State Coverage Initiatives

Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals

by Stan Dorn
Senior Research Associate
The Urban Institute

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About the author

Stan Dorn, J.D., Senior Research Associate at the Urban Institute, has more than 20 years experience working on health policy issues at the state and national levels. He is currently one of the nation's leading experts on default enrollment systems as applied to Medicaid and the State Children's Health Insurance Program (SCHIP). Before Urban Institute, Mr. Dorn was a Senior Policy Analyst at the Economic and Social Research Institute, where he specialized in complex, innovative policy design to expand health coverage, including ground-breaking research into the novel Health Coverage Tax Credit enacted in 2002; the development of incremental reform options as part of the Covering America project, funded by the Robert Wood Johnson Foundation; and working with diverse, national stakeholders to develop a consensus around innovative health coverage expansion proposals. Mr. Dorn's previous work includes service as Managing Attorney at the National Health Law Program's Washington office and Health Division Director at the Children's Defense Fund during its successful national campaign to enact SCHIP in 1996-97.

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Executive Summary

"If you build it, they will come," cannot be the motto of state health reformers. Simply offering health coverage subsidies, even coupled with vigorous outreach and simple application forms, is no guarantee that uninsured residents eligible for subsidies will receive insurance. Without careful attention to enrollment mechanisms, take-up can be slow, endangering a new program's reputation and even survival before it has a chance to prove itself. More fundamentally, unless eligible people enroll, a health coverage expansion cannot reach its most basic objective of improving access to essential health care.

With a range of public and private benefits, automatic enrollment has achieved great success in quickly reaching a large proportion of the target population. For example:

- Less than six months following its first effective date, Medicare Part D provided low-income subsidies for prescription drug coverage to 74 percent of eligible beneficiaries because subsidies went automatically, without any filing of applications, to all Medicare beneficiaries who received Medicaid or Supplemental Security Income (SSI) the prior year.
- At firms where new workers establish 401(k) accounts by completing application forms, 33 percent enroll. At companies where new employees are placed in 401(k) accounts unless they reject participation by completing "opt out" forms, 90 percent enroll.
- Medicare Part B covers more than 95 percent of eligible seniors by automatically enrolling them and deducting premium payments from their Social Security checks unless, within a certain time after turning 65, the seniors complete forms opting out of coverage.
- By its eighth month of implementation, the new Commonwealth Care program in Massachusetts reached 32 percent of eligible individuals who were limited to traditional enrollment strategies. For an eligibility category where individuals were enrolled based on income information known to the state's previous uncompensated care program, the total number of enrollees exceeded the state's estimated size of the entire eligible population – effectively reaching 100 percent take-up.

Similar strategies can help other state-based coverage expansions succeed. Automatic approaches can address three critical functions: identifying the uninsured; determining their eligibility; and enrolling them in coverage. For example:

- States can tap into sources of data about income and coverage that identify uninsured residents who may qualify for subsidies, enrolling them in coverage unless they "opt out."
- Uninsured schoolchildren can be identified on child health forms that parents complete when their children start school in the fall. For such uninsured children, states can access income data to identify those who appear likely to qualify for Medicaid or the State Children's Health Insurance Program (SCHIP) and provide them with presumptive eligibility, followed by assistance completing forms and transitioning to ongoing coverage. Uninsured children with incomes too high for subsidies can be offered unsubsidized coverage. For example, their parents can be mailed insurance cards that are activated by calling a toll-free number.
- Among both children and adults, the uninsured can be identified when they seek health care, when state income tax forms are filed (particularly in states that offer an Earned Income Tax Credit), when W-4 forms are completed to establish or change wage withholding on the job, when the newly unemployed apply for unemployment compensation, when children age off their parents' insurance policies or Medicaid/SCHIP coverage, and at other key life junctures. When any of these mechanisms identifies an uninsured person, the state can use available data to ascertain potential eligibility for subsidies and facilitate enrollment. As with the approach to children described above, uninsured adults who are ineligible for subsidies can be offered unsubsidized coverage and mailed telephone-activated insurance cards.
- Residents could apply for coverage by providing little more than basic identifying information and allowing the state to access existing data and determine eligibility for coverage.
- When other means-tested programs have already found that an individual has income low enough to qualify for health coverage subsidies, the state could automatically deem that individual income-eligible for such subsidies.
- The state could define eligibility in terms that fit with available data. For example, household income could be determined based on recent quarters of wage earnings data combined with prior-year income tax data about other forms of income, with opportunities for households to come forward and show lower income levels qualifying for larger subsidies. A similar approach is now used to means-test premium subsidies for Medicare Part B.

These are relatively novel strategies in the context of state coverage expansions, and working through the details involves complex challenges. For example, it will be essential to incorporate strong safeguards of privacy and data security into any data-driven enrollment system. States pursuing such systems will also need to be assiduous and creative in maximizing federal matching funds to support development and operation of the necessary information technology.

Rigorous testing of information exchange systems before implementation may need to be coupled with strong early warning systems, phased-in implementation, and clearly designated "rapid response" capacity after implementation to address the possibility of error, particularly during a new program's early days. Despite these and other challenges, pursuing automatic enrollment strategies is worth serious consideration as a key and often-overlooked building block for major health care reforms now being debated in state capitols across the country.

Introduction

State policymakers are in a period of extraordinary activity debating and, in many cases, enacting major health coverage expansions. In the design of such reforms, often overlooked are the precise mechanisms through which eligible individuals enroll and retain coverage. Such mechanisms make a tremendous difference in determining the proportion of eligible individuals who receive coverage as well as the speed with which a new program reaches its goals.

This monograph seeks to help state-level policymakers, stakeholders, and advocates think about building efficient and effective enrollment mechanisms into the structure of major coverage expansions. It covers three topics: first, the importance of enrollment mechanisms; second, the key features of two basic enrollment models, traditional and automatic; and third, potential applications of automatic enrollment to health coverage expansions under consideration around the country.

I. The importance of significant and rapid enrollment

Enrollment is obviously essential to coverage expansion reaching its goal. Only if eligible individuals enroll can the uninsured receive coverage and improved access to health care.

Enrollment of already eligible individuals also yields financial benefits. If eligible people get sick, there is a very good chance that their providers will help them enroll into available health coverage, at state expense. Early detection and treatment of illness can forestall some of these costs.

From a different perspective, rapid accomplishment of high enrollment levels can be important to program sustainability. Even if a new coverage program expands enrollment as quickly as can be reasonably expected, the perception of low initial coverage levels creates political vulnerability. Opponents of a particular reform may use low enrollment numbers to discredit a new program, making a bad "first impression" that can be hard to shake. For example, less than a year after its enactment, Maine's innovative Dirigo Health program was labeled a failure in some quarters based on enrollment that fell short of proponents' hopes, even though the program was pursuing a normal trajectory for newly created health subsidy programs. Other states can reduce such risks through a number of strategies, including enrollment mechanisms that promote rapid take-up.[1,2]

II. Basic enrollment models

Policymakers designing health care reforms must choose between two basic models of enrollment. All too often, the choice is not made consciously. This section of the report explains these two models, notes some of the advantages of each approach, and provides examples of why this choice is so important.

A. The traditional model

The traditional model for public benefit enrollment places the burden of action squarely on potential beneficiaries. To receive coverage, consumers must submit applications, provide information showing potential eligibility, and fulfill the procedural requirements of the administrative agency. The government agency's responsibility is limited to offering subsidies or services, educating the public about available assistance, and processing applications rapidly and accurately.

With a great deal of work, this model can reach a large proportion of intended beneficiaries. Simplifying and streamlining the application process, reducing or eliminating premiums, and educating eligible populations can increase enrollment. But two groups of eligible individuals inevitably remain without coverage under this basic model: namely, eligible people who do not apply; and eligible people who apply but fail to complete the application process. Furthermore, the traditional model typically takes several years to reach its potential, creating political vulnerability, as noted previously. These characteristics are not shared by automatic enrollment strategies.

B. Automatic enrollment models

With automatic enrollment, public officials become more active, lifting much of the application burden from potentially eligible individuals. Such approaches typically use one or more of three basic mechanisms:

- *Default enrollment*, through which people are enrolled if they *fail* to complete a form opting out of coverage;
- *Data-driven enrollment,* through which eligible individuals are enrolled into coverage based on data already accessible to public officials rather than on information provided by applicants; and
- *Facilitated enrollment,* through which public agencies or their community-based private contractors proactively reach out to potentially eligible individuals and help them enroll. Facilitators can undertake such tasks as completing forms based on information provided by the applicant, compiling necessary documents, proactively tracking the status of completed applications, resolving problems that arise during the application process, etc.

These approaches share the common feature of largely or entirely dispensing with the need for potential beneficiaries to complete paperwork in order to obtain or retain coverage, thereby reducing dramatically the number of eligible individuals who are denied coverage for procedural reasons, including failing to apply.

C. Trade-offs between these two models

While the precise advantages and disadvantages of each model depend on the context and manner in which it is used, some trade-offs generally apply.

1. The traditional model

At a fundamental level, the traditional model has several features that some state officials may find advantageous. First, it is familiar and so does not involve the uncertainties and risks of pursuing the more novel automatic approach. Auto-enrollment has been used with great success for many public and private programs, as demonstrated below. However, its utilization for Medicaid and SCHIP has been limited.[3,4] Applying the automatic enrollment model to major health coverage expansions will, in many cases, require innovation, generate consequent risks and uncertainty, challenge the culture of administering agencies, and require inevitable

fine-tuning and mid-course adjustment. Second, as with any policy that prevents enrollment, the traditional model lowers public sector health care spending. But this particular approach to cost containment has special features. The traditional public benefits enrollment model gives state officials subtle spigots with which to limit the number of beneficiaries. Under the rubric of tightening program administration and preventing waste, fraud, and abuse, officials can require additional steps before applicants enroll or beneficiaries retain coverage. Each such step means that fewer eligible individuals enroll or stay on the program, lowering program spending. Couched in the rhetoric of protecting program integrity, these policy changes can be harder for opponents to resist than are other measures to limit spending.

Along similar lines, because the traditional model depends on potential beneficiaries taking the initiative to apply for coverage, enrollment can be reduced and costs controlled by simply conducting less outreach. Such steps typically fall "below the radar screen" of advocates, providers, and the public. By contrast, policy changes that curtail eligibility, limit benefits, or reduce provider reimbursement rates can require legislation or regulatory changes, with associated notice to the public.

A shift to automatic enrollment would make it harder to use these subtle measures to control costs. Rather, public officials wishing to save money may need to change eligibility rules, abandon automatic enrollment approaches, increase premium charges, cut benefits, or reduce provider reimbursement. These more overt policy changes can generate effective opposition and risk public disapproval.

How observers view this feature of the traditional enrollment model exemplifies the timeworn adage, "Where you stand depends on where you sit." Those who place a premium on states' ability to control costs may want to retain the capacity to tighten the enrollment spigot through procedural changes to the application process and through providing less information to potential beneficiaries about available assistance. On the other hand, this feature of the traditional model may trouble two groups: those who want to see uninsured people receive coverage; and those who believe that government officials should be honest and open in disclosing policy proposals and decisions about the operation of publicly-funded health coverage.

2. Auto-enrollment models

Auto-enrollment strategies have several advantages. As shown by the examples below, they can reach more eligible individuals and increase the speed with which a new program accomplishes its objectives. They can also reduce public agencies' operational administrative costs, albeit after an up-front investment in administrative infrastructure. Finally, by using data sources that may be more accurate than some applicants' memories and paper records, auto-enrollment can reduce the number of ineligible individuals receiving benefits.

More broadly, the auto-enrollment model moves toward resolution of a longstanding tension facing public benefit programs—namely, the choice between two desirable goals:

- Promoting program integrity by tightening the application process; and
- Increasing enrollment of eligible individuals and lowering administrative costs by simplifying the application process.[5]

Through granting eligibility based on government data and trained application assisters—rather than information that consumers put on application forms—auto-enrollment strategies offer the promise of simultaneously increasing coverage, reducing administrative costs, and safeguarding program integrity. That promise has already been realized with other public benefits that have taken advantage of automatic enrollment.[6]

D. Examples of enrollment models in action

Following are examples that include several head-to-head comparisons of these two enrollment models. Some preliminary cautions are important, however. The use of automatic rather than traditional enrollment is sometimes just one of several factors responsible for higher enrollment levels. More fundamentally, higher enrollment levels, *per se*, do not necessarily signify program superiority. Many other policy design features, as well as the context in which programs operate, are important to any sound assessment of a program's overall level of success. Put differently, the following examples are not intended to show that the more automated programs are necessarily better than the juxtaposed programs that use more traditional enrollment methods. Rather, these examples make only the narrow point that more automatic enrollment mechanisms can increase the odds that a new program reaches its intended beneficiaries rapidly and in large numbers.

Example One: SCHIP and Food Stamps vs. Medicare Part D Low-Income Subsidies

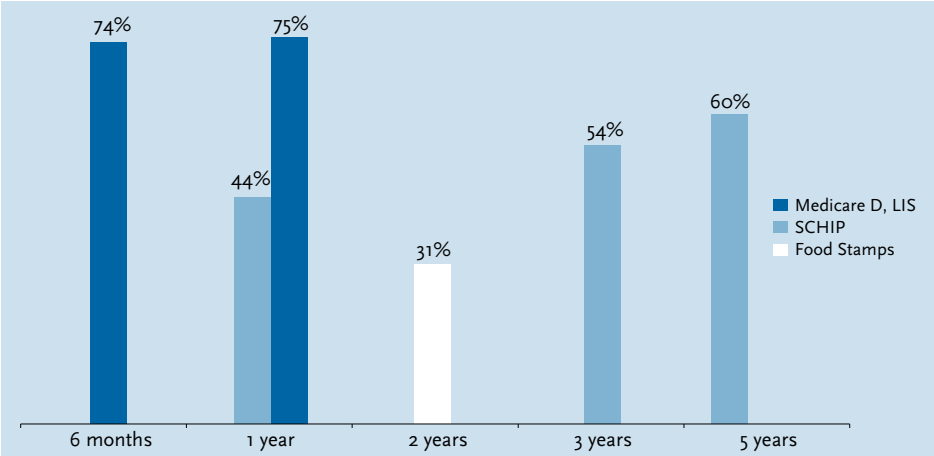
The State Children's Health Insurance Program (SCHIP) has made an enormous contribution to children's health and well-being. Since its enactment in 1997, low-income children have seen a significant increase in coverage and improved access to care, at a time when similarly situated adults have suffered major coverage losses and reduced access to essential services.

Following SCHIP's enactment, states engaged in a remarkable round of outreach efforts and streamlining and simplification of application forms and procedures. As a result, SCHIP enrollment far exceeded the record of other traditional means-tested programs. Food stamps, for example, reached only 31 percent of eligible individuals after its second year of implementation.[7] By contrast, SCHIP reached 44 percent of eligible children a year after the statute's effective date; within five years, SCHIP reached 60 percent of eligible children.

By contrast to these traditional public benefits, low-income subsidies for Medicare Part D (the new prescription drug program) reached nearly three-fourths (74 percent) of eligible beneficiaries in less than six months. (See Figure 1.) This represented the highest take-up rate ever achieved by a federal means-tested program during its first year. However, very few eligible people (14 percent) actually completed application forms and enrolled. Fully 60 percent were enrolled automatically.

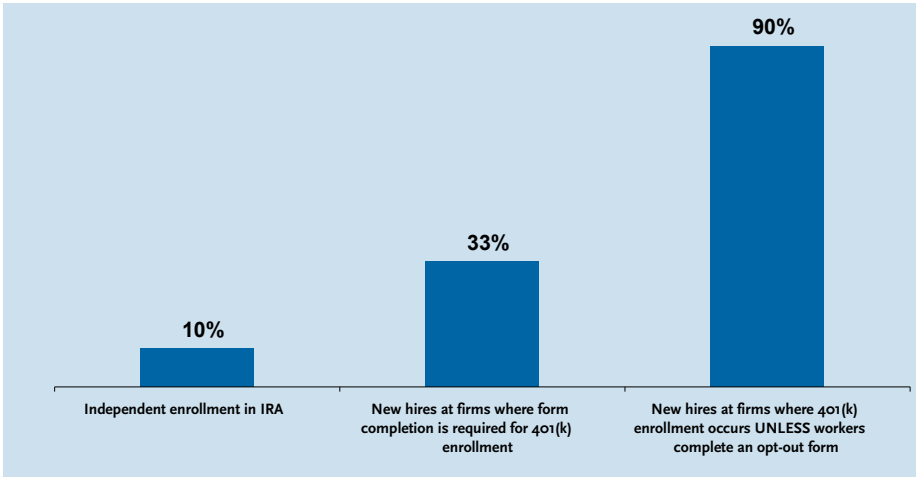
This result was achieved because beneficiaries who did not apply at Social Security Administration (SSA) offices were automatically enrolled into Medicare Part D

Figure 1. Enrollment as a percentage of eligible individuals, at various time periods following program effective date: SCHIP vs. Medicare Part D Low-Income Subsidy (LIS) vs. Food Stamps



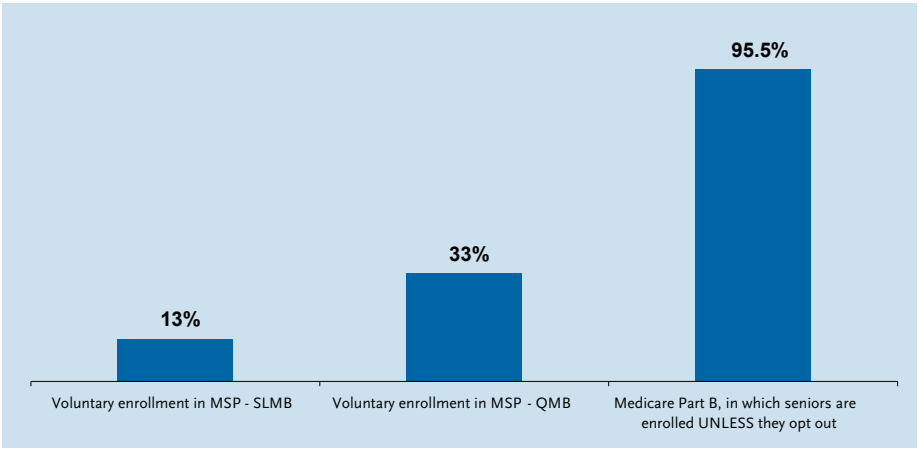
Source: GAO, 2007; Selden, et al., 2004[8]; CMS, unpublished data, 2006.

Figure 2. Percentage of eligible workers who participate in tax-advantaged retirement accounts



Sources: Etheredge, 2003;[10] EBRI, 2005; [11] Laibson, 2005.[12]

Figure 3. Percentage of eligible individuals who receive various Medicare benefits



Sources: Federman, et al.;[13] Remler and Glied, 2003.[14] Note: The Medicare Savings Programs (MSP) includes payment of Part B premiums and out-of-pocket cost-sharing for Qualified Medicare Beneficiaries (QMB) – that is, beneficiaries with incomes under 100 percent of the federal poverty level (FPL); and payment of Part B premiums for Specified Low-Income Medicare Beneficiaries (SLMB) – that is, beneficiaries with incomes too high to be QMBs but at or below 120 percent FPL.

plans and provided low-income subsidies if they received either Medicaid or Supplemental Security Income the previous year. Such receipt was ascertained based on data matches with state Medicaid agencies and the SSA.

Example Two: Tax-preferred retirement savings

If individuals are asked to enroll, on their own, in an Individual Retirement Account (IRA), approximately one in ten will complete this process. When workers starting a job are handed forms by their new employer and told that completing such forms will result in establishment of a 401(k) account, roughly one in three enroll. Strikingly, when new employees are enrolled in 401(k) accounts unless they complete forms turning down such enrollment, nine in ten enroll. (See Figure 2.) All these vehicles involve precisely the same tax incentives for retirement savings. And whether the default is enrollment or non-enrollment, 401(k) accounts are funded, in whole or in part, through reductions in workers' take-home pay. Nevertheless, setting the default as enrollment rather than non-enrollment makes a dramatic difference to take-up rates. Based on this research, pension reform legislation in the previous Congress gave employers new tax incentives to use auto-enrollment for retirement savings accounts.[9]

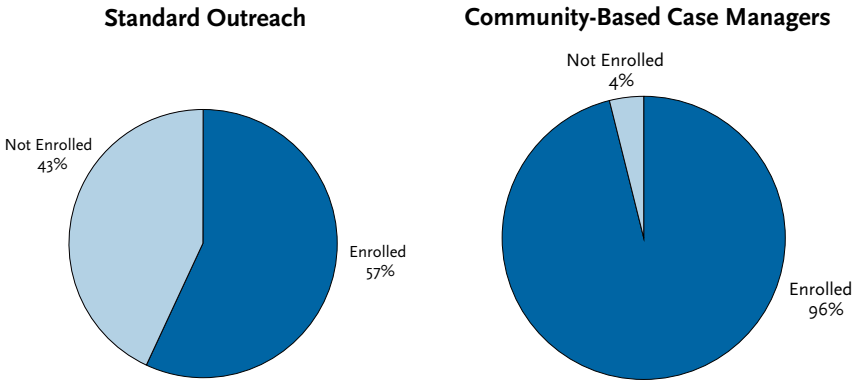
Example Three: Medicare Savings Programs vs. Medicare Part B

Medicare Savings Programs—including Medicaid eligibility categories for Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries—subsidize premiums and, in some cases, out-of-pocket cost-sharing for poor and near-poor Medicare beneficiaries. To receive this assistance, beneficiaries must apply through their state's Medicaid program. Fewer than a third of eligible beneficiaries participate. By contrast, with Medicare Part B, which covers physician visits and certain other outpatient services, more than 95 percent of eligible seniors enroll. (See Figure 3.) That is because, unless they decline coverage within a certain period of time after turning 65, seniors are automatically enrolled into Medicare Part B, with premium payments deducted from their Social Security checks.

Example Four: Standard Medicaid/SCHIP outreach vs. community-based case managers

A study published in *Pediatrics*[15] compared the effect on low-income, Latino families in Boston of (a) standard Medicaid/SCHIP 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 when necessary, 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. (See Figure 4.)

Figure 4. Medicaid/SCHIP enrollment among low-income, Latino children in Boston: standard outreach vs. community-based case managers

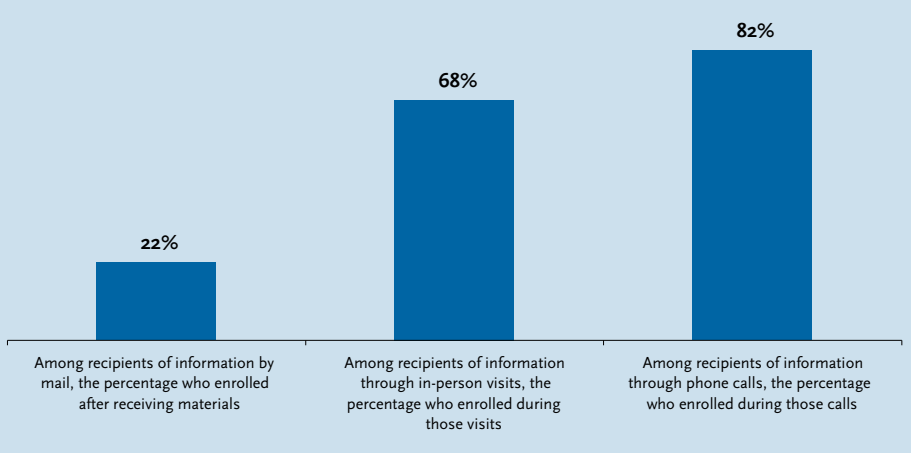


Source: Flores, et al., Pediatrics, December 2005.

Example Five: Continuing medical education

A study of General Practitioners in England showed that, even with highly educated professionals, proactively facilitated enrollment greatly increases take-up, whether the enrollment takes place over the phone or in person. The study found that when physicians were mailed packets describing an education program about detecting and treating patients' substance abuse and were asked to sign up, only 22 percent enrolled. When physicians received in-person visits explaining the program, 68 percent enrolled during the visit. When the same information was provided by telephone call, 82 percent enrolled during the call. (See Figure 5.)

Figure 5. Physician enrollment in education program, by form of outreach



Source: British Journal of General Practice, September 1999.[16] *Note: this study involved enrolling British General Practitioners into a program of training to identify and treat substance abuse among patients.*

Example Six: Medicaid/SCHIP renewals in Louisiana

Beginning in July 2001, Louisiana's Medicaid program changed its renewal procedures for children. Under the new approach, the state renews coverage based on data from Food Stamps and TANF programs as well as other state income information. If such data do not establish eligibility, state workers obtain additional information through telephone conversations with families. Only if follow-up efforts by state staff can obtain neither data nor information over the phone are families asked to complete forms to retain their children's health coverage. As a result, the percentage of children whose coverage was terminated at renewal fell from 28 percent in June 2001 to 8 percent in April 2005. (See Figure 6.) During the latter month, fully 53 percent of renewals were done purely on the basis of data, without requiring any information from parents.[17] (See Figure 7.)

Example Seven: Enrollment into Commonwealth Care in Massachusetts

One of the recent health reforms enacted in Massachusetts created a new Commonwealth Care (CommCare) program. In its original form, CommCare covered, without premiums, individuals ineligible for Medicaid who had incomes at or below 100 percent of Federal Poverty Level (FPL). Between 101 and 300 percent FPL, CommCare premiums were charged on a sliding scale.

For many years, the state has operated an Uncompensated Care Pool (UCP), providing hospital care and certain outpatient services to the uninsured. In establishing CommCare, state officials automatically enrolled all individuals previously served by the Uncompensated Care Pool who had income at or below 100 percent FPL. Individuals with incomes above 100 percent FPL, who would have been charged CommCare premiums, received traditional outreach and were encouraged to enroll.

By the program's eighth month, more people under 100 percent FPL were enrolled than state officials previously estimated qualified for the program. Between 101 and 300 percent FPL, one-third (32 percent) of projected eligibles enrolled. (See Figure 8.)

Of course, auto-enrollment was not the only difference between these two groups. The group subject to traditional enrollment was required to pay premiums, for example, which discouraged some from enrolling. In addition, relative to the traditionally enrolled group, the auto-enrolled group had a higher proportion of potentially eligible individuals who had used the UCP and so were known to the state. Nevertheless, automatic enrollment was an important factor producing rapid and high take-up. The state is currently expanding automatic enrollment to individuals with incomes between 100 and 150 percent FPL and has eliminated the need for such enrollees to make premium payments.

Other examples of auto-enrollment are described in Appendix 1.

III. Applying automatic enrollment to health coverage expansions

The previous section illustrated the potential impact of default enrollment, data-driven enrollment, and proactively facilitated enrollment, which can be much more effective than traditional enrollment models in covering eligible individuals rapidly and in large numbers. This section applies these auto-enrollment strategies to three functions that are essential to any effective health coverage expansion:

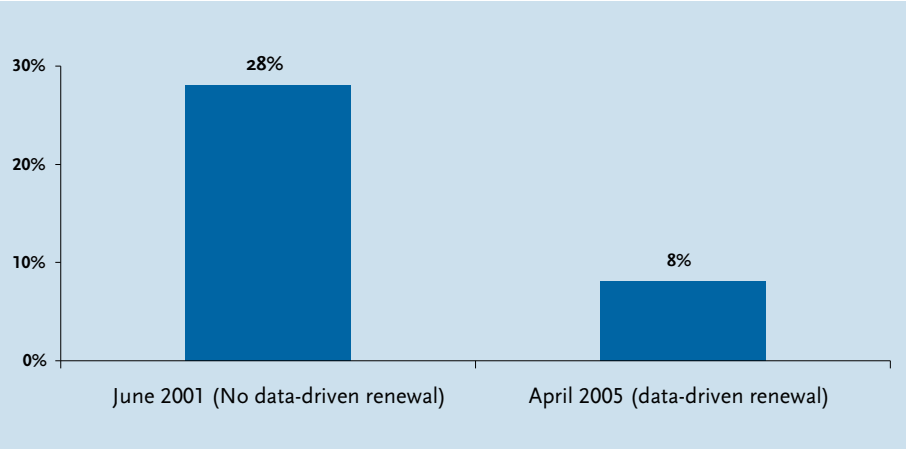
1. Identifying the uninsured;
2. Determining subsidy eligibility; and
3. Enrolling individuals into coverage.

This portion of the paper addresses each function, in turn. However, as a preliminary matter, the analysis begins with a discussion of data issues that arise with many different automatic enrollment strategies. The final section explores how states can reduce the risk of errors when implementing these innovative approaches.

A. Data issues

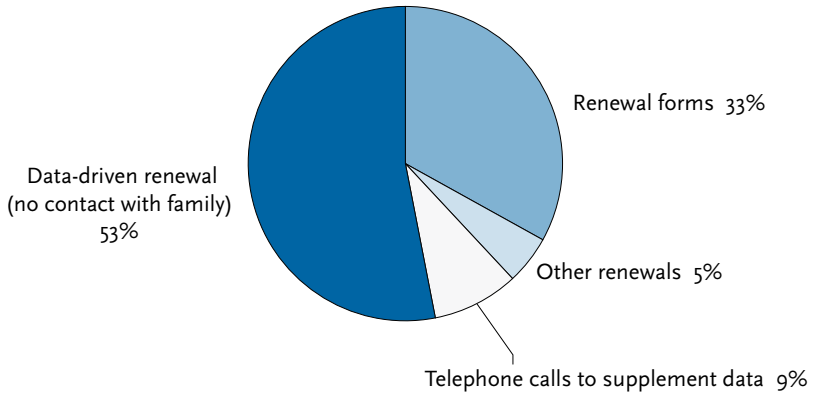
Data drive many of the automatic enrollment strategies discussed below. Two cross-cutting issues involving data are privacy and accessing federal reimbursement for developing information technology infrastructure.

Figure 6. Percentage of Louisiana children losing Medicaid at renewal, before and after implementation of data-driven renewals



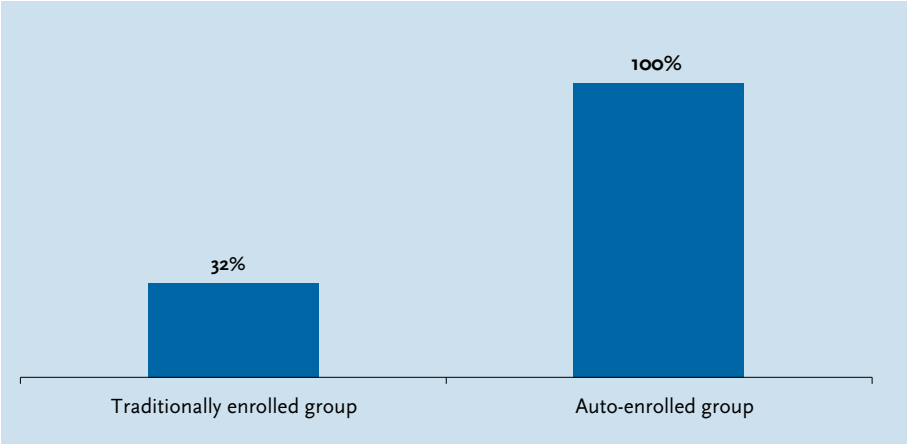
Source: Summer and Mann, June 2006.

Figure 7. Medicaid renewals for Louisiana children: April 2005



Source: Summer and Mann, June 2006.

Figure 8. Enrollment into CommCare, by method of enrollment: June 2007 (eighth month of program implementation)



Source: Commonwealth Connector Authority, June 2007 (unpublished data).

1.Privacy and related issues

Many of the strategies described below rely on accessing personal data, which may be protected by state statute. Accordingly, to gain access to such data, state legislation may be needed, along with interagency agreements between the health program and the agency that stores the pertinent data. In addition, the health coverage agency would need to follow other legal requirements and best practices to safeguard privacy and data security, described in Appendix 2. Such practices include steps to make sure that data are used only for specified purposes (in this case, determining whether individuals qualify for health coverage and enrolling them, if eligible). Also important are measures to prevent unauthorized access, use, modification, or disclosure of personal data and mechanisms to hold accountable individuals and organizations (including private contractors) that breach privacy or data security requirements.

Both to protect privacy and to build trust, individuals need to receive notice of the intended use of their personal data, whenever possible, along with information about how to "opt out." For example, workers beginning a job could receive a form stating that information from their employer may be used to see if the worker qualifies for help with health coverage, unless the worker objects by contacting a specified state agency.

On the other hand, the privacy analysis is different in a state that mandates health coverage. A state using available data to identify residents who violate the law need not seek advance consent from the lawbreakers, particularly when such residents have already provided the pertinent data to third parties.[18]

2. Federal support for information technology development

Information technology (IT) is the linchpin of much automatic enrollment. Many public programs currently lack the information technology needed for some of the approaches discussed in this paper. Investment in IT infrastructure is thus required for many states to use these strategies, and federal financial support makes such investment significantly more feasible.

Enhanced federal matching funds are available to support Medicaid Management Information Systems (MMIS). Medicaid programs have typically used MMIS to pay provider claims. For MMIS development, the federal government pays a 90 percent match; for MMIS operation, the federal government pays 75 percent of costs.[19] In recent years, the Centers for Medicare and Medicaid Services (CMS) and state Medicaid programs have been updating MMIS systems through a major, new initiative, called Medicaid Information Technology Architecture (MITA). MITA's goal is reengineering data systems across the entire Medicaid enterprise, to help the entire program achieve its goals more effectively and efficiently. However, longstanding federal regulations, dating from the 1970s, deny MMIS enhanced funding to eligibility systems.[20]

Federal legislation is pending that would provide enhanced federal matching funding for IT improvements related to automatic enrollment.[21] More importantly, even under current law, enhanced match may be possible. MITA provides enhanced federal matching rates for the development of Electronic Health Records (EHRs). Eligibility information, such as participation in other means-tested programs, can be incorporated into each beneficiary's EHR. Such information may have clinical significance, so its inclusion makes sense from the standpoint of improving quality of care. The IT development needed for the efficient, automatic importation of eligibility information into EHRs may thus qualify for enhanced MMIS match through MITA.

B. Identifying the uninsured

This section of the paper discusses three approaches to identifying the uninsured: using key life events; comparing "master lists" of state residents in the target group and people who have health coverage; and developing a "Please Figure It Out For Me" application form.

1. Key life events

This first strategy for identifying the uninsured focuses on key life junctures through which many uninsured pass and which already contain procedures that can be modified to allow the uninsured to self-identify and request coverage. At each of these junctures, individuals could be given the opportunity to check one box that would indicate four things: the individual's lack of health coverage; the individual's request for state help in obtaining coverage; the individual's request that state officials access the individual's otherwise confidential data if necessary to evaluate potential eligibility for health coverage; and permission for state officials and their private contractors to contact the individual if necessary to establish eligibility for free or low-cost health coverage. In addition to checking such a box, the applicant would provide the minimum information needed for the state to access data about income – generally speaking, names, dates of birth, and social security numbers for the adults in the household and for the uninsured people seeking coverage. (For further considerations in developing a form in this context, see Appendix 3.)

One cautionary note is important. The whole point of such a form is to keep to an absolute minimum the amount of work required from the consumer, thereby maximizing identification of the uninsured and beginning the process of determining their eligibility and ultimately enrolling them into coverage. To achieve this objective, health officials will need to resist the temptation to request information that is useful but not essential.

Following are some key life events during which the uninsured can be identified:

- *W-4 forms* for withholding of earnings are completed whenever a worker starts a new job or changes withholding arrangements. In some companies, they are completed every year. A state with an income tax could modify its version of the W-4 form to give workers an opportunity to identify family members who are uninsured and to request coverage, as described above. This approach should not impose appreciable new burdens on employers, who would simply continue to forward information from completed W-4 forms to state revenue agencies, which in turn would provide data about the uninsured to the agency administering the health coverage program.

- *State income tax forms* could be modified to give filers an opportunity to identify uninsured family members and to ask for help with coverage. As with the W-4 forms, the state income tax agency would forward information to the health coverage agency. Using the income tax form could be particularly useful in states with Earned Income Tax Credits (EITC) that supplement the federal EITC. In such states, a large proportion of low-income households file EITC forms. Nationally, the credits are received by 86 percent of eligible families with children and 45 percent of eligible households without dependent children.[22]
- *Health care visits* could be structured so providers, who routinely seek insurance information for billing purposes, give uninsured patients an opportunity to request free or reduced-cost coverage from the state, as described above. The provider would forward information to the state health coverage agency for further steps. Hospitals and community health centers may be particularly promising provider groups, given their high volume of Medicaid billing and, in some cases, the presence of outstationed state eligibility workers.

  Hawaii, North Carolina, and Oklahoma have contracted with individual hospitals and health care centers to identify uninsured children and facilitate their enrollment, steps that proved financially beneficial to providers while helping enroll the eligible uninsured.[23]

  To identify uninsured individuals on a larger scale, a state could require such providers to assume these responsibilities as a condition of licensure or receiving reimbursement from state health coverage programs, including Medicaid, the State Children's Health Insurance Program (SCHIP), and public employee coverage. A state pursuing this strategy could provide retroactive reimbursement for the episode of care that leads to enrollment into health coverage. Such reimbursement would give both provider and patient an incentive to complete the enrollment process.
- *The annual start of school* provides an opportunity to identify uninsured children. Health forms that parents complete each year could ask if children are uninsured and give parents an opportunity to request health coverage. If such a request is forthcoming, school officials could forward the information to the state health coverage agency for eligibility determination and enrollment.

  To maintain schools' support, it may be important to focus education officials' involvement on this carefully defined "transmitting" role, thereby limiting health officials' demand for school administrative resources. Also important is assuring federal matching funds. Since the activities discussed here are clearly related to outreach and enrollment, federal matching funding should be approved, even in the current climate of contention around school claiming of Medicaid administrative costs. [24]
- *Applications for other public benefit programs* could give low-income households an opportunity to request health coverage. This longstanding practice would be particularly important in states pursuing Express Lane Eligibility strategies, described below.
- *Job loss* is frequently a point at which people lose coverage. Accordingly, opportunities for laid-off workers to request help with health coverage could be added to state application forms for unemployment compensation. By state statute, such opportunities might also be added to notices health plan administrators are required to provide to laid-off workers under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, which applies to firms with 20 or more workers. Most states already have so-called "mini-COBRA" laws that apply to smaller employers.
- *Children aging off Medicaid, SCHIP and parents' insurance policies* could routinely be given forms and access to on-line portals allowing them to request health coverage. This would help address uninsurance among young adults, the age group most likely to lack coverage.

2. Master list comparison

This strategy is simple in concept: compile one master list of all people who are the focus of coverage expansion (such as children, in the case of a state that seeks to cover all uninsured children); compile a second master list of all people in the target group who have health coverage; and compare the two lists to identify the uninsured.

To see how this approach might play out in practice, the following sections discuss available data on health insurance coverage, potential statewide application of this strategy, and more focused applications.

a. Information about individuals' health coverage

Until recently, accessing automated information about private insurance, including employer-sponsored insurance (ESI), did not seem feasible. No data warehouse contains such information about all state residents. Moreover, when state Medicaid and SCHIP agencies have asked employers to identify their workers with health coverage – or even whether firms offered coverage – employers have sometimes refused to do so, claiming that the Employee Retirement Income Security Act (ERISA) forbids states from compelling employers to provide information about health coverage.[25]

This situation changed with enactment of the Deficit Reduction Act (DRA) of 2005. Section 6035 of the DRA requires each state to pass legislation mandating insurers, including employer plans governed by ERISA, to furnish information about all the coverage they provide to Medicaid enrollees. This requirement's purpose is to help Medicaid agencies collect third-party liability (TPL) payments from private insurers who cover Medicaid beneficiaries. CMS has been working with states and industry representatives to determine the precise data elements and transmission procedures through which plans will provide coverage information to state Medicaid programs.[26] Those same conduits can be used more broadly to identify individuals with private health coverage who are not enrolled in Medicaid.

Although some may argue that ERISA forbids states' use of this information for purposes beyond Medicaid TPL collections, the better argument is probably to the contrary. While Congress limited the DRA requirement to state legislation that mandates the provision of insurance information about Medicaid beneficiaries, nothing in the federal law bars states from going beyond those minimum requirements in using available information. More important, in the DRA (unlike earlier legislation concerning Medicaid TPL), Congress amended only the Medicaid statute, not ERISA itself. This suggests that Congress did not view ERISA as forbidding states from compelling employers to provide information about employee benefits, including health coverage.

In any event, it will be important for state officials interested in auto-enrollment strategies to track CMS implementation of DRA Section 605 to see whether viable, efficient processes emerge through which state coverage initiatives could tap into data identifying state residents who receive private coverage. Coupled with the state's own data about Medicaid and SCHIP enrollment, this newly available information about private coverage should provide a fairly comprehensive list of insured residents within the state.

b. Statewide application of the master list strategy

A master list strategy to identifying those without insurance is not unprecedented, even on a statewide scale. Several states take a similar approach to identifying drivers without automobile insurance, comparing vehicle registration and driver license records with insurance companies' enrollment information. In California, for example, when the State Department of Motor Vehicles matched its records against enrollment data provided by auto insurance companies, insurance status was shown for more than 23 million out of 28 million vehicles for which insurance was required.[27] Governor Schwarzenegger has proposed using a similar approach to identifying state residents who fail to purchase health coverage,[28] comparing lists of all state residents with data from insurers identifying enrollees.[29]

c. Narrower applications of the master list strategy

This strategy can also be applied on a smaller scale. Once the state has a list of all residents with insurance, that list can be cross-checked against "clean" lists of individuals to whom the enrollment initiative applies, such as people receiving other public benefits. As another example, if a state seeks to help employees of small firms that have chosen to partner with the state, the employers' identification of employees and dependents could be matched against data provided by insurers to identify those without other sources of coverage.

One particular use of this strategy merits special mention. States can cross-match Medicaid and SCHIP eligibility files against the records of other public assistance programs to identify low-income households who lack public coverage. For example, officials in Indiana, Utah, and the city of Baltimore have done such matching with the records of the National School Lunch Program (NSLP) to identify uninsured children in particular school districts.[30] Along similar lines, New York City's Human Resources Administration (HRA) matched Food Stamp and Medicaid files to identify children who received Food Stamps but not Medicaid. As a one-time initiative, HRA sent the parents of such children a notice stating that, unless the parents returned a form declining child health coverage, the children would have their eligibility for Medicaid determined and would be enrolled, if eligible. Only 2 percent of the families opted out, and the remaining children, when found eligible, were enrolled into Medicaid. Altogether, more than 15,000 children received Medicaid through this effort.[31]

Uninsured, poor parents represent one target group with enormous potential to be reached by this strategy to cross-match data from health programs and other need-based programs. States that offer Medicaid to poor parents can use children's Medicaid eligibility files to identify potentially eligible parents who are not enrolled in Medicaid. Such parents' receipt of private coverage is irrelevant to their Medicaid eligibility, since when otherwise eligible individuals receive private insurance, they qualify for Medicaid supplemental services and cost-sharing protection (sometimes called "wrap-around" coverage).

In many cases, the children's eligibility files have enough information from which the parents can be found eligible and enrolled directly into Medicaid. In other cases, additional information may be needed, obtainable through state-accessible data or intensive application assistance, as explored below. Either way, if states placed into Medicaid all unenrolled parents who were shown by their children's eligibility records to have incomes at or below 100 percent FPL, slightly more than half (54 percent) of all poor, uninsured parents would receive coverage. (See Figure 13.) Not only would this strategy be effective in reaching the target population of poor, uninsured parents, it would be efficient, benefiting very few people with insurance. Among poor parents who do not receive Medicaid but whose children do, four-fifths are uninsured. (See Figure 14.)

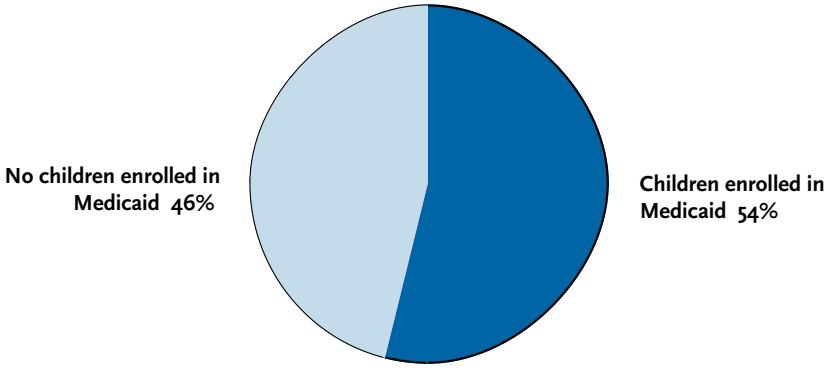
3. The "Please Figure it Out For Me" application form

A state with well-developed connections to pertinent data sources could give consumers a radically simplified approach to seeking health coverage. That is, an individual could ask the state to determine his or her eligibility for health coverage, based on data available to the state. Such a form would ask only about elements of eligibility, if any, for which satisfactory data were unavailable. (Of course, applicants would need the opportunity to appeal the state's determination, if unfavorable, and to show eligibility on other grounds.) A similar approach has been used by the Internal Revenue Service (IRS) with the Earned Income Tax Credit (EITC). Families qualifying for the EITC can ask the IRS to calculate the size of the credit rather than do the calculations themselves.[32]

C. Determining eligibility

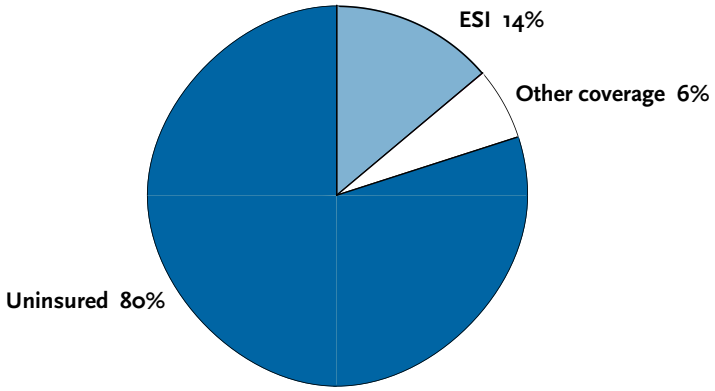
Once uninsured individuals have been identified, the state must determine their eligibility for subsidies. To explore how automatic mechanisms can help perform that function, this section looks at the use of government income data to determine eligibility. It then discusses data about other elements of eligibility. Finally, it explores an approach for modifying

Figure 13. Uninsured parents with incomes at or below 100 percent of FPL, by children's receipt of Medicaid: 2002



Source: Dorn and Kenney, op cit.

Figure 14. Health coverage of parents who do not receive Medicaid, whose children receive Medicaid, and who have incomes at or below 100 percent of FPL: 2002



Source: Dorn and Kenney, op cit (calculations by S. Dorn, June 2007). Note: ESI means employer-sponsored insurance.

ordinarily applicable Medicaid and SCHIP methodologies to expedite eligibility determination, based on the findings of other need-based benefit programs.

1. Using income data to determine eligibility

As explored in Appendix 4, states have access to considerable data showing residents' income. However, relatively recent data are limited to employment earnings. Employers report new hires and quarterly earnings to State Workforce Agencies administering unemployment compensation programs. Such data are several months old.

Many other types of income data are older. For example, unearned income, self-employment income, and income received as a contractor rather than an employee are reported to income tax agencies, state and federal. The data are thus accessible for both income tax filers and non-filers. However, they are reported only annually and can thus be out of date.

Following are three strategies for addressing this dichotomy and the challenge of outdated income data: presumptive eligibility, which is limited to children and pregnant women; defining eligibility based on available data; and using available income data to focus intensive application assistance and obtain additional information.

a. Presumptive eligibility

Although presumptive eligibility is unavailable to non-pregnant adults, children can be presumptively enrolled into Medicaid and SCHIP based on income data accessible to state agencies. Such data should be able to meet the standard for presumptive eligibility—namely, "on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility."[33] Moving children from presumptive to ongoing coverage is a key challenge for states implementing this strategy. For example, Washington State and California attempted to provide health coverage to children based on the income determinations of the National School Lunch Program (NSLP). However, the initiatives foundered when 69 percent of children in Washington and 75 percent in California failed to complete the truncated Medicaid application process required to transition from presumptive to ongoing eligibility.[34] To prevent this problem from recurring, states could take several approaches:

- A state could provide intensive application assistance to presumptively eligible children. Either state employees or workers at community agencies contracting with the state could help families complete forms, gather documents, and take other steps needed to complete the application form.
- Families could be sent cards inviting them to call toll-free numbers for assistance or to provide supplemental information on a secure web site. Louisiana takes a similar approach when renewing children's eligibility, in cases when state-accessible data are insufficient to determine eligibility.[35]
- The application form for transitioning from presumptive to ongoing coverage could be "pre-populated" with information already known to the state. The family could be asked to supplement and correct the form as needed. The state would evaluate eligibility based on the pre-populated information if corrections were not forthcoming.[36]

b. Defining eligibility based on available data

Automated strategies make the most sense when rules are simple and volume is high.[37] Accordingly, a state wishing to take advantage of automation to secure a high volume of eligible enrollees should consider making its eligibility methodologies simple, with an eye to fitting easily accessible sources of data.

The power of this strategy is illustrated by the Social Security Administration's (SSA) approach to means-testing Medicare Part B premiums. Medicare Part B pays for physicians' services and much other outpatient care. Before enactment of the Medicare Modernization Act of 2003 (MMA),[38] Medicare subsidized 75 percent of Part B premiums for all beneficiaries. MMA changed this arrangement, basing subsidy levels on household income, starting in January 2007.

In means-testing Medicare Part B premiums, household income is determined for each calendar year automatically, based on available data from several years in the past. More recent information counts only if the beneficiary comes forward to show that household income has dropped enough to warrant a larger subsidy. For example, a beneficiary's income level and consequent level of subsidy is determined for calendar year 2009 as follows:[39]

- If by October 15, 2008, SSA can access federal income tax data for 2007, such data determine the beneficiary's income level for all of calendar year 2009. In other words, data from two to three years in the past determines income, hence subsidy levels.

- If by October 15, 2008, SSA cannot access federal income tax data for 2007, income tax data for 2006 determine the beneficiary's income level for 2009, on an interim basis. Once federal income tax data for 2007 become available, the beneficiary's 2009 income level is corrected to conform to the 2007 data, with adjustment and reconciliation of prior Part B premium payments for 2009.
- The beneficiary may experience a major life-changing event that lowers 2009 income below 2007 levels. If that reduction is sufficiently large that the beneficiary qualifies for a larger subsidy of Part B premiums, the beneficiary may apply to SSA for a revised income determination. If SSA agrees, the beneficiary's income level and subsidy amount are adjusted accordingly for 2009.
- On the other hand, if the beneficiary's income for 2009 is significantly above the individual's 2007 level, the beneficiary is under no obligation to report the change. In such cases, household income is based on 2007 income, with subsidies provided accordingly.
- Specified procedures inform the beneficiary of each determination and allow the beneficiary to make corrections.

This approach puts a premium on certainty and administrative ease in determining eligibility for subsidies. A state could take a similar approach in covering the uninsured, as follows:

- Because data about resources are harder to access than are data about income, resources would be irrelevant to eligibility for health coverage subsidies.
- Eligibility would be for a defined period of time (such as 6 months or 12 months). Eligibility would not change if household circumstances changed during that period of time. Many states already use this approach for children, providing 12 months of continuous eligibility "regardless of whether the child experiences changes in family income or other circumstances that would render him/her ineligible for Medicaid during the 12 month period."[40]
- Eligibility would be based on the most current income information available to the state when eligibility is being determined. For example, the state could determine employment earnings based on recent data about new hires and quarterly earnings. Other forms of income could be determined based on prior-year information from state income tax agencies.[41]
- Consumers would be informed of the state's income determination and its basis. They would have an opportunity to demonstrate lower income than the amount determined by the state, either by correcting state errors or by showing changed circumstances. To qualify for Medicaid matching funds as well as to detect and address administrative errors, standard notice and appeal procedures would need to apply as well.

This approach would provide income determinations based entirely on state-accessible data, without any need for households to estimate income. Such an income methodology should qualify for matching federal funds. Under Social Security Act Section 1902(r)(2), states may use less restrictive methodologies for determining income than are employed by the most closely related cash assistance programs. As explained by CMS, "This means that States can elect to disregard different kinds or greater amounts of income and/or resources than the cash assistance programs do."[42] A state could thus qualify for Medicaid matching funds by disregarding all household income above the level determined using the above method.[43]

Such a methodology could reduce the number of erroneous eligibility determinations. The approach described here substantially lowers the number of applications that involve assertions by or documents from consumers, each of which needs to be addressed and evaluated by state staff. As a result, many sources of error would be eliminated. So long as CMS approves a State Plan Amendment establishing this income methodology, the state should be protected from liability under either Medicaid Eligibility Quality Control (MEQC) procedures[44] or the Administration's Payment Error Rate Measurement (PERM) program.[45]

By the same token, this simplification of the process for evaluating applications may substantially reduce ongoing administrative costs (albeit after an initial investment in administrative infrastructure) and improve continuity of care and coverage for enrollees. It may also increase health plans' desire for program participation, since premium payments would be assured for the full eligibility period.

Medicare Part B means-testing is not the only precedent for using prior-year data to determine subsidy levels for subsequent, 12-month periods. For example, the low-income subsidy program under Medicare Part D grants current-year eligibility based on prior-year receipt of Medicaid and SCHIP, as noted above, regardless of subsequent changes in income or assets. Along similar lines, President Bush's first-term proposal to provide low-income,

working households with health insurance tax credits would have determined household income based entirely on prior-year tax income.[46] This suggests that administrative ease and certainty, rather than the relatively stable incomes of the elderly, may underlie the Administration's repeated use of prior year tax data to determine income for purposes of health coverage subsidies.

Despite these precedents some policymakers may be troubled if state subsidies were based on outdated information about household income. A state could avoid that issue by designing eligibility policy to reach either of two distinct goals:

1. Determining eligibility based on income at the time of the application, rather than income at the time covered by available data; or

2 Determining eligibility based on changing income levels throughout the period when individuals receive subsidies.

To achieve the first goal while still preserving some of the administrative benefits of relying on existing data, a state could determine household income based on available data; notify the household of the determination; and request corrections, by a date certain, in either direction, up or down. If the household does not provide corrections by that date, the data-based income determination would be the basis of the household's eligibility.[47] A household's failure to make a correction showing increased income would be addressed using standard procedures for mistakes or fraud on application forms.

To achieve the second goal, a state could impose clear legal duties for enrolled individuals to inform the state of significant changes in income or resources that take place *during* the eligibility period. With such a provision in place, an exceptional case of a subsidy recipient experiencing a dramatic and sudden increase in income or assets without informing the state could bring forth a vigorous and credible response from responsible officials. On the other hand, such a requirement would increase the risk of erroneous eligibility determinations (and consequent exposure to federal financial sanctions) since eligibility would be affected by circumstances that are inherently unknowable to the state at the moment of eligibility determination. More fundamentally, if eligibility is determined by "real time" income, which changes from month to month, automatic eligibility strategies become substantially more difficult to pursue, because income data are not available in real time except from the enrollee.

A related but distinct methodological simplification deserves special mention. States may realize significant administrative gains if small differences in income do not affect eligibility for subsidies – in other words, if broad income bands apply to each subsidy level. For example, if a state provided Medicaid, without premium charges, to children with incomes up to 185 percent FPL, it would not matter whether a particular family's income was at 130 percent or 180 percent FPL. Either way, the children would qualify for the same subsidy.

Such broad income bands have several advantages. First, providing coverage for 12-month periods, without regard to post-application income fluctuation, may be more justifiable if minor changes in income would not affect subsidy eligibility. Second, a state could realize administrative savings from broad eligibility bands. For example, if income is determined based on state data except where consumers come forward to seek a larger subsidy, broad income bands would reduce the number of people who take such steps. Third, a state is less likely to grant erroneous subsidies if small differences in income do not affect subsidy levels; this may lower a state's risk of federal sanctions under the MEQC and PERM procedures described previously. On the other hand, the trade-off for such simplicity is that subsidy levels are not as finely correlated to income.

c. Targeting Intensive Application Assistance based on Income Data

A final approach would direct intensive application assistance to people who, based on available income data, seem likely to qualify. Either by phone or in-person visits, staff from a state agency or its community partners could contact such individuals and help them complete the application process, filling out requisite forms over the phone or in-person. An analysis of this approach done in the context of Medicare Part D concluded that a well-executed strategy would cost an average of $66 per successfully enrolled individual reached by telephone and $127 for a well-targeted, in-person effort.[48]

As noted previously, when Louisiana officials simplified renewal procedures, they sent beneficiaries post cards asking them to call a toll-free number during specified hours. That was more effective than calling beneficiaries at hours when they may or may not have been home.[49] Depending on the characteristics of the target group, such post cards could also direct consumers to Web sites where applicants could provide the necessary information.

2. Using other data to determine eligibility

As explained in Appendix 4, data showing individuals' assets, citizenship, and immigration status are available but somewhat limited. To address such limitations, a state can make factors like assets irrelevant to eligibility; use data to establish eligibility whenever satisfactory data are available; and provide targeted, intensive application assistance to help consumers demonstrate their eligibility, where such data are unavailable or incomplete.

3. Express Lane Eligibility

This strategy has received considerable discussion in prior research.[50,51,52] The basic concept is that, once another means-tested program has found that an uninsured person has family income below the maximum income level for health coverage, the health program (Medicaid or SCHIP) grants income-eligibility. This strategy could potentially reach a large proportion of uninsured children and adults who qualify for but are not enrolled in Medicaid or SCHIP, since many benefit from other means-tested assistance. For example, more than 70 percent of all low-income, uninsured children live in families participating in Food Stamps, the National School Lunch Program (NSLP), or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).[53] A state Earned Income Tax Credit (EITC) may be even more effective, given the high proportion of low-income households receiving EITC, as noted above.

Depending on the non-health program, a similar approach could be taken to establishing eligibility for requirements other than income, such as assets, state residence, U.S. citizenship, and satisfactory immigration status. For example, the Food Stamp program applies citizenship and immigration status requirements comparable to those used for Medicaid and SCHIP. Accordingly, an Express Lane strategy might find children to be U.S. citizens or qualified aliens based on the findings of Food Stamps. On the other hand, NSLP does not have any citizenship or immigration status restrictions, so Medicaid and SCHIP would need to use something other than the findings of NSLP to establish these elements of eligibility, even if NSLP data were used to identify income-eligible children.

To operationalize Express Lane Eligibility, application forms for non-health programs could give parents a chance to request health coverage for their uninsured children. For that purpose, parents would authorize the non-health program to share eligibility information with Medicaid or SCHIP.

States pursuing this strategy have encountered several obstacles. The first is the absence of IT infrastructure sufficient to automate the connection between non-health programs and Medicaid or SCHIP programs and to identify children already enrolled in health coverage. This issue was discussed on page 10, including approaches to obtain enhanced federal funding to develop the requisite IT. Two other obstacles involve eligibility methodologies and the relationship between Medicaid and SCHIP, as discussed below.

Eligibility methodologies

Eligibility methodologies differ between health and non-health programs. For example, the definition of household members whose income and needs are taken into account in determining income may not be identical. Likewise, health and non-health programs may use different deductions that apply in reducing gross to net income. As a result, even when a non-health program has found an uninsured person to have income below the maximum level permitted for Medicaid or SCHIP, state health programs have been required to determine eligibility for health coverage almost from scratch, asking families to complete application forms. When such forms are not completed, coverage is not provided.

Numerous bills proposed in the current Congress, many with bipartisan co-sponsorship, would give states the option, via State Plan Amendment or special demonstration project, to disregard such methodological differences in granting eligibility for Medicaid and SCHIP based on the findings of other means-tested programs.[54] In the meantime, three strategies are available to states that are interested in this approach:

- First, if the income-eligibility threshold for Medicaid is sufficiently far above maximum income-eligibility for the non-health program, it may be virtually certain that someone who is income-eligible for the non-health program is income-eligible for Medicaid as well, despite methodological differences between programs. For example, Food Stamps is limited to families with gross income under 130 percent FPL and "net" income (after making pertinent deductions for certain work-related and other costs) below 100 percent FPL. If a state Medicaid program covered children up to 150 percent FPL (as determined by the Medicaid program, with its income disregards), almost any child who received Food Stamps would necessarily be income-eligible for Medicaid.

- Second, a state plan amendment could create a new income disregard, as permitted by Social Security Act Section 1902(r)(2). For example, a state could enroll Food Stamp children into Medicaid by disregarding all household income above the net income amount determined by the Food Stamp program. Since the Food Stamp program has found net income at or below 100 percent FPL for all Food Stamp recipients, this disregard would qualify as income-eligible for Medicaid all children receiving Food Stamps.

  As indicated above, states have been long allowed to use income-disregards quite aggressively to cover people who otherwise would have been ineligible, in some cases because of income substantially higher than nominal eligibility standards for health coverage.[55] Nevertheless, it is not yet known whether CMS would approve the income disregard described here, which (as applied to children) would primarily expedite enrollment by fully eligible children and only incidentally extend eligibility to children with incomes marginally above otherwise applicable Medicaid eligibility thresholds.

- Third, a waiver under Section 1115 of the Social Security Act could permit a state to disregard methodological differences between health and non-health programs. Such a waiver would be well within that Section's authorization of "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid or SCHIP.

  One administrative requirement that such waivers must meet is federal budget neutrality. This requirement can be addressed through counting unspent SCHIP dollars and allocations of Disproportionate Share Hospital (DSH) funds in the "current law" baseline against which waiver costs would be measured.

These approaches have not yet been proposed to CMS. However, this policy direction is consistent with the Administration's support for legislation in the previous Congress that would have given states the option to disregard methodological differences with non-health programs in finding children income-eligible for Medicaid or SCHIP.[56] Moreover, the Administration has already accepted Express Lane Eligibility into low-income subsidies (LIS) for the new Medicare Part D benefit. The LIS statute allows automatic enrollment when LIS and another program have eligibility rules that are "substantially the same."[57]

Pursuant to this authority, the Bush Administration determined that Medicare beneficiaries who receive Medicaid automatically qualified for and would be enrolled into LIS. This determination applied even to Medicare Savings Programs (MSP) in the six states that apply no assets test;[58] by contrast, LIS eligibility is limited to individuals with assets under statutorily specified levels. Nevertheless,

because the similarities between program eligibility rules outweighed the differences, the Administration provided automatic, Express Lane eligibility to these Medicare beneficiaries.

The expedited eligibility strategy discussed here involves much more modest differences in *methodologies*, such as income disregards and the definition of household members whose needs and income are taken into account in determining a child's eligibility. Unlike the case of the low-income subsidy program ignoring the absence of asset limits for certain MSP programs, no difference of eligibility *standards* is involved here. It may be difficult to justify giving states less flexibility in covering low-income children than the Medicare program now uses in covering low-income seniors.[59]

Medicaid vs. SCHIP coverage

A state wishing to uses Express Lane Eligibility to enroll children into Medicaid and SCHIP needs to address SCHIP's "screen and enroll" requirements.[60] These rules mandate that, before enrolling a child into a separate SCHIP program, a state must screen that child for potential Medicaid eligibility and, if the child qualifies for Medicaid, place the child in Medicaid rather than SCHIP.

Such requirements pose a challenge to the design of Express Lane strategies. Suppose a non-health agency finds that a child has income that would qualify the child for a separate state SCHIP program. The "screen and enroll" process would seem to require putting that child's family through the Medicaid application process before the child could be enrolled in SCHIP. Obviously, this directly contravenes the objective of the Express Lane strategy, which is to enroll children into coverage without requiring their families to complete application forms.

The above-described congressional proposals would address this situation by giving states new options. For example, a state could set an income threshold at least 30 points above its FPL income standard for Medicaid. Children would go into Medicaid if the non-health program found income below that threshold and into SCHIP if the non-health program found income above the threshold.

Even under current law, states can take several approaches to meeting "screen and enroll" requirements in the context of Express Lane strategies. For example:

- States could grant presumptive eligibility for children whom non-health agencies have found to have incomes within the SCHIP range.[61] Proactive application assisters could then work with the families of these children and help them complete forms needed to transition into ongoing coverage.
- Without presumptive eligibility (PE), a state could enroll children with sufficiently low income directly into Medicaid. Higher income children would receive targeted, intensive assistance to determine whether they qualify for Medicaid or SCHIP.
- With or without PE, the process of determining Medicaid eligibility for this group of children could be streamlined through pre-populating application forms with information known to the state, as explained above.
- As a worst-case scenario, a state could limit Express Lane eligibility to children whose income, as found by the non-health agency, would qualify them for Medicaid. No further screening would be required.

D. Enrolling individuals into coverage

Once uninsured individuals have been found eligible for coverage, they need to be enrolled. With traditional Medicaid and SCHIP coverage, this process is not mysterious, even during the current, managed-care era, when a health plan must be selected after the eligibility determination. An individual submits an application form for health coverage; is found eligible; is offered a choice of plans in which to enroll; and is enrolled into a particular plan by default if the individual fails to choose. But what happens if the individual has not submitted a traditional application form? The following sections explore state options for answering that question.

1. Default enrollment

A state could use default enrollment to provide eligible, uninsured individuals with health coverage, so long as premiums are not charged.[62] Such individuals could be informed that they have been found to qualify for subsidized health coverage; told that they will be enrolled unless they object by a date certain; and placed in coverage if a timely objection is not lodged. (For an example of how New York City used this approach to provide Medicaid based on Food Stamp records, see page 12.)

Default enrollment strategies offer the incidental advantage of providing a powerful tool to reward high-quality care and low premiums. State officials can channel a high percentage of default enrollees to health plans that meet such criteria.[63] Health plans value default enrollees as likely to use comparatively few services, on average, compared to voluntary enrollees.

By the same token, this strategy risks that default enrollees may not understand that they have health coverage. If that happens, health coverage may not translate into improved access to health care. Moreover, if the state uses capitated payments rather than fee-for-service reimbursement, health plans may receive payments without providing health care in return.[64] Several strategies can be used to guard against this risk:

- In order for capitated payments to begin, the managed care organization (MCO) could be required to obtain a signed copy of the final enrollment paperwork (such as the standard statement of rights and responsibilities);
- For a default enrollee, the state could withhold capitated payments, in whole or in part, until the MCO has documented the provision of at least one service;
- Each MCO's documented level of preventive services (check-ups, well-child visits, etc.) to default enrollees could be a major factor in its future share of default enrollees;[65]
- Eligibility information could be made available to community providers at the point of service, thereby informing enrollees of their coverage when they seek care; and,

- The state could require the MCO to provide prompt, monthly encounter data for default enrollees. If such data show serious problems with underutilization of care, the state could intervene aggressively. For example, state officials could quickly shift default enrollees to better-performing plans.

A second risk with default enrollment is that individuals enrolled by default may not live at the last address known to the state health agency. Confirmation of address could thus be important before starting coverage. Such confirmation could be obtained through requiring the MCO to contact the household directly before capitated payments begin; sending a health coverage card that must be activated by phone, as discussed in the next section; consulting records of other public programs, the internet, schools, and health care providers; etc.

2. Expedited enrollment

For beneficiaries to whom default enrollment does not apply, an expedited enrollment strategy is worth considering. Proposed in other contexts by Ruth Kennedy, director of Louisiana's child health programs,[66] this strategy has the state send each potential beneficiary a health insurance card with an affixed strip of tape stating that the beneficiary must call a toll-free number to activate the card. For many consumers, this approach will be familiar from credit-card activation. An accompanying letter could make clear the beneficiary's premium liability (if any).

Automated voice response would allow enrollment during hours when the phone number is not staffed. If the beneficiary calls at a time when the toll-free line is staffed, the beneficiary could receive patient education along with the ability to enroll by responding to a simple telephone prompt. The caller may need to enter some identifier, such as the social security number's final digits, to ensure that the right person has received the card. While some beneficiaries may not take the initiative to call, those who do call would know that they have health coverage, and the state would know they sent the card to the right address.[67]

Another approach would assign eligible individuals randomly to contracting MCOs, which would contact those individuals and enroll them into coverage. This approach involves a conflict between (a) the beneficiary's ability, without undue pressure, to select the health plan that best meets his or her needs; and (b) maximizing enrollment of eligible individuals without the state assuming costly administrative burdens. One resolution of that conflict would permit such MCO marketing only after failed outreach attempts by state agencies or private contractors unaffiliated with any particular plan. That way, MCOs would be involved only with individuals who would not otherwise choose a plan.[68]

Finally, strategies that place individuals in a randomly chosen plan need to provide reasonable opportunities to change plans. One such opportunity could be within a defined period of time following initial enrollment. Annual open enrollment periods could also be available for people who want to change plans. In addition, enrollees could be given the opportunity to change plans for good cause, at any time. Not only do these disenrollment opportunities preserve some individual choice after a plan has been chosen by default, they provide the state with "real time" data to track in watching for emerging problems. A large number of disenrollment requests involving a particular MCO may suggest the need for more intensive state monitoring.

3. Automating premium payments

With state coverage expansions that impose premium costs on enrollees, policymakers designing automatic enrollment procedures need to give careful consideration to how premiums will be collected. To reduce the risk of non-payment and the consequent problems noted above, state officials could consider several approaches to automating premium payments.

First, state officials could add new payroll deductions to state tax systems. Depending on the details of the coverage expansion, such deductions could be universally applicable; come into play unless workers opt out; or be offered as an option that workers must affirmatively elect.

New payroll deductions are unlikely to impose large administrative costs on employers, who already make at least seven or eight standard deductions (federal and state individual income taxes, employer social security and Medicare taxes, worker social security and Medicare taxes, unemployment insurance, and workers compensation) plus, in many cases, voluntary deductions for savings and retirement plans (pensions, 401(k) plans), life insurance, cafeteria benefit plans, etc. To administer the current system of payroll deductions, employers typically either contract with payroll administrative service firms, purchase off-the-shelf products like Quickbooks, or develop their own proprietary software. Employer payroll deductions pay more than $3.5 trillion in annual taxes and disburse more than $600 billion in health insurance premiums.[69] While these mechanisms would need adjustments to accommodate a new payroll deduction and associated information flows, building on this existing administrative structure to collect premiums is unlikely to impose significant new marginal costs on employers. It is thus not surprising that, according to national surveys, most employers (including those that do not cover their workers) are willing to be assigned new administrative responsibilities to help their workers enroll into coverage.[70]

Second, state officials can offer enrollees multiple options for automating premium payments. In addition to payroll withholding, such options could include automatic payments from credit cards or debit accounts. Premium discounts could apply to individuals who enter into such arrangements or who pre-pay several months of premiums.[71]

E. Addressing the risk of error

As noted above, Medicare Part D has illustrated the power of auto-enrollment strategies, reaching an extraordinary proportion of individuals eligible for low-income subsidies within six months of the new program's effective date. Unfortunately, that same recent history illustrates some of the risks of auto-enrollment undertaken with insufficient safeguards.

For example, Medicare Part D beneficiaries have the option to have their premiums withheld from Social Security checks, as has been done for decades with Medicare Part B. Beneficiaries requesting this approach to premium payment have experienced errors, in many cases. Some people have had insufficient withholding, resulting in disenrollment for nonpayment of premiums. Others have had excessive withholding, reducing the income on which they depend. With both scenarios, beneficiaries and advocates report a failure of decision-makers to take responsibility for fixing problems. In the words of one expert, "CMS tells beneficiaries to call their drug plan, drug plans tell beneficiaries to call SSA, and SSA tells beneficiaries to call CMS…. Advocates across the country report that regional CMS offices have told them that their clients will be put on 'the list' maintained by the regional CMS office, and that the problem may not be resolved for as much as a year."[72]

Undoubtedly, Medicare Part D involves a much more complex and large-scale information exchange than is needed for automatic enrollment into state coverage expansions. This new Medicare benefit requires data interfaces between state Medicaid programs, Medicare, the Social Security Administration, thousands of diverse health plans with diverse IT systems, and hundreds of thousands of pharmacies throughout the country, all in a program serving more than 40 million Americans. Nevertheless, the lessons of Medicare Part D can be useful to states that are exploring automatic enrollment. Testing information systems rigorously before implementation, appointing specific government agencies that are empowered to track and solve emerging problems, and establishing early warning systems may prove critically important in states that use automated approaches to enroll their uninsured residents into health coverage.

1. End-to-end IT testing

As urged by the U.S. Government Accountability Office (GAO), "end-to-end" testing of data-matching and information transmission systems can be critically important in spotting and remedying IT problems before they affect large numbers of people. This involves, not just trying each piece of a multi-entity information-transmission system in isolation, but testing the entire system working together, "end-to-end."[73]

An example of successful system testing involves the novel advance payment mechanism created for the Health Coverage Tax Credit (HCTC) program, which was signed into law on August 6, 2002. The credits pay 65 percent of qualified health insurance premiums for certain workers displaced by international trade and certain early retirees. The advance payment mechanism is complex. Each month, IRS invoices beneficiaries for their 35 percent premium payment, which they send to IRS, which furnishes it to the Financial Management Service of the Department of Treasury, which combines it with the 65 percent HCTC and sends a full premium payment to the health plan in which the individual is enrolled along with identifying information, arriving in time for the health plan's normal monthly due date for premiums. After a two-month "beta test" involving transmission of identifying information and dollars, the credit became operational on August 1, 2003, less than a year after the HCTC law was signed. Although the program has had other problems, the advance payment mechanism has operated smoothly, without major errors or glitches.[74]

2. A clearly designated agency empowered for rapid response

The above-described experience with beneficiaries failing to receive help resolving errors in withholding Part D premiums from their social security checks suggests the importance of having a single "rapid response" agency that beneficiaries, advocates, and stakeholders can contact when problems arise.

To succeed, such an agency needs the following capacities:

- Contact information disseminated widely to consumers, advocates, and other stakeholders;
- The opportunity for consumers to designate authorized representatives who can obtain from the state otherwise private information and communicate on the beneficiary's behalf, potentially bringing a level of expertise that permits efficient and effective problem-solving that helps both the consumer and the state agency;
- Front-line state workers with access to case information required to diagnose problems, the authority to solve such problems on an individual basis, and a mandate to convey emerging trends to management;
- Databases that supplement such informal communications to track emerging issues and automatically bring problematic trends to the prompt attention of agency management; and
- The authority for agency management to change policies and procedures when needed to solve systemic problems.

3. Other early warning systems

Information-gathering systems could be incorporated into the design of automatic enrollment systems to provide "early warnings" of emerging problems. For example, a state could conduct regular focus groups of enrollees and plans could be required to provide monthly encounter data, to track and report all requests for disenrollment (informal and formal), and to track and report beneficiary complaints.

Traditional Medicaid "Notices of Action" likewise represent both an early warning system flagging emerging problems and an important protection against errors, safeguarding beneficiaries and applicants from harm. When adverse decisions result from information external to health agencies, it is important to provide consumers with clear information about the nature and source of such information, thereby allowing errors to be corrected at their source.

Finally, some states may choose to phase-in innovative policies, perhaps starting with particular localities. During that phase-in, the policies' impact can be carefully studied, risks assessed, and mitigation measures devised. Such local fine-tuning before statewide implementation may be worth serious consideration, depending on how significantly the particular policy departs from prior practice.

IV. Examples of applying automatic enrollment to particular expansions

The previous section showed how automatic enrollment strategies can be used to identify the uninsured, to determine eligibility, and to enroll beneficiaries into coverage. This section provides examples of how that three-step analysis could be applied to particular coverage expansions.

The first example involves a state policy to provide health coverage to all children. Officials in states focused on adults, rather than children, may nevertheless find this example useful because it illustrates, in concrete terms, how the three functions described above can be integrated into a single policy that seeks to maximize enrollment by eligible individuals. Similar policies may be effective with adults as well.

The second example involves mandating that every state resident must obtain health coverage. The discussion explores how automatic enrollment strategies can either comprise an alternative to such a mandate or help the mandate accomplish its goals.

Appendix 5 sets out a third example involving state policies to subsidize health coverage for low-income employees of small firms.

Not discussed here are approaches to automating *renewals* of coverage. Such automated strategies can reduce the number of uninsured and lower state administrative costs that result from caseload "churning." These approaches have been explored in other papers, which are commended to the reader.[75]

A. State policies to cover all children

To illustrate the application of the three-function analysis explained in the previous section of this report, following is one example of how automatic enrollment could help a state provide health coverage to all of its children.

1. Identifying uninsured children

A state could identify uninsured children as follows:

- As a condition of licensure or contracting with state health coverage programs (such as Medicaid, public employee coverage, SCHIP, etc.), each hospital and community health center would be required to undertake various steps.

  - When a child receives care (including at birth) without a known source of health insurance, the health care provider's staff would:

    - Inform the parents that, if the child enrolls in health coverage, the parents will not be charged for the cost of the stay or visit; and

    - Ask parents if they want help obtaining health coverage for the child, which the state offers for free or at reduced cost for families with low or moderate income.

  - If parents request help with health coverage, staff would (either orally or by providing a form) ask the parents for:

    - Permission for the state to examine the family's otherwise confidential information to determine whether the child qualifies for free or low-cost health coverage;

    - Social Security Numbers for the child and for each adult in the household (explaining that providing such numbers for adults is voluntary, not mandatory, but that the information will help the state determine the child's eligibility quickly and with less inconvenience to the parents);

    - An estimate of total, monthly family income received other than as wages from an employer (such as income received as a contractor, through self-employment, from interest and dividends, etc.); and

    - A statement of whether the child is a U.S. citizen.

  - The staff provides the above information to the state through a digital conduit, such as key-data-entry into a state-furnished database that is periodically synchronized with the state health agency through secure channels.

  Note: as part of this strategy, the state would give the provider retroactive reimbursement for the pertinent episode of care, as payment in full (without patient cost-sharing) if, in fact, the children ultimately receive coverage.

- When children start school each year, the health form that parents provide to schools would be modified to ask parents whether their children have insurance; and, if not, whether the parents would like help obtaining health insurance for the child, which is available for free or at reduced cost for families with low or moderate income. If parents request such help, the school would provide them with a supplemental form requesting the information described above in connection with hospitals and community health centers. The school would then forward the completed forms (digitally, if possible) to the state health agency.

2. Determining eligibility

When the state health agency receives the above-described information about uninsured children, as well as applications sent in through more traditional venues (including welfare offices, the mail, and the internet), it would conduct a data match with the following sources of income information:

- Other public benefit programs with eligibility data in digital form;
- The state's new hires and quarterly earnings databases; and
- The state's income tax agency.

The state would then determine the child's income-eligibility as the lesser of the following:

- The family income level found by any other public benefit programs within the recent past (perhaps within six months before the family requested help with health coverage);
- The most recent employment earnings shown by the new hires and quarterly earnings database, plus prior-year tax records and family estimates (if any) for other forms of income; or

- Income as ordinarily determined by the state's Medicaid and SCHIP programs.

If none of those methods yields an income determination, the state would send a card asking the family to call a toll-free number during specified hours so state officials can gather information needed to determine eligibility. If no such call results, the state would send the household a formal application form.

Once the state obtains an income determination, the household is informed of the determination and receives an opportunity for correction, supplementation, and appeals.

If citizenship or satisfactory immigration status is not confirmed, the child receives presumptive eligibility. Intensive application assisters help the family compile documents, complete necessary forms, and transition from presumptive to ongoing coverage. Such assisters are employed by community-based agencies contracting with the state.

3. Enrollment into coverage

Once a child is found eligible, the family is informed and given several opportunities to select a health plan. If the family makes no choice, the state enrolls the child in a plan chosen by default. The choice of default plans is made by an algorithm that takes into account the premium charged by the plan; the plan's prior record of service to default enrollees; the plan's geographic area; and whether prior claims data show a relationship between the family and the plan's participating providers.

When a child is enrolled by default with a particular MCO, the family is given a time-limited opportunity to change plans before the next annual, open enrollment period. The MCO is contractually obliged to contact the family and verify the address and continue coverage during the first month of enrollment during each eligibility period. In addition, a portion of the MCO's capitated payments is withheld until the MCO provides the state with information confirming at least one covered service the child received. Finally, the MCO is required, by contract, to provide full, monthly encounter data for all default enrollees, which the state monitors on an ongoing basis to detect and address emerging problems. If problems develop, and the MCO and state cannot resolve such problems to the state's satisfaction, the state's remedies would include moving default enrollees to other MCOs.

An uninsured child who is ineligible for subsidies can enroll in the state's SCHIP plan, at cost. Such a child is mailed an insurance card, activated by calling a toll-free number, accompanied by a letter explaining the cost of unsubsidized coverage and methods through which the family can challenge the state's determination of ineligibility for coverage. If the family activates the card, premium discounts are offered to encourage agreement to automate monthly premium payments through paycheck withholding or credit card payments. Whether or not payments are automated, the underlying premium charged to the family reflects average risk levels for the state's uninsured children, which are quite low. To achieve that result, the state compensates participating plans if enrollees' aggregate claims reach designated levels that exceed average amounts for children.[76]

B. Coverage expansions and individual mandates

The enrollment strategies described in this paper can be used in several distinct ways that inform policymakers' decisions about whether and, if so, how to require each state resident to obtain health coverage.

1. Default enrollment as an alternative to individual mandates

For policymakers who view individual mandates as constituting undesirable government coercion or who fear that individual mandates could impose unaffordable costs on low- and moderate-income families, automatic enrollment may provide an alternative or precursor to mandates. Such policymakers could argue, in effect, "Before we enact individual mandates, let's see how far we get with the kind of automatic enrollment that has allowed Medicare to cover nearly all of America's seniors."

This approach would use the "key life events" strategy to identify uninsured individuals, who would be charged premiums based on state-accessible income data and enrolled in health coverage unless they "opted out." Such a state policy could include a "trigger" providing that, if the combination of subsidies and default enrollment did not reduce the percentage of uninsured residents to a specified level by a date certain, an individual mandate would then be imposed.

2. Automatic enrollment to make an individual mandate effective

Policymakers who want all residents to purchase insurance must go beyond simply enacting a mandate, even one backed up by sanctions. Often cited as a precedent for mandating the purchase of health insurance, compulsory auto insurance laws, with sanctions that include license suspensions and criminal penalties, are far from universally effective. In 2004, 14.6 percent of drivers in the U.S. lacked auto insurance – ironically, nearly the same proportion as Americans without health insurance.[77]

Automatic enrollment methods described above can help identify uninsured individuals, determine their subsidy eligibility, and enroll them into coverage. Not only can that effectuate an individual mandate, it can make the requirement less punitive. Such a mandate can be reframed as simply ensuring that everyone receives coverage and pays premiums based on what they can afford.

Conclusion

For the current round of state health reforms to succeed, effective enrollment mechanisms will be necessary. State officials could borrow a page from other public and private benefit programs that have quickly reached a large proportion of their intended beneficiaries by using automatic enrollment strategies that largely dispense with any need for such beneficiaries to come forward and complete paperwork.

These approaches represent a departure from traditional public benefits. Like any major change, automatic enrollment creates complex challenges that require careful thought and attention. Such challenges have been mastered in other contexts, however, and they may be worth tackling by state officials who want to see their state's residents enrolled in health coverage, not just offered subsidies that may or may not be used.

Appendix 1: Other examples of auto-enrollment

Such examples are numerous, including the following:

- New Jersey and Pennsylvania each enroll motorists by default into certain forms of auto insurance. New Jersey's default coverage excludes a right to sue and so has low premiums. In Pennsylvania, the default has high premiums and a right to sue. In each state, motorists can opt for the other form of coverage, but 80 percent and 75 percent of drivers in New Jersey and Pennsylvania, respectively, remain in their states' default systems, even though they are polar opposites.[78]
- In many European countries, consent to organ donation is presumed. In the U.S., non-consent is presumed. A contrary notation on drivers' licenses avoids each default. The organ donation rate exceeds 90 percent in the former nations and falls below 20 percent in the U.S. [79]
- In Vermont, the state WIC agency conducts Medicaid outreach for children, which has led to the development of effective computer interfaces between the WIC and Medicaid programs. Since 1989, a single application process has been used for both WIC and Medicaid, so that an application arriving at either program is processed for both purposes. As a result, 97 percent of children receiving WIC in Vermont have health coverage.[80] Nationwide, by contrast, 61 percent of WIC participants receive Medicaid,[81] and 12 percent of children receiving WIC are uninsured.[82]
- For many years, WIC has provided automatic, so-called "adjunctive" eligibility for pregnant women and children receiving Medicaid, TANF, or Food Stamps, without requiring any individual proof of income or other eligibility for WIC.
- Families that receive TANF likewise qualify automatically for Food Stamps, even though some TANF recipients have assets too high for Food Stamp eligibility.[83]
- The National School Lunch Program (NSLP) uses two forms of automatic enrollment that, together, provide 43 percent of free meals. NSLP's auto-enrollment mechanisms include "categorical eligibility," through which a parent requests free meals and demonstrates eligibility by showing receipt of Food Stamps or cash assistance, without providing any proof of income; and "direct certification," through which a child is found eligible based on receipt of Food Stamps or cash assistance and is enrolled directly into NSLP based on data from these other programs. The latter mechanism typically gives parents a chance to "opt out" if they object to their children receiving free school lunches. As of the 2004-2005 school year, 17 percent of free school lunch enrollees were categorically eligible, and 26 percent were directly certified.[84] The latter option lowered school district administrative costs (particularly when implemented through computer matching), reduced the proportion of inaccurate eligibility determinations, and increased NSLP participation by eligible children. As a result, Congress passed legislation in 2004 mandating that all school districts implement direct certification by the 2008-2009 school year.[85] One study found that, among children qualifying for NSLP based on receipt of other public benefits, only 1 percent were otherwise ineligible.[86]
- Dick, et al[87] examined four states' SCHIP programs and their approaches to redetermining eligibility. Each state sent redetermination forms to families as children's eligibility was coming to an end. Three states terminated coverage if those forms were not returned. In those states, approximately 50 percent of SCHIP enrollees lost coverage at redetermination. By contrast, Florida asked families to complete forms showing any changes to income or other pertinent circumstances; that state continued eligibility unless the families returned a form showing a change. In Florida, redetermination months saw no higher disenrollment than during any other month—namely, below 10 percent of the SCHIP caseload, or less than one-fifth the disenrollment levels in other states.

Appendix 2: Privacy and data security policy concerns and legal issues

These issues arise in two basic forms: policy options that states may wish to embody in health coverage initiatives where data exchange plays a central role in enrollment; and legal constraints that states must take into account in designing such initiatives. Each set of issues is addressed in turn below.

A. Data Security

The security of data about personal information is becoming increasingly important, given the rise of identity theft as a major category of crime. To protect against breaches of data security, several policies and procedures have been identified as particularly important by the GAO: "(1) access controls, which ensure that only authorized individuals can read, alter, or delete data; (2) configuration management controls, which provide assurance that only authorized software programs are implemented; (3) segregation of duties, which reduces the risk that one individual can independently perform inappropriate actions without detection; (4) continuity of operations planning, which provides for the prevention of significant disruptions of computer-dependent operations; and (5) an agencywide information security program, which provides the framework for ensuring that risks are understood and that effective controls are selected and properly implemented."[88]

GAO also highlighted the importance of a system for reporting to external authorities security breaches and other adverse incidents. With rigorous adherence to such a system, "organizations can reduce the associated risks if they take steps to detect and respond to them before significant damage occurs. Accounting for and analyzing security problems and incidents are also effective ways for an organization to improve its understanding of security threats and potential costs of security incidents, as well as pinpointing vulnerabilities that need to be addressed so that they are not exploited again."[89] All of these safeguards can be incorporated into state's design of data-based enrollment systems that protect data security. In addition, state agencies could borrow data security procedures from the following federal requirements that apply "for the secure electronic exchange of information over networks: user identification and validation, secure transmission of data, assurance that the data are not changed in transmission, and assurance that parties to a transaction cannot later repudiate the transaction. To provide these elements, the federal government … is encouraging federal agencies to incorporate public key infrastructure (PKI)… [through which certain very large numbers, with hundreds of digits, some of which are known publicly and others of which are known only privately, allow an agency to] electronically place and then verify a person's identity and ensure that electronic files do not get changed before, during, or after electronic transmissions."[90]

B. Privacy

Moving from data security to the related question of privacy, two distinct issues are raised by advocates. The first concerns the improper use or disclosure of private information, such as information about income. GAO has suggested that the risk of such violations can be reduced by "sending electronic data to other agencies over dedicated, secure computer lines; installing software that authenticates users and gives them access to only data that they are authorized to examine; establishing anomaly detection that notifies officials when a user has accessed something out of the ordinary; and using PKI." [91]

The second concern involves the belief that data collected for one purpose should not be used for a different purpose without the consent of the individual who provided the original data. As a practical matter, if documents provided in the course of data-gathering discuss in general terms the purposes for which data may be used, this concern can be satisfied. While this aspect of privacy can seem purely theoretical, particularly when the information about subsequent data use is contained in fine print that few read, the fine print can prove helpful when state health agencies reach out to potentially eligible individuals. Some individuals who are the subject of outreach may be suspicious about how they were identified. State officials or their private contractors can respond to these suspicions by pointing to the documents that gave notice of later data use.

More broadly, a leading electronic privacy advocacy group has described as follows the generally accepted principles of "Fair Information:"

> "**Collection Limitation**: requires lawful, fair, and legitimate data collection.
>
> "**Data Quality**: requires accuracy, completeness, and timeliness of data.
>
> "**Purpose Specification**: requires entities to articulate why data is [sic] being requested and prohibits its use for other purposes.
>
> "**Use Limitation**: requires consent for use of information inconsistent with the purpose of which it was collected.
>
> "**Security Safeguards:** requires procedures to stop unauthorized access, use, modification, or disclosure of data.
>
> "**Openness**: requires transparency of personal data practices, including notice of databases and the identity and location of the data controller.
>
> "**Individual Participation:** requires access to, correction of, and sometimes destruction of personal information.
>
> "**Accountability**: requires legal rights to ensure compliance."[92]

Another checklist of privacy principles was articulated by GAO in the context of protected health information, based on the privacy rule promulgated by HHS in implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

> **"Uses and disclosures**. Provides limits to the circumstances in which an individual's protected … information may be used or disclosed by covered entities and provides for accounting of

certain disclosures; requires covered entities to make reasonable efforts to disclose or use only the minimum information necessary to accomplish the intended purpose for the uses, disclosures, or requests, with certain exceptions such as for treatment or as required by law.

"**Notice**. Requires most covered entities to provide a notice of their privacy practices including how personal … information may be used and disclosed.

"**Access**. Establishes individuals' rights to review and obtain a copy of their protected … information held in a designated record set.

"**Security**. Requires covered entities to safeguard protected … information from inappropriate use or disclosure.

"**Amendments**. Gives individuals the right to request from covered entities changes to inaccurate or incomplete protected … information held in a designated record set.

"**Administrative requirements**. Requires covered entities to analyze their own needs and implement solutions appropriate for their own environment based on a basic set of requirements for which they are accountable.

"**Authorization**. Requires covered entities to obtain the individual's written authorization for uses and disclosures of personal … information with certain exceptions, such as for treatment, payment, and health care operations, or as required by law. Covered entities may choose to obtain the individual's consent to use or disclose protected … information to carry out treatment, payment, or health care operations, but are not required to do so."[93]

Of course, the data under discussion here are different than information about personal medical conditions. Nevertheless, they involve analogous privacy considerations. As state officials develop practices that enroll individuals into health coverage based on the transmission of personal data, the above checklists contain elements worth considering for potential incorporation into state policy.

C. Legal constraints

Both federal and state legal issues must be analyzed before implementing an information-based auto-enrollment strategy.

Federal law

In terms of federal legal safeguards that apply to privacy and data security, data exchange with federal agencies will often require interagency agreements with various elements specified by federal law, including the Privacy Act of 1974[94] and the Computer Matching and Privacy Protection Act of 1988.[95] In addition, HIPAA imposes duties on state agencies that share personal information, as noted by CMS: "HIPAA requires entities that maintain or transmit information covered by HIPAA to maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information. Entities must also protect against unauthorized uses or disclosures of the information. Further, Federal regulations require that the entity disclosing the information obtain satisfactory assurance from the requesting entity that the information will be appropriately safeguarded. Pursuant to 45 CFR § 164.502(e)(2), the assurance must be documented in a written agreement."[96]

In a State Medicaid Director Letter dated September 20, 2006,[97] CMS discussed HIPAA as well as the following additional legal duties that involve data privacy and security:

> "45 CFR 95.621 provides that State agencies are responsible for the security of all automated data processing systems involved in the administration of [HHS] programs, and includes the establishment of a security plan that outlines how software and data security will be maintained. This section further requires that State agencies conduct a review and evaluation of physical and data security operating procedures and personnel practices on a biennial basis….
>
> "State agencies are bound by the requirements in section 1902(a)(7) of the Social Security Act (the Act), as further interpreted in Federal regulations at 42 CFR 431.300 to 307. These provisions require that use or disclosure of information concerning applicants and recipients is permitted only when directly connected to administration of the State plan.
>
> "All organizations should perform either an internal risk assessment, or engage an industry recognized security expert, to conduct an external risk assessment of the organization in order to identify and address security vulnerabilities. Weaknesses or gaps in your security program should be quickly remedied. Organizations should train staff on their responsibilities, and on the consequences of failing to secure sensitive beneficiary information, as often as is required by the security requirements outlined in this letter."

In addition to stressing the importance of the issue and CMS' willingness to sanction states that violate federal rules relating to data security and privacy, the letter further noted the need for states to ensure that contractors abide by data security and privacy rules; to include in vendor contracts remedies for breaches of privacy and data security; and to establish a process for reporting violations (and ensuring that vendors so report) to specified state and federal officials.

State law

In addition to these federal requirements, state laws must be taken into account. If a health agency wishes to access data held by a different state agency, state laws may constrain disclosure by the custodian of the data. Accordingly, statutory and regulatory changes may be needed to obtain data that indicate potential eligibility for health coverage. In addition, HIPAA does not preempt general privacy statutes at the state level, and some states have enacted safeguards more rigorous than those embodied in federal law. In states with such statutes, compliance will be important for legal viability and potentially for political acceptability as well, since

whatever conditions led to enactment of a state's general privacy statutes may continue to exist, including active interest groups concerned about privacy.

One final variable can be important in addressing both policy and legal questions raised by information sharing. As noted in the main body of this report, when individuals provide information to a government agency that is potentially relevant to eligibility for health coverage, the forms completed by such individuals could state that information provided on the forms may be used to determine potential eligibility for subsidized health coverage and to enroll eligible individuals into coverage. Such forms can be either "opt-in" or "opt-out"—that is, they could give people an ability to consent to information transfer by checking a box or the right to prevent information transfer by checking a box. The former approach is more protective of privacy, but the latter is more likely to extend health coverage to large numbers of eligible individuals. Either approach can make it easier, both politically and legally, for custodians of eligibility information to consent to disclosure.

Appendix 3: Form Design Considerations for Key Life Events

Several points are important in designing forms that individuals experiencing key life events can use to begin a chain of events that culminate in health coverage. First, states could use these forms to gather a small amount of information about eligibility elements as to which recent data may not be available, such as an estimate of income not paid as wages from an employer.

Second, households could complete these forms either in writing or on-line.

Third, while the absence of social security numbers (SSNs) can complicate the process of successful data matching, it does not preclude it. For example, Minnesota officials found that, without SSNs, they could match birth certificate data with 93 percent of Medicaid women undergoing labor and delivery, as identified through Medicaid administrative data. Just the mother's exact name, the mother's exact date of birth, the father's last name, and the mother's hospital admission date (as shown by Medicaid data) allowed a match rate above 85 percent.[98]

Fourth, while each individual seeking Medicaid or SCHIP is required to provide or apply for a SSN, family members who are not seeking coverage are not required to provide SSNs. In fact, state Medicaid and SCHIP programs are forbidden from conditioning eligibility on the provision of SSN information for such family members. [99]

This legal obstacle reflects important policy concerns. Many immigrant families include undocumented immigrants ineligible for federally-matched, non-emergency health care as well as other family members, citizens or qualified aliens, who are eligible for Medicaid or SCHIP. Mandating the provision of SSNs for family members not seeking health coverage could prevent families from seeking coverage for eligible members, including children.

Following is one approach to resolving this trade-off between accessing family income data and encouraging immigrant families to seek health coverage for eligible family members. A state's application materials could inform families that, if they supply SSNs for all adults in the household, eligibility will be determined more quickly and the household will be spared considerable effort pulling together records. At the same time, those materials could explain that providing such SSNs is voluntary and that eligibility will be determined as quickly as possible, whether or not SSNs are provided. A number of states already take this approach.

Appendix 4: Sources of data potentially relevant to eligibility

Before addressing specific data issues, several comments about interagency collaboration are important. First, state health officials may find it useful to work with state income tax agencies and child support agencies to identify the data sources used by those other programs. Not only may those conversations yield an increased understanding of potentially useful data bearing on individual eligibility for coverage, they could help identify the changes in state law and the necessary resources required for health coverage agencies to gain access to such data.

More broadly, collaboration with other government agencies within and outside a particular state's government is a central piece of much data access described below. State health officials accordingly may need to be prepared to develop and nurture new relationships as well as to negotiate satisfactory interagency agreements.

Much data show whether particular individuals have characteristics that state policymakers could define as relevant to eligibility for health coverage subsidies. Discussed in turn below are sources of data about income, assets, immigration status and citizenship, and SSNs.

A. Income

This section of the report addresses sources of income data potentially accessible to states; the adequacy of such income data; and legal issues that may arise when health agencies seek to access such data.

Sources of income data

State health programs already have considerable access to data showing household income. Pursuant to federal legal requirements that Medicaid programs and certain other public assistance programs operate Income Eligibility Verification Systems (IEVS), each state has a system for matching applicants' and beneficiaries' identity, shown by SSN, to income data housed by the Internal Revenue Service, the Social Security Administration, and quarterly earnings and new hires data that employers report to their state's State Workforce Agency (SWA), which administers the Unemployment Insurance program.[100]

In addition, many state Medicaid programs are housed in the same agency that runs other means-tested programs, like Food Stamps, TANF, and WIC. In such cases data from the eligibility files of such programs may be accessible to help determine eligibility for health coverage, provided the information is used only for that purpose.

Particular types of income have special data sources available. For example, federal income tax laws require withholding from gambling winnings, providing a data trail indicating which individuals received such income. State income tax laws may provide parallel access to such data.

Adequacy of income data

While helpful, these data sources are far from perfect. One issue involves timeliness. Quarterly earnings data from SWAs can be three to five months old. And aside from information about employment earnings subject to withholding based on W-4 forms, income tax records typically show financial circumstances from a previous tax year. For some individuals, prior-year tax data represent the only source of state-accessible information about unearned income, income received through self-employment, and work as an independent contractor rather than as an employee.

From whatever source, old income information can be problematic. Household income fluctuates significantly for many families with low-wage workers. One study looked at families with children who, for at least one month during the year, had income below 185 percent FPL, the income eligibility threshold for NSLP. Roughly two-thirds (63 percent) of these families experienced at least one change in eligibility during the year, with income moving above or below 185 percent FPL. More than two in five (44 percent) experienced two or more eligibility changes during the year. By far the most important factor responsible for these eligibility shifts was changed hours of work or changed hourly wages.[101]

Aside from timeliness, questions of accuracy have arisen about income data from certain sources. For example, with NSLP, research for several years has shown error rates that range from 12 percent to 33 percent. However, these studies generally compare August income, which families report on NSLP application forms, and income in subsequent months through December, when school authorities verify income for a sample of families. A recent study of income fluctuation among NSLP-eligible families found that, on average, 27 percent of families who are income-eligible in August of a given year experience income increases that make them ineligible by December. This finding suggests that income fluctuation, rather than errors (deliberate or inadvertent) by families and schools may have been the crucial factor underlying the majority of errors ascribed to NSLP.[102] That suggestion is strengthened by recent U.S. Department of Agriculture research finding 3.4 percent error rates in local schools' eligibility determinations for NSLP.[103]

A third limitation on some income data involves cumbersome access. For example, NSLP is administered locally rather than statewide. Statewide data exist but, in some cases, are less recent than data housed by local school agencies.[104] Health officials may need to consider whether, depending on the details of state data as well as the operation of state law and politics, work would be needed, district by district, to obtain necessary data-sharing agreements.[105] On the other hand, NSLP programs are now being encouraged to develop data match procedures through which Medicaid and SCHIP eligibility files can be accessed to verify NSLP eligibility. Mutual, statewide data exchange can thus serve the interests of both programs.

In sum, it is often possible to compile a reasonable picture of family income based on data about recent quarterly earnings reported to SWAs, which capture income changes for employees; unearned income during the prior year, as reported to IRS, which undergoes less change than earnings; the absence of self-employment income or unchanging levels of such income reported to IRS during prior years; and additional financial information available from other sources, including both means-tested programs and special sources of data that involve particular kinds of income (such as lottery winnings).

Legal issues

Legal requirements are important to analyze in developing a strategy to access data outside the IEVS system. State statutes safeguarding data confidentiality may need to be amended, including state statutes governing tax data. (See Appendix 2, for information related to privacy

and confidentiality.) In addition to gaining access to previously unavailable data, statutory changes may be needed to expand the purposes that can be served through accessing data. Under the approaches discussed here, the purpose of identifying potentially eligible individuals and enrolling them into coverage may need specification, in addition to the purpose of verifying eligibility and terminating coverage for the ineligible.

Unfortunately, certain otherwise promising federally-housed sources of income data are currently off-limits to state Medicaid and SCHIP programs. In particular, the National New Hires Data Base, which was established to facilitate child support enforcement and which contains quarterly earnings data and new hires information from federal employers and companies in every state, is governed by a federal statute that limits the agencies and purposes for which access is permitted. State Medicaid and SCHIP programs are not among those with federal statutory permission to access these data. The pending national legislation described on page 10 may, if passed, provide state health agencies with access to these data.

B. Assets

Assets can be relevant to eligibility for health coverage. For example, while children typically qualify for Medicaid and SCHIP without regard to assets, poor adults in most states cannot qualify if their assets exceed specified levels.

Data about household assets can be obtained from other means-tested programs with asset requirements, such as Food Stamps. In addition, state officials may be able to benefit from the Social Security Administration's (SSA) pilot project on asset verification for purposes of Supplemental Security Income. The SSA has contracted for electronic asset verification with Acuity, Inc., which is the Official Registrar of the American Bankers Association U.S. Routing and Transit Codes. In this role, Acuity is required to maintain current information on more than 110,000 financial institutions across the United States. The initial pilot project for New York and New Jersey increased financial institution response rates, reduced response times, achieved administrative savings, and prevented more than $300 million in improper benefit payments, according to Acuity. The company has indicated its openness to providing similar data matches to other state and federal public benefits programs.[106]

Another potential data match opportunity to gather information about assets involves the Financial Institutions Data Match program operated by child support enforcement agencies. Under this program, financial institutions within a given state as well as nationally provide information about assets, based on name, SSN, and other identifying information for non-custodial parents who are defaulting on their child support obligations.[107] Child health agencies could perhaps "piggyback" on this system to obtain automated access to information about bank accounts.[108]

C. Immigration status and citizenship

Income may not be the only criterion for eligibility for health coverage subsidies. Non-citizens seeking Medicaid or SCHIP are required to document immigration status as a "qualified" alien. Within the Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS) administers the System for Alien Verification of Entitlements (SAVE), through which public agencies and employers can obtain information about immigration status. The query proceeds once the agency has an immigrant's so-called "A number" or "I number," which can be found on key immigration documents.[109] However, these data are now queried to confirm the validity of proffered immigration documents, not to substitute for the need to show papers.

More fundamentally, SAVE has a longstanding reputation for frequent inaccuracy and delays.[110] This may soon change, however. Federal immigration authorities are under enormous pressure to develop a reliable, efficient, comprehensive system for digitally confirming individual immigration status. One source of that pressure is the Real ID Act, which mandates that, by May 2008, every state's agency for issuing drivers licenses must, in granting or renewing such licenses, confirm drivers' identity and immigration status with various electronic databases, including SAVE. A second source of pressure to improve immigration records involves employer verification of work authorization. For example, proposed national immigration reform legislation would have established a system through which employers would be required to obtain digital confirmation of their new employees' work authorization.[111] Even now, USCIS offers employers the option, free of charge, to query SAVE over the internet to verify satisfactory immigration status of new workers. As employers and drivers, not just state public benefit programs, become affected by SAVE's shortcomings, improving the SAVE system is likely to become an elevated policy priority for federal elected officials.

Along similar lines, Section 6036 of the Deficit Reduction Act of 2005 (DRA) requires state Medicaid programs to verify applicants' claims of U.S. citizenship, using original documents whenever possible. (Exempt from this requirement are certain Medicaid eligibility categories, such as eligibility based on age over 64, disability, and status as a foster care child.) This requirement has been interpreted to allow reliance on citizenship records of other public agencies as well as birth certificates contained in state Vital Statistics databases. Such reliance has several limitations, however. For example, states using birth certificate records must document that the applicant is the same individual as the person named on the birth certificate; and states typically are currently unable to access birth certificate data housed by other states, although efforts are underway to establish national repositories of such data. It is possible that, in 2007, Congress may revise this section of the DRA.

D. Social Security Numbers

Finally, as noted in the previous section, individuals seeking Medicaid or SCHIP must provide their SSN. The Social Security Administration operates an online Social Security Number Verification Service (SSNVS) with several systems for verifying the validity of particular Social Security Numbers.[112] Questions have been raised about the adequacy of such systems. However, as pressure mounts for federal authorities to give employers (and states) a low-cost, accurate, efficient system for digital verification of valid SSNs, such a system may become increasingly useful for purposes of facilitating eligibility determinations for health coverage that qualifies for federal matching funds under Medicaid or SCHIP.

Appendix 5: Applying automatic enrollment to coverage expansions focused on employer-based coverage

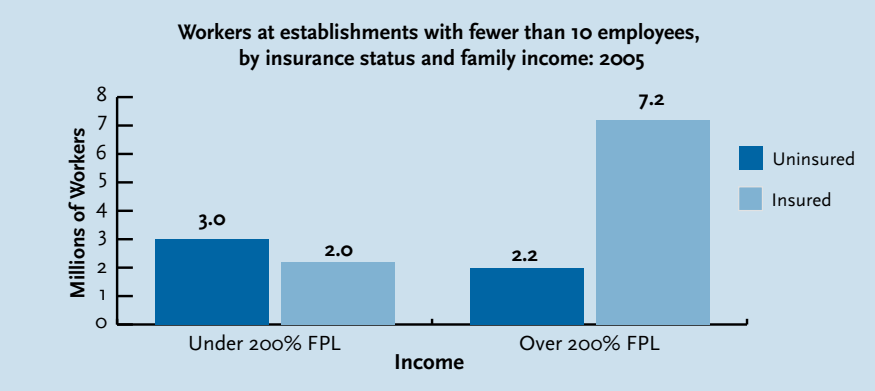
Many states propose to help uninsured workers access employer-sponsored insurance. Some such proposals aim at the 20 percent of uninsured workers who decline their employers' offers of employer-sponsored insurance.[113] Others seek to encourage small employers to offer coverage for the first time.

In either event, it can be important to identify low-income employees at the target firms. At small firms, low-income workers constitute the bulk of uninsured employees. (See Figures 9-10.)[115] If subsidies go to *all* workers at small firms, new public resources will mostly benefit the already insured. By contrast, if intensive subsidies are targeted carefully to *low-income* workers, the uninsured can receive coverage. Put differently, subsidies will increase both their effectiveness and efficiency if they are targeted at and designed to make coverage affordable to low-income workers.[114]

State policymakers wishing to target subsidies to uninsured workers at particular firms (such as small companies or micro-firms) accordingly need a strategy to identify such workers with comparatively few resources. It is not feasible to ask employers to determine which of their workers has family income below specified levels. Not only would that impose an administrative burden that many firms may be loath to shoulder, it would violate workers' privacy, since employers would need to ask about the income earned by spouses and other family members.

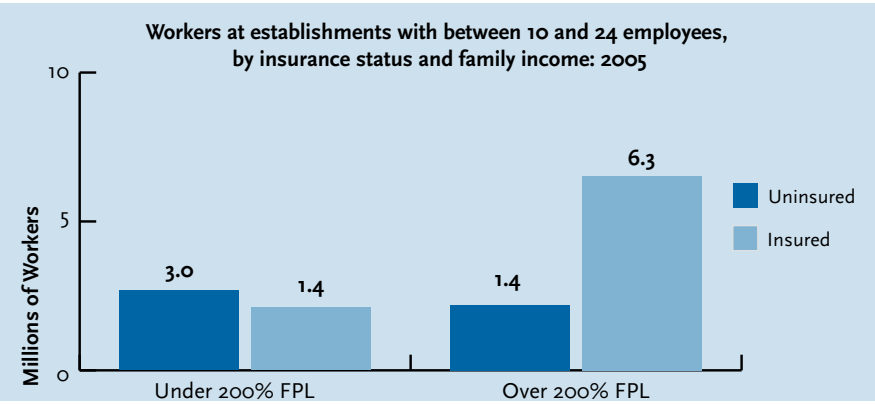
States can obtain information about worker income and consequent eligibility for subsidies through three strategies, discussed in turn below: traditional application forms; using wages, rather than income, as the basis of subsidy eligibility; and using state-accessible data to provide subsidies without requiring workers to submit applications.

Figure 9. Among micro-firms' employees, most uninsured workers have low incomes



Source: Clemans-Cope and Garrett (Urban Institute) 2006. Unpublished estimates based on the February 2001 and 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2001 and 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

Figure 10. Among small firms' employees, most uninsured workers have low incomes



Source: Clemans-Cope and Garrett (Urban Institute) 2006. See source information for Figure 9.

The traditional approach to identifying eligible workers: ask them to complete application forms

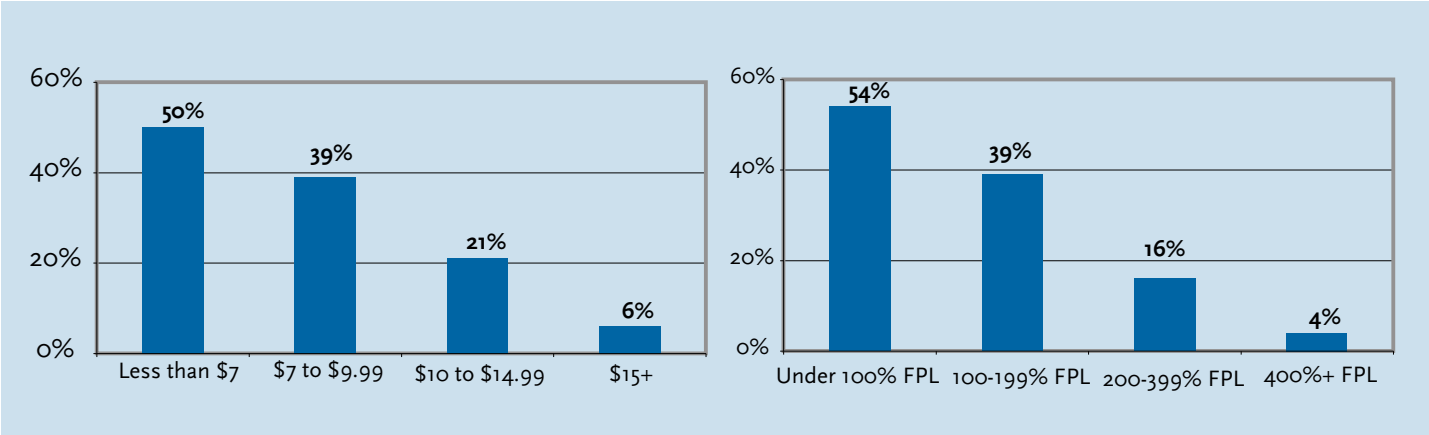
Under the traditional approach to identifying income-eligible workers, the state would require employees to complete application forms demonstrating income-eligibility. As the main body of the report shows, the likely result is that many eligible workers would fail to complete such forms and so remain uninsured.

Grant subsidies based on information about wages, which the employer can easily report

One alternative to that traditional approach would use low wages as a proxy for low income. A state could thus grant subsidies to workers whom employers identify as receiving low hourly wages. While some low-wage workers have spouses with much higher income and offers of health insurance, basing subsidies on low wages may be nearly as effective and efficient as focusing on workers with low total family income. (See Figures 11 and 12.)

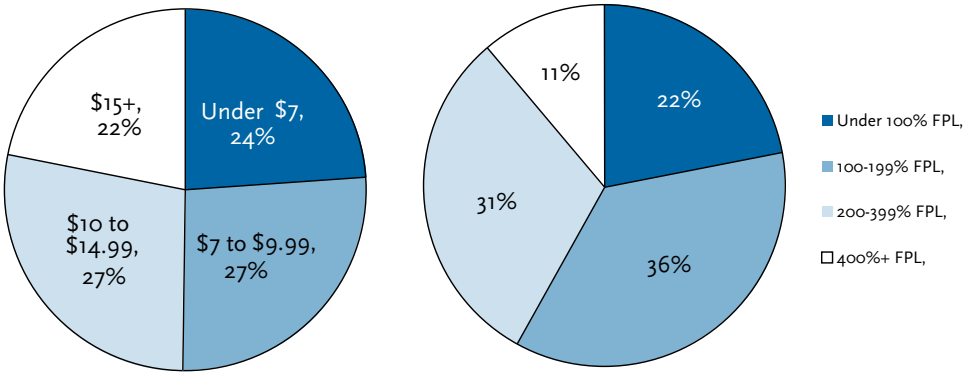
However, using wages, rather than income, to determine subsidy eligibility has several countervailing disadvantages. First, Medicaid and SCHIP eligibility is framed in terms of family income, rather than wages. Accordingly, a state basing subsidies on wages rather than income may have difficulty accessing federal matching funds to help finance subsidy costs. Second, a small proportion of low-wage workers may have spouses (or other family members) with much higher incomes. Granting this subset of low-wage workers subsidies could provide public funds to some residents who can obtain health insurance on their own. Ultimately, a state's health coverage expansion could be discredited based on one or two well-publicized examples of higher-income people receiving health

Figure 11. Income vs. hourly wages – percentage of workers without health coverage, 2005



Source: Clemans-Cope and Garrett (Urban Institute) 2006. Unpublished estimates based on the February 2001 and 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2001 and 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

Figure 12. Income vs. hourly wages – distribution of uninsured workers, 2005



Source: Clemans-Cope and Garrett, op cit.

insurance coverage subsidies targeted at low-wage workers. However, neither concern would be a factor if a state used wages to target intensive application assistance, while still basing eligibility on household income.

Drive enrollment with state-accessible data, rather than application forms

A second alternative to the traditional approach would make family income the touchstone of eligibility for subsidies but determine eligibility based not on workers completing application forms but on automated data connections. Under this approach, either the state agency or employer would give each worker notice that, unless the worker indicates a contrary preference by a date certain, the employer will provide the state with identifying information to allow the state to determine whether the worker is entitled to help paying for health insurance. If a worker failed to opt out by that date, the employer would furnish the worker's identifying information, including SSN, to the state agency, which would match those identifiers with income data (and other data pertinent to eligibility) described above (including information about spousal SSNs available from prior-year income tax records). As a result, the state would develop an initial estimate of the worker's family income. The state agency could then give the worker a notice stating the amount of income found by the state; asking the worker to correct that statement, if necessary; and indicating that subsidies (or the lack thereof) would be provided accordingly unless the worker files an objection by a date certain.

Employers would not be heavily burdened by providing workers' SSNs. As noted in the main body of this report, even the smallest employers already are required to provide this information as part of numerous payroll deductions, forwarding both deducted wages and information to multiple state and federal agencies. Even if additional information is required, adding minimal information demands into this existing system would add little marginal cost. At the same time, by using data, rather than application forms, to determine eligibility and by setting the default as enrollment rather than uninsurance, this approach promises a dramatically higher take-up rate and consequent impact on health coverage, compared to more traditional approaches.

Endnotes

1 Such risks can also be reduced by setting realistic expectations during the debate over enactment and, following program adoption, continuing to keep engaged whatever coalition advocated for the legislation's passage. (*State of the States: Building Hope, Raising Expectations,* State Coverage Initiatives, January 2007)

2 Riley, T. "The Politics of Creating and Sustaining Comprehensive Health Care Coverage Initiatives," at the National Academy for State Health Policy 19th Annual State Health Policy Conference, October 15, 2006

3 Part D of this section describes Massachusetts' use of automatic enrollment into the state's new Commonwealth Care program and Louisiana's use of automatic enrollment strategies to renew Medicaid and SCHIP eligibility for children. Part III of this report mentions state initiatives that have used health care providers and school lunch program data to identify uninsured children as well as New York City's use of Food Stamp eligibility data to auto-enroll 15,000 children into Medicaid. Along similar lines, Appendix 1 discusses Vermont's use of WIC applications as gateways to health coverage. Because of that effort, only 3 percent of WIC-recipient children in Vermont are uninsured, compared to 12 percent of such children nationally.

4 Dorn, S. and G. Kenney, "Automatically Enrolling Eligible Children and Families Into Medicaid and SCHIP: Opportunities, Obstacles, and Options For Federal Policymakers," prepared by the Economic and Social Research Institute and the Urban Institute for the Commonwealth Fund, June 2006.

5 Smallwood, D.M. et al. "Income volatility and the implications for food assistance programs," *Focus*, University of Wisconsin–Madison Institute for Research on Poverty, Vol. 22, No. 2, Summer 2002, pp. 56-60.

6 For example, the National School Lunch Program (NSLP) uses Food Stamp and Temporary Assistance for Needy Families (TANF) data to provide free school lunches. Research commissioned by the U.S. Department of Agriculture (USDA) concluded that that such "direct certification" improved both program access (more eligible children received free meals) and program integrity (a higher percentage of children receiving subsidies were eligible). (Gleason, T., et al., "Direct Certification in the National School Lunch Program—Impacts on Program Access and Integrity," prepared by Mathematica Policy Research, Inc., and Decision Information Resources for Economic Research Service, U.S. Department of Agriculture, October 2003, E-FAN-03-009.) According to state and local officials, direct certification lowered operational costs. (Cole, N., et al., "Data Matching in the National School Lunch Program": 2005, "Volume 1: Final Report," prepared by Abt Associates, Inc., for the Office of Analysis, Nutrition, and Evaluation, Food and Nutrition Service, USDA, February 2007, Report No. CN-06-DM.) One case study found an 80 percent reduction in administrative costs, taking into account both infrastructure development and operating costs. (Food and Nutrition Service of the Minnesota Department of Children, Families and Learning, "Free and Reduced Price Meal Eligibility Cost Study," March 2002.) Along similar lines, for many years, WIC has provided automatic or "adjunctive" eligibility to pregnant women and infants who receive Medicaid, Food Stamps, etc. According to the U.S. Government Accountability Office (GAO),"Federal administrators at USDA noted that adjunctive eligibility is one of the most important tools now used to address program integrity and access issues in a way that cuts across programs." ("Means-Tested Programs: Information on Program Access Can Be an Important Management Tool," April 8, 2005, GAO-05-221.)

7 GAO, "Medicare Part D Low-Income Subsidy: Progress Made in Approving Applications, but Ability to Identify Remaining Individuals is Limited." May 8, 2007. GAO-07-858T.

8 Selden, T. M. et al. "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002," *Health Affai*rs, September/October 2004, pp. 39-50.

9 Section 902 of the Pension Protection Act of 2006, Public Law No. 109-280.

10 Etheredge L. *Health Insurance Coverage At Transitions: What Works, What Doesn't Work*, Maryland Department of Health and Mental Hygiene, State Planning Grant. April 11, 2003.

11 Copeland C. *401(k)-Type Plan and IRA Ownership*, Employee Benefit Research Institute, January 2005.

12 Laibson, D. "Impatience and Savings," *National Bureau of Economic Research Reporter*, Fall 2005, pp. 6-8. See also: Choi, J.J. et al., *For Better or For Worse: Default Effects and 401(k) Savings Behavior*, National Bureau of Economic Research Working Paper 8651, December 2001; and, Choi J. J. et al. *Defined Contribution Plans for Passive Investors*, July 5, 2004

13 Federman, A.D. et al. "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs*, January/February 2005, Vol. 24, No. 1, pp. 263-270.

14 Remler, D. K. and S.A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health,* January 2003, Vol. 93, No. 1, pp. 67-74.

15 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.

16 Lock, C.A. et al. "A randomized trial of three marketing strategies to disseminate a screening and brief alcohol intervention programme to general practitioners," *British Journal of General Practice,* Vol. 49, No. 446, pp. 695–698.

17 Summer, L. and C. Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*, June 2006, prepared by the Georgetown University Health Policy Institute for the Commonwealth Fund.

18 A U.S. Department of Justice manual explains, "An important line of Supreme Court cases states that individuals generally cannot reasonably expect to retain control over mere information revealed to third parties, even if the senders have a subjective expectation that the third parties will keep the information confidential. For example, in United States v. Miller, 425 U.S. 435, 443 (1976), the Court held that the Fourth Amendment does not protect bank account information that account holders divulge to their banks. By placing information under the control of a third party, the Court stated, an account holder assumes the risk that the information will be conveyed to the government. Id. According to the Court, 'the Fourth Amendment does not prohibit the obtaining of information revealed to a third party and conveyed by him to Government authorities, even if the information is revealed on the assumption that it will be used only for a limited purpose and the confidence placed in the third party will not be betrayed.' Id." (United States Department of Justice, Criminal Division, Computer Crime and Intellectual Property Section, *Searching and Seizing Computers and Obtaining Electronic Evidence in Criminal Investigations*, July 2002.)

19 24 U.S. Code Section 1396b(a)(3)

20 42 CFR 433.112(c) and 42 CFR 433.111(b)(3).

21 Such provisions are included in S. 1364, S. 1224, S. 1213, S. 895, H.R. 2147, H. R. 2055, and H.R. 1535 of 110th Congress.

22 GAO, Letter from James R. White to The Honorable William J. Coyne, December 14, 2001, GAO-02-290R Earned Income Tax Credit Participation, calculations by S. Dorn, 2007.

23 Southern Institute on Children and Families, Covering Kids & Families National Program Office, *Promising Practices From The Nation's Single Largest Effort To Insure Eligible Children And Adults Through Public Health Coverage*, Robert Wood Johnson Foundation, April 2007.

24 According to CMS, "Federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid." *Medicaid School-Based Administrative Claiming Guide*, May 2003.

25 Leddy, T. "Expanding Coverage for Adults: State Experiences and Lessons," at National Academy for State Health Policy, *18th Annual Health Policy Conference*, August 8, 2005.

26 Dear State Medicaid Director Letter re Third Party Liability, December 15, 2006, SMD# 06-026, and enclosures.

27 California Department of Motor Vehicles, *Auto Liability Notification: January 2006*, Document #ALN.IP.V2.0, Vehicle Financial Responsibility Program – Processing Manual, April 13, 2006.

28 Jordan R. "California proposal: Get health insurance or pay fine, The Schwarzenegger administration considers putting teeth in its plan to require coverage for all," *Los Angeles Time*s, April 11, 2007.

29 Several sources of information list most of a given state's residents, including state income tax records, quarterly employment reports provided to State Workforce Agencies, drivers license data, voter registration rolls, and (for children) school attendance records, supplemented with birth certificate data. These sources of information

inevitably contain errors. For example, some residents would not be on any of these lists, including families who are isolated from social service networks. Others listed at a particular address would have moved to other locations, perhaps outside the state. Supplemental data could provide some corrective information, including publicly available data from the U.S. Postal Service about household moves as well as state records of death, marriage and divorce, but errors and omissions would inevitably remain and need to be taken into account in developing sensible policy. Such a statewide effort can perhaps best be viewed as developing a good, but neither complete nor perfect, target list of residents who may be uninsured and to whom additional efforts could be directed, as described in later sections of this report.

30 Southern Institute on Children and Families, op cit.

31 Dorn and Kenney, op cit., citing the Children's Partnership.

32 Internal Revenue Service, *Earned Income Credit (EIC), for use in preparing 2006 Returns*, Publication 596, Cat. No. 15173A.

33 Social Security Act Section 1920A(b)(2)(A) (42 U.S.C. 1396r-1a(b)(2)(A)).

34 Dorn and Kenney, op cit.

35 Kennedy, R. "Enrollment, Marketing & Outreach for Coverage Expansions: The Louisiana Experience," *State Coverage Initiatives National Workshop*, AcademyHealth State Coverage Initiatives Program, January 25, 2007.

36 A similar approach is used by some state Medicaid programs and SCHIP programs in renewing eligibility. Florida's application of this approach and the resulting dramatic impact on children's coverage is discussed in Dick A.W, et al, "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review*. Spring 2002, Vol. 23, Number 3, pp. 65-88. The Social Security Administration (SSA) uses an even more aggressive approach in renewing eligibility for Medicare Part D low-income subsidies. If SSA's records show no change in household income or assets, SSA simply continues eligibility without asking the enrollee to confirm the accuracy of those records. (Memo from Abby L. Block, to All Medicare Advantage Organizations, etc., re: *Redetermination of Low-Income Subsidy (LIS) Eligibility for 2007*, CMS, Center for Beneficiary Choices, January 31, 2007.) And as noted above, if data available from other means-tested programs or SWAs show that a child remains eligible for Medicaid or SCHIP, Louisiana's health program renews eligibility without requesting any additional information from parents.

37 Geffen, M., *The Transformation of Human Service Administration,* American Public Human Services Association – IT Solutions Management 2006 Conference.

38 Pub. L. 108-173.

39 Federal Register, Vol. 71, No. 208, Friday, October 27, 2006, 62923-62940.

40 Richardson, S. Dear State Official letter, Health Care Financing Administration, August 27, 1997.

41 As noted previously, these agencies have data about income for non-filers as well as filers, although processing and applying the data to health coverage determinations is likely to be easier for individuals who have filed tax returns. Of course, if the state offers an Earned Income Tax Credit, low-income households are substantially more likely to file tax returns.

42 CMS, *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources*, May 11, 2001.

43 SCHIP match should be even easier to access, given the SCHIP statute's broad grant of state discretion. Generally speaking, SCHIP eligibility rules are prohibited only if they discriminate on the basis of health condition, cover children who would have qualified for Medicaid under the state's pre-SCHIP rules, substitute for employer-based coverage, or, within a defined group of children, cover those with higher income without covering those with lower income. Social Security Act Section 2102(b) (42 U.S.C. 1397bb(b)).

44 MEQC procedures, at state option, either (a) require states to implement specified quality control procedures or (b) deny federal matching dollars to the extent CMS finds error rates above 3 percent.

45 Under PERM, each state's eligibility determinations (and other decisions) receive intensive focus once every three years, with public reporting of error rates and corrective action plans required.

46 *Economic Report of the President*, *together with the Annual Report Of The Council Of Economic Advisers*, February 2002. Along similar lines, when a person seeks low-income subsidy based on an application to the Social Security Administration, rather than through receipt of Medicaid or SSI the prior year, that person's income is determined using procedures and methods applied for purposes of SSI, and low-income subsidy for Medicare Part D eligibility is granted for one year. When SSI determines net earnings from self-employment (NESE), if an individual has been engaged in the same business or trade for several years without large variations in such income, and the individual does not indicate that a change is likely during the coming year, SSI determines NESE based on prior-year tax records. Social Security Act Section 1860D-14(a)(3)(C); 42 CFR 423.774(b); Social Security Administration POMS Section SI 00820.230.

47 As noted above, a similar approach is used to renew Medicaid eligibility in Florida and eligibility for low-income subsidies under Medicare Part D.

48 Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes,* National Council on Aging, 2005.

49 Kennedy, R. op cit.

50 Dorn and Kenney, op cit.;

51 Horner, D. and B. Morrow, *Opening Doorways To Health Care For Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance*, prepared by the Children's Partnership for the Kaiser Commission on Medicaid and the Uninsured, April 2006.

52 Horner, D. with B. Morrow and W. Lazarus, *Building an On-Ramp to Children's Health Coverage: A Report on California's Express Lane Eligibility Program,* prepared by the Children's Partnership for the Kaiser Commission on Medicaid and the Uninsured, September 2004.

53 Dorn and Kenney, op cit.

54 Such provisions are included in S. 1364, S. 1224, S. 1213, S. 895, H.R. 2147, H. R. 2055, and H.R. 1535 of the 110th Congress.

55 According to federal statute, Medicaid eligibility is limited to children age 1-5 with income at or below 133 percent FPL. For children age 6-18, the income limit is 100 percent FPL. (Social Security Act Section 1902(l)(2)(B) and (C).) Nevertheless, even before adoption of SCHIP, Section 1902(r)(2) allowed states to cover children at substantially higher income levels by disregarding, for example, all income between those thresholds and 185 percent FPL, extending coverage to the latter income level in Connecticut, New Hampshire, New Mexico, and New York, as well as higher levels in several other states. (National Governors Association Center for Best Practices, *MCH Update: Early State Trends in Setting Eligibility Levels for Children and Pregnant Women*, September 30, 1998.)

56 The legislation, S. 1049, of the 109th Congress was cosponsored by then-Majority-Leader Frist (R-TN) and Senator Bingaman (D-NM).

57 42 U.S. Code Section 1395w-114(a)(3)(B)(v)(II).

58 *Statement of Patricia Nemore*, Center for Medicare Advocacy, Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, May 03, 2007.

59 The expedited strategy discussed here is more modest than that already accepted by the Bush Administration not simply because of the longstanding formal distinction in federal Medicaid law between eligibility standards and methodologies. As an empirical matter, express lane eligibility for children would have a much smaller effect covering otherwise ineligible people than does the automatic enrollment of MSP beneficiaries into LIS in states without an MSP asset requirement. In such states, granting low-income subsidies based on MSP receipt increases the number of eligible individuals by approximately 20 percent, according to national data. (Rice T. and Desmond K., "Who Will Be Denied Medicare Prescription Drug Subsidies Because of the Asset Test?" *The American Journal of Managed Care*, January 2006, Vol. 12 No. 2, pp. 46-54, calculations by S. Dorn, June 2007.) By contrast, under the approach discussed in the text, children would rarely (if ever) qualify for health coverage based on different income methodologies, since eligibility thresholds tend to be much higher for health coverage than for other needs-based programs. For example, the nutrition programs described above are limited to families with gross income below 185 percent of FPL (or lower levels, in the case of Food Stamps). SCHIP typically covers children with net income (calculated after various deductions) up to at least 200 percent of FPL, which translates into a higher gross income threshold. Very few (if any) children with gross incomes below 185 percent of FPL, as calculated by nutrition programs, would have net incomes above 200 percent of FPL, as calculated by health programs.

In addition, many MSP programs use income methodologies that are more expansive than the

methods used for low-income subsidies. For example, 18 states disregard in-kind income for MSP, and 10 states count resident grandchildren among household members whose needs are taken into account in determining eligibility, effectively increasing the amount of income that beneficiaries can receive and still qualify for assistance. *Testimony of Monica Sanchez,* Deputy Director, Medicare Rights Center, Hearing Before the United States House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, May 15, 2007.

60 42 U.S.C. 1397bb (b)(3)(A) and (B).

61 It is not clear whether current federal law would permit presumptive eligibility to be limited to such children. Presumptive eligibility must be available statewide and may not be limited to designated subgroups of children. (State Medicaid Director letter from Sally R. Richardson, HCFA, October 10, 1997). On the other hand, by definition it cannot be granted to all comparably situated children, Presumptive eligibility applies only to the children who are within the group receiving outreach from the entities qualified to grant presumptive eligibility. If such entities conduct outreach among, for example, uninsured children attending particular school districts, only those children will receive presumptive eligibility, not children in other districts. A similar result would apply under the approach discussed here, so long as it was not restricted to children with particular characteristics like age or income. The state Medicaid or SCHIP agency would be qualified to grant presumptive eligibility and would do so to all qualified children who are the subject of the agency's presumptive eligibility-related outreach—namely, those whose likely eligibility is shown by the findings of other means-tested agencies.

62 If premiums are charged, default enrollment becomes trickier. Default enrollees who do not understand their situation may fail to make premium payments, causing disenrollment, administrative costs for the state, and damage to consumers' credit rating. A state can guard against this result with special rules that govern the initial period following enrollment (such as the first 90 days). During that period, if a default enrollee neither pays premiums nor uses services, the enrollee could be considered to have opted out of coverage. In that case, the enrollee would not have any financial liability. At the same time, before completing the disenrollment process, the state could give such an individual notice and an opportunity to enroll by paying past due premiums.

Default enrollment for beneficiaries who need to pay premiums seems most justifiable in a state that mandates coverage, since such beneficiaries will be legally required to make at least some premium payments. On the other hand, in a voluntary health coverage system, the challenges involved in default enrollment for people with premium obligations may cause some state officials to turn to the expedited procedures described in the next section.

63 Auto-assignment to particular plans would need to take into account claims data showing prior relationships between particular enrollees and providers in plan networks, the geographic area served by each plan, and other factors. Such auto-assignment mechanisms are familiar to Medicaid agencies that mandate enrollment into managed care plans, including for beneficiaries who fail to choose a plan.

64 While real, this risk should not be exaggerated. Automatic enrollees into Medicare Part D plans, for example, use their coverage more than do most other enrollees. From January through May 2006, automatically enrolled dual Medicare/Medicaid eligibles filled an average of 5.03 prescriptions per member per month, compared to 2.90, 2.72, and 2.91 prescriptions for stand-alone prescription drug plans, Medicare Advantage plans with prescription drugs, and Medicare retiree drug subsidy coverage, respectively. CMS data, analysis by S. Dorn, March 2007. Of course, the Medicare population is quite different from younger, uninsured people. Medicare's automatic enrollees previously received Medicaid coverage of prescription drugs and thus were accustomed to using coverage, which may be less characteristic of younger groups previously without insurance. Moreover, such utilization by Medicare-Medicaid beneficiaries does not necessarily mean they receive adequate access to medication. This group of dual eligibles is likely to have much greater average need for prescription drugs than do other Medicare Part D enrollees. Put simply, the information about prescription drug use by dual eligibles is meant to make only the narrow point that default enrollment does not necessarily mean zero service utilization.

65 Since default enrollees are less likely to need health care than are enrollees who take the initiative to obtain coverage, a key touchstone of performance for default enrollees needs to be preventive services that everyone needs, rather than treatment of health problems.

66 Kennedy, op cit.

67 States that offer enrollees a choice among health plans face a tension between maximizing enrollment and promoting choice. To accommodate these competing goals, a state could send information to consumers about available coverage options; and if the consumers do not enroll, provide an insurance card that would be activated by calling a toll-free number, as described above. The letter accompanying the card would make clear that the consumer was randomly assigned to one of several available health plans, described in accompanying materials. A caller to the toll-free number could select one prompt to enroll in the randomly chosen plan. Other prompts would allow a choice between plans or, when the call center is staffed, a conversation with a state employee or contractor who could help the caller select a plan.

68 Washington State's Basic Health Program (BHP) has long attempted to navigate this basic conflict in that state's financial sponsor program. Sponsors pay beneficiaries' premiums, help consumers select a health plan, and counsel enrollees on the appropriate use of health care. While BHP health plans are forbidden to serve as sponsors, community health centers that participate in such plans can sponsor beneficiaries. These financial sponsors play an important role in reaching the most vulnerable individuals. Among financially sponsored enrollees, 81 percent have incomes below the federal poverty level, 60 percent are non-white, and 32 percent lack a high school degree. For individual enrollees without sponsorship, those proportions are 53 percent, 16 percent, and 7 percent, respectively. (State of Washington Health Care Authority, *A Study of Washington State Basic Health Program*, Project Funded by Oregon Health Policy and Research, HRSA State Planning Grant, June 2002.)

69 Etheredge, L., et al. *Administering Medicaid + Tax Credits Coverage Initiatives*, Health Insurance Reform Project of George Washington University and the National Academy for State Health Policy. February 28, 2007.

70 Whitmore, H., et al., "Employers' Views on Incremental Measures to Expand Health Coverage," *Health Affairs*, Nov./Dec. 2006, Vol. 25, No. 6, pp.1668–78.

71 The text does not address the options for states who wish to offer unsubsidized coverage to uninsured individuals with incomes too high for subsidies. Unfortunately, individuals who foresee health problems are disproportionately likely to take advantage of such offers. The result is health care claims far above the average for state residents as whole. To cover such claims, premiums need to be relatively high, further increasing the average risk-level of enrollees, further increasing premiums, etc. To avoid that kind of destabilization, a state could use default or facilitated enrollment into unsubsidized coverage, which would lower enrollees' average risk level. Steps like subsidized reinsurance, stop-loss coverage, and risk-adjusted payments to health plans could keep premiums to the level that would apply if an average-risk population enrolled.

This approach may be particularly important to coverage expansions aimed at uninsured children, whose average risk level is low, allowing affordable premiums to be charged. A recent study of a countywide initiative in California found, for example, that chronically ill children were disproportionately likely already to have Medicaid coverage; and that while the average annual cost of a child in the highest-cost 10 percent of Medicaid-enrolled children was $6,522, the average cost for other Medicaid children was only $265 a year. Embry M. Howell, "High-Cost Children in Public Health Insurance Programs: Who, Why, and How Much?" *Health Policy Brief No. 21*, Urban Institute, June 2007.

72 Testimony of Vicki Gottlich, Esq, Center for Medicare Advocacy, Inc. *Medicare Prescription Drug Benefit Program: Monitoring Early Experiences*. United States Senate Committee on Finance. May 2, 2007, also discussing other problems with the new program.

73 GAO, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*, May 2007. GAO-07-272.

74 Dorn, S. and T. Kutyla, *Health Coverage Tax Credits Under The Trade Act Of 2002: A Preliminary Analysis Of Program Operation*, prepared by the

Economic and Social Research Institute for the Commonwealth Fund, April 2004.

75 Summers and Mann, op cit.

76 To ensure that insurers retain an incentive to control costs, the state would pay only a portion of claims that exceed a specified per capita level.

77 In terms of drivers without auto insurance, the proportion ranges from 4 percent in Maine to 26 percent in Mississippi. Insurance Research Council, *Uninsured Motorists, 2006 Edition*, June 28, 2006, summarized at http://www.ircweb.org/news/20060628.pdf.

78 Sunstein, C.R. and R.H. Thaler. "Libertarian Paternalism Is Not An Oxymoron," *University of Chicago Law Review*, Fall 2003, Volume 70, Number 4, pp. 1159-1202.

79 Ibid.

80 Dorn and Kenney, op cit., citing the Children's Partnership.

81 S. Bartlett, E. Bobronnikov, and N. Pacheco, et al., *WIC Participant and Program Characteristics 2004*, prepared by Abt Associates, Inc., for Office of Analysis, Nutrition, and Evaluation, U.S. Department of Agriculture, March 2006, WIC-04-PC.

82 Dorn and Kenney, op cit.

83 Farrell, M. et al. *The Relationship of Earnings and Income to Food Stamp Participation,* The Lewin Group and the Cornell Center for Policy Research, for the Economic Research Service of the Food Assistance & Nutrition Research Program, E-FAN-03-011, November 2003.

84 Office of Analysis, Nutrition and Evaluation, U.S. Department of Agriculture, *Analysis Of Verification Summary Data: School Year 2004-2005 (Corrected)*, November 2006.

85 Dorn and Kenney, op cit.

86 Newman, C. *The Income Volatility See-Saw: Implications for School Lunch*, Economic Research Service USDA, August 2006.

87 Dick A.W. et al., op cit.

88 Gregory C. Wilshusen and David A. Powner. "Testimony Before the Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology, Committee on Homeland Security, House of Representatives," *Information Security: Persistent Weaknesses Highlight Need for Further Improvement*, April 19. 2007. GAO-07-751T. For further applications of the GAO's rubric, see GAO, *Information Security: Further Efforts Needed to Address Significant Weaknesses at the Internal Revenue Service*, March 2007, GAO-07-364.

89 Wilshusen, G.C. and Powner, D.A. "Testimony Before the Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology, Committee on Homeland Security, House of Representatives," *Information Security: Persistent Weaknesses Highlight Need for Further Improvement*, April 19. 2007. GAO-07-751T.

90 GAO. *The Challenge Of Data Sharing: Results of a GAO-Sponsored Symposium on Benefit and Loan Programs*. August 2000. GAO-01-67. (GAO Data Sharing)

91 GAO Data Sharing, op cit.

92 Hoofnagle, C.J. *Privacy Self Regulation: A Decade of Disappointment*. Electronic Privacy Information Center. March 4, 2005.

93 Koontz, L.D. and D.A. Powner. Testimony Before the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia; Committee on Homeland Security and Governmental Affairs, U.S. Senate. *Health Information Technology: Early Efforts Initiated but Comprehensive Privacy Approach Needed for National Strategy*. GAO. February 1, 2007. GAO-07-400T.

94 5 U.S. Code Section 552a.

95 Public Law 100-503. See also Office of Management and Budget (OMB) Guidelines (54 Fed. Reg. 25818, June 19, 1989); and Appendix I to OMB Circular No. A-130, 61 Fed. Reg. 6428, February 20, 1996. For an example of an interagency agreement involving states accessing data from federal agencies, see Memoranda of Agreements and Model Agreements for Public Assistance Reporting Information System (PARIS), available at http://www.acf.hhs.gov/programs/paris/agreements/index.html.

96 Letter from Joseph E. Vengrin, HHS Deputy Inspector General for Audit Services, to Leslie V. Norwalk, Esq., CMS Acting Administrator, re: Review of Nevada's Medicaid School-Based Administrative Expenditures for Calendar Years 2003 and 2004 (A-09-05-00054), December 18, 2006.

97 SMDL #06-022.

98 Gyllstrom, M.E., et al. "Linking Birth Certificates with Medicaid Data to Enhance Population Health Assessment: Methodological Issues Addressed." *Journal of Public Health Management and Practice*. July 2002. Vol. 8, No. 4, pp. 38-44.

99 Letter from Sally Richardson, Director, Center for Medicaid State Operations, Health Care Financing Administration, September 10, 1998. 42 CFR 457.320(b)(4).

100 A limitation on SWA data accessible through IEVS is that these data exclude earnings from employers in other states and from federal agencies. More generally, one potential challenge in using IEVS to identify eligible but unenrolled individuals is that some agencies that are the source of income data – notably, IRS – take the view that data sharing is authorized by federal statute only in verifying applicants' income, not in identifying eligible individuals who have not applied for benefits. Accordingly, state officials pursuing data-driven approaches to enrollment may need to pursue one of two strategies: namely, including procedural mechanisms that allow a claim to be made that individuals have notice of the intended use of data and so an application of sorts has been filed (for example, by including language in state W-4 and income tax forms that, unless individuals object, the state will use available data to determine their eligibility for health coverage); and seeking income information from state income tax agencies not bound by federal statute.

101 Newman, C. "Income Volatility Complicates Food Assistance," *Amber Waves*, Vol. 4, Issue 4, USDA Economic Research Service. September 2006, pp. 16-21.

102 Newman, op cit.

103 This number applies only to eligibility determinations based on applications by the parents in which the parents provided information about their income. As noted in the Appendix above, more than 40 percent of free lunches provided by NSLP now are granted based on income information from other means-tested programs (commonly Food Stamps and Temporary Assistance for Needy Families). (USDA, Office of Analysis, Nutrition, and Evaluation, *Accuracy of SFA Processing of School Lunch Applications – Regional Office Review of Applications (RORA) 2006*, April 2007.)

104 Cole, N. and C. Logan, *Data Matching in the National School Lunch Program: 2005*, "Volume 1: Final Report," prepared by Abt Associates Inc. for USDA Food and Nutrition Service, Office of Analysis, Nutrition, and Evaluation, February 2007.

105 Another district-by-district variation is important. Under so-called "Provision 2" and "Provision 3" of NSLP, certain school districts have the option to determine individual family income once every three years. Between those determinations, the district receives an overall level of federal financial support for school meals based on the most recent set of triennial determinations. However, only 6.6 percent of students receiving free meals do so based on Provisions 2 and 3. (USDA Office of Analysis, Nutrition and Evaluation, *Analysis of Verification Summary Data, School Year 2004-2005 (Corrected)*, November 2006. See also Gleason, T. Tasse, K. Jackson et al., *Direct Certification in the National School Lunch Program—Impacts on Program Access and Integrity—Final Report*, Mathematica Policy Research, Inc., and Decision Information Resources, Inc., prepared for the Food Assistance & Nutrition Research Program of the U.S. Department of Agriculture, October 2003, E-FAN-03-009.)

106 Newman, B. Statement for the hearing record, Hearing on the Use of Technology to Improve Public Benefit Programs, House Ways and Means Committee, April 5, 2006.

107 Section 466(a)(17) of the Social Security Act [42 U.S.C. 666 (a)(17)].

108 GAO Data Sharing.

109 USCIS, *Systematic Alien Verification for Entitlements (SAVE) Program* (undated: received from http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=71cf58f91f08e010VgnVCM1000000ecd190aRCRD&vgnextchannel=91919c7755cb9010VgnVCM10000045f3d6a1RCRD on May 10, 2007).

110 Electronic Privacy Information Center. *SAVE System Can't Save Itself From 11-Year History of Inaccuracy, Unreliability*. April 2007.

111 See, e.g., Section 274A(d) of S.2611 (Comprehensive Immigration Reform Act of 2006), which passed the Senate by a 62 – 36 vote in 2006.

112 See http://www.ssa.gov/employer/ssnv.htm.

113 Garrett, B., *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, July 2004.

114 Under this rubric, effectiveness is defined as the percentage of otherwise uninsured workers at a given firm who receive coverage; and efficiency is defined as the percentage of subsidy recipients at that firm who would have been uninsured without subsidies.

115 Similar patterns of uninsurance and income apply to workers at larger companies. At companies with 25-99 workers, 1.7 million employees are uninsured with incomes below 200 percent FPL. Above that income threshold, 1.2 million are uninsured. Those with insurance number 2.2 million below and 10.6 million above 200 percent FPL. At firms with 100 or more workers, the corresponding totals are 4.4 million (uninsured, below 200 percent FPL), 3.1 million (uninsured, above 200 percent FPL), 8.4 million (insured, below 200 percent FPL), 56.7 million (insured, above 200 percent FPL). Clemans Cope and Garrett, unpublished data.