

Implementing National Health Reform: A Five-Part Strategy for Reaching the Eligible Uninsured

Timely Analysis of Immediate Health Policy Issues

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Summary

Health coverage programs often fall short of their enrollment goals. Even the Children's Health Insurance Program (CHIP), now quite successful along with Medicaid in reaching uninsured children, suffered low enrollment rates during its early years.

By contrast, programs like Low-Income Subsidies for Medicare Part D and Massachusetts's 2006 health reforms rapidly achieved high participation levels by using reliable data to identify eligible consumers, qualify them for assistance and enroll them into coverage. For similar results when the Patient Protection and Affordable Care Act's (ACA) main provisions begin in 2014, federal policy-makers could pursue a strategy with five parts:

1. **A proactive national campaign that uses data to identify the uninsured and enroll them into coverage.** On their federal income tax returns, uninsured taxpayers could be allowed to request subsidized coverage and authorize the use of their tax information to establish eligibility. That could start the enrollment process for the 86 percent of uninsured consumers who file such returns, including 75 percent of the uninsured with incomes below poverty.
2. **Basing eligibility determinations on reliable data, whenever possible.** Information already in government hands could establish eligibility without delaying enrollment until uninsured consumers have completed forms that, in effect, tell the government what it already knows.
3. **Partnering with states to help consumers receive hands-on assistance** applying for Medicaid, CHIP and subsidies in the exchange. Such assistance will

probably be essential to many consumers who find it difficult to navigate even a simplified process. Consumers may also need this help if data are not enough to establish their eligibility.

4. **Consumer-friendly enrollment systems.** Consumers could provide identifying information on a secure Web site, see their household circumstances as shown by reliable data, make necessary corrections and receive an eligibility determination in real-time. They could either choose a health plan or ask the exchange to pick one, based on information volunteered by the consumer. A consumer who neither selects a plan nor asks the exchange to do so would be assigned by default to a low-cost plan. If premiums are charged, such default enrollment would become effective only if the consumer promptly made the first monthly payment.
5. **Effective interagency coordination.** Interagency efforts to maximize enrollment of the eligible uninsured are likely to be more successful if one federal entity is designated to take the lead.

By reducing the number of uninsured, these steps could help achieve the ACA's basic goals for expanding coverage. They could also contribute to the effective implementation of insurance reforms, since enrolling the healthy as well as the sick will help prevent such reforms from increasing premiums charged in the exchange. And by qualifying consumers for assistance through matches with reliable data, rather than by requiring public employees to manually evaluate and verify traditional application forms, this approach is likely to lower administrative costs, deter fraudulent applications and reduce the number of erroneous eligibility determinations.



Introduction

According to the Congressional Budget Office (CBO), the Patient Protection and Affordable Care Act (ACA) will cover more than 30 million uninsured.¹ Most are low- and moderate-income people who will qualify for Medicaid, the Children's Health Insurance Program (CHIP) or subsidies for premiums and out-of-pocket costs in the exchange.

Policy-makers cannot count on enrollment reaching projected levels. Recent history is filled with coverage expansions that failed to achieve anticipated results, at both federal and state levels. For example, roughly 2 million laid-off workers and their families received subsidies for COBRA coverage under the American Recovery and Reinvestment Act of 2009, but CBO had projected that 7 million would benefit.² An earlier program providing Health Coverage Tax Credits (HCTC) to laid-off workers covered fewer than one in five eligible uninsured,³ with enrollment reaching less than 30 percent of the levels forecast by CBO.⁴ And at the state level, Maine's Dirigo Health did not come close to reaching proponents' expectations, undermining the initiative's credibility with the public.⁵

If the eligible uninsured do not enroll, the consequences will go beyond a failure to improve their access to care and economic security. Many who remain uninsured will pay a penalty. Moreover, if healthy people disproportionately remain uninsured, the ACA's insurance reforms could increase premiums charged in health insurance exchanges, potentially to unsustainable levels.

Fortunately, the ACA gives policy-makers the tools to avoid these problems. This report describes a five-part strategy through which federal officials can maximize enrollment of the eligible uninsured into subsidized coverage. By using 21st-century information technology to base eligibility determinations on reliable data whenever possible, this strategy also promises to lower public-sector

administrative costs, cut red tape for families, deter fraudulent applications and reduce the number of erroneous eligibility determinations.

As others have correctly observed,⁶ state efforts will play a central role in determining the effectiveness of ACA's coverage expansion. Federal decisions will also be important, however. This analysis primarily addresses the federal government's role, although it touches on potentially helpful state actions that federal policy could permit, encourage or require.

Part 1: A proactive national campaign that uses data to identify the uninsured and enroll them into coverage

For most eligible uninsured to receive subsidized coverage in 2014, it will be necessary but not sufficient to streamline enrollment, educate the public and facilitate applications. In recent years, the coverage expansions that quickly achieved high levels of participation also used data proactively to qualify and enroll eligible people, without delaying coverage until the completion of formal application forms. For example:

- *Low-income subsidies (LIS) under Medicare Part D* reached nearly three in four eligible beneficiaries (74 percent) less than six months after the new benefit was first available. Four in five enrollees (81 percent) qualified without any need to file applications. Their eligibility was established, and they were enrolled into subsidized coverage, based on the Center for Medicare and Medicaid Services' (CMS) proactive initiation of data matches with state Medicaid programs and the Social Security Administration (SSA).⁷ Participation rates later reached 81 percent, with data matches (rather than applications) yielding 85 percent of all LIS enrollment.⁸
- *Massachusetts 2006 health reform legislation* reduced the percentage of uninsured residents to the lowest level ever observed in any state.⁹

Roughly one in four newly insured residents received subsidized coverage based on data matches with the state's preexisting "free care pool," without any need to file application forms. After nine months of program operation, more than 80 percent of enrollees into the state's new subsidy program qualified based on these data matches.¹⁰

By contrast, many federal and state programs without such proactive, data-driven enrollment strategies have fallen significantly short of their goals, including the programs mentioned earlier. Even CHIP, which together with Medicaid, now covers 82 percent of eligible children,¹¹ took a long time to achieve these results. Despite considerable outreach and streamlining of applications during the program's start-up phase, only 60 percent of eligible children participated in CHIP fully five years after states could first offer coverage in 1997.¹² As the Congressional Research Service observed as late as 2001, "Until recently, there was general disappointment with the implementation progress under SCHIP, due to low enrollment rates early in the program."¹³

Put simply, the federal government cannot sit back and trust that, armed with good information, faced with a requirement to obtain coverage, and given options for easy enrollment, tens of millions of uninsured will rapidly come forward on their own and obtain health insurance. A proactive, data-driven enrollment initiative will be needed for the ACA to avoid slowly rising enrollment levels during the initial years of full implementation.

One possible candidate for such a proactive initiative involves the filing of income tax returns. A significant percentage of the uninsured who qualify for assistance could be identified and enrolled into coverage as part of the tax filing process. In fact, the ACA specifically authorizes HHS to permit consumers to apply for subsidies by "request[ing] the Secretary of the Treasury to provide [tax return] information... directly

to the Exchange.¹⁴ More broadly, the legislation permits consumers to initiate an eligibility determination by authorizing the disclosure of relevant data, rather than by completing formal application forms.¹⁵

An estimated 86 percent of uninsured Americans file federal income tax returns. Even among the uninsured with incomes below the federal poverty level (FPL), fully 75 percent file tax returns (Figure 1).

When taxpayers file their returns in 2014 and later years, they will be providing most of the information needed to determine their eligibility for Medicaid, CHIP and subsidies in the exchange, as the following section

of this report makes clear. Why not let taxpayers use their returns to apply for subsidized coverage? Requiring them to also complete a largely redundant subsidy application form would add little value, compared with the resulting government administrative costs, burdens on families and consequent reduction in enrollment among the eligible uninsured.

Policy-makers could establish mechanisms through which, at the taxpayer's option, filing a tax return starts the eligibility determination and enrollment process.¹⁷ For example, taxpayers could be required to identify any uninsured household members on a supplemental form filed along with the

1040.¹⁸ To help such family members obtain coverage, the form would:

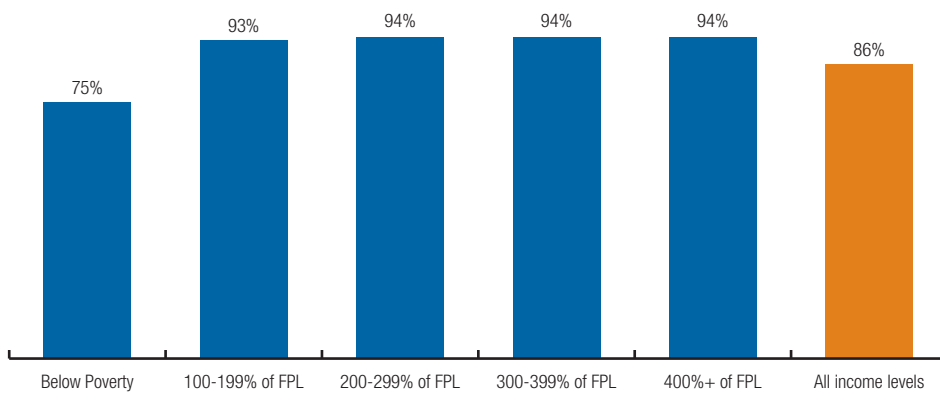
- Give a taxpayer the option, by checking a box to—
 - » Authorize IRS conveyance of relevant tax return data to the taxpayer's exchange for the purpose of determining eligibility for subsidized health coverage;
 - » Authorize the exchange to use other available information to determine eligibility, if necessary; and
 - » Enroll uninsured household members into coverage, if they qualify for Medicaid, CHIP or subsidized coverage in the exchange;
- Ask for the best way to contact the taxpayer if necessary to complete the eligibility determination and enrollment process; and
- Provide information about health insurance exchanges and available health coverage subsidies.

To be most effective, such a tax-based initiative would benefit from IRS outreach to tax preparation software vendors and to both paid and volunteer tax preparers.¹⁹

Most low-income tax returns are filed early in the year, so income information on those returns is relatively current. For example, by March 2, 2007, 69 percent of tax returns claiming the Earned Income Tax Credit (EITC) for 2006 had been filed, compared to 39 percent among returns in general (Figure 2).

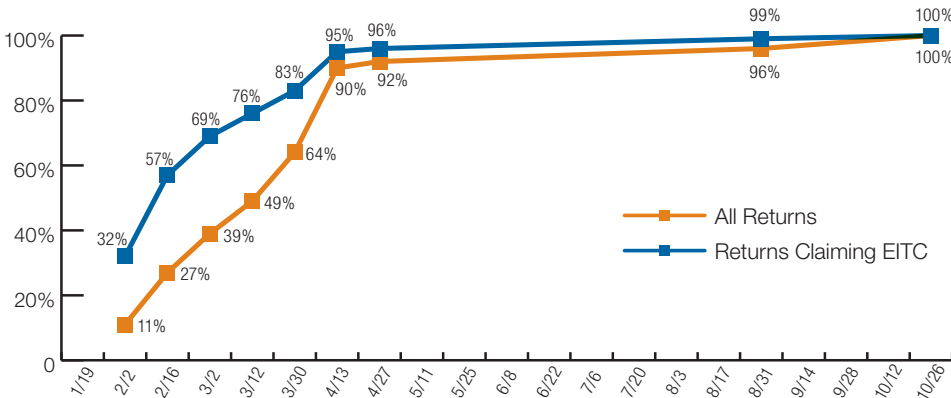
This approach has precedents. For example, families can have their federal income tax data automatically “pre-populate” application forms for federally funded college student aid.²⁰ Along similar lines, one of the most successful HCTC initiatives was a small “consent” pilot project. When taxpayers called the HCTC program office, they were asked if they wanted their contact information shared with their state to see if they could receive additional assistance. In the one state where the pilot was fully

Figure 1. The estimated percentage of uninsured who filed federal income tax returns, by income: 2004



Source: 2005 CPS, using the methodology described in Dorn, Garrett, et al.¹⁶

Figure 2. The percentage of all individual income tax returns that were filed by various dates, all returns vs. returns claiming EITC: Tax Year 2006



Source: IRS, Statistics of Income Division, Tax Year 2006 Taxpayer Usage Study (author's calculations).

Note: The listed percentages do not take into account any returns for tax year 2006 that were filed after October 26, 2007. IRS-published data include only the dates for which data points are shown in this Figure.

implemented, 83 percent of taxpayers consented. When state officials contacted them, more than 90 percent were enrolled into coverage.²¹

Of course, people make mistakes on their tax returns, despite the information they receive on W-2s, 1099 forms and the like. IRS corrects up to 7 million returns a year (less than 5 percent of all returns) for math errors, failure to include information available from third-party sources or special audits of returns claiming EITC.²² When such corrections are made for people receiving health insurance tax credits, the amount of such credits will likewise need to be revisited.²³

This approach could potentially yield administrative cost savings for IRS. As with any effort to increase coverage, if fewer people are uninsured, fewer will go through IRS enforcement efforts. However, unique to this strategy is that the above-described notice, provided through supplemental tax forms, might be structured to fulfill, for many taxpayers, IRS' duty under the ACA to "send a notification [of services available in the Exchange] to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage."²⁴

Not only would this approach increase IRS' ability to identify uninsured taxpayers and greatly reduce the cost of mailing out notices, letting taxpayers begin the application process by checking a box would make the required IRS notice substantially more effective in helping uninsured taxpayers receive coverage. Long experience teaches that simply sending notices that encourage consumers to apply for assistance typically yields disappointing results, even when such notices tell consumers about valuable public benefits that cost them nothing to obtain. For example, in 2002 the Social Security Administration sent 16.4 million letters to low-income Medicare beneficiaries who appeared to qualify for Medicare Savings Programs (MSP) based on federal income data. The letters provided information about MSP, which pays some or all Medicare

cost-sharing, depending on income. The letters also included a phone number that could be called to enroll. Roughly 74,000 people—0.5 percent of letter recipients—enrolled in MSP as a result.²⁵

Of course, the ACA's individual mandate will increase consumer responsiveness to similar communications in the future. On the other hand, the requirement of making premium payments to enroll in coverage could reduce such responsiveness. Even if these two countervailing factors play out in a way that makes such "direct mail" campaigns substantially more effective than in the past, only modest results are likely.

IRS officials may be concerned that using the tax filing process to facilitate enrollment into health coverage could set a precedent for other benefit programs. But this particular benefit program is unique in the degree to which IRS is deeply involved in program administration. Not only is IRS responsible for enforcing the requirement that nearly all Americans must have coverage, the subsidies themselves include tax credits as a major component. IRS thus bears considerable responsibility for the success of the ACA's health coverage expansion. It does not seem unreasonable for IRS to make a major commitment to the effectiveness of that expansion.

Policy-makers interested in a large and rapid increase in health coverage starting in 2014 will likely need to go beyond traditional methods and implement highly proactive, data-driven mechanisms to substantially expedite enrollment. Regardless of which such mechanism is used, it will be important to carefully design the consumer experience. Consumer responses can be greatly affected by even small changes in how choices are framed and described, the complexity of language used, the volume of information provided, the medium used for communication, the steps that consumers are asked to take and similar factors. Intensively field-testing these mechanisms with consumers may thus be needed before their widespread deployment.

The approach described here may not fully replicate the completely automatic enrollment procedures that proved so effective with Medicare Part D and in Massachusetts by placing eligible consumers into subsidized coverage without any need for them to take action. If such procedures, which have been used to great effect in other benefit programs as well,²⁶ could be applied to the ACA, early enrollment of eligible, uninsured consumers would increase, perhaps by significant amounts.²⁷

A gradual rather than a rapid rise in enrollment would give health care workforce strategies more time to build capacity before providers must absorb the full increase in demand for care that will result from ACA's coverage expansion. But even taking into account existing constraints on health care supply, many policy-makers may seek to rapidly maximize enrollment of the eligible uninsured, both to improve access to care and to reduce adverse selection into subsidized coverage. These policy-makers will probably need to take proactive steps like those discussed here, which ask the uninsured to self-identify and which permit them to apply for coverage by simply checking a box on their tax returns.

Part 2: Basing eligibility determinations on data, whenever possible

Critically important to simplifying application procedures is using data from reliable, third-party sources to establish eligibility, rather than denying coverage until consumers who can already be identified as eligible have described and documented their circumstances. In addition to expediting enrollment, such data-driven eligibility can also reduce administrative costs and erroneous eligibility determinations.²⁸ As the Government Accountability Office observed:

"Improved information systems, sharing of data between programs, and use of new technologies can help programs to better verify eligibility and make the application process more efficient and less error prone. These strategies can

improve integrity not only by preventing outright abuse of programs, but also by reducing chances for client or caseworker error or misunderstanding. They can also help programs reach out to populations who may face barriers.”²⁹

ACA §1413(c)(3)(A)(ii) thus requires that, “to the maximum extent practicable,” all subsidy programs, including Medicaid, must “determine... eligibility on the basis of reliable, third party data, including information” from tax records, quarterly earnings and new hires’ reports, other public benefit programs and so forth.³⁰

For people to qualify for assistance on the basis of reliable data, the definition of eligibility must match available data. Otherwise, consumers need to provide documentation that supplements the data, which complicates the application process and may prevent some eligible individuals from enrolling. Recent federal reforms that achieved high participation rates thus involved eligibility definitions that precisely matched available data, such as Low-Income Subsidies for Medicare Part D, described earlier, for which receipt of Medicaid or Supplemental Security Income in the prior calendar year automatically qualifies beneficiaries for assistance in the current year; and Medicare Part B premium subsidies, which are means-tested based on beneficiaries’ federal income tax returns two years in the past.³¹

Consistent with this approach, the ACA structures tax credits and out-of-pocket cost-sharing subsidies in the exchange so eligibility is based on available data. Income-eligibility is defined in terms of modified adjusted gross income (MAGI). Prior-year income tax records establish eligibility for advance payment of tax credits and cost-sharing subsidies in the exchange unless consumers come forward to demonstrate changed circumstances.³²

With Medicaid, data-based eligibility rules and procedures are no less important. If local social service offices must use traditional, labor-intensive methods to process the enormous

volume of Medicaid applications that they may face under the ACA, state administrative costs could become unsustainable, and Medicaid enrollment is likely to lag. Finding that many of the states with a particularly large percentage of uninsured who will qualify for Medicaid under the ACA have historically enrolled a relatively small proportion of their Medicaid-eligible residents, Sommers and Epstein concluded that, without “a fundamental shift” in how Medicaid processes applications and determines eligibility, Medicaid will fall far short of the participation levels projected by CBO.³³

Serious inequity could result if only Medicaid—and not subsidized coverage in the exchange—is denied until applicants estimate and document current income levels using traditional methods, which include providing pay stubs and employer affidavits. In effect, such a bifurcated system would create an information superhighway for somewhat higher income people seeking tax credits, while the lowest-income uninsured remain relegated to ox carts and muddy cow paths when they apply for help.

ACA appears, at first glance, to limit the use of data in qualifying the uninsured for Medicaid. ACA provides that, while MAGI will govern Medicaid’s future eligibility determinations, MAGI “shall not be construed as affecting or limiting the application of the requirement... to determine an individual’s income as of the point in time at which an application for medical assistance... is processed.”³⁴

Read carefully, this section does not impose any new requirements to base Medicaid eligibility on point-in-time information. Rather, it states that MAGI does not override whatever requirements about timeliness of income information existed under earlier Medicaid law. These preexisting requirements are consistent with using information about the recent past to determine current income. For example, with SSI-linked Medicaid, current self-employment income is calculated based on the previous year’s tax records,

which, depending on household circumstances, may or may not need to be supplemented with information about more recent profit and loss.³⁵

HHS is responsible for interpreting this “point-in-time” section consistently with the numerous other ACA provisions that require data-based, streamlined eligibility determinations for all subsidy programs,³⁶ including Medicaid. To discharge this responsibility, HHS could make clear that *the “point-in-time” language in ACA permits the use of data to establish Medicaid eligibility when such data are sufficiently recent to show consumers’ current eligibility.* If available data show a reasonable certainty of qualifying for assistance,³⁷ Medicaid eligibility would automatically be established unless there is good reason to believe that the data are mistaken, incomplete or outdated. For example, consistent with the longstanding practice of some Medicaid programs, one year’s tax returns could establish income-eligibility during the first three calendar months of the following year.³⁸ After those first few months, current income levels could often (but not always)³⁹ be determined with more recent records, including both public and private sources of information about earnings and new hires. And if recent information shows income substantially below the maximum threshold of Medicaid income eligibility, eligibility might be established without demanding the prior presentation of pay stubs and employer affidavits.

When available data show eligibility for subsidies in the exchange, rather than more generous Medicaid benefits, applicants could receive a notice indicating that, if household circumstances have worsened since the period covered by the data, providing more recent information may result in additional assistance. *“Point-in-time” income documentation would thus be a method for establishing Medicaid eligibility when other approaches fail,* rather than a procedural requirement applicable even when such documentation would add

little or no value to the accuracy of eligibility determination.

For Medicaid, CHIP and subsidies in the exchange, data will frequently show whether applicants meet eligibility requirements other than income. Citizenship can often be documented by a data match with records from the Social Security Administration (SSA), which will not issue a Social Security card to adults unless they prove citizenship or authorization to work in the United States.⁴⁰ Satisfactory immigration status can frequently be demonstrated by Department of Homeland Security records (and perhaps SSA records as well, for immigrants who received a Social Security number based on an SSA determination of legal permanent residence).⁴¹ Even a lack of access to affordable ESI might be shown for many uninsured consumers through the data that employers and insurers will be required to report to IRS under the ACA.⁴²

Of course, for numerous consumers, data will not suffice to establish eligibility. In such cases, applicants may need to furnish documentation that requires manual processing. This is one of many reasons why individual consumer assistance will likely be an integral part of any effective program to maximize enrollment of eligible individuals into subsidized coverage, as discussed in the next section. It is also a reason why, under the approach described in the previous section of this paper, consumers beginning the enrollment process by checking a box on their tax returns would be asked for contact information. This would let application assisters follow-up by obtaining needed documentation or answers to unresolved questions. But if federal officials wish to maximize participation among eligible individuals during the early years of full ACA implementation, they may need to be mindful of ACA's command that "to the maximum extent practicable" Medicaid, CHIP and the exchange must "establish, verify and update eligibility using ... data matching."⁴³

Part 3: Partnering with states to help consumers receive hands-on assistance

Many types of consumer assistance will be important to the effective operation of the ACA. As noted earlier, Massachusetts' 2006 reforms successfully enrolled most eligible individuals. One key strategy involved funding community-based organizations and giving providers financial incentives to work with consumers and fill out applications. Among all successful subsidy applications, 60 percent were thus completed, not by consumers themselves, but by community organizations and health care providers submitting applications on the consumers' behalf via the state's on-line "virtual gateway."⁴⁴

Other states have likewise found that consumer assistance increases enrollment in health programs.⁴⁵ This is consistent with research showing, with both health coverage and other benefits, that providing enrollment assistance can have a dramatic impact on participation that cannot be duplicated by simply providing consumers with information and asking them to take action on their own.⁴⁶

Even with data playing a central role verifying and establishing eligibility, individual consumer assistance will be needed to maximize coverage for the uninsured who qualify for help, including the many for whom data will not fully establish eligibility.

Enrollment assistance is one of the functions served by exchange Navigator programs.⁴⁷ However, ACA does not fund Navigators until 2015, when they will be supported through the same funding stream that the state uses to pay other administrative costs of the exchange. Before then, federal grants finance exchanges, but ACA forbids such grants from paying for Navigator services.⁴⁸

To fill some of this gap, federal grants fund exchange call centers, which can be tasked to complete application

forms and help with plan selection, thus fulfilling many important Navigator functions. For example, call centers could reach out to uninsured consumers who provide contact information on the IRS forms described in the first section of this report; the centers could then (a) obtain any additional information needed to qualify these consumers for assistance, and (b) help them choose a health plan.

Of course, consumers may not know whether they qualify for Medicaid or subsidies in the exchange. Indeed, much of ACA's architecture, with a single application form serving all programs and seamless "behind the scenes" processing of applications, seeks to eliminate any need for consumers to sort themselves among programs. Consistent with that basic approach, federal policy-makers could encourage each state to combine Exchange, CHIP and Medicaid administrative dollars to fund a single, integrated system of consumer assistance (potentially with private support helping states pay their share of Medicaid administrative costs).⁴⁹ Establishing an adequately resourced, well-trained network of trusted community organizations and exchange call centers to help consumers navigate through what many will find to be a confusing new world will likely be an important part of maximizing eligible individuals' coverage.

Part 4: Consumer-friendly enrollment systems

Considerable research establishes that, for public and private benefit programs, more people join when less work is required to enroll.⁵⁰ Recognizing this common-sense insight, the ACA asks HHS to develop a single application form for all subsidy programs that is as simple as possible and that requests the minimum information needed to determine eligibility.⁵¹

Such a simple, streamlined form is just the starting point in removing needless paperwork from the application process. In each state, the following procedure could establish eligibility for Medicaid, CHIP and subsidies in the

exchange based on available data while making adjustments to reflect changes in household circumstances since the period covered by such data:

1. A consumer can begin the application process by (1) providing identifying information, such as name, Social Security number, address and date-of-birth; and (2) asking for government records to be used to see whether the consumer qualifies for help.
2. Whether through such consent to disclosure or by describing household circumstances on a traditional form, when a consumer applies for subsidies, all relevant data, including federal income tax information and more recent records of quarterly earnings and new hires, are gathered, compiled into a user-friendly report and presented to the consumer for confirmation.⁵² The consumer is informed that eligibility will be established based on the presented information unless the consumer makes a correction. If the consumer fails to act—for example, if the consumer did not apply on-line but instead requested coverage on his or her tax form, so the report needed to be mailed—eligibility is established based on the data match. The “default” in case of inaction is thus coverage, rather than continuing uninsurance.⁵³
3. If the most recent available data, as potentially modified by the applicant, establish eligibility for assistance, the individual receives aid accordingly, whether through Medicaid, CHIP or subsidies in the exchange.
4. When a consumer qualifies for tax credits in the exchange, he or she is informed that, if income has fallen since the period covered by available data, the consumer may be able to obtain additional help (including through Medicaid) by filing a supplemental application demonstrating changed circumstances. A similar policy already applies to Medicaid and CHIP under Express Lane Eligibility when

states use prior-year income tax data to qualify children for assistance.⁵⁴

5. If available data are not sufficient to determine eligibility, the applicant is asked to answer the questions left open by the available data.
6. If available data show apparent ineligibility, the applicant receives notice and an opportunity to appeal, as provided in ACA §1411(f).

Already, Wisconsin is establishing an on-line system through which a consumer can provide identifying information, see a “read-out” of household circumstances shown by available data, and obtain an eligibility determination by confirming the data’s continuing accuracy or making necessary modifications.⁵⁵ HHS has made clear that such real-time eligibility determinations must be standard operating procedure in states that use newly available enhanced federal funds to upgrade information technology systems needed for the data-driven eligibility contemplated by ACA.⁵⁶

Of course, it will be necessary but not sufficient to streamline the process of qualifying for subsidies, since individuals found eligible for tax credits will remain uninsured until they enroll in a health plan offered through the exchange. With Medicaid and CHIP as well, most beneficiaries receive coverage through private health plans contracting with the state.

If a consumer qualifies for subsidies but fails to choose a plan, gaps in coverage can result, as illustrated by a recent study comparing Medicaid enrollment in California counties with and without health plan choices. In counties with just a single Medicaid plan, more than 95 percent of applicants received coverage during their first month of eligibility. In the counties where consumers needed to choose a health plan, fewer than 1 percent enrolled in their first month, only half were enrolled after 3 months, and 1 in 6 (15-17 percent) were still not enrolled fully 7 months after establishing eligibility. In counties with health plan choices, beneficiaries were significantly more likely to be hospitalized for conditions

that can often be prevented by outpatient care.⁵⁷

To avoid these problems, Medicaid and CHIP programs typically counsel consumers (either directly or through contractors) to help them select health plans. A similar function will be performed by the exchange, using Navigators or call center staff. But many Medicaid programs also apply routines through which, after their eligibility is established, consumers have a defined period of time in which to choose a plan. If they fail to do so, a plan is chosen for them. If a similar “default plan” mechanism applied to subsidized coverage in the exchange, fewer consumers might fall between the cracks and remain uninsured after eligibility determination.⁵⁸

However, unlike most Medicaid and CHIP coverage, subsidized plans in the exchange will charge premiums, which some default enrollees may not pay. Such non-payment could generate needless administrative costs for insurers and damage consumers’ credit ratings. To prevent these results, policy-makers could specify that, with default enrollment in the exchange (a) coverage does not begin until the first month’s premium has been paid; and (b) to avoid adverse selection, such premium payment must be received within a specified interval or the consumer loses the right to join the plan until the next open enrollment period.

While many policy-makers might view default enrollment as better than going without coverage, consumers are presumably more likely to receive the kind of coverage that meets their needs if they select a plan. On the other hand, long experience teaches that many consumers can be confused and overwhelmed by the need to make health plan choices, even when individual consumer assistance is offered.⁵⁹ Inability to synthesize available information and identify one alternative as clearly preferred can cause procrastination or a failure to make a decision, as explained by Hanoch and Rice’s analysis of the literature: “one of the primary sources of decision

conflict arises when people are faced with competing alternatives and feel incapable of trading one option for another and in which no option stands out... [R]ather than risking the potential regret associated with choosing the less than optimal choice, decision makers instead respond to their preference uncertainty by either delaying or opting out of choosing entirely.”⁶⁰

One approach worth considering would give consumers the option to ask the exchange to select an appropriate plan based on key facts volunteered by the consumer, such as the family’s address, doctor, any prescription drugs that are regularly used, etc.⁶¹ This would be analogous to the increasingly widespread practice, with retirement savings, of giving workers the option, rather than to allocate contributions across specified investment vehicles, to simply state the anticipated date of retirement and have the retirement fund automatically balance and re-balance investments over time to achieve good results by the worker’s specified “target date.”⁶² The exchange, along with Medicaid and CHIP, could likewise permit consumers to ask the state to pick a plan, based on key information provided by the consumer. Some people who would otherwise delay or avoid choosing a health plan might welcome this option as meeting their needs more effectively than default enrollment into a randomly chosen plan.⁶³

Part 5: Effective interagency coordination

At the federal level, much of the work described above requires the cooperation of multiple agencies, including the following:

- Within HHS—
 - » CMS’s Center for Medicaid, CHIP and Survey & Certification;
 - » CMS’s Center for Consumer Information and Insurance

Oversight, which is responsible for exchanges;

- » The Office of General Counsel;
- » The Office of Child Support Enforcement, which administers the National Directory of New Hires, which is an important source of information about recent employment earnings;⁶⁴
- » The National Coordinator for Health IT, which has been developing policy and procedures for data-driven eligibility determinations;
- » The Office of the Secretary;
- The Social Security Administration, which will need to provide eligibility-related information about citizenship, income and potentially immigration status;
- The IRS, which will administer tax credits, enforce the individual coverage requirement, provide eligibility-related data about income and employer-sponsored insurance to exchanges and to state health coverage programs, and conduct outreach to uninsured taxpayers;
- The Treasury Department, which plays a key role establishing tax policy;
- Agencies that administer other need-based programs, such as the U.S. Department of Agriculture’s Supplemental Nutrition Assistance Program (SNAP, formerly known as “Food Stamps”), which could potentially provide data that establish and verify eligibility for subsidized health coverage;⁶⁵ and
- The Office of Management and Budget, which must approve all regulations before promulgation.

The effective collaboration of these diverse offices could be facilitated by a national coordinator for enrollment and retention. Enrollment-related tasks could easily lose out to the many other priorities competing for attention, and productive synergies between diverse

parts of the government could fall by the wayside, unless a specific entity within the federal government coordinates the interagency effort to maximize participation by the eligible uninsured.

One possible approach is suggested by the example of intellectual property enforcement, which is addressed by eight different federal agencies. Legislative efforts to help these agencies work together included establishment of a coordinating council in 1999; creating an office of coordinator, located in the Department of Commerce, in 2006; and moving the coordinator into the White House beginning in December 2009, supported by a new interagency advisory committee charged with working with the coordinator to craft a government-wide strategic plan for intellectual property enforcement.⁶⁶ Whether the identical or a modified approach to interagency coordination applies to enrolling the eligible uninsured under the ACA, these efforts are more likely to succeed if one national entity has lead responsibility to help relevant federal agencies work together in taking effective action to help eligible consumers receive coverage.

Conclusion

One of the core goals of the ACA is providing health coverage to more than 30 million uninsured Americans. Unless federal policy-makers engage in a proactive, multifaceted effort to maximize participation by consumers who qualify for help, the legislation could easily fall short of its goals. But if the country’s leaders effectively use the ACA’s 21st-century tools to qualify eligible people for help, along with time-tested methods for helping consumers navigate what can seem like a confusing and complicated system of enrollment and retention, policy-makers may be able to reach the legislation’s ambitious coverage objectives while lowering administrative costs and reducing eligibility errors.

Notes

- 1 CBO, *Estimate of the direct spending and revenue effects of an amendment to the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010*, March 20, 2010.
- 2 Government Accountability Office, *GAO Proactive Testing of ARRA Tax Credits for COBRA Premium Payments*, GAO-10-804R, June 14, 2010 <http://www.gao.gov/new.items/d10804r.pdf>; U.S. Department of the Treasury, *Interim Report to The Congress on COBRA Premium Assistance*, June 2010; Congressional Budget Office, *Conference agreement for H.R. 1, the American Recovery and Reinvestment Act of 2009*, (table entry "Title III - Health Insurance Assistance"), February 13, 2009, <http://www.cbo.gov/ftpdocs/99xx/doc9989/hrlconference.pdf>; Joint Committee on Taxation, *Estimated Budget Effects of the Revenue Provisions Contained in the Conference Agreement for H.R. 1, the "American Recovery and Reinvestment Tax Act of 2009"*, JCX-19-09, February 12, 2009, <http://www.jct.gov/x-19-09.pdf>.
- 3 HCTC also helped early retirees receiving pensions from the Pension Benefit Guaranty Corporation. Stan Dorn, *Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, February 2008.
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- 5 D. Michael Frink and George M. Linge, "Maine's Dirigo Health Reform Act - Is it Working?" *FORC Quarterly Journal of Insurance Law and Regulation*, vol. XV, Edition VII, Summer 2006, <http://www.curtisthaxter.com/pub.php?id=11>; Debra Lipson, James Verdier, Lynn Quincy, Robert Hurley, Elizabeth Seif, Shanna Shulman, and Matt Sloan, *Leading The Way? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms*, Final Report, prepared by Mathematica Policy Research, Inc., for the Robert Wood Johnson Foundation and the Commonwealth Fund, November 2007, <http://www.mathematica-mpr.com/publications/PDFs/DirigoFinalrpt.pdf>.
- 6 E.g., Alice Weiss and Laura Grossman, *Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today*, prepared by the National Academy for State Health Policy for the California HealthCare Foundation, March 2011.
- 7 Stan Dorn, *Automatic Enrollment Strategies: Helping State Coverage Expansion Achieve Its Goals*, prepared by the Urban Institute for the State Coverage Initiatives Program of AcademyHealth, supported by the Robert Wood Johnson Foundation, August 2007.
- 8 Author's calculations, Center for Medicare and Medicaid Services, *LIS-Eligible Medicare Beneficiaries with Drug Coverage, As of February 1, 2009*, February 20, 2009.
- 9 E.g., Sharon K. Long and Paul B. Masi, "Access And Affordability: An Update On Health Reform In Massachusetts, Fall 2008," *Health Affairs*, Web Exclusive, May 28, 2009: w578-w587; Sharon K. Long and Karen Stockley, "Sustaining Health Reform in a Recession: An Update on Massachusetts as of Fall 2009," *Health Affairs* June 2010; 29(6): 1234-1241.
- 10 For more information about this and other innovative policies that led to high participation levels, see Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, prepared by the Urban Institute for the Robert Wood Johnson Foundation and the State Health Access Reform Evaluation, November 2009.
- 11 Genevieve M. Kenney, Victoria Lynch, Allison Cook, and Samantha Phong, "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" *Health Affairs* October 2010; 29(10): 1920-1929.
- 12 Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes In Eligibility And Coverage Among Children, 1996-2002," *Health Affairs*, September/October 2004; 23(5): 39-50.
- 13 Elicia Herz and Evelyne Parizek Baumrucker, *Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?* Congressional Research Service, Updated January 8, 2001, <http://www.policyarchive.org/handle/10207/bitstreams/1043.pdf>.
- 14 ACA §1411(c)(4)(B). Such a system must be consistent with Internal Revenue Code Section 6103, which defines the circumstances under which the IRS can share tax return information.
- 15 ACA §1413(c)(2)(B)(ii)(II).
- 16 See Stan Dorn, *Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform*, prepared by the Urban Institute for the Pharmaceutical Research and Manufacturers of America, December 2009; Stan Dorn, Bowen Garrett, Cynthia Perry, Lisa Clemans-Cope, Aaron Lucas, *Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and SCHIP*, prepared by the Urban Institute for First Focus, February 2009.
- 17 Using tax returns as launching pads for enrollment into subsidized coverage is consistent with ACA enrollment periods. During 2014, when this tax return strategy is likely to make its biggest dent in the number of uninsured, ACA permits an extended enrollment period. This could easily run through April 15, 2014, in time for most uninsured tax filers to seek subsidized coverage. After 2014, open enrollment could potentially include the first month or two of the calendar year. And even after open enrollment ends during a year, returns will identify some uninsured who can be enrolled immediately into coverage, including those who qualify for Medicaid and CHIP, which can begin at any time, as well as taxpayers who lost coverage in response to life events that trigger a special enrollment period inside the exchange.
- 18 While this requirement asks taxpayers to identify their uninsured family members, it leaves them free to decide whether or not to authorize the use of their tax return to start an application for assistance. If the form described in the text is optional rather than required, many fewer taxpayers will complete it. However, an optional form might be widely used if IRS made a small payment to tax preparers for each uninsured client who completes the form. Such payments would, in effect, share with tax preparers IRS' administrative cost savings described later in this section.
- 19 IRS could require paid tax preparers to have a basic familiarity with this "consent to disclosure" process along with other aspects of the ACA that may affect the preparation of federal income tax returns.
- 20 Internal Revenue Service, *Free Application For Federal Student Aid (FAFSA)*, June 14, 2010, http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_12059_912224_0_0_18/6-Rushin_IRS-FAFSA-06142010.pdf.
- 21 Dorn 2006, op cit.
- 22 *2009 IRS Data Book*, Tables 2, 9a and 14; *2008 IRS Data Book*, Table 15. Note: for Table 15, the 2008 rather than the 2009 data book was used, because the 2009 table is atypical, as it includes the effects of the rebate recovery credit. The information in these five tables does not allow an unduplicated count, so the number in the text is an upper bound.
- 23 This is one of several examples when new data could flag changes in circumstances that might affect subsidy eligibility. Other examples would include reports of new hires, layoffs, or changed earnings sent to state workforce agencies or provided by private vendors. Both to ensure that those who qualify for additional assistance receive it and to prevent taxpayers from incurring year-end liability to the Internal Revenue Service based on annual income that exceeds projected levels, policy-makers could establish mechanisms through which such data (a) automatically generate notices to both consumers and the applicable subsidy programs and (b) with consumers' advance consent, trigger automatic adjustments to tax credits and cost-sharing subsidies in the exchange.
- 24 ACA §1502(c).
- 25 Government Accountability Office, *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries*, GAO-04-363, March 2004. In the case of MSPs, sending notices increased the volume of phone calls, but few consumers managed to complete the enrollment process. More recently, the states of Iowa and New Jersey engaged in similar efforts that yielded comparable results. Taxpayers were required to indicate on state income tax returns whether their children had insurance coverage. Parents who indicated that their children were uninsured were mailed application forms for child health programs, along with information about how to apply. In Iowa, roughly 1 percent of parents returned application forms and applied for coverage. Brenda Freshour Johnston, *Reaching Uninsured Children: Iowa's Income Tax Return and CHIP Project*, prepared by the Iowa Department of Human Services for the State Health Access Reform Evaluation project of the Robert Wood Johnson Foundation, with the State Health Access Data Assistance Center serving as national program office, August 2010. New Jersey mailed out approximately 172,000 specially streamlined applications to parents with uninsured children; roughly 750 children enrolled—less than ½ of one percent of the children in families who received state mailings. John Guhl and Eliot Fishman, *New Jersey Family Care: Express Lane Eligibility*, State Coverage Initiatives program national conference, July 2009.

- 26 Examples include 401(k) retirement savings plans, David Laibson, "Impatience and Savings," *National Bureau of Economic Research Reporter*, Fall 2005, pp. 6-8, John Beshears, James J. Choi, David Laibson, and Brigitte C. Madrian, *The Importance Of Default Options For Retirement Savings Outcomes: Evidence From The United States*, National Bureau of Economic Research Working Paper 12009, January 2006; automobile insurance, Johnson, E. J., Hershey, J., Meszaros, J., & Kunreuther, H., "Framing, Probability Distortions, and Insurance Decisions," *Journal of Risk and Uncertainty*, 7:35-51, 2003; and agreement to participate in on-line surveys, Eric J. Johnson, Steven Bellman, and Gerald L. Lohse, "Defaults, Framing and Privacy: Why Opting In-Opting Out," *Marketing Letters* 13(1):5-15, 2002.
- 27 With Medicaid, for which premiums are not charged, purely automatic enrollment may be possible under the ACA, even when coverage is furnished by managed care organizations (MCO) contracting with the state. If available data show eligibility, consumers can be given a chance to select a plan. If they fail to do so within a specified period, one can be chosen for them. Such automatic enrollment was an important feature of Massachusetts' successful use of data to provide coverage to roughly 1 in 4 formerly ineligible consumers. Dorn, Hill, and Hogan, op cit. To prevent wasteful capitated payments, a state could withhold the first such payment for a default enrollee until the consumer first uses covered services, thus giving the MCO an incentive to reach out to default enrollees and help them obtain care. Alternatively, the state could provide automatic enrollees with fee-for-service coverage, converting them into managed care only after they first seek care. A similar approach is now being used by Louisiana, in its implementation of Express Lane Eligibility. Stan Dorn, Ian Hill, and Fiona Adams, *Express Lane Eligibility in Louisiana*, prepared by the Urban Institute for the State Health Access Reform Evaluation project of the Robert Wood Johnson Foundation, with the State Health Access Data Assistance Center serving as national program office (forthcoming).
- 28 For examples of data-driven eligibility resulting in administrative cost savings for health coverage and other public benefits, see Andrea Cohen, Melinda Dutton, Kerry Griffin, and Gregory Woods, *Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York*, prepared by Manatt Health Solutions for the United Hospital Fund, 2008; Ruth Kennedy, "LaCHIP Outreach, Enrollment, & Retention," paper prepared for the *Winter Medicaid Administrative Management Conference* (New Orleans, LA) January 17, 2007; P. Gleason, et al., *Direct Certification in the National School Lunch Program—Impacts on Program Access and Integrity*, prepared by Mathematica Policy Research, Inc., for the U.S. Department of Agriculture (USDA), 2003, Report E-FAN-03-009; N. Cole, *Data Matching in the National School Lunch Program: 2005*, "Volume 1: Final Report," prepared by Abt Associates, Inc., for USDA, 2007, Report CN-06-DM; Food and Nutrition Service of the Minnesota Department of Children, Families and Learning, *Free and Reduced Price Meal Eligibility Cost Study*, March 2002. For examples of reduced eligibility errors, see M. Ponzia, P. Gleason, L. Hulsey, and Q. Moore, *NSLP/SBP Access, Participation, Eligibility, and Certification Study: Erroneous Payments in the NSLP and SBP*, "Volume I: Findings, Final Report," prepared by Mathematica Policy Research, Inc., for USDA, October 2007. See also the discussion of WIC adjunctive eligibility and program integrity in Government Accountability Office, *Means-Tested Programs: Information on Program Access Can Be an Important Management Tool*, GAO-05-221, March 2005. For a GAO study concluding that categorical eligibility, which automatically grants food stamps based on data matches with TANF programs, cuts administrative costs and reduces errors, see Government Accountability Office, *Supplemental Nutrition Assistance Program: Payment Errors and Trafficking Have Declined, but Challenges Remain*, GAO-10-956T, July 28, 2010.
- 29 Government Accountability Office, *Means-Tested Programs: Information on Program Access Can Be an Important Management Tool*, GAO-05-221, March 2005.
- 30 This ACA provision cross-references the data "described in Social Security Act §§1137, 453(i), and 1942(a)." Section 1137 describes information currently accessible through the Income and Eligibility Verification System, or IEVS, including data from the IRS and the Social Security Administration (SSA); state quarterly wage records and new hires information available from State Workforce Agencies (SWA); and immigration status data available from the Department of Homeland Security through the Systematic Alien Verification for Entitlements (SAVE) Program. Section 453(i) describes the National Directory of New Hires. NDNH combines quarterly wage records and new hires data from all SWAs and the federal government. Section 1942(a) describes eligibility files maintained by public benefit programs, state income tax records, state records about private insurance coverage maintained for purposes of Medicaid Third Party Liability enforcement, and vital records data about births in any state.
- 31 As with Part D LIS, if a beneficiary's circumstances have worsened since the baseline tax year, he or she can file an application form qualifying for additional assistance, but if such steps are not taken, the tax data are determinative. Stimulus payments under 2008 tax legislation likewise based 2008 payments on 2007 tax data, although taxpayers could file 2009 returns documenting claims to additional sums, based on lower income in 2008 than in 2007.
- Along similar lines is the President's proposal to change the eligibility rules for federally subsidized college grants and loans. The proposal would align those rules with IRS data, limiting eligibility requirements to items that can be verified based on information on income tax returns. The Council of Economic Advisers found that, in addition to increasing participation by simplifying enrollment, defining eligibility based on available data could prevent fraud, reduce eligibility errors, and retain eligibility targeted to need. Council of Economic Advisers, *Simplifying Student Aid: The Case For An Easier, Faster, And More Accurate FAFSA*, September 2009.
- 32 ACA §1412(b).
- 33 Benjamin D. Sommers and Arnold M. Epstein, "Medicaid Expansion — The Soft Underbelly of Health Care Reform?" *New England Journal of Medicine*, November 25, 2010; 363(22): 2085-2087.
- 34 Social Security Act §1902(e)(14)(H)(i), added by ACA §2002.
- 35 POMS Section SI 00820.220, *How to Verify Net Earnings from Self-Employment (NESE)*. Medicaid income methodologies are based on those used by the former AFDC program or by SSI, whichever is the most closely related category of assistance.
- 36 Section 1413(c)(3)(A)(ii) makes clear that, whenever possible, third-party data must be used, not just to "verify" eligibility, but also to "establish" it. Further, §§1413(b)(1)(A)(iv), 1411(c)(4)(B), 1411(g)(1) require that application forms and procedures must impose on consumers the least possible burdens—a goal directly advanced by using data, rather than requiring applicants to describe household circumstances on application forms, to qualify consumers for assistance. Moreover, CMS has already made clear that ACA is subject to longstanding Medicaid requirements that eligibility methods must be "reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary. State Medicaid Director Letter # 10-005 (PPACA # 1), *New Option for Coverage of Individuals under Medicaid*, April 9, 2010. Finally, ACA §1104 has been described by HHS as governing, among other things, eligibility determinations for Medicaid and the Exchange. See, e.g., proposed 42 CFR 433.112(b)(12) in CMS, *Notice of Proposed Rulemaking on Federal Funding for Medicaid Eligibility Determination and Enrollment Activities*, Federal Register, November 3, 2010, available at http://www.ofr.gov/OFRU/upload/OFRData/2010-27971_PI.pdf; November 3, 2010, letter from Joel Ario and Cindy Mann to State Medicaid Directors, State Health Officials, and State Health Insurance Commissioners, *Federal Support and Standards for Medicaid and Exchange Information Technology Systems*. Section 1104 creates Social Security Act §1173(a)(4), which requires that HHS must promulgate standards that "enable determination of an individual's eligibility and financial responsibility for specific services ... at the point of care," a requirement that would be impossible to meet if eligibility determination for Medicaid required a consumer's presentation of recent pay stubs or similar documents; that data-based transactions must "be comprehensive, requiring minimal augmentation by paper or other communications;" and that HHS "shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers." 1173(a)(4)(A)(i) and (ii), (B).
- 37 This is the standard that Louisiana applies in its nationally acclaimed approach to renewing children's coverage. When available data show a reasonable certainty of continued eligibility, children's coverage is renewed automatically. If additional information is needed, families are encouraged to provide it by phone. Only if all else fails are families asked to complete forms describing current circumstances. As a result, 19 in 20 children (95.4 percent) have their eligibility continued at renewal, and fewer than 1 in 100 (0.7 percent) loses coverage for procedural reasons. Ruth Kennedy, personal communication 2010, providing state administrative data for December 2009. At the same time, federal audits found Louisiana to have an eligibility error rate of 1.54 percent—far below the national average of 6.74 percent. Louisiana Department of Health and Hospitals,

Louisiana Medicaid Recognized as a National Best Practice for Administrative Efficiency, November 20, 2009, <http://www.dhh.la.gov/news.asp?Detail=1556>.

³⁸ Judith Arnold, personal communication.

³⁹ In some cases, data cannot establish eligibility. As one example, independent contractor income is not included in quarterly wage reporting. If an application is filed late in the year, income tax records showing prior-year independent contractor income cannot be updated based quarterly earnings data. On the other hand, the most common sources of income fluctuation among low-income households involve changed hours of work and wage levels, which are often reflected in quarterly earnings records. C. Newman, "Income Volatility Complicates Food Assistance," *Amber Waves*, USDA Economic Research Service, September 2006, Volume 4, No. 4, pp. 16-21. In a second example, there will be cases in which eligibility cannot be immediately determined based on data because tax records are too stale to establish current income levels but subsequent earnings reports are not yet available.

⁴⁰ During the first three months that states were allowed to document children's citizenship based on data matches with SSA, 24 states were testing or had adopted this option, which successfully confirmed citizenship for 94 percent of applicants. Donna Cohen Ross, *New Citizenship Documentation Option for Medicaid and CHIP is Up and Running: Data Matches with Social Security Administration Are Easing Burdens on Families and States*, Center on Budget and Policy Priorities, April 20, 2010.

⁴¹ SSA data matches might be used to confirm lawful presence in the U.S. for immigrants whom SSA has already found to be legal permanent residents, for purposes of issuing a Social Security card. Before it provides a Social Security Number (SSN) to a non-citizen, SSA obtains proof from U.S. Citizenship and Immigration Services that the non-citizen "has been lawfully admitted to the United States, either for permanent residence or under authority of law permitting him or her to work in the United States." 20 C.F.R. 422.107(e)(1). Under SSA administrative guidelines, the same evidence must be presented to document status as a "Permanent Resident Alien," or PRA, as has traditionally been required to show status as a qualified alien in establishing Medicaid eligibility. See POMS Manual Sections RM 00203.410, "Evidence of Alien Status for an SSN Card for an Alien Lawfully Admitted for Permanent Residence;" RM 00202.230, "Form SS-5 - Evidence Blocks (PBC, EVI, EVA, EVC, and PRA);" and RM 00203.600, "List of Documents Establishing Lawful Alien Status for an SSN Card". When a consumer has already provided one government agency with documents proving a key fact relevant to eligibility, it makes little sense to deny benefits until the consumer has provided a second agency with those same documents.

For many immigrants who qualify for Medicaid, CHIP, or subsidies in the exchange, SSA data will not be sufficient to establish their eligibility. Such data do not show the date on which an immigration status was granted, which is usually needed to determine Medicaid eligibility for adults (and in some states, children). Further, some legally present immigrants have not tried to obtain Social

Security cards and so would not be included in SSA records. As a final example, small differences in the spelling of a name or other factors can prevent a match with SSA records, even for immigrants who have received Social Security cards. Accordingly, more traditional verification procedures with the Department of Homeland Security will need to apply when SSA data matches do not confirm satisfactory immigration status.

⁴² See ACA §§1502, 1512, 1514. In addition, many states have good access to information about private insurance coverage today for purposes of enforcing Medicaid third-party liability requirements.

⁴³ ACA §1413(c)(3)(A)(i).

⁴⁴ Robin Callahan, *Transforming Enrollment Systems: Massachusetts' Experience*, National Academy for State Health Policy, Maximizing Enrollment for Kids National Briefing, December 10, 2010.

⁴⁵ See, e.g., Ian Hill, Corinna Hawkes, et al., *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Cross-Cutting Report on the Findings from Ten State Site Visits*, prepared by the Urban Institute and Mathematica Policy Research, Inc., for the U.S. Department of Health and Human Services, Revised June 2004, http://www.urban.org/UploadedPDF/1001343_schip.pdf; Mireille Jacobson and Thomas C. Buchmueller, "Can Private Companies Contribute To Public Programs' Outreach Efforts? Evidence From California," *Health Affairs*, March/April 2007; 26(2): 538-548; Gerry Fairbrother, Jennifer Stuber, Melinda Dutton, Roberta Scheinmann, and Rachel Cooper, "An Examination of Enrollment of Children in Public Health Insurance in New York City Through Facilitated Enrollment," *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 81(2): 191-205, 2004; A. Aizer, "Public Health Insurance, Program Take-Up, And Child Health," *The Review of Economics and Statistics*, August 2007, Vol. 89, No. 3, pp 400-415.

⁴⁶ Laura Summer and Jennifer Thompson, *Best Practices to Improve Take-Up Rates in Health Insurance Programs Final Report*, prepared by the Georgetown Health Policy Institute for the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 18, 2008; Victoria Wachino and Alice Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children*, National Academy for State Health Policy, 2009. For example, a study published in *Pediatrics* compared the effect on low-income, Latino families in Boston of (a) standard Medicaid/CHIP outreach versus (b) intensive application assistance provided by community-based case managers who proactively identified potentially eligible families, helped them apply for coverage, helped complete application forms, and tracked applications through to completion, intervening on behalf of low-income families to solve problems. While the standard outreach methods enrolled 57 percent of eligible children, 96 percent of eligible children targeted by community-based case managers received coverage. Flores, G. et al. "Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children" *Pediatrics*. December 2005. Vol. 116, No. 6, pp. 1433-1441.

As another example, a randomized, controlled experiment examined the effect of facilitated enrollment on submission of the Free Application for Federal Student Aid (FAFSA) by certain low- and moderate-income families filing federal income tax returns with H&R Block. These were families with members between the ages of 15 and 30 who had not yet attended college. The control group was given brochures about the process of applying for student aid. With the first experimental group—the "form completion" group—H&R Block staff used tax return data and family interviews to complete the FAFSA, filing the form electronically if the family approved. The second experimental group—the "information-only" group—received written, personalized estimates of eligibility for student aid, based on their tax returns, along with information about tuition costs at nearby colleges and encouragement to complete the application process, but H&R Block did not complete the form on behalf of consumers.

Among dependents, completing the form on behalf of the family raised the proportion submitting applications from 40.2 percent to 55.9 percent—a 40 percent relative increase—and ultimately raised their likelihood of attending college by 25 to 30 percent. Among independent adults, the form completion intervention nearly tripled the likelihood of filing for student aid, raising the form submission rate from 13.8 percent to 39.5 percent. Simply furnishing information had no statistically significant effect on the likelihood of submitting applications, among either dependents or independent adults. Eric P. Bettinger, Bridget Terry Long, Philip Oreopoulos, and Lisa Sanbonmatsu, "The Role Of Simplification And Information In College Decisions: Results From The H&R Block FAFSA Experiment," *National Bureau of Economic Research Working Paper 15361* (September 2009).

⁴⁷ It may be important to distinguish between Navigators that facilitate individual enrollment and those that serve the small group market. Small firms could likely receive effective help from "trade, industry, and professional associations," "chambers of commerce," "resource partners of the Small Business Administration," as mentioned in ACA §1311(i)(2)(B), as well as traditional insurance brokers and agents. But with low- and moderate-income consumers seeking coverage through the exchange's individual market, "consumer-focused nonprofit groups" will probably be better positioned to guide the target group through the potentially confusing process of qualifying for assistance and enrolling into coverage. To achieve this goal efficiently, Navigator resources could thus be divided, in proportion to the anticipated enrollment in the exchange's individual and small group markets, between entities that serve low- and moderate-income individuals and those that serve small firms.

In addition, policy-makers could identify the multiple functions that Navigators need to fulfill in the individual market by looking to the experiences of states that have successfully facilitated the enrollment of low-income consumers into subsidized coverage. Massachusetts again furnishes a useful example, with a network of contracts that includes not just "street level" community groups but also "back-up" organizations that offer expertise in the rights and responsibilities

of health consumers. The state provides regular briefings and updates in multiple locations, ensuring that community organizations learn about new developments and state officials hear about emerging problems. An exchange's Navigator program that serves the individual market could thus be asked to fulfill each of these functions—"hands-on" facilitated enrollment, legally sophisticated "back-up" that is independent of the state, ongoing regional training, and flagging of emerging problems to guide state policy development.

48 ACA §1311(i)(6).

49 See November 3, 2010, letter from Joel Ario and Cindy Mann to State Medicaid Directors, State Health Officials, and State Health Insurance Commissioners, *Federal Support and Standards for Medicaid and Exchange Information Technology Systems*, noting the possibility of allocating the cost of consumer assistance between Medicaid, CHIP, and administrative funding for the exchange.

50 Medicaid and CHIP programs have found that simplifying application and retention procedures can increase participation. Wachino and Weiss, *op cit.* For broader research outside the arena of health coverage showing the impact of structured defaults, see Laibson, *op cit.*; Beshears, et al., *op cit.*; Johnson, et al., 2002, *op cit.*; and Johnson, et al., 2003, *op cit.*

51 See ACA §§1413(b)(1)(A), 1413(b)(1)(A)(iv), and 1411(g)(1).

52 Such a statement needs to be carefully constructed and field tested with consumers to ensure that the reader can easily comprehend it and decide whether changes are needed. For example, income may need to be shown in weekly or monthly amounts rather than annual numbers. If the consumer is enrolling on-line, the website could directly furnish the statement in real time. In other cases, the statement may need to be sent by mail or email.

53 Setting the default as enrollment rather than non-enrollment can greatly increase participation rates, as illustrated by the behavioral economics research cited in earlier notes, including the classic example involving 401(k) retirement accounts. When an employer establishes an account and enrolls new workers who complete forms, 33 percent participate. By contrast, when new employees are enrolled unless they complete forms opting out, enrollment reaches 90 percent. Laibson, *op cit.*

In terms of subsidized health coverage, a precedent comes from "administrative renewal," which the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) describes as providing the parent with "a pre-printed form completed by the State based on the information available to the State" along with notice that "eligibility of the child will be renewed and continued based on such information unless the State is provided other information." Social Security Act 2015(a)(4)(E) (i), added by CHIPRA §104. State officials report that this approach, one of several best practices of which a state must implement at least five to obtain performance bonuses under CHIPRA, greatly increases participation rates and lowers administrative costs without undermining program integrity. Andrea Cohen, Melinda Dutton, Kerry Griffin, and Gregory Woods, *Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York*, prepared by Manatt Health

Solutions, a division of Manatt Phelps & Phillips, LLP, for the United Hospital Fund, 2008, http://www.manatthealthsolutions.com/publications/articles/Streamlining_Renewal.pdf.

54 If prior-year state income tax data show income-eligibility for Medicaid, a state implementing Express Lane Eligibility provides the child with Medicaid, without requiring any more recent information. If prior-year income tax data show that the child qualifies CHIP, the child receives that subsidy as an initial matter. However, the family also receives a notice explaining how it can seek more generous Medicaid coverage by applying for subsidies using standard Medicaid procedures, which can include the use of more recent income information. See Social Security Act §1902(e)(13), subparagraphs (H), (A)(I) (I) and (II), and (C)(ii)(III), added by CHIPRA §203(a).

55 Wisconsin Office of Health Care Reform, *Test Drive the Insurance Exchange*, accessed on 3/21/2011, <http://www.healthcarereform.wisconsin.gov>.

56 Office of Consumer Information and Insurance Oversight and CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems*, Version 1.0, November 3, 2010.

57 C. Millett, A. Chattopadhyay, and A. Bindman, "Unhealthy Competition: Consequences of Health Plan Choice in California Medicaid," *American Journal of Public Health*, e-published Sept. 23, 2010:e1-e6.

58 Rules that identify the plan into which a consumer is enrolled by default can fulfill multiple objectives. Most important is to provide beneficiaries with coverage likely to be in their best interests, taking into account relative premium costs, out-of-pocket cost-sharing, consumer address, and available information about the consumer's health care needs. But default enrollment can also be used as leverage to lower premiums in the exchange—an approach that Massachusetts successfully employed, Dorn, Hill, Hogan, *op cit.*—or to reward plans that meet state objectives related to quality improvement, delivery system reform, and the like.

59 For example, when Florida's Medicaid program gave beneficiaries multiple health plan options with diverse benefits, more than 40 percent did not select a plan and so had one chosen by default. Despite the availability of call centers to help consumers sort through their options, more than half found it hard to understand health plan information and hard to pick a plan, only half knew about available counseling to help with plan choices, and most did not understand even such basic facts as consumer opt-out rights or the approximate number of health plan choices. Teresa A. Coughlin, Sharon K. Long, Timothy Triplett, Samantha Artiga, Barbara Lyons, R. Paul Duncan, and Allyson G. Hall, "Florida's Medicaid Reform: Informed Consumer Choice?" *Health Affairs* 27(6): w523-w532 (published online 14 October 2008); Jessica Greene and Ellen Peters, "Medicaid Consumers and Informed Decisionmaking," *Health Care Financing Review* 30(3):25-40, Spring 2009.

60 Yaniv Hanoch and Thomas Rice, "Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance," *The Milbank Quarterly*, 84(1):37-73, 2006.

61 A similar alternative would present consumers with a small number of plans that meet the

criteria specified by consumers, such as inclusion of a particular provider or low cost-sharing amounts for particular prescription drugs. However, this alternative would probably be less effective in promoting enrollment since consumers would still face a choice between plans that might trigger the ambivalence and uncertainty described by Hanoch and Rice.

62 By the end of 2008, three-quarters of 401(k) plans offered target-date funds as an option. Jack Van Derhei and Sarah Holden, *401(k) Plan Asset Allocation, Account Balances, and Loan Activity in 2008*, the Employee Benefit Research Institute and the Investment Company Institute, October 2009.

63 Given the novelty of this approach to health plan selection, field-testing could be important to see whether, in fact, this option would be selected by many consumers.

64 Unlike state-specific new hires data bases, NDNH includes federal employment as well as reports from employers in all states. NDNH thus provides information about earnings from multi-state employers, information that such employers are required to report to only one state workforce agency and that are not typically included in other states' databases.

65 CMS could make clear that, when SNAP or another public benefit program has already found someone to have income below 138 percent of FPL, the state can automatically qualify such a person as income-eligible for Medicaid. Social Security Act §1902(e)(14)(D)(ii), added by ACA §2002(a), expressly allows this with Express Lane Eligibility (ELE) for children, but ACA also authorizes CMS to reach this result for adults through 1115 waivers. According to new Social Security Act §1902(e)(14)(D)(i)(I), MAGI does not apply to "[i]ndividuals who are eligible for medical assistance under ... a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance." That same authority could apply to children, if CHIPRA's authorization for states to implement ELE via State Plan Amendment expires after FY 2013.

For example, SNAP is limited to households with gross incomes at or below 133 percent FPL. In theory, different household definitions used in SNAP and the federal income tax system mean that a few SNAP recipients may have MAGI slightly above 138 percent FPL and so qualify for subsidies in the exchange rather than Medicaid. But after a family has completed the SNAP eligibility determination process and been found to qualify, the value added by requiring the family to go through a second such process seems greatly outweighed by (a) the burden imposed on the family and the resulting possibility that an eligible family will remain uninsured because it does not complete the process; and (b) the administrative costs of making a second, largely redundant eligibility determination. Accordingly, interpreting the Affordable Care Act to authorize 1115 waivers as suggested here would help accomplish the legislation's basic goals.

66 Government Accountability Office, *INTELLECTUAL PROPERTY: Agencies Progress in Implementing Recent Legislation, but Enhancements Could Improve Future Plans*, GAO-11-39, October 2010.

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