Ten Ways to Make Health Coverage Enrollment and Renewal Easy

By Jennifer Sullivan

On January 1, 2014, as a result of the Affordable Care Act, millions of people will qualify for affordable health coverage that isn't available to them today. That new coverage will be possible due to expanded Medicaid eligibility and to tax credits for the purchase of private coverage. But much work needs to be done between now and 2014 to ensure that people who want to sign up for that coverage can easily do so.

States will establish new online marketplaces called health insurance exchanges where people can shop for health coverage and find out if they qualify for tax credits to purchase private coverage or for Medicaid or the Children's Health Insurance Program (CHIP). But when enrollment for expanded coverage starts in 2013, how will the process work for consumers? Will it be like comparison shopping at "Orbitz.com" (with an integrated process to find out whether you qualify for a discount), or will it be like completing an annual income tax return—an arduous exercise that most Americans dread?

Fortunately, although the scale of this coverage expansion is unlike anything ever attempted before in this country, there are experiences both within the health coverage realm and beyond it that offer lessons on how best to ensure simple, seamless, streamlined enrollment. While the particular processes that work best will vary by state, population, and program design decisions, the following are key elements of an easy enrollment process that can guide enrollment policy decisions in any state. We present these elements in the order that individuals might encounter them as they proceed through the enrollment process (not in order of importance).

1 Assume That Everyone Qualifies for Some Form of Coverage

States have historically designed their eligibility systems in ways that were geared toward keeping people *out* of programs, rather than inviting them *in*, because program rules meant that only certain people would qualify. But starting in 2014, nearly everyone will qualify for some kind of health coverage, and many people will qualify for help with the cost of that coverage. This fundamental paradigm shift means that, from now on, eligibility systems should be designed to determine *what kind of coverage someone is eligible to receive,* not *if* someone is eligible. Although determining which form of coverage and how much assistance someone should receive will be complicated in some cases, this need not encumber the process for the majority. *The underlying assumption should always be that every person is eligible for coverage*.

2 Use a Single, Simple Application

The Affordable Care Act requires states to employ a single, joint application—one that can be filed online, in person, over the phone, or through the mail—for Medicaid, CHIP, and tax credits. Experience with children's coverage in Medicaid and CHIP clearly demonstrates that families find it easier to enroll when the same application can be used to determine eligibility for multiple programs.[1] Although states have the option to use different applications for the two different programs, all but two states now offer a joint application.[2] To avoid confusing consumers, it is also important that applications be short and ask only for information that is absolutely necessary to make a determination. Simply combining two or more complicated applications into one long form does not simplify the process for consumers.[3]

Using a single application for Medicaid, CHIP, and tax credits complements the notion of assuming that everyone is eligible for some form of coverage. All three programs will use the same income definition (Modified Adjusted Gross Income), making it easier to use a single application to determine eligibility.[4] States will have flexibility in how they design their application and enrollment processes. The simpler these processes are, the more likely consumers will be to complete the application and enroll in coverage.

3 Enrollment Can Happen Anywhere

Beginning with the first open enrollment period in 2013, consumers will be able to go to a single website to apply for and enroll in coverage (Medicaid, CHIP, tax credits, or Basic Health[5]). By tapping into a federal "data services hub" that is currently under construction by the Department of Health and Human Services (HHS), state exchanges should be able to locate all or most of the data necessary to make eligibility determinations (such as data on income and whether the individual has job-based coverage).

The Affordable Care Act requires the agencies that administer health coverage programs in states to work collaboratively. In some states, a single agency may handle eligibility determinations for multiple kinds of coverage. In other states, agencies that administer Medicaid, CHIP, and the tax credits might operate separately but they still need to establish a clear, seamless "behind-the-scenes" process to route applications appropriately. They must also ensure that if a person is determined to be ineligible for one form of coverage, his or her information is automatically passed along to the agencies that administer the other forms of coverage until that person gets enrolled. This will help ensure that consumers do not encounter any dead ends in their application process.

Web-based applications should offer opportunities to increase the places where people can enroll in coverage: at home, at grocery stores, community health centers, state fairs, sporting events, places of worship, and more.

4 Provide Coverage Immediately to Those Who Appear Eligible

While making eligibility determinations can be extremely complicated, a process called "presumptive eligibility" makes it easy to determine that a person is likely to be eligible for coverage based on his or her stated income. States can already use this process to enroll certain women and children in Medicaid and CHIP coverage temporarily (for up to 60 days) while the full determination is completed.[6] The Affordable Care Act gives states new authority to use presumptive eligibility for adults in Medicaid as well beginning in 2014, and the law simplifies and standardizes income definitions among Medicaid, CHIP, and the tax credits. This should make it even easier to get Medicaid-eligible people covered and make sure they receive health services as soon as they apply, as long as they meet basic screening criteria.

5 Simplify Citizenship Documentation

Federal law requires that citizenship information be verified in order for individuals to enroll in Medicaid, CHIP, or tax credits.[7] This need not be an onerous process. Thanks to the CHIP Reauthorization Act of 2009 (CHIPRA), Medicaid and CHIP agencies in more than 30 states are already working in cooperation with the Social Security Administration to verify Medicaid and/or CHIP applicants' citizenship based on data in Social Security databases.[8] Experience suggests that this option can be used to accurately verify citizenship for up to 95 percent of applicants while also proving far simpler for consumers and less expensive for states.[9]

The Affordable Care Act allows states to verify applicants' citizenship using this same data-matching process in coordination with the Social Security Administration. Applicants should be required to submit additional paperwork only if their citizenship cannot be verified using this process.

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6 Use Existing Information to Determine Eligibility

Data-matching can and should go beyond just citizenship verification. For example, income information is required to assess whether a person is eligible for Medicaid, CHIP, or tax credits. Today in Medicaid, states often require people to provide paper documentation (such as pay stubs), and then the state compares this information to data in state and federal databases. The Affordable Care Act requires states to actively use existing sources of reliable third-party data to establish eligibility as a *substitute* for requiring consumers to submit paper documentation.

The Affordable Care Act also requires state and federal agencies to establish data-sharing agreements to share the information that is needed to make eligibility determinations. In addition, the Secretary of HHS has developed health information technology (HIT) standards for enrollment processes that allow for electronic matching using existing federal and state data.[10] These standards should guide the integration of enrollment systems across multiple programs, including health coverage programs and other kinds of social services programs, such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

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7 Make It Easy to Get Help

Simplification and automation are integral components of modernized enrollment systems, but personal application assistance will continue to be important. State experience has shown that systems improvements go a long way, but they can never replace the crucial assistance that consumer hotlines and community-based organizations provide. For example, during the first two years after Massachusetts enacted its health reform legislation, applications that were submitted by application assisters (health care providers and community-based organizations) accounted for more than half of new enrollment.[11]

Consumers need to be able to contact a trained professional who can provide personalized technical assistance to help complete, submit, or check the status of an application or renewal and to get assistance when they encounter language or cultural barriers.[12] Even the most high-tech, coordinated systems will still require a human element to be successful. States will need to establish more comprehensive consumer assistance programs to help people learn about and sign up for health coverage, and additional funding—both public and private—will be needed to support such programs.

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8 Promote 12-Month Eligibility Periods

Getting people covered for 12 months at a time, and allowing them to *keep* that coverage even if their circumstances change, helps to ensure that people receive the health services they need without the disruptions that can occur when more frequent renewals are required. This increased stability improves health care for consumers and can reduce costs—both administrative costs and the cost of coverage itself.[13]

The federal government and states will need to make sure that it is easy for consumers to provide information that might change their eligibility for health coverage (for example, a change in income or the birth of a child). When changes in circumstances affect an individual's eligibility for coverage, he or she should be able to move from one form of coverage to another seamlessly, without experiencing a lapse in coverage.

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9 Make Renewal Easy

Making it easy for people to *get* coverage is only half the battle; enrollment policies also need to ensure that it is easy for people to *keep* their coverage once enrolled. States have used many successful strategies to promote continuous coverage, including sending pre-printed forms that families need to return only if their information has changed, allowing people to renew by phone, allowing people to "re-up" their health coverage at the same time they recertify their eligibility for other programs (like SNAP), and using existing state databases to verify as much of the information that is needed to determine ongoing eligibility as possible.

All of the simplifications that are envisioned for the enrollment process—such as the ability to enroll online using a single form for tax credits, Medicaid, and CHIP; as well as data-matching agreements, improved health information technology standards; and the availability of culturally and linguistically appropriate application assistance—apply equally to the renewal process. Ensuring that eligible people maintain continuous coverage saves states and the federal government administrative costs, and it means that consumers will be covered when they need health care, which will also help control health care costs as well.[14]

10 Measure, Improve, Repeat

This time-honored quality improvement mantra is just as true for enrollment as it is for any process. The gains so far, largely in children's coverage in Medicaid and CHIP, were born out of state officials' and advocates' continuous efforts to identify and address problems as they occurred. It will be easier for policy makers to make the right choices about how to build and adapt improved enrollment systems if there are robust data to inform these decisions. This includes demographic data about who is applying, where, and how. Health care stakeholders will play an important role in working with state and federal program administrators to ensure that the right data are collected—and analyzed—to ensure that the learning process continues even after expanded coverage is initially rolled out in 2013-2014.

Using enrollment best practices will maximize the number of Americans who are enrolled in health coverage.

Conclusion

Using these enrollment best practices as a guide will position states to maximize the number of uninsured Americans who are quickly and easily enrolled in coverage. Ensuring that Americans get enrolled will also take concerted public education campaigns to let people know that coverage and financial aid are available to them and that signing up for coverage is easy. For more information on Enroll America's efforts to make these visions a reality, and to find out how you can get involved, visit us online at www.enrollamerica.org.

Endnotes

[1] Donna Cohen Ross and Ian Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13, no. 1 (Spring 2003), available online at http://futureofchildren.org/publications/journals/article/index.xml?journalid=41&articleid=145&sectionid=953.

[2] Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, and Jessica Stephens, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2011), available online at http://www.kff.org/medicaid/8130.cfm.

[3] Presentation: *Consumer Voices: What Motivates Families to Enroll in Coverage?* (Princeton, NJ: Robert Wood Johnson Foundation, GMMB, and Lake Research Partners, September 14, 2010), available online at http://www.insurekidsnow.gov/professionals/outreach/webinars/challenging_times_motivate_families_slides.pdf.

[4] Some categories of Medicaid eligibility, such as disability-related coverage and coverage for certain low-income seniors, may still require a different application, since eligibility standards for these groups are significantly different than they are for most individuals who will be eligible for Medicaid or tax credits.

[5] States have the option to offer a Basic Health plan for low-income adults who are not eligible for Medicaid and who have income below 200 percent of the federal poverty level in lieu of offering these individuals tax credits for the purchase of coverage through an exchange.

[6] Under current law, states can use presumptive eligibility for Medicaid and CHIP for children, pregnant women, and women who are likely to be eligible for Medicaid under the breast and cervical cancer categories.

[7] Individuals must be U.S. citizens or legal residents who have been in the U.S. for at least five years to enroll in Medicaid or CHIP (and states have the option to expand Medicaid and/or CHIP to legally residing children and pregnant women who have been in the U.S. for fewer than five years). Individuals must be U.S. citizens or legal residents to enroll in exchange coverage (with or without tax credits). Undocumented immigrants are ineligible for Medicaid, CHIP, and exchange coverage (with or without tax credits).

[8] Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, and Jessica Stephens, op. cit.

[9] Judith Solomon and Donna Cohen Ross, *New Children's Health Law Reduces the Harmful Impact of Documentation Requirement* (Washington: Center on Budget and Policy Priorities, April 23, 2009), available online at http://www.cbpp.org/files/4-23-09health.pdf.

[10] *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0* (Washington: Centers for Medicare and Medicaid Services, May 2011), available online at http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf; *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 1.0* (Washington: Office of Consumer Information and Insurance Oversight and Centers for Medicare and Medicaid Services, November 2010), available online at http://www.hhs.gov/ociio/regulations/joint_cms_ociio_guidance.pdf.

[11] Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Insurance* (Washington: Urban Institute, November 2009), available online at http://www.urban.org/publications/411987.html.

[12] Jennifer Edwards, Lisa Duchon, Eileen Ellis, Caroline Davis, Rebecca Kellenberg, Jodi Bitterman, Catherine Hess, and Alice Weiss, *Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States* (Washington: National Academy for State Health Policy, February 2010).

[13] Gerry Fairbrother and Joseph Schuchter, *Stability and Churning in Medi-Cal and Healthy Families* (Los Angeles: The California Endowment, March 2008), available online at http://www.calendow.org/Collection_Publications.aspx?coll_id=6&ItemID=42#.

[14] *The High Costs of Churning: Why Retention Makes Sense Even in Tight Times* (Philadelphia: Public Citizens for Children and Youth, Pennsylvania Health Law Project, and Community Legal Services of Philadelphia, September 2010), available online at http://www.phlp.org/wp-content/uploads/2011/04/Retention-costs-Executive-Summary-9-2010.doc.pdf.