrollment being handled through automated processes that occur behind the scenes. In a modernized system environment, policy and program goals drive the operation of technology, not the other way around.[4]

A number of states have already taken significant steps to streamline and automate their eligibility and enrollment systems for Medicaid and other public coverage, in advance of health reform. States may be able to build on or adapt these approaches to produce the consumer-friendly and seamless health coverage systems required by the health reform law. More comprehensive integration of eligibility and enrollment systems to include other public assistance programs as well can also occur, whether phased in once the integrated system for health coverage is well-established, or built in from the outset.

- **Utah** uses a modernized enrollment system called eREP that supports eligibility determinations for subsidized health coverage (as well as for numerous additional federal and state programs). Through use of a "smart" online application, which asks only the questions necessary for the program(s) an individual is screened eligible and applies for, and a back-end interface with numerous federal, state, and private databases and data warehouses, eREP effectively bridges program and agency "silos" to streamline the enrollment process. The back-end data-brokering system provides eligibility workers with filtered, organized, reconciled information from existing databases based on one simple search. When an applicant submits an application (either online through Utah Helps — **http://utahhelps.utah.gov/** — or through an eligibility worker), eREP automatically uses its eFIND function to identify and pull all pertinent information from available databases into the eREP database. At that point, an eligibility worker collects any additional necessary information or documentation and runs the eligibility data through the rules "engine."

  eREP has increased administrative efficiency, with the eFIND portion of the system saving an estimated $2.1 million in administrative costs each year and eREP as a whole saving even more. eREP was built and is maintained in-house, and is constantly evolving and adding features and data sources. Currently, Utah is exploring ways to mine available eligibility data earlier in the application and renewal process so that applicants are not asked to provide information already in state databases, as well as ways to automate the rules engine further.

- Social Interest Solutions (SIS) operates a web-based screening and application tool called One-e-App. With One-e-App, which is used in **Arizona**, **California**, **Indiana** and **Maryland**, low-income families and individuals can provide information about their household one time and be screened simultaneously for multiple health and social services programs and other support services. One-e-App has both an assisted model (whereby providers and community-based organizations can assist their clients with applications) and a self-service model (whereby applicants themselves can access the system from home, work, or a public location such as a library or school).

  One-e-App uses a sophisticated rules engine and business logic that routes application data and documentation (in many cases electronically) to the appropriate health and other programs for which applicants are determined preliminarily eligible. The system requests only necessary information, based on the client's answers as he or she completes the application. The system also handles renewals and change of circumstance applications, utilizing stored data to support these activities. In some states, in real time, One-e-App identifies Medicaid applicants already known to Medicaid, determines whether their Medicaid or CHIP coverage is current, and notifies them that their application was received. For certain categories of applicants, presumptive eligibility is granted in real time, allowing the applicant to obtain services immediately.

How can states get started on developing modernized, ACA-ready enrollment systems?

As states embark on designing and deploying a system capable of streamlined and coordinated enrollment under health reform, the following considerations are important:

Think system-wide: As states begin designing and constructing their Exchanges and their enrollment Web sites, it is essential that they think of these as pieces of an integrated eligibility and enrollment system that includes Medicaid and CHIP, as well as the Exchange. In fact, the Exchange is required to identify individuals who are eligible for Medicaid and CHIP and ensure that they are enrolled without having to submit additional information or paperwork. Likewise, applicants to Medicaid who are determined ineligible must be enrolled in Exchange coverage with no additional requirements. To achieve that result, Medicaid and CHIP leaders must be closely involved in planning the Exchange, and Exchange policies, procedures, and supporting technologies cannot be designed or built as a separate silo. To accomplish such system-wide coordination, states will need to address governance issues head-on; a growing number of states are establishing a single entity or office to oversee the Exchange and enrollment system enterprise and granting it the necessary authority.

Simplify underlying program rules: States can reduce the complexity involved in building a new enrollment system by first simplifying their Medicaid and CHIP eligibility and enrollment rules as much as possible. The ACA's requirement that modified adjusted gross income (MAGI) be used to determine income for all health subsidy programs is designed to ensure alignment across the programs. By minimizing application and verification requirements to the fullest extent allowable under federal law, states can both simplify the eligibility and enrollment process and further facilitate alignment across health subsidy programs. Simplification and alignment measures make it easier to program the relevant enrollment technology and to automate eligibility and enrollment processes, as well. Most important, simplifying program rules will promote the seamlessness between health subsidy programs that the health reform law envisions.

Automate as much as possible: Because millions of additional people will be entering health coverage in 2014 and renewing coverage periodically thereafter — at which time their eligibility for all health subsidy programs must again be evaluated — the demands on the enrollment system will be great. To maximize the efficiency of eligibility and enrollment processes, they should be automated as much as possible. Pulling data from available databases to support screening and eligibility determinations, automating renewal, and adopting Express Lane Eligibility are among the steps states can take. Automation reduces the administrative burden on individuals and families seeking health coverage, as well as the workload burden on agencies.

Evaluate and leverage existing assets: Building a modernized enrollment system is a complex task. While it is possible to build such a system starting from scratch, this is not a realistic scenario given the expense and the need to have a system up and running by 2014. Thus, it is crucial that states identify existing databases and legacy systems that will be involved in the effort and use an enterprise service bus (ESB) or other connective IT to facilitate communication between these disparate systems, creating a "system of systems." This approach allows states to quickly leverage their existing systems' capabilities to accomplish the key functions required by the ACA, while modifying and improving their back-end systems at their own pace, in accordance with changing needs or policy.

Build in safeguards: To ensure that the enrollment system works well, states should test it before implementation, paying particular attention to whether it properly applies policies and rules. Evaluation and monitoring should continue after the system is implemented. Also, the enrollment system should include a mechanism for flagging cases that require human review, such as when a data match is not possible because of inconsistencies or data entry errors, or when an individual will lose coverage altogether. It should provide the consumer with an opportunity to review and update data and correct errors early in the process, as well. In addition to these systems safeguards, as well as essential due process protections, states should maintain community-based enrollment assistance as an integral piece of the enrollment system. Consumer and community organizations and providers can be partners in helping to identify and address enrollment problems and facilitate enrollment and renewal for individuals unable to manage self-service options.

Work with federal partners: The ACA establishes a strong supportive role for the federal government in the development and design of health reform and its administrative systems. HHS will assist states through the operation of and anticipated improvements to the federal informational Web portal (**www.healthcare.gov**), the release of a model template for state Exchange Web portals, the development of a model single, streamlined application form, and the issuance of standards and protocols for electronic data exchange to support eligibility and enrollment (including the production of "reference software" and a web-based verification interface for use by states). Each of these steps is intended to make it easier for states to meet the expectations of the ACA. In addition, a couple of existing federal efforts have laid the groundwork for the systems interoperability required under health reform. The Medicaid Information Technology Architecture (MITA) initiative has developed a technology and business roadmap for Medicaid system modernization, which states are generally using to enhance their Medicaid Management Information Systems (MMIS), but which can also be used to drive greater interoperability in eligibility and enrollment systems. The Federal Health Architecture (FHA) is building the infrastructure to enable federal agencies to easily share health and eligibility information. Such federal interoperability will ultimately also support state data-matching efforts and collaboration.

Access ACA funding: The ACA authorizes a number of grants that could be used to support the design and development of a modernized enrollment system. First, states can apply for Exchange planning and establishment grants; they must obtain such grants by March 23, 2011 or lose out on them altogether.[5] These grants are intended to focus on the Exchange. However, since Exchanges must have the ability to inform individuals about Medicaid, CHIP, or any other state or local public program, determine their eligibility for such programs, and enroll them in the appropriate program, these grants should be available to help states design and structure a system in which the Exchange connects and works with Medicaid and CHIP enrollment systems. Second, §1561 of the ACA provides grant funding to states and localities to develop or adapt existing systems to meet the new standards and protocols for electronic enrollment adopted by the Secretary, as mentioned earlier.

Look beyond the ACA for funding: Other sources of federal funding are also available for Medicaid and CHIP systems improvements. For example, states can obtain federal funding at a 90/10 matching rate for the overhaul or enhancement of mechanized data and claims processing and information retrieval systems in accordance with MITA, with prior approval. Such systems may be an integral part of a state's modernized enrollment system.[6] In addition, to the extent that a state's enrollment systems are being incorporated into its health information exchange (HIE) and health IT plans under the American Recovery and Reinvestment Act (ARRA), the state could pursue some support for this effort at the enhanced Medicaid funding level (90/10 match) provided under that Act. Building a modernized enrollment system involves numerous agencies and, as a result, will require coordinating and optimizing disparate funding streams. Partnerships with private foundations and others to support this process are also important opportunities for states to pursue.

Conclusion

When crafting the ACA, Congress recognized that building consumer-friendly enrollment and renewal processes would require tight coordination across agencies. The new law establishes the expectation that systems should enroll individuals with the minimum possible burden and handle transitions seamlessly, and it provides the support to build eligibility and enrollment systems that are up to this task. With a quickly approaching 2014 deadline, states must begin working together in partnership with federal agencies and stakeholders to put critical policies and systems in place. As states address the immediate challenge of designing and building an Exchange, coordination with Medicaid and CHIP at all points in the enrollment process — from application at the front-end, to data retrieval and verification at the back-end — is a fundamental organizing principle. With modernized enrollment technology, states can help bridge existing silos, connecting program agencies in order to help America's families.

APPENDIX 1

Required Features of Enrollment Systems for Health Subsidy Programs under the ACA

Required Feature of State Enrollment System	Statutory Basis in ACA
Provide individuals and families the option of an online, self-service process to apply for and renew coverage	§1413 and §2201, creating new §1943(b)(1) of the Social Security Act (SSA)
Provide meaningful application support and alternatives to the online application for those who want them	Support: §1311(i) and §2201 (New SSA §1943(b)(1)(F)) Alternatives: §1413
Retrieve and exchange relevant eligibility data from available databases, to the maximum extent practicable	§1413(c) and §2201, new SSA §1943(b)(3)
Replace paper-based procedures with electronic ones	§1411(c), §1413(c) and §2201, new SSA §1943(b)(3)
Ensure smooth transitions between all health programs	§2201, new SSA §1943(a) and (b)
Use secure interfaces and safeguard shared data	§1413(c) and §2201, new SSA §1943(b)(1)(D)
Facilitate cross-program enrollment initiatives, such as Express Lane Eligibility	§2002
Function as a doorway to other critical safety-net programs, including available state or local public programs, in addition to all health subsidy programs and other human services	§1311(a) and (d)(4)(F); §1561
Provide presumptive eligibility	§2202 expands this option for state Medicaid programs
Allow for timely, cost-effective IT systems updates and modifications	§1561
Ensure that all new systems and features are built using technology that can be scaled larger and that promotes integration system-wide	§1561

APPENDIX 2

Ways to make the most of IT-supported enrollment under health reform: Three Use Cases

Applicant-initiated online application. To minimize the number of fields an applicant has to complete manually in applying for a health subsidy program through the single online application, the applicant could be given an opportunity to query other programs and databases, as well as available verification systems and tax return data, for the information that those sources already hold about the applicant. An electronic inquiry would be made using the minimum information necessary to authenticate identity and perform a reliable match against the other systems. This process is akin to tax filing software that gives filers the option of filling in tax form fields manually or having the software service provider retrieve the information from online sources on the filer's behalf. Once the relevant information is plugged into the rules engine, an eligibility or presumptive eligibility determination could be made in real time and sent back to the applicant.

State-initiated large-scale enrollment upon initial implementation of the ACA. A large number of currently uninsured individuals who will become eligible for health subsidy programs under the ACA are already known to other public programs and supports such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), unemployment insurance, etc. In some instances, these individuals have authorized data sharing with Medicaid for purposes of outreach and enrollment, or the forms could be easily modified to obtain that consent. With such authorization, data and findings held by these other programs could be used to identify eligible individuals and begin the eligibility and enrollment process along the lines taken by Louisiana in its Express Lane Eligibility (ELE) effort. Using ELE for uninsured children in SNAP, Louisiana enrolled 10,545 children in one flip of the switch.
(See **http://www.kff.org/medicaid/8088.cfm**)

Under health reform, a large-scale enrollment scenario would most likely involve the relevant health agency running data matches to identify uninsured individuals enrolled in other need-based programs, retrieving and organizing relevant eligibility data and findings (modified adjusted gross income (MAGI) for those applying on the basis of income and relevant ELE findings for Medicaid and CHIP-eligible children),[7] and running available data and findings through a rules engine to determine eligibility. With the eligibility finding in hand, the agency could offer families a simplified enrollment procedure through which they could opt in to coverage and pick a health plan, such as mailing the family a notice of eligibility or the relevant health insurance card and a phone number for activating coverage.

State-initiated renewal. To minimize the burden of the renewal process on families and agencies, the health subsidy program in which the applicant is enrolled could query other programs and/or verification systems for updated eligibility data to pre-populate a renewal form, which could then be mailed to the enrollee or made available online. Going one step further, the enrollment system could automatically perform that data query and automate the renewal process at the end of an enrollment period, or when the individual renews eligibility for another public program and submits updated information. This ex parte, automated renewal process is currently being used by numerous state Medicaid programs, which use SNAP recertification as the basis for renewing Medicaid.[8]

[1] States can develop their own application if it meets the same standards. ACA §1413.

[2] The workgroup's recommendations, and explanatory appendices, were adopted on September 17, 2010, and are available at: **https://healthit.hhs.gov/aca/section1561**.

[3] For further discussion of these features, see *Building Efficient and Effective Medicaid and CHIP Enrollment Systems: Core Requirements to Ensure the Greatest Value for Children and Families* at: **http://www.childrenspartnership.org/EECoreFunctions**.

[4] The Children's Partnership, *E-Health Snapshot: Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices* (2007) **http://www.kff.org/medicaid/7647.cfm**.

[5] ACA §1311(a) and (d)(4)(F).

[6] However, at present, improvements classified as eligibility system improvements only qualify for the standard 50/50 matching rate. 42 CFR 433.112

[7] Express Lane Eligibility (ELE) is the eligibility methodology for children, authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA), that allows Medicaid and CHIP agencies to borrow and rely upon specific eligibility findings from other public program agencies. The ACA specifically identified ELE as an exception to the required use of modified adjusted gross income (MAGI) to determine income eligibility; the law includes a few other exceptions as well (ACA § 2002). While not guaranteed, it is possible that CMS could authorize the use of ELE for adults, whether through an 1115 waiver or an interpretation of the language in the ACA. For further information on ELE, please visit: **www.childrenspartnership.org/expresslane.**

[8] United Hospital Fund, *Reducing Paperwork to Improve Enrollment and Retention in Medicaid and CHIP* (October 2009) **http://www.medicaidinstitute.org/publications/880624**.

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