

**Reconciling House and Senate Health Reform Proposals:  
Eligibility, Enrollment, and Retention Policies that Will  
Maximize Health Coverage among the Low-Income  
Uninsured**

Stan Dorn  
Senior Fellow  
The Urban Institute  
Washington, DC

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## Summary

If policymakers want health reform legislation to maximize health coverage among low-income, uninsured Americans who qualify for help, eligibility rules for all subsidies—Medicaid, the Children’s Health Insurance Program (CHIP), and premium and cost-sharing assistance in the exchange—need to make enrollment and retention simple, seamless, and as automatic as possible for consumers.

The eligibility rules and procedures contained in the Patient Protection and Affordable Care Act, passed by the Senate (Senate bill), and the Affordable Health Care for America Act, passed by the House (House bill), include many promising elements. However, neither bill extends to Medicaid the streamlined enrollment procedures that will help consumers receive subsidies in the exchange. With Medicaid accounting for 41 percent of the coverage expansion forecast by the Congressional Budget Office (CBO), a failure of Medicaid to achieve its goals could undermine the overall effectiveness of reform. And with multiple subsidy systems operating under either version of the legislation, consumers could easily fall between the cracks and fail to receive coverage.

To avoid such difficulties, this analysis suggests that health coverage among uninsured Americans who qualify for subsidies could be maximized through a policy that includes the following components:

- **The streamlining provisions contained in Section 1413 of the Senate bill**, which require a single application form and eligibility system for all subsidies under reform (Medicaid, CHIP, and subsidies in the exchange) and which take other steps to base eligibility on government data whenever possible, thereby reducing the need for consumers to complete forms before receiving or retaining coverage;
- **The corrections to that section contained in Senate Amendment 3167**, which apply to Medicaid the same streamlined procedures for eligibility and enrollment that are planned for the exchange; and
- **A compromise between annual eligibility periods in the Senate bill and “real time” eligibility updates in the House bill** that establishes annual subsidy eligibility, as a general rule, while making exceptions for essential mid-year adjustments.

## Background

Millions of uninsured who qualify for help may fail to enroll in subsidized coverage unless reform legislation implements policies that maximize participation among eligible individuals. Even CHIP, which benefited from simplified enrollment and significant public education efforts, reached just 60 percent of eligible children fully five years after the original 1997 legislation became effective,<sup>1</sup> even though the vast majority of parents wanted their children to obtain this coverage.<sup>2</sup>

While a mandate will increase enrollment, it does not guarantee high participation levels. Sherry Glied and colleagues thus concluded that mandates are most likely to be widely followed when several factors are present, including that “compliance is easy.”<sup>3</sup>

In recent years, health coverage expansions that rapidly achieved high participation levels have avoided the need for most consumers to file application forms. Low-income subsidies (LIS) for Medicare Part D, for example, reached 74 percent of eligible seniors less than six months after the program began. Most qualified based on data matches, not application forms.<sup>4</sup> Beneficiaries automatically received LIS if data showed they received Medicaid or SSI the previous year.

Along similar lines, Massachusetts's 2006 reforms used data from the state's uncompensated care pool to qualify for the new Commonwealth Care program roughly 25 percent of all newly insured individuals.<sup>5</sup> And when application forms were required, more than half were filed, not by consumers, but by community-based organizations contracting with the state or by safety-net providers. The state also made enrollment simple and seamless for consumers, even though four separate programs provided coverage or subsidized uncompensated care. These four programs shared a common application form, and eligibility for all programs was determined by a single, statewide office within Medicaid. As a result, consumers did not need to distinguish between subsidy programs; they simply filed an application for assistance and learned about the help for which they qualified. These strategies for eligibility determination and enrollment, along with an individual mandate and generous subsidies for the low-income uninsured, reduced the proportion of state residents without coverage. Less than two years after the state's reforms were first implemented, only 2.6 percent of nonelderly residents were uninsured—the lowest level ever recorded in any state.

For national health reform to reach most of the uninsured, similar streamlined procedures for eligibility determination and enrollment will be required. Such efforts are necessary for any coverage expansion, but they are particularly important with the legislation now before Congress. More than one subsidy system will operate under reform, which can make it easy for uninsured consumers to fall between the cracks. In addition, effective national systems for eligibility determination, enrollment, and retention will be needed for Medicaid and CHIP (if the latter program continues in existence), not just subsidies in the exchange. Under both bills, fully 41 percent of the increased coverage anticipated by CBO will take place through Medicaid and CHIP,<sup>6</sup> so a failure of these programs to accomplish their coverage goals could significantly impair the overall effectiveness of reform.

Medicaid may be at particular risk of enrolling less than its share of the uninsured. Facing serious budget problems and the potential for increased Medicaid costs under reform, states may not have compelling financial incentives to maximize enrollment. And since the individual mandate may not apply to the lowest-income consumers who qualify for Medicaid, cumbersome application and retention procedures could have a particularly pronounced effect inhibiting enrollment by the Medicaid-eligible uninsured.

The remainder of this issue brief explores how these problems could be addressed by building on policy elements present in the Senate and House proposals. The report begins by summarizing key features of both bills.

## **Subsidies offered by proposed legislation**

To place this issue in context, it may be helpful to review some key features of health coverage subsidies offered under the Senate and House bills:

- **Citizenship and immigration status.** Both proposals limit all assistance to citizens and immigrants who are legally present in the United States.
- **Medicaid.** The bills take slightly different approaches.
  - The Senate proposal extends Medicaid to cover all uninsured children and adults with incomes up to 133 percent of the federal poverty level (FPL). Income-eligibility is based on modified gross income (MGI), which is defined in terms of federal income tax information.
  - Under the House bill, Medicaid extends to 150 percent of FPL. For parents and children, income is defined as under the current Medicaid program. For newly eligible childless adults, Executive branch administrative agencies will define income.

- **CHIP.** The bills take very different approaches.
  - The Senate continues CHIP through FY 2019, providing full funding through 2015.
  - The House bill terminates CHIP after FY 2013.
- **Premium and cost-sharing subsidies to purchase coverage in the exchange.** Both bills offer this assistance to income-eligible consumers without affordable access to employer-sponsored insurance. To qualify, consumers must have incomes that are too high for Medicaid and CHIP but do not exceed 400 percent of FPL. Both bills define income-eligibility for such subsidies based on federal income tax principles. The Senate provides subsidies in the form of fully refundable, federal income tax credits, which can be paid in advance to insurers when monthly premiums are due. An agency within the Department of Health and Human Services (HHS) determines eligibility for advance payment, conveying the appropriate findings to the Internal Revenue Service (IRS), which then makes the appropriate payment.
- **Application process for subsidies.** Both bills envision that consumers can apply at the exchange, at their state’s Medicaid program, or (if CHIP continues) through their state’s CHIP program. Important details vary, as explained below.

## Section 1413 of the Senate bill

Section 1413 of the Senate proposal contains many policies that could increase enrollment and retention, including the following:

- As in Massachusetts, a common eligibility system applies to all subsidy programs (Medicaid, CHIP, and subsidies in the exchange):
  - A single application form is used for all programs; and
  - No matter where or how that form is filed, eligibility for all subsidy programs is determined automatically without any need for the applicant to complete additional paperwork. The relevant government agencies work together "behind the scenes" to determine eligibility seamlessly and invisibly to the consumer.
- A consumer can seek subsidized coverage without completing a full application. Each applicant has the option to simply provide identifying information and request a determination of eligibility based on information in government hands, including income tax data.
- Eligibility is established and revised based on data, whenever possible.

These policy elements reinforce other important provisions in the Senate bill that expedite eligibility determination for subsidies in the exchange. Such provisions allow methods for verifying eligibility that increase administrative efficiency and reduce burdens on applicants; limit subsidy applications to “only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction”; and require rules for calculating family size and household income that place “the least burden” on subsidy-eligible individuals who seek coverage.<sup>7</sup>

The House bill does not incorporate similar policies. Under the legislation,

- Each system of assistance—state Medicaid programs and subsidies in the exchange—can have its own, separate application form. There is no requirement that, regardless of where an application is filed, consumers

receive a determination of eligibility for all relevant subsidies.<sup>8</sup> As a result, some uninsured consumers may be forced to navigate through multiple subsidy programs. Those unable to do so successfully could remain without coverage even if they qualify for help.

- No process is established through which a consumer can, in lieu of completing an application form, request a determination of subsidy eligibility based on data in public records. As a result, some consumers will be asked to submit redundant applications providing information the government already has; and as behavioral economics research teaches, requiring applications can reduce program participation.<sup>9</sup>
- Systems for eligibility determination, enrollment, and retention are not required to minimize burdens on consumers or to use data to establish eligibility, whenever possible.

On the other hand, several policies in the House proposal would expedite enrollment:

- The House bill would automatically place consumers into subsidized coverage in the exchange if (a) the consumers do not opt out of such coverage and (b) they either (1) apply and qualify for subsidies but do not select a plan or (2) lost coverage when a plan in the exchange terminated its participation.<sup>10</sup>
- The legislation would establish a process through which eligibility for subsidies in the exchange is “deemed” based on information outside application forms. If such a mechanism were extended to include Medicaid and CHIP, it could usefully complement the Senate bill’s requirement of basing eligibility for all subsidies on data, whenever possible.<sup>11</sup>

In short, by incorporating both Section 1413 from the Senate bill along with the other streamlining provisions contained in both chambers’ proposals, policymakers can go a long way towards helping the legislation achieve its coverage goals.

## **Senate Amendment 3167**

Senate Amendment 3167 to H.R. 3590, offered by Senator Bingaman (D-NM), proposed technical changes to the language of Section 1413, which Senator Bingaman originally sponsored in the Senate Finance Committee. Three of these changes could have a particularly significant effect on enrollment as they would prevent Medicaid’s exclusion from the streamlined eligibility process used by the exchange.

### **No questions on application forms that are irrelevant to eligibility**

The amendment provides that application forms may not request information that is irrelevant to eligibility. This extends to Medicaid and CHIP the limits that other provisions of the Senate bill apply to subsidy applications in the exchange, as described above.

### **Methods for states to claim enhanced federal matching funds without requiring applicants to furnish information that is irrelevant to eligibility**

Consistent with the goal of limiting questions on application forms to the minimum needed for eligibility determination, the amendment specifies that, rather than use application forms to determine the proportion of newly eligible Medicaid adults who qualify for an enhanced Federal Medical Assistance Percentage (FMAP), Medicaid programs would audit a statistically valid sample of enrollees. Similar sampling now determines Medicaid error rates.<sup>12</sup>

Without this amendment, a Medicaid program could use application forms to see whether adults would have qualified for Medicaid in 2009.<sup>13</sup> Reform legislation will let a state claim FMAP far above standard levels for newly eligible adults, but such favorable federal match will be limited to people who would not have qualified for Medicaid under 2009 rules.<sup>14</sup> In most states, such rules required assets of less than a specified value as well as other household characteristics<sup>15</sup> that will no longer be relevant to whether applicants qualify for Medicaid in the future; reform legislation will extend Medicaid to all nonelderly residents whose incomes fall below a specified percentage of the federal poverty level, as noted above.

If application forms request, not just the information required to establish eligibility for Medicaid under reform, but also the information needed to determine whether applicants would have qualified for Medicaid in 2009, fewer households are likely to complete the forms and enroll. Asset tests alone require consumers to compile and present a significant quantity of information,<sup>16</sup> which in turn likely prevents some eligible individuals from receiving coverage.<sup>17</sup>

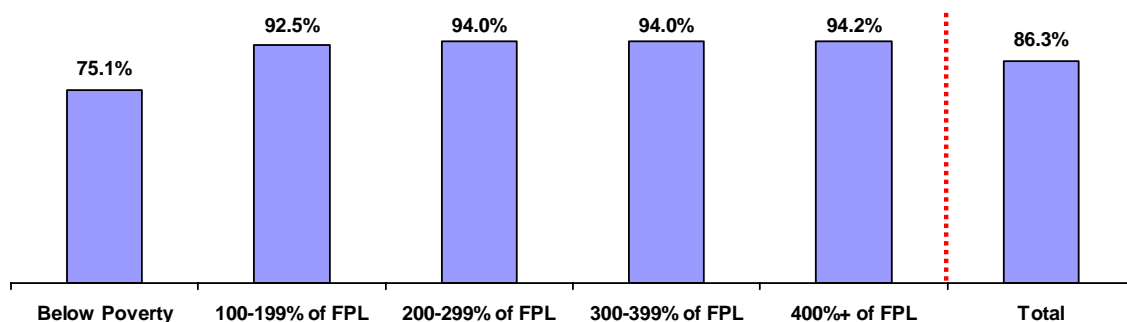
To address this issue, the amendment permits state Medicaid programs to claim enhanced FMAP by auditing statistically valid samples of Medicaid beneficiaries. Under this amendment, eligibility under 2009 Medicaid rules would only be evaluated for sampled beneficiaries, and the evaluation would take place only after they have been found eligible and enrolled into coverage.<sup>18</sup>

Such a policy has precedents, beyond the use of sampling to determine Medicaid error rates. California’s family planning waiver uses sampling to document the proportion of service recipients who qualify for Medicaid match. Further, the HHS Departmental Appeals Board has approved the use of sampling to claim federal match in appropriate cases.<sup>19</sup>

**A common eligibility methodology for all subsidies, with special Medicaid rules operating as a fall-back**

The amendment addresses differences between Medicaid’s eligibility methodology and the methodology used for subsidies in the exchange. With the latter subsidies, both chambers’ bills base income eligibility on a variant of Adjusted Gross Income, defined in terms of federal income tax information, as noted above. More than 6 out of 7 uninsured consumers (86.3 percent) file federal income tax returns.<sup>20</sup> Even among the uninsured with incomes below the federal poverty level, an estimated 75.1 percent are tax filers (Figure 1).<sup>21</sup>

**Figure 1. Among the Uninsured, the Estimated Percentage Who Filed Federal Income Tax Returns, by Income (2004)**



Source: Urban Institute analysis of March 2005 CPS-ASEC and IRS income tax data for tax year 2004.

Notes: FPL refers to the federal poverty level. For methodology, see Stan Dorn, *Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform* (Washington, DC: Urban Institute, 2009); and Stan Dorn, Bowen Garrett, Cynthia Perry, Lisa Clemans-Cope, and Aaron Lucas, *Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and SCHIP* (Washington, DC: Urban Institute).

Accordingly, most uninsured would have their enrollment and retention expedited if the information on income tax returns could establish subsidy eligibility,<sup>22</sup> without requiring the filing of additional application forms. Not only would such data-based eligibility increase participation levels, it could potentially lower administrative costs and reduce the likelihood of eligibility errors.<sup>23</sup> To gain these advantages, both Senate and House bills establish eligibility for subsidies in the exchange based on prior-year income tax returns.

By contrast, Medicaid methodologies, in both bills, prevent tax data from establishing eligibility, even though most uninsured who will qualify for Medicaid file income tax returns. The Senate bill determines income for Medicaid purposes based on household circumstances at the time the application is processed. This has the advantage of allowing immediate eligibility when income drops below prior levels. But it makes enrollment more difficult. Traditionally, Medicaid applicants must document current income by completing forms and providing copies of recent pay stubs or affidavits from employers.

Along similar lines, Medicaid rules about income sources continue to apply, under the Senate bill. This may require, for example, distinguishing between parental income, which is relevant to children's Medicaid eligibility under current law, and step-parent income, which is irrelevant.<sup>24</sup> Income tax records do not contain the information needed to make this distinction.

The House bill takes a broader approach by retaining all current Medicaid methodologies in establishing eligibility for parents and children.<sup>25</sup> In addition to the methodological differences that continue under the Senate bill, the House bill's Medicaid methodologies include income disregards. For example, some households can reduce their countable income, for Medicaid purposes, based on child care payments, which might not appear on tax forms.

Because of Medicaid methodologies that require information not contained in tax data or other easily accessible government records, some households will probably need to establish Medicaid eligibility by filling out application and renewal forms and supplying paper documentation of eligibility.<sup>26</sup> This process is likely to prevent many families from enrolling and retaining coverage, even if they are eligible. In addition, state Medicaid programs will be unable to achieve administrative savings by maximizing the use of data matches to establish eligibility. Instead, traditional, labor-intensive procedures for processing and verifying applications will continue to be needed. Since reform legislation will substantially increase the number of eligibility determinations required of state Medicaid agencies, cutting the average cost of each eligibility determination would be an important step towards easing state administrative burdens.

Amendment 3167 tries to bring Medicaid within the more streamlined system operating in the exchange while retaining the additional coverage provided by Medicaid's distinctive income methodologies. The amendment thus provides that, if eligibility methodologies used in the exchange show that an applicant meets Medicaid's eligibility standards, the individual immediately receives Medicaid, without any further action by either the state or the applicant. Medicaid's unique eligibility methodologies would come into play, however, if the procedures used in the exchange did not qualify an individual for Medicaid. In such a case, the applicant could obtain an immediate redetermination by providing the additional information needed to decide eligibility using Medicaid's unique methodologies. One implication of Amendment 3167 is that a data-driven, national process could qualify people for Medicaid as well as subsidies in the exchange (and CHIP, if the program continues), facilitating both enrollment and retention.

Here is how such an approach could work in practice. If data matches show that someone qualifies for Medicaid, based on the usual rules that apply in the exchange, the person would receive Medicaid. If such matches show that someone qualifies for subsidies in the exchange rather than Medicaid, the person would receive a notice explaining that additional subsidies may be available through Medicaid. The notice would also explain how to seek a redetermination of Medicaid eligibility, indicating that additional information may need to be provided for the state

to determine whether the person qualifies on the basis of Medicaid's unique income methodologies.

The Medicaid statute already takes a similar approach to Express Lane Eligibility (ELE). Established as a state option in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), ELE permits a state to grant Medicaid to children based on another government program's findings, even if Medicaid and the other program use different eligibility methodologies. However, if the other agency's findings do not establish Medicaid eligibility through ELE, the state must notify the family that the child might qualify for more generous coverage if standard Medicaid methods were used to reevaluate the child's eligibility, and the state must apply such methods to qualify the child for Medicaid, if possible.<sup>27</sup>

## **A compromise on eligibility periods for subsidies**

Under both House and Senate bills, initial subsidy eligibility in the exchange is generally determined based on prior-year income tax records, which can greatly facilitate eligibility determination and enrollment, as noted above. However, when household circumstances change after the applicable income tax year, the two proposals vary. The House bill permits consumers to seek and obtain additional subsidies during "special enrollment periods"—for example, after they have experienced a significant drop in income, a change in marital status, or the birth of a child. Further, the bill requires consumers to report significant, mid-year changes in income or other household circumstances, and subsidy eligibility is adjusted accordingly. If consumers fail to report such changes and, at the end of the year, they turn out to have received too much in subsidies, the excess must be repaid in full.<sup>28</sup>

With the Senate bill, by contrast, consumers cannot change the subsidies they receive in the exchange for a full year after they first enroll in subsidized coverage. As noted above, the Senate proposal provides such subsidies in the form of fully refundable federal income tax credits. When a consumer requests advance payment of the credits, subsidies are based on prior-year income tax records, rather than circumstances at the time of application, unless such circumstances have changed significantly. If at the end of the year income tax returns show that advance payments received during the year turned out to be excessive, the consumer must repay the balance.<sup>29</sup> However, for consumers with incomes at or below 400 percent of the federal poverty level, the maximum amount that can be required for repayment is \$400 or \$250, depending on tax filing status.<sup>30</sup>

Each chamber's approach has advantages and disadvantages. Compared to the Senate bill, the House bill's approach achieves important gains in dealing with the income fluctuations that frequently affect low-income households.<sup>31</sup> The House bill increases such households' subsidies when their circumstances worsen significantly, thus preserving the affordability of coverage. This approach also attempts to target resources efficiently by preventing payment of excess subsidies to people whose fortunes have improved. And the House bill remedies the Senate proposal's absence of any mechanism for individuals to reduce their subsidies voluntarily mid-year, thereby avoiding year-end debts to the government.

On the other hand, the House bill's real-time approach to eligibility in the exchange has several disadvantages. First, the House bill's requirement that households must report income changes could cause apparent problems with program integrity. It seems virtually certain that many busy workers will fail to report, for example, that their hours of employment have increased or that a bank account is paying more in interest. With subsidies that change based on almost any shifts in income,<sup>32</sup> audits are likely to show that many enrollees no longer qualify for the subsidies they receive; some will be found to receive too much help, and others too little.

Historically, the National School Lunch Program (NSLP) experienced similar problems. Before 2005, eligibility for free and reduced-price school lunches was based on family income at the start of the school year. Families were required to report income changes after that point, but few did so. As a result, mid-year audits typically showed that many children did not qualify for the assistance they were receiving. This was an important factor leading to high error rates, which undermined NSLP's reputation for program integrity.<sup>33</sup> A similar perception may apply to subsidies under reform if, as in the House bill, subsidy recipients are required to report changes in household circumstances.

Second, because the House bill requires excess subsidies in the exchange to be repaid at the end of the year, without "safe harbor" limits like those in the Senate bill, low-income households may be deterred from applying for subsidies. A similar requirement to repay all excess credits has helped discourage the vast majority of low-wage earners from claiming advance payments under the earned income tax credit (EITC) program. Despite extensive and repeated outreach efforts, no more than 3 percent of EITC recipients claim advance payment, in part because year-end reconciliation can unexpectedly increase tax liability.<sup>34</sup>

In devising final legislation, a hybrid policy that seeks to retain the major advantages of both bills could increase participation by the low-income families who qualify for subsidized coverage. Such a compromise would combine selected elements from current bills with new provisions needed to bridge the gap between the two proposals. To be specific, the final legislation could use annual reconciliation with "safe harbors" to capture most changes in household circumstances, while permitting mid-year subsidy changes in compelling cases. Under this approach—

- If year-end reconciliation shows that someone received excess subsidies in the exchange, he or she would be required to repay the excess, subject to safe-harbor limits, as in the Senate bill.
- As a rule, 12-month eligibility periods, based on available data at the time of application, would apply to all subsidies, including Medicaid and CHIP. However, to reflect changes since the period covered by such data, subsidies could be adjusted mid-year in three cases, which would need to be specified through language added to the current versions of the legislation:
  1. To lessen the need for year-end reconciliation, individuals could voluntarily reduce their exchange subsidies, just as workers can reduce their income tax withholding to avoid owing money to IRS at the end of the year.
  2. If household circumstances worsen, subsidy recipients could seek additional help. Such applications would be granted only if, based on standards developed by HHS and Treasury, the resulting change in subsidies would significantly lower households' premiums or out-of-pocket health care costs.<sup>35</sup>
  3. If reliable, third-party data (such as reports of quarterly income and new hires from state workforce agencies<sup>36</sup> or HHS reports showing that a subsidy recipient enrolled in Medicare) show significant changes in household circumstances, as defined by HHS and Treasury, eligibility would be adjusted automatically.<sup>37</sup>

If lawmakers adopt the Senate bill's approach of using federal income tax credits to subsidize coverage in the exchange, mid-year adjustments to advance payment amounts would be administratively feasible, even though IRS cannot be expected to make real-time income determinations at multiple points throughout the year. The Senate bill already contemplates that

HHS, not IRS, will determine eligibility for advance payment. Further, the current legislation provides that, when consumers apply for advance payment, they may obtain additional help by documenting changes in household circumstances since the most recent year's income tax data. Just as HHS must process such requests, it could determine whether changes following the initial application for advance payment warrant adjusting advance payment amounts. If anything, this approach would reduce IRS administrative burdens, since year-end reconciliation would be less frequent and tend to involve smaller amounts if advance payment amounts were adjusted during the year to reflect changing household circumstances.

## Conclusion

Nitty-gritty questions of eligibility, enrollment, and retention have received little attention in the popular press. But such issues may ultimately play a central role in determining whether reform legislation achieves one of its most basic goals—covering America's low-income uninsured. As House and Senate bills are reconciled, policymakers can build on the best elements of both proposals in developing realistic, effective eligibility systems that, whenever possible, establish eligibility based on data rather than paperwork from consumers. Such an approach could greatly simplify enrollment and retention, thereby increasing the number of eligible uninsured who receive coverage, while potentially reducing eligibility errors and cutting administrative costs.

## Acknowledgements

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## Notes

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<sup>1</sup> Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes in Eligibility and Coverage among Children, 1996–2002," *Health Affairs*, September/October 2004; 23(5): 39–50;

<sup>2</sup> Genevieve M. Kenney, Allison Cook, Lisa Dubay, *Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children?* December 14, 2009, prepared by the Urban Institute for the Robert Wood Johnson Foundation.

<sup>3</sup> Sherry A. Glied, Jacob Hartz, and Genessa Giorgi, "Consider It Done? The Likely Efficacy of Mandates for Health Insurance," *Health Affairs*, November/December 2007; 26(6): 1612–1621.

<sup>4</sup> Data from the Centers for Medicare and Medicaid Services (CMS), June 6, 2006.

<sup>5</sup> Stan Dorn, Ian Hill, 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, November 2009.

<sup>6</sup> Author's calculations from Congressional Budget Office (CBO), *Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment*, December 19, 2009; CBO, H.R. 3962, *Affordable Health Care for America Act*, November 20, 2009. The percentage in the text was derived by dividing the total increase in coverage through Medicaid, CHIP and the exchange by the total increase in coverage estimated for Medicaid and CHIP over the period for which CBO projected a reduction in the number of uninsured. That period began in 2013 and 2014 for the House and Senate bills, respectively.

<sup>7</sup> These three policies are set forth in Section 1411(c)(4)(B), Section 1411(g)(1), and new Internal Revenue Code Section 36B(e)(3), respectively.

<sup>8</sup> The House bill permits the exchange to find applicants eligible for Medicaid, but it is not clear how that will be possible, given the methodological differences between subsidy programs, described below, and the absence of any requirement for a single application form serving both programs. And if both federal authorities and the individual applicant consent, a Medicaid program can determine eligibility for subsidies in the exchange, but the absence of such consent can require an unsuccessful Medicaid applicant to submit a second application to the exchange.

<sup>9</sup> The classic example involves 401(k) retirement savings. If new employees must complete an application form before they join their company's 401(k) plan, roughly a third enroll. If they are placed in the plan without completing an application—that is, if they are signed up unless they complete a form opting out—participation reaches 90 percent. David Laibson, "Impatience and Savings," *National Bureau of Economic Research Reporter*,

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Fall 2005, pp. 6-8.

<sup>10</sup> See Section 305(b)(3).

<sup>11</sup> See Section 341(b)(1).

<sup>12</sup> See Social Security Act Section 1903(u) [42 U.S.C. 1396b(u)].

<sup>13</sup> This issue was raised at an Alliance for Health Reform briefing on December 1, 2009. See Stan Rosenstein, *Enrollment, Simplification, Health Care Reform, and Medicaid*, December 1, 2009, prepared by Health Management Associates, Inc., for the Alliance for Health Reform, <http://www.allhealth.org/briefingmaterials/StanRosenstein-1662.ppt>

<sup>14</sup> The 2009 date is taken from the House bill. Read literally, the Senate bill's language seems to provide enhanced FMAP to anyone who, on the day of health reform's statutory enactment, was either (a) ineligible for Medicaid or (b) eligible for but not enrolled in Medicaid in a state operating a waiver program with a waiting list. See Social Security Act Section 1905(y)(2)(A) (42 U.S.C. 1396d(y)(2)(A)), added by Section 2001(a)(3) of the Senate bill. Presumably, the drafters meant to define the "newly eligible" as people who, given their circumstances when they receive Medicaid coverage in the future, *would have been ineligible* under state law in effect when the legislation was passed, not who *in fact were ineligible on that date*. Under the latter, literal meaning, a state could not claim enhanced FMAP for a 23-year old, poor, childless man in 2017 if, when health reform was signed into law, he was a child who then qualified for Medicaid.

<sup>15</sup> For example, in many states, parents are covered only if their children meet former welfare programs' requirement of "deprivation"—that is, a parent must be absent, incapacitated, or (in some cases) unemployed.

<sup>16</sup> Laura Sumner and Lee Thomas, *How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits*, May 2004, Prepared by the Center on an Aging Society, Georgetown University, for The Commonwealth Fund; The Lewin Group, *Simplifying Medi-Cal Enrollment: Options for the Assets Test*, June 2003, prepared for the California HealthCare Foundation.

<sup>17</sup> One research study found that states without asset tests had higher Medicaid/CHIP enrollment for children, compared to states with asset tests. Karl Kronebusch and Brian Elbel, "Simplifying Children's Medicaid And SCHIP," *Health Affairs*, May/June 2004; 23(3): 233-246.

<sup>18</sup> As with the Medicaid Eligibility Quality Control process, the actual circumstances of sampled families would be analyzed. The audit would thus go beyond the information in the state's eligibility records.

<sup>19</sup> E.g., *New York State Dept. of Social Services*, DAB No. 1134 (1990), cited with approval in *Connecticut Department of Social Services*, DAB No. 1982 (2005). See also *Illinois Department of Public Aid*, DAB No. 1320 (1992); *New York State Department of Social Services*, DAB No. 1216 (1991); *Ohio Department of Human Services*, DAB No. 900 (1987).

<sup>20</sup> Stan Dorn, *Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform*, December 2009, prepared by the Urban Institute for the Pharmaceutical Research and Manufacturers of America. And even for the uninsured who do not file tax returns, employers file income information through quarterly income reports to state workforce agencies and annual W-2 and 1099 forms sent to IRS.

<sup>21</sup> The proportion varies by household type. Among children and parents, filers comprise 85.6 and 85.2 percent of the poor uninsured, respectively. For childless adults, the proportion falls to 67.8 percent. This is consistent with prior research finding that, among individuals who qualify for Earned Income Tax Credits, participation rates are much higher for families with children than with childless adults. General Accounting Office, *Earned Income Tax Credit Participation*, December 14, 2001, GAO-02-290R.

<sup>22</sup> Under the Senate's relatively complex definition of Modified Gross Income, new forms and systems may be needed for data matching. If policymakers simplified the definition of income—for example, to base eligibility on Adjusted Gross Income (without modification) and the number of dependents in the household—current systems may allow a "real time" or "near real time" match of pertinent information from tax records. U.S. Department of Education, *Report to Congress on Efforts to Simplify the Free Application for Federal Student Aid (FAFSA)*, January 16, 2009.

<sup>23</sup> Dorn, op cit.; Government Accountability Office, *Means-tested Programs: Information on Program Access Can Be an Important Management Tool*, March 2005, GAO-05-221

<sup>24</sup> The relevant provision of the Senate bill is somewhat ambiguous. As another possible meaning, new paragraph (14)(H) of Social Security Act Section 1902(e), added by Section 2002(a) of the legislation, could incorporate Medicaid rules that determine whether income is truly "available," hence countable for eligibility determination purposes.

<sup>25</sup> With nontraditional Medicaid populations, federal officials are instructed to develop appropriate methodologies.

<sup>26</sup> If the final legislation retains the Senate provision authorizing the determination of children's eligibility based on Express Lane Eligibility, children in states that elect this option can qualify for Medicaid and CHIP based on state income tax records or income determinations made by other government agencies. Social Security Act Section 1902(e)(14)(D)(ii) [42 U.S.C. 1396a(e)(14)(D)(ii)], added by Section 2002(a) of the Senate bill.

<sup>27</sup> Social Security Act 1902(e)(13)(A)(i)(I) and (II), added by Section 203(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

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<sup>28</sup> Under some circumstances, additional penalties apply.

<sup>29</sup> If additional subsidies are owed to the taxpayer, they are claimed on the year-end return.

<sup>30</sup> These amounts are indexed after 2014.

<sup>31</sup> Constance Newman, “Income Volatility Complicates Food Assistance,” *Amber Waves*, ERS/USDA, September 2006; 4(4):16-21.

<sup>32</sup> Because premium amounts vary directly with income, each change in income, no matter how small, changes the amount of applicable subsidies. This will be true even if the same percentage of income cap applies to premium payments throughout an income band, as for households between 300 and 400 percent FPL under the Senate bill, for whom premiums are capped at 9.8 percent of income. If income rises within that band, the dollar amount equaling 9.8 percent of income also rises.

<sup>33</sup> In the Child Nutrition and WIC Reauthorization Act of 2004, NSLP eligibility was reformed so that changes in household circumstances during the year no longer affected eligibility for free or reduced-price lunches. As characterized by the U.S. Department of Agriculture, “this change has eliminated errors related to income volatility.” Katherine Ralston, Constance Newman, Annette Clauson, Joanne Guthrie, and Jean Buzby, *The National School Lunch Program: Background, Trends, and Issues*, Economic Research Report Number 61, July 2008.

<sup>34</sup> The other major factor is a preference for lump-sum payments. Government Accountability Office, *Advance Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS’s Efforts to Reduce High Noncompliance*, August 2007, GAO-07-1110; Joanna Stamatiades and James Cook, GAO, Eric Larson, Internal Revenue Service, *Demographic and Noncompliance Study of the Advance EITC (AEITC)*, Presented at the 2008 IRS Research Conference, June 11, 2008.

<sup>35</sup> Alternatively, lawmakers could incorporate the House bill’s definition of “special enrollment periods,” which is a more open-ended grant of authority to HHS. See Section 305(b)(2)(B).

<sup>36</sup> Such reports would pick up a large proportion of changes in low-income households’ income, since most such changes result from fluctuating hours of employment and wage levels. Newman, op cit. This mechanism would be particularly effective if all health programs—Medicaid, CHIP, and subsidies in the exchange—gained access to the National Directory of New Hires, which combines employment records from all states and the federal government. See, e.g., Government Accountability Office, “Questions from Chairman Wally Herger to Dr. Sigurd Nilsen,” in *The Unemployment Compensation Aspects of the U.S. Department of Labor FY2007 Budget*, Hearing before the Subcommittee on Human Resources, House Ways and Means Committee, May 4, 2006; Frank J. Murphy, *HUD’s Results on Eliminating Improper Payments*, June 15, 2009; Office of the Chief Financial Officer and Employment and Training Administration, U.S. Department of Labor, *Unemployment Insurance National Directory of New Hires Pilot Report*, September 21, 2005.

<sup>37</sup> Under standard Due Process principles, beneficiaries may need to receive notice of such changes along with an opportunity to make corrections and file administrative appeals.