

# **Using SNAP Receipt to Establish, Verify, and Renew Medicaid Eligibility**

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May 2013



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## Summary

States expanding Medicaid eligibility under the Patient Protection and Affordable Care Act (ACA) can substantially expedite Medicaid enrollment and retention for participants in the Supplemental Nutrition Assistance Program (SNAP). In these states, 97 percent of SNAP recipients will qualify for Medicaid. Even where SNAP provides broad-based categorical eligibility that extends gross income limits to at least 185 percent of the federal poverty level (FPL), 94 percent of SNAP recipients will qualify for health coverage. SNAP receipt can thus verify Medicaid applicants' financial eligibility and allow administrative renewal for consumers who receive Medicaid. At the start of 2014, states may be able to quickly provide numerous SNAP recipients with health coverage for which they qualify, enrolling the eligible uninsured while greatly lessening anticipated burdens on social services offices.

## Introduction

Beginning in 2014, ACA §1413 provides that Medicaid programs and other insurance affordability programs must “to the maximum extent practicable establish, verify, and update eligibility... using ... data matching...” and “determine ... eligibility on the basis of reliable, third party data.”<sup>1</sup> The Centers for Medicare and Medicaid Services (CMS) have thus promulgated regulations specifying the following:<sup>2</sup>

- Data matches will verify a Medicaid applicant's attestations of eligibility whenever they are “reasonably compatible” with such attestations. If both data and attestations show income at Medicaid levels, they will be considered reasonably compatible. In such cases, Medicaid eligibility will be established without asking the applicant for documentation.
- At redetermination of an enrollee's Medicaid eligibility, if reliable data show that a beneficiary continues to qualify, Medicaid coverage will be administratively renewed. The beneficiary will be sent a notice indicating the basis for the state's decision and explaining the beneficiary's legal duty to provide any necessary corrections. If the beneficiaries do not respond, their coverage will continue.

This data-driven approach to eligibility determination is an attempt to increase participation levels among eligible consumers, reduce the proportion of program dollars used for administration, and increase the accuracy of eligibility outcomes. CMS has helped states make the transition by giving Medicaid programs 90 percent federal matching funding to support the necessary investment in information technology, along with 75 percent funding for the operational expenses involved in automated eligibility determination.<sup>3</sup>

In this report, we analyze the potential of SNAP records to provide data for verifying financial eligibility for Medicaid. We use the Transfer Income Model, Version 3 (TRIM3), to estimate the overlap between SNAP participation and Medicaid eligibility under the ACA, assuming that states expand eligibility to all citizens and qualified immigrants with modified adjusted gross income (MAGI) up to 138 percent of FPL.<sup>4</sup> We conclude that receipt of SNAP establishes a sufficiently high probability of Medicaid-level incomes to verify attestations of financial eligibility, to permit administrative renewal, and to justify the highly streamlined Medicaid enrollment of numerous SNAP recipients who will qualify for health coverage in 2014.

This report emerged from a body of ongoing research for the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (HHS/ASPE). That

research investigates the integration and coordination of eligibility determination, enrollment, and retention between health and human services programs under the ACA. The authors are grateful for the research support provided by HHS/ASPE for our larger project as well as for the development of TRIM3. In addition, the authors thank the California HealthCare Foundation for supporting this separate report, which builds on but is distinct from the work conducted for ASPE.

## **The relationship between SNAP receipt and Medicaid eligibility under the ACA**

### ***Background information about SNAP***

After Medicaid, SNAP is the nation's largest state- and locally-administered need-based program. Reaching more than 45 million people, benefits are typically limited to individuals with net income—that is, gross income minus applicable disregards—at or below 100 percent FPL. When determining income, SNAP defines households based on family relationship and the common purchase and preparation of food. Income disregards are generally similar to those used by pre-ACA Medicaid, with certain exceptions, such as SNAP's deduction for so-called "excess shelter costs." Under ACA rules, SNAP and Medicaid will find most low-income people to have the same or similar incomes. When the two programs differ, SNAP will typically classify consumers as having higher income.<sup>5</sup>

The amount of monthly SNAP benefits is based on family size and net income; with each \$1 drop in income, benefits rise by approximately 30 cents. SNAP's process for determining eligibility and benefits includes rigorous requirements for verification and regularly updating information, both because of the precise income measurement needed to set benefit levels and to avoid penalties under SNAP's quality control system. As a result, federal officials estimate that only one to two percent of SNAP households are ineligible.<sup>6</sup>

Under the traditional SNAP program, gross income may not exceed 130 percent FPL in households without elderly members or people with disabilities. However, some states have extended gross income limits above this level under rules for "broad-based categorical eligibility" (BBCE). Notwithstanding that extension, 83 percent of SNAP recipients have gross incomes below the poverty level.<sup>7</sup> Even in BBCE states, just 4.8 percent of all SNAP recipients have gross incomes above 130 percent FPL.<sup>8</sup>

Like Medicaid and other federally-funded public benefits, SNAP is limited to U.S. citizens and qualified immigrants. In recent years, SNAP programs have made great strides modernizing program administration. Streamlining enrollment and retention procedures has improved program participation, reduced error rates, and increased efficiency.<sup>9</sup> From 2002 to 2010, the proportion of eligible individuals receiving benefits rose from 54 percent to 75 percent.<sup>10</sup>

SNAP is available to children, parents, and childless adults. Typically, the latter group is subject to strict work requirements that often have the effect of limiting SNAP receipt to three months of benefits within each 36-month period. However, because of high unemployment levels, 46 states are exempt from this special work requirement through the end of the current federal fiscal year (September 30, 2013).<sup>11</sup>

## ***A methodological overview***

Our tabulations come from TRIM3’s microsimulation techniques, which estimate both SNAP recipients and people who will qualify for assistance under the Medicaid program rules that will apply starting on January 1, 2014, in states that expand eligibility under the ACA. TRIM3 is maintained and developed by the Urban Institute, under primary funding from HHS/ASPE.<sup>12</sup>

Our estimates describe the overlaps between Medicaid eligibility under the ACA (assuming expansion in 2014) and SNAP receipt during the average month in calendar years 2009 and 2010, based on the 2010 and 2011 Current Population Survey-Annual Social and Economic Supplement (CPS-ASEC). We consider only people under age 65 who do not receive Medicare. Our simulation of Medicaid eligibility includes only MAGI-based coverage up to 138 percent FPL, Medicaid coverage of recipients of Supplemental Security Income (SSI), and children’s pre-2014 Medicaid eligibility (whether funded through Titles XIX or XXI of the Social Security Act). We thus may underestimate the proportion of Medicaid-eligible consumers among SNAP recipients under age 65 by excluding: (a) Medicare beneficiaries who also qualify for Medicaid;<sup>13</sup> and (b) non-SSI-recipient adults who qualify for pre-ACA Medicaid eligibility above 138 percent FPL. Further, our results rely on self-reported survey information, which is subject to measurement error and requires assumptions to construct SNAP and tax filing units and to impute certain unreported income elements and disregards. In addition, our national estimates do not fully take into account the effect of broad-based categorical eligibility, since a number of states first implemented BBCE in 2010, half-way through the period covered by our underlying survey data, and another four states adopted BBCE policies in 2011 or 2012.<sup>14</sup> To address the latter limitation, we specifically highlight findings about the characteristics of SNAP recipients in the states that were providing such extended SNAP eligibility as of July 1, 2009.

Our results do not identify the health insurance status of Medicaid-eligible SNAP recipients. As we discuss below, some have employer-sponsored insurance (ESI). While ESI does not preclude Medicaid eligibility, Medicaid beneficiaries who retain ESI have their coverage limited to so-called “wrap-around” payment of employer premiums, out-of-pocket cost-sharing, and services outside the employer’s benefits package. Finally, these results do not simulate labor market responses, including ESI changes, to modifications of health policy. More information on the methods used for this report is contained in the methodological appendix.

## ***Our national findings***

At the national level, our key findings are as follows (table 1):

- 97 percent of SNAP recipients will qualify for Medicaid if all states expand eligibility as provided by the ACA.
- In states that, as of July 1, 2009, extended BBCE to gross income levels of at least 185 percent FPL,<sup>15</sup> 94 percent of SNAP recipients will qualify for Medicaid. (Note: this report’s subsequent references to “BBCE/185+ states” are limited to those described in the previous sentence.)
- Medicaid eligibility will be slightly less likely for adult SNAP recipients than for children—95 percent, compared to 98 percent. In BBCE/185+ states, 91 percent of adult SNAP recipients will qualify for Medicaid.

**Table 1. Medicaid eligibility under the ACA among SNAP recipients under age 65 who do not receive Medicare, by age of SNAP recipient and state expansion of broad-based categorical eligibility**

Age of SNAP recipients	States	Total number of SNAP recipients (millions)	Percentage of SNAP recipients who will qualify for Medicaid under ACA expansion
All (0-64)	All	36.9	97%
	BBCE/185+	5.7	94%
Adults (19-64)	All	18.2	95%
	BBCE/185+	2.9	91%
Children (0-18)	All	18.7	98%
	BBCE/185+	2.8	98%

*Source:* TRIM3 analyses conducted in April 2013, using 2010-11 CPS-ASEC. *Note:* Assumes all states expand Medicaid to 138 percent FPL. States categorized here as BBCE/185+ are limited to those that extended eligibility to gross income of at least 185 percent FPL for all households as of July 1, 2009. Totals reflect monthly averages during 2009 and 2010, assuming application of 2014 Medicaid eligibility rules under the ACA and SNAP participation levels in 2009 and 2010. Medicaid eligibility categories are limited to MAGI-based eligibility up to 138 percent FPL, receipt of SSI, and children’s eligibility for Medicaid (whether funded through Title XIX or Title XXI of the Social Security Act) under their state’s pre-2014 rules. Table is limited to individuals under age 65 who do not receive Medicare.

These results are consistent with earlier research by the Center on Budget and Policy Priorities that analyzed SNAP administrative data describing SNAP households who include at least one member who is under age 65 and not receiving SSI.<sup>16</sup> The study found that 75 to 80 percent of such households are *certain* to qualify for Medicaid, based on information already contained in their SNAP case records. The remaining 20 to 25 percent were found *likely* to have members who qualify for Medicaid, but their eligibility could not be established with certainty, based on SNAP administrative data alone. For example, SNAP counts as a single household two unrelated adults who live, shop, and prepare food together, but each adult is considered a separate household for purposes of Medicaid eligibility. To account for the two programs’ different household definitions, the Center’s study classifies this two-adult household as certain to qualify for Medicaid only if the two adults’ combined income falls below the Medicaid eligibility threshold for a household of *one*.

Because our study relies on survey data that goes beyond what is included in SNAP records, we are able to estimate the Medicaid eligibility status for all SNAP recipients. We use detailed income and demographic information available for each household member in the CPS-ASEC to construct appropriate Medicaid households and calculate their MAGI. To continue with the above example, a household that consists of two Medicaid-eligible adults can be identified as such by TRIM3 even if, using SNAP administrative records alone, and applying the business rules described in the Center’s study, the household cannot be classified as certain to qualify for Medicaid, but can only be characterized as likely to be eligible. The survey data and microsimulation techniques underlying the current study also address many (but not all) other situations where eligibility could not be established with certainty based on the administrative data used in the prior study.<sup>17</sup> That said, the estimates presented here are based on survey data and subject to measurement error, whereas the Center’s study uses administrative data from the

SNAP quality control system. The two studies are thus best viewed as complementary companion pieces that reflect the strengths and weaknesses of their respective data sources and that present different types of estimates that support a range of state policy options.

## **Implications for State Medicaid policy**

### ***Using SNAP receipt to verify attestations of financial eligibility***

As noted earlier, an applicant's sworn attestations of Medicaid-level income are verified whenever data matches from reliable sources are "reasonably compatible" with such attestations. Presumably, data showing that an individual Medicaid applicant receives SNAP are more than enough to meet this standard, given our findings about the very high probability of Medicaid eligibility among SNAP recipients.

### ***Using SNAP receipt to trigger administrative renewal***

When a beneficiary's enrollment period is approaching its end, and reliable data show continued eligibility, coverage is renewed administratively. As explained above, the consumer receives a notice explaining the basis of the state's eligibility determination and describing the consumer's legal obligation to make necessary corrections. If the consumer does not make a correction, the coverage continues. The state receives some information from the consumer's inaction, but less than from a sworn attestation on an application form, so it makes sense that the available data must establish a higher probability of eligibility for administrative renewal than for verifying applicant attestations.

States could presumably apply administrative renewal to a beneficiary who receives SNAP, which establishes a 97 percent likelihood of Medicaid eligibility (table 1). This holds true in BBCE/185+ states, where SNAP receipt establishes a 94 percent overall likelihood of Medicaid eligibility (table 1), and where, in each state, the likelihood of Medicaid eligibility reaches at least 93 percent for all SNAP recipients and 89 percent for SNAP adults (table 2).

### ***Using SNAP receipt to facilitate the rapid enrollment of Medicaid-eligible consumers as Medicaid expansion begins***

As the ACA's Medicaid expansion first gets under way in 2014, states may be able to streamline the enrollment of consumers into Medicaid based on their receipt of SNAP. Such initiatives would cover numerous uninsured SNAP recipients who qualify for Medicaid, with little or no manual involvement by social service caseworkers. States pursuing these strategies would seek rapid and significant coverage gains for Medicaid-eligible consumers, while sparing social services offices a potentially overwhelming flood of Medicaid applications.

It is beyond this paper's scope to flesh out such initiatives' parameters. Our primary goal is to describe their great potential, given our findings.

States could take many different approaches to such enrollment efforts.<sup>18</sup> To illustrate how the simple fact of SNAP receipt can help establish financial eligibility for Medicaid, consider a strategy that applies the logic of administrative renewal. A state identifies all SNAP recipients who do not receive Medicaid and sends them notices like those used for administrative renewal. The notices might say, among other things:

- Based on SNAP receipt, the consumer appears financially eligible for Medicaid and so has been identified for possible enrollment into health coverage;

- To be financially eligible for Medicaid, income may not exceed various specified monthly levels, depending on household size;<sup>19</sup>
- The consumer has a legal obligation to inform the state by a specified date if, in fact, household income exceeds Medicaid levels; and
- If the consumer thinks that household income might exceed Medicaid levels, the consumer should immediately contact the state by calling a toll-free number.<sup>20</sup>

If the state fails to hear from the consumer by the specified date, it could presumably find the consumer financially eligible for Medicaid. *Just as the combination of SNAP receipt, state notice, and consumer non-response establishes financial eligibility for Medicaid with administrative renewal, so that identical combination could presumably establish financial eligibility for Medicaid in the context of data-based enrollment.* Of course, before the consumer receives Medicaid, all non-financial requirements must be satisfied as well.<sup>21</sup>

In addition to determining eligibility and structuring enrollment procedures,<sup>22</sup> states providing Medicaid to multiple SNAP recipients may want to consider their approach to employer-sponsored insurance (ESI). Our microsimulation found that 17 percent of Medicaid-eligible SNAP participants receive ESI (results not shown). Potential strategies include the following:

- *A coverage-definition approach* would apply after SNAP recipients qualify for Medicaid but before they receive coverage. During that period, states would work with third-party liability (TPL) contractors to identify which newly enrolling SNAP recipients already have ESI. Those who retain ESI would obtain Medicaid “wrap-around” coverage that supplements the employer plan, rather than full Medicaid.
- *A population-definition approach* would apply when states are identifying the SNAP recipients to be targeted by enrollment efforts. States would work with TPL contractors to exclude ESI enrollees from their target lists. In BBCE/185+ states, this would raise the proportion of Medicaid-eligible people targeted for enrollment from 94 to 95 percent for all SNAP recipients and from 91 to 93 percent for SNAP adults (data not shown).<sup>23</sup> Such exclusion would reduce the odds of “crowding-out” ESI, and it would focus outreach and enrollment efforts on the uninsured, rather than SNAP recipients who already have coverage. Medicaid-eligible consumers with ESI could apply for and receive wrap-around coverage, but they would not be included as targets of an enrollment initiative.

Further work to analyze policy options along these general lines could yield major dividends, given the high proportion of Medicaid-eligible consumers among SNAP recipients and the benefits of quickly and efficiently enrolling them into coverage.

## State estimates

The following table shows our key findings for each state and the District of Columbia.



**Table 2. Among SNAP recipients under age 65 who do not receive Medicare, the percentage who will qualify for Medicaid under the ACA's expanded eligibility, by age and state**

	All SNAP recipients (0-64)	Children (0-18)	Adults (19-64)
TOTAL US	97%	98%	95%
Alabama	99%	100%	99%
Alaska	99%	99%	99%
Arizona*	95%	95%	95%
Arkansas	98%	99%	98%
California	98%	100%	96%
Colorado	97%	98%	96%
Connecticut*	95%	99%	92%
Delaware*	93%	96%	91%
District of Columbia	98%	100%	96%
Florida	93%	93%	92%
Georgia	99%	100%	98%
Hawaii	98%	100%	95%
Idaho	99%	100%	99%
Illinois	97%	98%	96%
Indiana	98%	98%	97%
Iowa	98%	99%	98%
Kansas	98%	99%	96%
Kentucky	99%	100%	99%
Louisiana	99%	100%	99%
Maine	96%	99%	93%
Maryland	96%	100%	93%
Massachusetts	94%	97%	93%
Michigan*	94%	99%	90%
Minnesota	100%	100%	99%
Mississippi	99%	100%	98%
Missouri	98%	99%	96%
Montana*	96%	98%	94%
Nebraska	99%	100%	96%
Nevada*	94%	96%	91%
New Hampshire	97%	100%	94%
New Jersey	97%	97%	96%
New Mexico	98%	100%	97%
New York	96%	97%	95%
North Carolina	97%	100%	95%
North Dakota*	93%	98%	92%
Ohio	98%	99%	98%
Oklahoma	99%	100%	98%
Oregon*	93%	93%	92%
Pennsylvania	96%	98%	95%
Rhode Island*	96%	99%	92%
South Carolina	98%	100%	97%
South Dakota	99%	100%	97%
Tennessee	99%	99%	98%
Texas	95%	97%	94%
Utah	99%	100%	98%
Vermont*	94%	100%	91%
Virginia	98%	99%	97%
Washington*	94%	100%	89%
West Virginia	99%	100%	99%
Wisconsin*	94%	100%	89%
Wyoming	97%	97%	97%

Source: TRIM3 analyses conducted in 2013, using 2010-11 CPS-ASEC. Note: See notes to table 1. States with asterisks extended SNAP via BBCE to gross income levels of at least 185 percent FPL for all households as of July 1, 2009.

## **Conclusion**

The ACA’s data-based eligibility determination, enrollment, and retention approach promises significant gains in participation levels, efficiency, and accuracy. If states use SNAP records to facilitate determinations of financial eligibility for Medicaid, many of these gains could materialize in short order, covering uninsured consumers even as they relieve the daunting burdens that could otherwise face social service offices and caseworkers. This one example of data-driven eligibility represents an exciting down payment on a much broader movement towards twenty-first-century eligibility determination for America’s insurance affordability programs.

## **About the Authors and Acknowledgements**

Stan Dorn and Lisa Dubay are senior fellows and Laura Wheaton and Paul Johnson are senior research associates at the Urban Institute. They are grateful for the assistance of the Urban Institute’s Matthew Buettgens, Linda Giannarelli, and Genevieve Kenney in reviewing earlier drafts of this paper; the aid of Matthew Buettgens and Linda Giannarelli in advising the microsimulation; as well as the work of Scott Forrey, Eva Hrubá, Hannah Schellhase, and Jerry Ta in making this publication available for public distribution on an extremely short time frame. Finally, the authors once again thank the California HealthCare Foundation for sponsoring our work and HHS/ASPE for supporting much of the research that undergirds this paper. None of these individuals or organizations is responsible for the opinions expressed in this report, which are the authors’.

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The California HealthCare Foundation, based in Oakland, California, works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care.

## Methodological Appendix

### *Data year and population*

The tabulations use the spring 2010 and 2011 CPS-ASEC files, with demographic data as of the month of the survey and income data for CY 2009 and CY 2010. Simulations are performed on both years of data and the results are averaged to provide sufficient sample size for state analysis. The data were not “aged” in any way to capture changes in demographics, employment/unemployment, or income since 2010. In particular, note that because the modeling uses 2010 as the base year, it does not reflect growth in the number of recipients receiving SNAP benefits between 2010 and 2013.

### *Determination of MAGI*

TRIM3 models Medicaid eligibility under the ACA according to final regulations promulgated by HHS and the Treasury Department.<sup>24</sup> MAGI includes the income of the taxpayer/spouse plus the income of any dependent who is required to file a tax return, as determined by TRIM3’s Federal Tax simulation. The regulations describe alternate family definitions covering individuals in certain circumstances, such as children living with unmarried parents or claimed as a dependent by a noncustodial parent, and individuals (any age) who do not expect to file a tax return and do not expect to be claimed as a dependent, or who are claimed as a dependent by someone other than a spouse or parent. The simulation models these alternate family definitions as described in the final regulations.

The final regulations also clarify that Medicaid eligibility is based on current monthly income or projected annual income rather than the prior year’s income. To capture this fact, the simulation computes MAGI as a percentage of the poverty guideline on a month-by-month basis, using the monthly income amounts developed for use in all TRIM3 simulations of benefit programs.<sup>25, 26</sup> MAGI includes all the types of income that are counted in AGI for tax purposes—earnings, pensions, asset income, taxable Social Security benefits, Unemployment Insurance, alimony, and capital gains, as well as the non-taxable portion of Social Security benefits. MAGI also includes foreign income and tax-exempt interest, which are not generally included in AGI. To the extent these sources of income are captured in the CPS-ASEC, they are not separately identifiable and are counted as income in the TRIM3 tax and benefit simulations.

### *Determination of Medicaid eligibility under the ACA*

The TRIM3 model is used to simulate eligibility under Medicaid and the Children’s Health Insurance Program (CHIP) assuming that the ACA has been fully implemented, and that all states have expanded Medicaid eligibility to 138 percent of poverty. Eligibility is assessed on a month-by-month basis.

Eligibility is simulated as follows:

1. Adults qualify for Medicaid if they have MAGI at or below 138 percent of the poverty guidelines, or if they have mandatory coverage as SSI recipients.<sup>27</sup> Other pathways are assumed to no longer be available. The simulation assumes no continuous coverage for adults.
2. Children ages 0-18, inclusive, qualify for Medicaid if they have MAGI at or below 138 percent of the poverty guidelines. States that currently (2010) apply continuous enrollment

to children are assumed to apply continuous enrollment to children newly-eligible under the ACA.

3. Children above 138 percent of the poverty guidelines qualify for Medicaid and CHIP if they qualify under their state's pre-ACA rules.

More details are provided below on the assumptions regarding pre-ACA pathways and the modeling of continuous coverage.

To exclude from our Medicaid eligibility estimates children who will qualify for coverage under separate CHIP programs, we applied the FPL thresholds listed for children's Medicaid coverage under both Title XIX and Title XXI programs as listed by the Kaiser Family Foundation's [statehealthfacts.org](http://statehealthfacts.org)<sup>28</sup> to reflect the findings of the Georgetown Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured concerning financial eligibility rules in effect in January 2013.<sup>29</sup> Children with incomes above those thresholds, defined using each state's pre-ACA income disregards and other income methodologies, were excluded from our estimates of Medicaid-eligible children.<sup>30</sup> We then consulted [statehealthfacts.org](http://statehealthfacts.org) to determine that California is the only additional state that has passed legislation that, before 2014, will shift children above 133 percent FPL from a separate CHIP program into a Medicaid program funded through Title XXI.<sup>31</sup> As a result, for California children, we assumed that, in 2014 and later years, children with incomes at or below the FPL threshold of the state's previous separate CHIP program will qualify for Medicaid. Children with incomes above that threshold, determined using the state's pre-ACA CHIP income disregards and other methodologies, were excluded from our estimates of Medicaid-eligible children.

### Assumptions regarding pre-ACA pathways

The simulation assumes that individuals age 19 and older would only have two pathways to Medicaid eligibility—having MAGI under 138 percent of poverty, or having mandatory coverage via SSI receipt.

However, children are modeled as eligible for Medicaid if they are eligible either under the ACA rules or through any prior pathway other than the Medically Needy pathway. This is an approximation of the “maintenance of effort” (MOE) requirements, but not a simulation of those requirements since it is not yet known exactly how states will convert their current pathways to use MAGI income. In other words, the simulation of MOE eligibility for children above 138 percent of poverty uses current (2010) measures of income, not the MAGI-equivalent measure that will actually be used under the ACA.

Note that when determining who among the population with income greater than 138 percent of poverty is covered by the child MOE requirement, we treat *all* persons under 19 who are eligible in 2010 as MOE-eligible under the ACA. This was done even if the 2010 pathway is an “adult” pathway (e.g. a pregnancy pathway, the 1931 parent pathway, and some waiver pathways). Also, persons over 138 percent of poverty who are age 19-20 may be eligible as Ribicoff children, or eligible through their state's optional “percentage-of-poverty” coverage of children (even though they are classified as adults in the tables).

The Medically Needy pathway is not modeled under the assumption that most non-institutionalized people under age 65 previously covered through Medically Needy eligibility would qualify for expanded Medicaid eligibility under the ACA, for subsidized coverage in health insurance marketplaces, or for ESI.<sup>32</sup>

Procedurally, the different treatment of the pre-ACA pathways for adults vs. children was modeled by performing two TRIM3 Medicaid simulations. The primary simulation simulated eligibility under the ACA (including MOE for children) but turned off all pathways through which adults could become eligible except for the 138-percent-poverty and SSI receipt pathways. In a second simulation, all pathways were set to their 2010 levels. If a child was ineligible in the first simulation but eligible in this second simulation through any pathway other than Medically Needy, he or she was considered to be eligible under the ACA (via the ACA's MOE requirement for children). In effect, this second simulation captures those children above 138 percent of poverty who would be eligible under the MOE requirement but only via a pathway that can also be used by adults (primarily the 1931 pathway, but also some state optional coverage of people with disabilities); child-only pathways have the MOE requirement simulated in the primary simulation.

### **Modeling continuous coverage**

As mentioned above, it is assumed that if a state previously allowed continuous coverage for children, that the policy would continue. For example, in states with 12 months of continuous coverage, if there is one month when a child passes the eligibility tests, he or she is counted as eligible for the remainder of the year. In reality, the child would only be covered in these months if he or she actually chose to enroll in Medicaid.<sup>33</sup>

The current policy of extending “continuous eligibility” to pregnant women for the duration of their pregnancy is assumed to not be continued under the ACA (even if the women initially became eligible as a child).<sup>34</sup>

### ***Determination of SNAP eligibility and receipt***

Eligibility and receipt of SNAP were based on TRIM3-simulated eligibility and participation in 2009 and 2010.<sup>35</sup> Eligibility rules and participation levels reflect the year of data being simulated. As noted previously, a number of states adopted BBCE rules during this period. BBCE rules were modeled if they were in effect for a given state as of July 1 of the year being modeled. Eligibility is determined based on the income and characteristics of a group of people within a household, referred to as the filing unit. TRIM3 simulates the nuances of whose income is counted and which persons in the unit are eligible for benefits. For example, in SNAP, lawfully present immigrants aged 18 or older are generally ineligible for assistance in their first five years in the United States, but their lawfully present immigrant or citizen children are eligible. Following SNAP rules, TRIM3 counts a pro-rated share of a lawfully present immigrant's income in determining eligibility for his or her children. In general, the tables for this report categorize a person as eligible for assistance if he or she is personally eligible (not simply in a unit where someone is eligible).

The simulation of SNAP receipt adjusts for the fact that SNAP is under-reported in the CPS-ASEC survey data.<sup>36</sup> The model selects a portion of the SNAP-eligible households who did not report the benefit as being recipients, so that these additional households combined with those who reported the benefit in the survey create a caseload that is very similar to the actual caseload in terms of size and key characteristics.

### ***Determination of whether a person should be categorized as a child in the tables***

This categorization attempted to follow the categorization that applies to most Medicaid eligibility pathways. A “child” was defined strictly in terms of age – anyone under 19 was categorized as a child, regardless of whether that person was married and/or was a parent.

### ***Average monthly eligibility vs. annual eligibility***

Since TRIM determines eligibility on a monthly basis, aggregate eligibility estimates can be calculated on either an average monthly or annual basis. Annual estimates consider a person to be eligible for a particular program if he or she is eligible for that program in a least one month of the year, and no consideration is given to the actual number of months he or she is eligible. For example, the same treatment applies to someone eligible for 12 months as for someone who qualifies for only 1 month. On the other hand, average monthly eligibility estimates adjust for months of eligibility by “pro-rating” each person by the number of months he or she is eligible. Accordingly, in the aggregate eligibility estimate, a person eligible for all 12 months will count 12 times as much as a person eligible for just 1 month.

The eligibility estimates presented in this report are all average monthly estimates, and reflect the overlap in monthly program eligibility. For example, a person who received SNAP for the first half of the year and Medicaid for the last half of the year would not be counted in table cells showing overlap in Medicaid eligibility and SNAP receipt. However, if eligibility for these programs overlapped in one month, then 1/12 of the person’s weight would be counted in the table, and if eligibility overlapped in all months, then the person’s full weight would be counted.

### ***State level estimates***

State-level estimates of Medicaid eligibility may differ from those produced by The Urban Institute Health Policy Center’s American Community Survey (ACS) version of the Health Insurance Policy Model (ACS-HIPSM) model and its CPS version of HIPSM. With respect to the ACS model, the underlying data for ACS-HIPSM is the ACS, not CPS-ASEC. Also, in this paper, eligibility determination for adults did not take into account pre-ACA eligibility rules that allow adults above 138 percent of FPL to qualify in some states. Furthermore, the ACS-HIPSM modifies state rules for adults to reflect adjustments that states have made since the enactment of the ACA and models the proposed disregard policy that ACA will impose in the future. TRIM3 has incorporated all elements of the ACA’s household definitions; HIPSM has not yet done so.

## Notes

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<sup>1</sup> ACA §1413(c)(3)(A).

<sup>2</sup> CMS. “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010.” *Federal Register*, Vol. 77, No. 57, Friday, March 23, 2012, 17144 (Medicaid final rule).

<sup>3</sup> CMS. “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities,” final rule, published in the April 19, 2011 *Federal Register* (76 FR 21950). See also CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0*, May 2011, <http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/exchangemedicaiditguidance.pdf>.

<sup>4</sup> In determining Medicaid eligibility under the ACA, 5 FPL percentage points are subtracted from MAGI. Accordingly, the gross income standard is 138 percent FPL but the net income standard is 133 percent FPL.

<sup>5</sup> Dorothy Rosenbaum and Shelby Gonzales. *A Technical Assessment of SNAP and Medicaid Financial Eligibility Under the Affordable Care Act (ACA)*, Center on Budget and Policy Priorities, March 21, 2013, <http://www.cbpp.org/files/3-21-13health.pdf>.

<sup>6</sup> Rosenbaum and Gonzales, op cit., Appendix 3.

<sup>7</sup> US Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis. *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2011*, by Mark Strayer, Esa Eslami, and Joshua Leftin. Project Officer, Jenny Genser. Alexandria, VA: 2012.

<sup>8</sup> Government Accountability Office. *Supplemental Nutrition Assistance Program: Improved Oversight of State Eligibility Expansions Needed*, GAO-12-670, July 2012, <http://gao.gov/assets/600/593070.pdf>. (GAO Report)

<sup>9</sup> US Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis, *The Evolution of SNAP Modernization Initiatives in Five States* by Lara Hulsey, Kevin Conway, Andrew Gothro, Rebecca Kleinman, Megan Reilly, Scott Cody, and Emily Sama-Miller. Project Officer, Rosemarie Downer. Alexandria, VA: March 2013.

<sup>10</sup> Dorothy Rosenbaum. *SNAP Is Effective and Efficient*, Center on Budget and Policy Priorities, Updated March 11, 2013.

<sup>11</sup> USDA Food and Nutrition Service. *Supplemental Nutrition Assistance Program (SNAP)—Able Bodied Adults Without Dependents Waivers for FY 2013*, March 21, 2012.

<sup>12</sup> TRIM3 requires users to input assumptions and/or interpretations about economic behavior and the rules governing federal programs. Therefore, the conclusions presented here are attributable only to the authors of this report.

<sup>13</sup> Such Medicare beneficiaries fall into two groups: those who receive all Medicaid benefits that are not covered by Medicare (so-called “dual eligibles”); and those who receive Medicaid payment of some or all Medicare premiums and out-of-pocket cost-sharing (beneficiaries of the “Medicare Savings Programs”).

<sup>14</sup> GAO Report.

<sup>15</sup> Some states with BBCE maintain the 130 percent FPL gross income limit. As of July 1, 2009, one BBCE state used a gross income threshold between 130 and 185 percent FPL.

<sup>16</sup> Rosenbaum and Gonzales, op cit.

<sup>17</sup> For example, our approach accounts for the differences between SNAP and Medicaid non-citizen rules, the presence of household members outside the SNAP unit, households with gross income (as defined by SNAP) above 138 percent FPL but MAGI that does not exceed 138 percent FPL, and households that claim the SNAP deduction for payers of child support. Notwithstanding those clarifications, some areas of uncertainty remain—including differences in the definition of self-employment income and issues involving tax dependents outside the household. Our study uses the self-employment income reported in the CPS-ASEC when determining eligibility for SNAP and Medicaid and does not capture tax dependency relationships involving non-household members.

<sup>18</sup> For example, the 75 to 80 percent of SNAP recipients who are certain to be financially eligible for Medicaid, as found by Rosenbaum and Gonzales, can be identified based on information in SNAP records. Accordingly, a state could develop software that queries SNAP records to identify such SNAP recipients and targets them for Medicaid enrollment. That software development would presumably qualify for 90 percent federal funding, as described above.

<sup>19</sup> Monthly income is suggested here, because it may be easier for consumers to grasp than annual income.

<sup>20</sup> A web address with obvious chat capacity could also be a viable option. However accomplished, the capacity for consumers to quickly interact with informed staff could be important for the state to provide. Given the complexity

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of MAGI rules for many households, expert help will often be needed to assess whether household income exceeds Medicaid thresholds, particularly for consumers whose MAGI is near 138 percent FPL.

<sup>21</sup> For example, a state would need to verify citizenship or satisfactory immigration status. In many cases, SNAP will have already verified these requirements, using methods identical to or more rigorous than Medicaid's. If so, Medicaid could rely on SNAP's prior determination. In other cases, Medicaid will need to use its own verification methods. Louisiana's Express Lane Eligibility (ELE) initiative took this approach to providing Medicaid to children based on their receipt of SNAP. While ELE itself was limited primarily to financial eligibility, citizenship and immigration status were often established by SNAP records showing verification methods at least as rigorous as those used by Medicaid. See Stan Dorn, Ian Hill, and Fiona Adams. *Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment Through Express Lane Eligibility*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, revised April 2012. For simplicity's sake, some Medicaid programs may choose to use their own methods with *all* SNAP recipients, rather than sort through the citizenship and immigration status determinations made by SNAP.

<sup>22</sup> As an example of the latter issue, some states may be concerned about how an enrollment effort directed at SNAP recipients would translate into managed care coverage. Many strategies are doubtless possible, but one possible approach is suggested by Massachusetts's 2006 reforms, where consumers automatically qualified for the state's new Commonwealth Care program (CommCare) based on eligibility records of the state's preexisting Free Care Pool. If eligible for premium-free CommCare, they were offered enrollment in a managed care organization (MCO). If they failed to select an MCO within two weeks, they were auto-assigned to a plan and enrolled. Eight months into the new program such "auto-converted" members represented more than 80 percent of CommCare participants. After more than a year, they numbered roughly a quarter of all newly insured state residents. Stan Dorn, Ian Hill, and Sara Hogan. *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, prepared by the Urban Institute for the Robert Wood Johnson Foundation and the State Health Access Reform Evaluation, November 2009.

Here is one of many possible strategies for adapting Massachusetts's approach to the context discussed in this paper. Consumers who are found eligible for Medicaid based on their receipt of SNAP could be given a chance to choose an MCO. If a consumer fails to choose, a plan would be assigned by default. It would then be up to the plan to obtain an indication of enrollee consent, perhaps as a condition of the plan receiving initial or ongoing capitated payments. Such indications might involve consent to plan enrollment, selection of a primary care provider, acceptance of rights and responsibilities, etc. The plan could seek such indications as part of its normal process of welcoming new members. Consumers could communicate these messages to the MCO telephonically, on-line, in writing, or through other modalities.

Such an approach gives consumers an opportunity to take the initiative by selecting a plan. But if a consumer does not take that step, this approach passes the baton to an entity that has both a financial motive and the capacity to secure enrollment. Creating such a back-up system, rather than leaving uninsurance as the default if the consumer fails to act, would increase the likelihood of high participation levels. By delaying plan-initiated enrollment until after an MCO has been selected, this approach would attempt to prevent the kinds of marketing problems that have sometimes been reported with Medicaid managed care plans in the past.

<sup>23</sup> Such a result makes sense, since ESI recipients tend to have higher incomes, all else equal.

<sup>24</sup> The final regulations are posted at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm> (Final Rule 42 CFR Parts 431, 433, 435, and 457 "Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010."). Section 435.603 "Application of modified adjusted gross income (MAGI)," (which begins on page 17,206 of the regulations) describes the alternative family definitions.

<sup>25</sup> In accordance with the final regulations, Medicaid eligibility is also assigned in cases where annual MAGI, as determined for purposes of eligibility for exchange subsidies, is less than 100 percent FPL.

<sup>26</sup> See the discussion, "Modifications to the Underlying Surveys," on the TRIM3 documentation page, <http://trim.urban.org/T3Technical.php>.

<sup>27</sup> SSI recipients are identified by TRIM3's baseline SSI simulations for 2009 and 2010, which augments the survey-reported data to correct for underreporting. Details on TRIM3's SSI model are available on the TRIM3 website's documentation page, <http://trim.urban.org/T3Technical.php>.

<sup>28</sup> <http://statehealthfacts.org/comparereport.jsp?rep=76&cat=4>.

<sup>29</sup> Martha Heberlein, Tricia Brooks, Joan Alker, Samantha Artiga and Jessica Stephens. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013*, Georgetown Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured, January 2013, <http://www.kff.org/medicaid/upload/8401.pdf>.



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<sup>30</sup> Where Title XIX Medicaid and Title XXI Medicaid were listed with different FPL thresholds for children of a particular age, we used the higher threshold.

<sup>31</sup> <http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4>.

<sup>32</sup> Note that in standard TRIM3 Medicaid simulations, individuals who report Medicaid in the survey but who do not appear eligible through any other pathway are assumed to be eligible for Medicaid due to high medical bills. Since this pathway is not used, some children with survey-reported Medicaid will not be simulated as eligible for Medicaid under the ACA if they are not eligible under either ACA rules or another pre-ACA pathway.

<sup>33</sup> To facilitate the analysis, the TRIM simulation was run assuming 100 percent enrollment.

<sup>34</sup> This assumption was incorporated into TRIM's Medicaid simulation via a special (and temporary) version of the simulation code (version 99.73).

<sup>35</sup> A complete description of TRIM3's modeling of SNAP eligibility and receipt is available on [trim.urban.org](http://trim.urban.org).

<sup>36</sup> Wheaton, Laura. 2007. "Underreporting of Means-Tested Transfer Programs in the CPS and SIPP," *2007 Proceedings of the American Statistical Association*, Social Statistics Section [CD-ROM], Alexandria, VA: American Statistical Association: 3622-3629, 2007.