EXECUTIVE SUMMARY

Open enrollment in 2014 exceeded expectations for consumer participation. Even at this early stage, the Patient Protection and Affordable Care Act (ACA) has significantly reduced the number of uninsured. Nevertheless, numerous consumers remain without coverage despite eligibility for Medicaid or subsidies to lower the cost of qualified health plans (QHPs) offered in health insurance marketplaces. Several features of the marketplace enrollment process made it difficult for many eligible uninsured to receive coverage, in both state-administered systems and marketplaces run by the federal government:

- **Disconnection between marketplaces and Medicaid.** In many states, uninsured consumers who apply to marketplaces and are classified as eligible for Medicaid must wait months for coverage after their applications are forwarded to state Medicaid agencies for further processing. One survey found that, as of late May, 2.9 million people were stuck in such backlogs. More recent reports indicate that such problems are persisting, albeit at a reduced magnitude, and they could spike again with marketplace enrollment opening again on November 15.

- **Procedural challenges facing special populations.** Immigrants, people with limited English proficiency and nontraditional households often faced technical obstacles to enrollment. Barriers described by application assistants in numerous states included Web site eligibility rules that incorrectly sorted low-income immigrants between Medicaid and QHP subsidies, an identity-proofing system that relied on the kind of credit history that many immigrants and low-income consumers lack, a failure to make marketplace information linguistically accessible to non-English speakers, and Web site business rules that assume traditional family structure (e.g., that minor children live with their parents).

- **Difficulty with plan selection.** In geographic areas with numerous QHP options, consumers sometimes found it so difficult to pick a plan that QHP selection could take twice as long as the entire subsidy application process, according to application assistants in multiple states. Many uninsured were unfamiliar with basic insurance concepts. Few if any Web sites provided reliable information about QHP provider networks.

To address these challenges, some states have implemented effective practices that warrant consideration by policy-makers in other states. Those practices, along with other promising strategies not used during the first

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in case study states. Reports that have been prepared as part of this ongoing project can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org). The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation’s work on coverage, visit [www.rwjf.org/coverage](http://www.rwjf.org/coverage).
year of open enrollment, are described for each of the three barriers identified above:

**To prevent Medicaid backlogs**

- **New York and Kentucky** each use a single eligibility system for all insurance affordability programs. Administering their marketplaces through public agencies, these states each operated a single system that gave most applicants real-time eligibility determinations that sorted each family member into the applicable program, whether Medicaid, CHIP or QHP subsidies.

- **Washington** uses the Medicaid agency’s computerized system to make eligibility decisions within the marketplace’s eligibility service. Using a quasi-public agency to administer its marketplace, Washington has Medicaid’s computerized system make a final eligibility determination for Medicaid based on attestations and data matches, whenever possible. As in New York and Kentucky, most eligible applicants qualify while they are still online at the marketplace.

- **States can operate freestanding computerized systems for Medicaid eligibility determination** that reduce the need to manually process applications coming from the marketplace. Even before the ACA, Oklahoma used such a system to automate verification for half of Medicaid applications. Now, under the ACA, data from federal and state sources could similarly verify many applicants’ sworn attestations of current income at Medicaid levels. Automated verification based on records showing such things as prior-year income, participation in the Supplemental Nutrition Assistance Program, and quarterly wages could greatly reduce the need for manual processing, preventing large Medicaid backlogs.

**To help disadvantaged populations overcome technical barriers to enrollment**

- **Application assisters** in multiple states have helped consumers overcome such barriers. By providing extra application assistance resources to disadvantaged communities, states could give more consumers the benefit of such expert aid.

- **States could address particular barriers.** As suggested by application assisters, state-based marketplaces (SBMs) and federally facilitated marketplaces (FFMs) could modify eligibility rules for immigrants, add methods for identity proofing that incorporate the observations of certified navigators and brokers, and prioritize the translation of forms and notices that require an appropriate response to prevent a denial or termination of coverage.

- **SBMs could partner with community-based organizations** to analyze obstacles and develop solutions that take into account the circumstances disadvantaged populations face. Such collaboration could both promote effective policy and build community buy-in.

- **State Medicaid and CHIP programs** have analyzed samples of applications that were incomplete or rejected for procedural reasons, learning where consumers got stuck and which procedural requirements led to denials. Similar efforts by SBMs and FFMs could identify underlying policies and practices that hinder enrollment under the ACA.

**To make QHP choices manageable for consumers**

- **California and Connecticut** focus default plan views on the options likely to be of greatest interest to consumers, even though consumers can opt to see other plans. Plans shown by default to subsidy-eligible consumers are at the silver level and in the coverage category requested by the consumer (e.g., single adult coverage). The default view automatically shows the effect of subsidies on premiums, deductibles and other out-of-pocket costs, including when consumers are browsing anonymously.

- **California, Connecticut, Maryland, Michigan, New York and Oregon** also standardize QHP designs within each metal tier. This has avoided the confusion that was sometimes observed in other states when, within a single tier, numerous plan options were offered with small, relatively inconsequential differences that few consumers readily understood.
INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) created two insurance affordability programs to help the low- and moderate-income uninsured obtain coverage:

- Expanded Medicaid eligibility to serve adults with incomes up to 138 percent of the federal poverty level (FPL), which the Supreme Court changed into a state option; and
- A combination of premium tax credits and cost-sharing reductions to subsidize the purchase of private, qualified health plans (QHPs) in health insurance marketplaces. Subsidies are available to consumers who
  - are ineligible for Medicare, Medicaid and the Children's Health Insurance Program (CHIP);
  - are not offered employer-sponsored insurance the ACA classifies as adequate and affordable; and
  - have incomes between 100 and 400 percent of FPL. In states with expanded Medicaid eligibility, the lower income bound rises to 138 percent of FPL for most consumers.¹

The end of the ACA's first open enrollment period has seen participation in marketplace coverage that was greater than expected² and a significant drop in the number of uninsured, particularly in states that expanded Medicaid.³ However, many eligible uninsured have not yet enrolled. Based on the country’s experience with CHIP, years may be needed to accomplish the ACA's enrollment goals as states learn from each other's successes and failures, eventually migrating toward a general consensus about effective practice.⁴

This paper seeks to inform that long-term process while helping state policy-makers and stakeholders refine their plans for the open enrollment period that runs from mid-November through mid-February. State decisions not to expand Medicaid eligibility to 138 percent of FPL have received considerable analysis elsewhere and are not the subject of discussion here. Our focus is on enrollment that takes place through the marketplaces, including through marketplace Web sites, whether consumers wind up in QHPs, Medicaid or CHIP. Here, we analyze what happens to consumers once they arrive at a marketplace, using whatever application assistance their marketplace makes available. An accompanying report examines marketplace decisions about public education and application assistance, which can have an equally important effect on enrollment levels.

This report begins by analyzing some of the most important obstacles to participation that emerged in the procedures that were used during open enrollment season for 2014. That analysis relies on two primary sources of information:

- Health Reform Monitoring Survey (HRMS) results from the first two quarters of 2014. The HRMS is a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation and the Urban Institute. For further information, see http://hrms.urban.org/.
- State-level interviews with policy-makers, consumer advocacy groups, navigators, application assisters and insurance brokers and agents. Based on semistructured interview protocols, researchers from the Urban Institute and, in some cases, Georgetown University’s Health Policy Institute and the Institute for Health Policy Solutions spoke with stakeholders in 22 states with state-based or partnership marketplaces, as well as two states with federally facilitated marketplaces (namely, Alabama and Virginia).

After analyzing obstacles to participation, the report describes promising practices implemented by particular states as well as other potential options for overcoming those obstacles.

ENROLLMENT PROCEDURES THAT OBSTRUCTED PARTICIPATION

Barriers that inhibit enrollment vary by state and population group. Here, the paper focuses on obstacles in three categories that, based on interviews, appeared particularly significant in many states, including those with state-based marketplaces (SBMs) and federally facilitated marketplaces (FFMs): disrupted linkages between marketplaces and Medicaid programs, procedural problems experienced by disadvantaged groups, and challenges in plan selection.
Disconnection between marketplaces and Medicaid

In many states, significant problems emerged when uninsured consumers who applied for coverage through a marketplace and were classified as eligible for Medicaid had their applications forwarded to the Medicaid program for further processing. Many consumers waited months before hearing from Medicaid. When word came, Medicaid often requested information that consumers had already provided to the marketplace. Sometimes Medicaid caseworkers used pre-ACA verification methods, denying coverage unless consumers furnished pay stubs or other documentation without first assessing whether available data was reasonably compatible with attestations of financial eligibility. A number of interviewees believed that such procedural obstacles may have prevented some eligible uninsured consumers from receiving coverage.

To assess this problem’s magnitude, Congressional Quarterly Roll Call surveyed Medicaid programs in all 50 states and the District of Columbia. The 41 responding states reported that at least 2.9 million pending Medicaid applications had not yet been processed as of late May 2014. The states with the largest backlogs were California (900,000 applications), Illinois (330,000), North Carolina (at least 298,840), Ohio (212,090), Virginia (183,643), Georgia (at least 159,313), Michigan (at least 123,381) and South Carolina (at least 113,429). Backlogs have diminished since May but have not disappeared, and they could once again grow during 2015 open enrollment unless connections between marketplaces and Medicaid programs improve.

In states with FFMs, these backlogs resulted, in part, from the limited ability of federal Web sites to transfer full electronic case files to state Medicaid programs. However, a number of SBMs—including those in California, Colorado, Maryland and Minnesota—also experienced significant disconnections and backlogs.

This problem has both legal and technological roots. Under Centers for Medicare and Medicaid Services (CMS) regulations, an SBM run by a quasi-public agency or non-profit corporation must let its state Medicaid program make the final determination of Medicaid eligibility. Further, most states with FFMs have the marketplace make preliminary rather than final determinations of Medicaid eligibility. This means the marketplaces forward applications to state Medicaid agencies for further analysis and conclusive findings of whether consumers qualify.

In states that use outdated information technology (IT) for Medicaid eligibility purposes, the handoff from the marketplace to Medicaid can involve computer systems from different generations that do not communicate with each other. As a result, Medicaid staff may need to manually input information from the marketplace, ask consumers for information they have already given the marketplace, or take other time-consuming steps to complete eligibility determination.

It is striking that the four states with the largest backlogs all determine Medicaid eligibility at the county rather than the state level. This adds an additional layer of intergovernmental relationships that must be successfully managed for low-income consumers to receive coverage.

Procedural challenges for disadvantaged populations

Interviewees in most states reported particularly troublesome technical barriers to enrollment for immigrants, people with limited English proficiency, and people with complex family situations. Marketplace enrollment systems did not appear designed with such consumers in mind. For example:

- Applicants’ identities were verified via the Federal Data Services Hub using Experian, one of the country’s major credit agencies. This made it hard to verify identities for low- and moderate-income consumers who lacked significant credit history, including many immigrants. Their applications were often stymied at the very start. Skilled application assisters could frequently overcome these obstacles through manual work-arounds, but many disadvantaged consumers did not receive such help.

- In some states that expanded Medicaid eligibility, FFMs and SBMs would automatically classify lawfully present immigrants with incomes at or below 138 percent of FPL as Medicaid-eligible. In fact, because of restrictions enacted as part of federal welfare reform legislation, federal Medicaid match is denied to many lawfully resident immigrants, such as non-pregnant, nondisabled adults whose lawful status was granted within the past five years. Such adults are eligible for QHP subsidies, not Medicaid. Fixing these errors was a high priority for application assisters and community groups, as the wrongful receipt of Medicaid, even if caused by an innocent mistake, can endanger an immigrant’s ability to remain in the U.S.
Linguistic access posed a problem in many states. Web sites were typically unavailable in languages other than English and Spanish. In some states, informants reported that Spanish versions of Web sites were poorly translated. Moreover, forms and notices were often written in English only, even if they were essential to enrollment. For example, such notices might inform an applicant that coverage would be denied unless the applicant provided certain information to the marketplace. Consumers who did not understand those notices and did not take the requested steps could remain uninsured, even if they qualified for insurance affordability programs (IAPs).

Applicants with complex or unusual family situations were sometimes ill-served by program business rules. For example, those rules in many states assumed that children under age 18 lived with their parents. In some cases, this made it difficult to enroll homeless children and foster children.

### Difficulty choosing a QHP

Many application assisters reported that after qualifying for QHP subsidies, consumers in areas with numerous options often found it difficult to select a plan. It was not unusual for QHP selection to take twice as long as completing the IAP application process, according to interviewees in multiple states.

Plan selection was further complicated by many consumers’ unfamiliarity with such basic financial health insurance terms as “premiums,” “deductibles,” and “coinsurance,” as well as such basic nonfinancial terms as “provider network” and “covered services.” Before the start of open enrollment, HRMS data confirmed this lack of knowledge. They showed, for example, that simple financial vocabulary words for health insurance were confidently understood by only 36 percent of white uninsured, 15 percent of Hispanic uninsured, and 26 percent of other uninsured consumers.

The difficulty of understanding plan descriptions that use these terms was amplified by the multiplicity of plan choices in much of the country. According to the U.S. Department of Health and Human Services, consumers in the average rating area must choose from among 47 QHPs offered by five carriers. Often, our interviewees reported that consumers were stymied when presented with numerous options within a single metal tier without meaningful plan variations between those choices.

Web site displays of plan information sometimes worsened plan selection challenges. Some consumers could not eliminate irrelevant plan views. For example, in one state, applicants seeking single adult coverage could not remove listings of plans that offered child-only coverage (although they could ask to have such plans listed last). In almost every state, assisters reported that consumers could not obtain comprehensive, current information about QHP provider networks from the marketplace Web site. Instead, they had to go to plan Web sites, and even there often could not distinguish between providers included in insurers’ pre-ACA networks and those participating in new QHP networks.

### OVERCOMING THESE OBSTACLES TO PARTICIPATION

#### Disconnection between marketplaces and Medicaid

New York and Kentucky avoided significant Medicaid backlogs and delays. In each of these states, one state agency administers both Medicaid and the state’s marketplace. Each state used a single eligibility system for all IAPs. Online applicants’ eligibility for Medicaid, CHIP and QHP subsidies was usually determined in real time—that is, while applicants were still online. New York and Kentucky thus avoided the kind of backlogs and bifurcated enrollment consumers faced in other states. However, FFM states and states with SBMs that are not run by state agencies may have difficulty using a single eligibility system for all IAPs.

Like Kentucky and New York, Washington state largely avoided backlogs and delays. However, unlike Kentucky and New York, Washington uses a quasi-public entity to administer the marketplace. As a result, the marketplace cannot make the final determination of Medicaid eligibility. Washington’s Medicaid program built a rules engine—a computer-operated system to make eligibility decisions. The rules engine automatically qualifies consumers for Medicaid whenever, based on the state’s business rules, data matches have sufficiently verified applicant attestations to establish eligibility. In Washington, Medicaid lends its rules engine to the shared eligibility service that evaluates IAP applications in the marketplace. As a result, if the rules engine finds an applicant eligible for Medicaid, such
Some FFM states have decreased Medicaid backlogs by using marketplaces to make a final determination of Medicaid eligibility rather than a preliminary assessment, followed by a referral to the state Medicaid agency, which makes the final decision. However, approaches to tightening the connection between FFMs and state Medicaid programs need to account for state concerns about the quality of federal eligibility data. For example, some states report that, for financial eligibility, they may receive from the FFM nothing more than the applicant’s attestations and selected elements from federal income tax returns, which the state may not consider sufficiently recent and detailed to provide satisfactory verification. Numerous Medicaid programs have thus resorted to manual verification, causing backlogs and increased administrative costs. Eventually, an approach like Washington’s may be possible with FFMs, where a state’s Medicaid rules engine operates inside a federally managed eligibility service, providing final determinations of Medicaid eligibility to applicants in real time. This strategy is not currently feasible, however, given other pressing IT issues facing FFMs.

In the meantime, states could consider developing Medicaid rules engines to process applications received from marketplaces, replacing manual eligibility determinations with data-based determinations whenever possible. Oklahoma’s pre-ACA experience illustrates the potential offered by this approach. Beginning in September 2010—years before the ACA’s new procedural requirements went into effect—Oklahoma’s Medicaid program was already encouraging applicants to apply online. Oklahoma used a rules engine with data matches to replace manual verification for approximately 50 percent of applicants.

Under the ACA’s new approach, Medicaid rules engines could specify the circumstances under which the previous year’s tax return and the applicant’s sworn attestations about current monthly income, under penalty of perjury, combine to establish eligibility without any need for further application processing. Such an engine would also define the circumstances under which (1) information received from the FFM is not sufficient to verify eligibility and specific state data sources are “ pinged” to obtain additional information; and (2) the combination of state and federal data provides sufficient verification of sworn attestations to qualify an applicant. For adults in states that have expanded Medicaid eligibility and for children in all states, the following examples illustrate the kinds of data that, under a state’s business rules, could automatically verify sworn attestations of current monthly income at Medicaid levels:

- During January through August, data from prior-year tax returns showing modified adjusted gross income (MAGI) at or below 138 percent of FPL. Such income establishes an 85 percent likelihood of current monthly income at Medicaid levels in January through April and an 80 percent likelihood in May through August.
- During September through December, a combination of (1) prior-year tax returns showing MAGI at or below 138 percent of FPL and (2) state quarterly wage records from earlier in the current year showing earnings at or below 80 percent of FPL. That combination establishes an 85 percent likelihood of current monthly income at Medicaid levels.
- Data showing the current receipt of benefits from means-tested human services programs. For example, among beneficiaries of the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families, 95 percent have MAGI at or below 138 percent of FPL. The same is true of 86 percent of recipients of housing subsidies, 78 percent of participants in the low-income home energy assistance program, and 75 percent of individuals in families receiving child care subsidies. CMS has made clear that, even without an attestation of income at Medicaid levels, SNAP receipt can establish Medicaid eligibility in the context of targeted enrollment efforts, which a number of states have already used to substantially increase Medicaid take-up. Combining the receipt of SNAP or other means-tested benefits with attestations of income at Medicaid eligibility levels could potentially be used more broadly to expedite Medicaid enrollment and prevent backlogs in FFM states and elsewhere.

This strategy’s greatest effect on backlogs would result from using automated rules engines to verify eligibility. However, as an initial transition phase, states can achieve useful progress without full automation. For example, granting Medicaid caseworkers rights to look up information in an applicant’s human services case file to supplement information received from the marketplace or Federal Data Services Hub can reduce the need for further manual verification. To illustrate, Alabama implemented Express Lane Eligibility (ELE) to automatically qualify children for
Medicaid based on SNAP and TANF data. In its initial approach to ELE, the state had caseworkers look up SNAP and TANF records, after which Alabama transitioned to automated data matching. The initial look-up approach achieved administrative savings, although the automated system yielded greater gains.22

**Addressing challenges that face disadvantaged populations**

Interviewees in multiple states reported that skilled application assisters provided intensive support, sometimes including translation or interpretation services, to help immigrants, people in complex or nontraditional households, and people with limited English proficiency overcome the barriers described above. If marketplaces target additional application assistance resources to such populations, more people could benefit from expert help. However, our informants also suggested several approaches that SBMs or FFMs could use to lower barriers themselves:

- To reduce the burdens experienced by immigrant applicants, eligibility rules that automate the treatment of immigrants with incomes at or below 138 percent of FPL could incorporate the immigration status characteristics that distinguish Medicaid from QHP-subsidy eligibility. This will require some customization to reflect state variations, such as the extent to which particular states have implemented available options to qualify children and pregnant women for CHIP and Medicaid based on lawful presence in the U.S. without satisfying such additional requirements as residence for at least five years.

- Marketplace procedures could add methods of verifying identity that do not depend on credit history. Such methods could incorporate the observations of certified navigators, brokers and other assisters when they work with applicants in person.

- Marketplace administrators understand that their Web sites need to be translated into languages other than English and Spanish that are spoken by significant numbers of low- and moderate-income residents. However, an equally urgent if not more pressing priority involves translating forms and notices that, without an appropriate response, can prevent eligible consumers from enrolling in coverage.

Going beyond individual barriers, two additional steps could address a range of problems. First, many informants strongly urged SBM leaders to engage seriously with community-based organizations that, during prior open enrollment periods, worked closely with immigrants and low-income households. Such organizations can provide useful information about the specific glitches that created problems, analyze proposed solutions to identify potentially unrealistic expectations about the circumstances facing disadvantaged populations, and jointly develop effective strategies to overcome key challenges. Such engagement can also increase community groups’ buy-in and enhance their commitment to helping the marketplace achieve its participation goals.

Second, SBMs and FFMs could carefully examine application procedures to answer two questions:

1. At what points during the application process did consumers frequently give up and abandon their applications?

2. What were the main procedural defects that led to the rejection of IAP applications without the marketplace being able to determine applicants’ actual eligibility for assistance?

For current purposes, it does not matter whether a marketplace has the data systems required for quantified, reliable answers to these two questions. Officials can simply collect samples from two sets of applications—those that were abandoned before completion, and those that were rejected for procedural reasons. Officials are likely to see the places where applicants frequently gave up and the common reasons for procedural denial. In most cases, officials will be able to identify the policies and practices that were probably responsible for those trends and decide whether to modify them. In the past, similar efforts have helped Medicaid and CHIP programs identify and overcome procedural obstacles that needlessly inhibited enrollment of eligible consumers.

**Facilitating QHP choice**

California and Connecticut took two steps that made it much easier for consumers to choose between available QHP options. First, marketplace Web sites in both states showed subsidy-eligible consumers default views that were limited to silver plans offering the type of coverage requested by the consumer, displaying the effect of subsidies on premiums, deductibles and other out-of-pocket costs. Such displays were even shown to anonymous browsers, whose subsidy eligibility was calculated based on their rough, unverified income estimates. Consumers could opt to see other available plans, but the initial, default view made decisions more
manageable by showing the relatively small number of options that were likely to be most relevant.

Second, plan design was standardized within each metal tier. Maryland, Michigan, New York and Oregon also took this approach. As a result, consumers were not asked to compare multiple insurance products with minor differences that were bewilderingly hard to assess. Behavioral economics research suggests that such simplification can make it easier for most people to understand available options and decide which choice best fits their needs. Our interviewees confirmed that, as a practical matter, most consumers in these states did not have difficulty with plan selection—a very different report than we received in other states.

SBMs and partnership marketplaces could pursue a more modest standardization strategy that requires insurers to meet a high threshold for proving that plan variations within a single tier offer significantly different choices. For example, carriers could offer (1) closed-panel HMOs; and (2) preferred provider organizations that provide access, with different cost-sharing amounts, to both network and non-network providers.

Carriers could likewise offer plans that offer significantly different trade-offs between (1) up-front cost-sharing via deductibles and copayment or coinsurance levels; and (2) back-end cost-sharing via out-of-pocket cost-sharing maximums, to the extent allowed by the statute. Plan options offering less significantly different tradeoffs would not be allowed under this approach.

CONCLUSION

With insurance affordability programs having started in January 2014, the ACA’s main coverage expansion has just begun. Based on the country’s prior experience with the successful CHIP program, it will take years before the ACA’s new systems operate smoothly and effectively in the majority of states. Achieving such progress will require careful, patient attention to enrollment obstacles. A number of states offer promising examples suggesting how such obstacles can be overcome. Other states and the federal government can build on these examples, improving the enrollment process for 2015 and beyond.

Eliminating insignificant plan variations within metal tiers would prevent a kind of carrier “gaming” that has emerged as a problem in some states, where insurers offer numerous plans that only vary slightly from one another. If a consumer asks to see available silver-level plans ranked based on premium cost, all the plans shown on the first browser screen—or even the first several screens—can be sponsored by a single carrier, even if only a few dollars separate the price of those plans from those of other carriers. As a practical matter, consumers wind up choosing from among a single insurer’s plans without seeing significant differences between the options presented to them. This can inhibit rather than facilitate robust competition between insurers and meaningful consumer choice.

As policy-makers consider narrowing the range of options within each metal tier, it is important to remember that such steps will not take away consumers’ choices among plans offered in different metal tiers. Choices in different tiers necessarily involve substantially different plan designs. Another approach being explored in a number of states involves developing tools that help consumers sort through available choices and make good decisions. Time will be required to evaluate the effectiveness of such tools with marketplaces’ key target audiences and to compare these strategies with approaches that make choices more manageable by reducing their number. Ultimately, many states may wind up balancing both general strategies, combining some limits on plan options with improved decision supports for consumers.
1. In states that expand Medicaid, the lower threshold of financial eligibility for QHP subsidies generally rises to 138 percent of FPL, because consumers with incomes at or below that level qualify for Medicaid, with one exception. Certain lawfully present noncitizens are ineligible for Medicaid because of their immigration status and so qualify for QHP subsidies, notwithstanding income below the ordinarily applicable lower income threshold for such subsidies.


7. 42 CFR 431.10(c)(2) requires eligibility decisions to be made by “a government agency which maintains personnel standards on a merit basis.”

8. In the income range for QHP subsidy eligibility (138 to 400 percent of FPL), only 55 percent of white adults (including both insured and uninsured), 36 percent of Hispanics and 43 percent of other adults were confident in their understanding of all simple financial health insurance terms. Long S and Goin D. “Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach.” Washington, DC: Urban Institute, 2014, http://hrms.urban.org/briefs/literacy-by-race.html.


11. Janet Varon, Northwest Health Law Advocates, personal communication, 2014. In cases where the rules engine does not definitively establish Medicaid eligibility, the Medicaid program conducts further work to determine eligibility.


13. In all but 17 states, Medicaid eligibility for children extends above 138 percent of FPL, defined in terms of modified adjusted gross income. CMS. State Medicaid and CHIP Income Eligibility Standards (For MAGI Groups, based on state decisions as of April 1, 2014).

14. States are not required to verify sworn attestations of financial eligibility. The only eligibility requirements that require verification involve citizenship and immigration status. If verification is required by state policy choice or federal law, ACA regulations require verification by data matches whenever available data are “reasonably compatible” with attestations.


16. Both this finding and that in the previous bullet are based on longitudinal data following consumers over time. Those data show, among consumers whose income during the prior calendar year was at specified levels, the percentage whose income during specified months of the current calendar year was at below 138 percent of FPL; and among those with prior-year income at certain levels and wages during the first months of the current year at specified levels, the percentage whose income during the final months of the current year was at or below 138 percent of FPL. For technical reasons related to the survey data, wage information from four rather than three months was used as a proxy for quarterly wage records. Dorn S, Buettgens M, Moody H and Hildebrand C. Using Past Income Data to Verify Current Medicaid Eligibility. Washington, DC: Urban Institute, 2013, http://www.urban.org/UploadedPDF/412920-Using-Past-Income-Data-to-Verify-Current-Medicaid-Eligibility.pdf.

One issue regarding SNAP is important to address. Ordinarily, SNAP eligibility is limited to households with gross incomes (as calculated by SNAP) at or below 130 percent of FPL. However, some states have implemented broad-based categorical eligibility that extends SNAP to recipients of noncash TANF services with gross incomes up to 185 percent of FPL or higher. In the latter states, 91 percent of adults receiving SNAP have MAGI at or below 138 percent of FPL; this percentage never dips below 89 percent for any state. If an adult in one of the latter states attests, under penalty of perjury, to income at Medicaid levels, and the state Medicaid program verifies that the adult has an open SNAP case, state policy-makers could potentially find that information sufficient to verify the attestation, given these high percentages.


20. Within six weeks (by November 15, 2013), the four states that first implemented these strategies—Arkansas, Illinois, Oregon and West Virginia—had enrolled approximately 63,000, 36,000, 70,000 and 54,000 people, respectively. Guyer J, Schwartz T and Artiga S, Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion, Manatt Health Solutions and the Kaiser Commission on Medicaid and the Uninsured, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf. Since the initial implementation of these targeted enrollment strategies, the number enrolled has increased. For example, Oregon reached more than 123,000 people by February 6, 2014. “Legislature Aimed at Improving Access to Cover Oregon, IT Oversight Bills.” Cascade Business News, Feb 18, 2014, http://www.cascadebusnews.com/newspages/e-headlines/4982-legislature-aimed-at-improving-access-to-cover-oregon-it-oversight-bills.

21. States have typically used human services case records to verify attestations about particular types of income. CMS has not formally approved using the final income findings of human services programs that are reflected in their eligibility determinations as verifications of MAGI attestations by applicants for Medicaid and CHIP, but indications are promising for states to pursue this approach.
