December 2021

Health Care's Fragmented Eligibility Systems: What Happens When Uninsured Families Enter Through the Wrong Door?

Rebecca Gordon, Policy Project Coordinator, Families USA

Stan Dorn. Director of the National Center for Coverage Innovation and Senior Fellow, Families USA

THE NATIONAL CENTER FOR COVERAGE INNOVATION | AT FAMILIESUSA

Executive summary

"No wrong door" eligibility is a key feature of the Affordable Care Act's (ACA) statutory design. Whether people seek health coverage from a marketplace, a Medicaid program, or the Children's Health Insurance Program (CHIP), they are supposed to be enrolled immediately into the coverage for which they qualify, even if that coverage is sponsored by a different agency than the one to which they applied.

This statutory requirement has been fulfilled in the District of Columbia and 11 states,[†] all of which operate their own marketplaces and use integrated eligibility systems that serve all health programs. The remaining 39 states use eligibility systems that, despite the ACA's command, are fragmented, at least to some degree. Thirty-two of them operate especially fragmented "assessment and file transfer" systems.[‡] In such states, when someone who qualifies for one program applies to a different program, the latter is forbidden from determining eligibility. The agency receiving the application can only assess eligibility, then transfer the applicant's file to the other program. The applicant must remain uninsured until the second agency finishes processing the application and makes a formal decision. **Prior research found that the ACA's coverage gains for parents were more than a third lower and for children were nearly 50% lower in states that operated assessment and file transfer systems, compared with people in other states.**

To learn more about what happens when families apply at the "wrong" agency and have their applications moved to a second agency before they can get health coverage, Families USA interviewed consumer assistance programs in 16 states with assessment and file transfer systems. We found serious and widespread problems with eligibility and enrollment systems, which appeared to violate applicable regulations and to prevent many eligible families from obtaining coverage.

These problems stem ultimately from the Obama administration's decision to permit fragmented eligibility systems as an accommodation to states that were wrestling with the challenges of making the many eligibility changes required for ACA implementation before 2014. Federal

[†] These states are California, Colorado, Connecticut, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont and Washington.

[‡] These states are Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah and Wisconsin. In the remaining seven states (Alabama, Alaska, Louisiana, Montana, Virginia, West Virginia and Wyoming), the federally facilitated marketplace determines Medicaid and CHIP eligibility when people seek coverage at the marketplace.

officials recognized the risks that would be posed by fragmented eligibility, so the administration included specific guardrails in 2012 regulations to limit these risks. When a family applies at one agency and is assessed as likely to qualify for coverage administered by a different agency, those guardrails require the family's file to be transferred to the second agency, which is required to determine eligibility promptly, without requesting a second application or any other information the family already provided the first agency.

Nearly a decade after these regulations were finalized, they have proven ineffective in protecting families from onerous paperwork requirements, delays, and confusion that obstruct enrollment. Based on our interviews with assistance programs that work directly with consumers, we found the following:

- **In 15 of the 16 states, consumer assistance programs reported that the paperwork burdens, confusion, and delays resulting from fragmented eligibility systems prevented eligible applicants from obtaining coverage.** The greatest harm was observed in families with limited English proficiency.
- In nine of the 16 states, consumer assistance groups saw no evidence of uninsured families having their files transferred to the marketplace after they applied to Medicaid or CHIP and were found potentially eligible for marketplace coverage.
- In 12 of the 16 states, consumers who applied to Medicaid or CHIP and were found potentially eligible for marketplace coverage were required to re-file the same application with the marketplace. In five states, families who applied at the marketplace and had their files transferred to Medicaid were required to complete and file the same application with the latter program, imposing needless paperwork requirements and delays that impeded enrollment.
- In 10 of the 16 states, consumers who applied at the marketplace, answered detailed questions and provided documentary proof of eligibility were required to answer those same questions and provide the same documents to Medicaid after their application was forwarded there. In eight states, families who sought coverage from Medicaid or CHIP and had their applications sent to the marketplace had to meet similar demands for redundant information provision.

Nearly a decade after these regulations were finalized, they have proven ineffective in protecting families from onerous paperwork requirements, delays, and confusion that obstruct enrollment.

A troubling example of the problems that can result when eligibility determination is bifurcated between government agencies comes from Texas, where the Medicaid program's computer system mistakenly classified children as adults in files transferred from the marketplace. In Texas, eligibility for children extends above 200% of the federal poverty level but ends for parents at 19% of the federal poverty level. Almost certainly, the vast majority of eligible children listed in these files were wrongly denied Medicaid or CHIP. This problem began in 2014 but was not discovered until 2019, and the consumer assistance program we interviewed was not confident the problem had been corrected by Spring 2021. It is impossible to know how many Medicaid-eligible Texas children have been denied health coverage as a result of this interagency disconnect.

To understand the demographic characteristics of people most at risk from fragmented eligibility systems, we analyzed U.S. Census Bureau data for states with assessment and file transfer systems. We found that African American children, Latino children and other children of color are in particularly great danger. While children of color are only 14% of these states' nonelderly residents, they comprise fully 32% of all Medicaid-eligible residents without health coverage — the group that is at risk of failing to receive coverage when their families seek help at the marketplace.

To fix the fragmentation that is preventing numerous eligible families from obtaining affordable health coverage, we urge the Biden administration to update agency rules and procedures to fully implement the ACA's "no wrong door" requirements. Such implementation has two major components:

1. ***In each state, establish a clear pathway toward using a single eligibility system or service to determine eligibility for all health programs.*** Achieving this goal will take time and considerable effort. Focused federal technical assistance will be key, and states will need to take advantage of enhanced federal funding for information technology development.
    - As an essential first step, federal officials should require the three state marketplaces that began operations in 2021[§] to integrate their eligibility systems with Medicaid and CHIP.
2. ***Ensure that the agencies with which applications are filed determine eligibility for all health programs, including those sponsored by other agencies.***
    - As an essential first step, the federal healthcare.gov platform should determine eligibility for Medicaid and CHIP whenever applicants, regardless of their state of residence, have incomes too low for marketplace financial assistance.

[§] These states are Nevada, New Jersey and Pennsylvania.

Introduction

Most uninsured families in America qualify for health coverage but are not enrolled.[1] One important contributing factor involves administrative barriers that make it harder for people to join health programs for which they qualify. In this report, we examine the role played by federal and state policy decisions about "no wrong door" eligibility under the Affordable Care Act (ACA). Relevant ACA provisions, analyzed in detail below, promise that, wherever uninsured people apply for coverage — whether at the Medicaid agency, the CHIP agency or the marketplace — they will quickly be enrolled in the program for which they qualify, even if that program is run by a different agency from the one that received the application. The "no wrong door" policy's core premise was that families seeking health coverage should not be forced to go from agency to agency until they find the program that fits their circumstances.

Eleven states and the District of Columbia run their own marketplaces and have realized the ACA's full specifications for a single system that determines eligibility for all programs, regardless of where an uninsured person applies.[2] In the other states, someone who qualifies for one program and applies to another is frequently unable to receive an immediate eligibility determination, followed by enrollment. Instead, the application can get transferred from one agency to the next. In such cases, the applicant remains uninsured until the second agency determines eligibility after completing its processing of the application, which sometimes includes requests for the applicant to provide additional paperwork.

This report examines the impact of such fragmentation on struggling families. Through interviews with consumer assistance programs in 16 states where highly fragmented systems determined eligibility for health coverage, we found that families were shuttled between programs, experienced lengthy delays and confusion, and were required to file redundant paperwork that prevented many eligible people from obtaining health coverage. We also analyzed U.S. Census Bureau data, finding that children of color were the single group whose coverage was placed most at risk by eligibility fragmentation. We conclude by calling on the Biden administration to take specific steps to fully implement the ACA's "no wrong door" requirements.

Most uninsured families in America qualify for health coverage but are not enrolled. One important contributing factor involves administrative barriers that make it harder for people to join health programs for which they qualify.

Background

Federal legal framework

ACA sections 1413 and 2201 set out clear specifications for "no wrong door" enrollment into insurance affordability programs (IAPs) like Medicaid, CHIP, and advance premium tax credits (APTCs) and cost-sharing reductions that help people buy coverage in health insurance marketplaces. Regardless of where an uninsured person applies, filing of a single, streamlined form is supposed to result in a determination of eligibility for the applicable IAP, after which the consumer is enrolled in the program for which the consumer qualifies.

The ACA's "no wrong door" statutes articulate three requirements:

1. In each state, all IAPs must use a single, common system for determining eligibility. This includes both a common application form and a shared electronic system or service for verifying and determining eligibility, based on, whenever possible, data matches with reliable information sources rather than applicant completion of paperwork.[3]
2. If an agency administering one IAP receives an application from someone who qualifies for a different IAP, the agency receiving the application must ensure that the applicant is found eligible for the other program and enrolled without delay.[4]
3. After someone files an application form, that person may not be asked for additional information or paperwork unless it is essential to determining eligibility.[5]

During the Obama administration, the federal Centers for Medicare & Medicaid Services addressed the ACA's "no wrong door" provisions by issuing proposed[6] and final[7] rules in 2011 and 2012, respectively.

The proposed rule met several of the above statutory requirements, including the requirement that marketplaces must determine eligibility for Medicaid and CHIP when they receive an application from someone who qualifies for those programs.[8] However, the proposed rule eliminated the requirement for all IAPs serving residents of an individual state to use a single electronic system or service to determine eligibility. Instead, multiple IAPs serving a single state's residents were allowed to use different electronic systems and services to determine eligibility. In a further departure from statute, Medicaid and CHIP programs were barred from determining APTC eligibility when an APTC-eligible individual applied through Medicaid or CHIP. Instead, Medicaid and CHIP agencies were directed to transfer the applicant's file electronically to the marketplace, which was forbidden from requiring a new application or seeking information that the individual had already given Medicaid or CHIP.

The hopes of past administration officials remain largely unfulfilled, nearly a decade after the final rule's promulgation. As a result, many families have been prevented from obtaining health coverage for which they qualify.

The final rule further weakened the proposed rule's implementation of "no wrong door." States were allowed to decide between two options. Each state could either be:

- A "determination and enrollment" state,[9] where the marketplace would determine Medicaid and CHIP eligibility, as in the proposed rule, after which applicants would promptly receive coverage; or
- An "assessment and file transfer" state, where the marketplace would merely "assess" potential Medicaid and CHIP eligibility for people with incomes too low for APTCs and transfer applicants' case files to the Medicaid agency electronically for further processing.

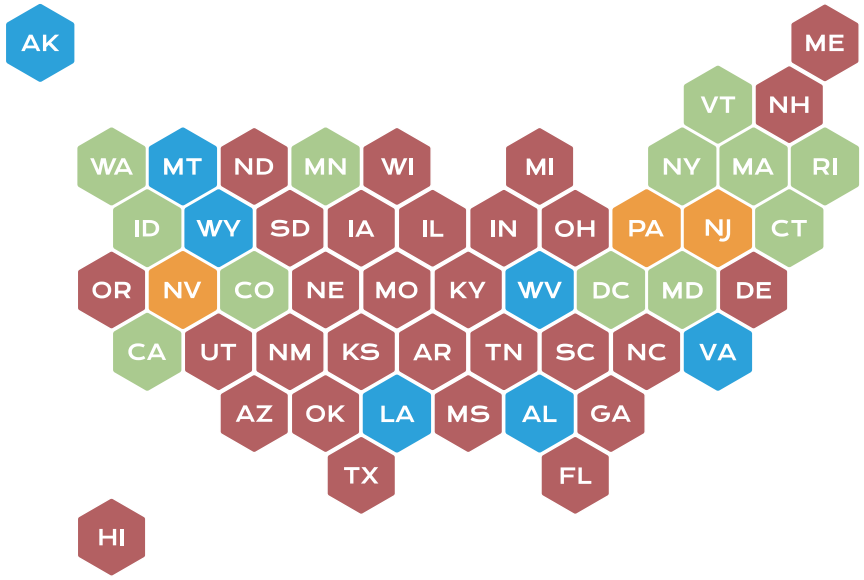
In explaining the final rule, administration officials acknowledged that "it would be ideal to have a single eligibility system because that will negate the need to transfer electronic accounts." Nevertheless, they stated that, if a state elected the assessment and transfer option, it would be "subject to the same goals and parameters around ensuring a streamlined consumer experience," so "there should not be duplicative applications, there should not be duplicative requests … for information from the same beneficiary … and there should not be delays in applications."[10] As will become evident below, these hopes remain largely unfulfilled, nearly a decade after the final rule's promulgation. As a result, many families have been prevented from obtaining health coverage for which they qualify.

State policy choices

Fourteen states and the District of Columbia operate their own marketplaces this year.[11] Except for the most recent state-based marketplaces to come online in Nevada, New Jersey and Pennsylvania, each state-based marketplace has an integrated eligibility system that serves all IAPs.[12] The three newest state-based marketplaces assess rather than determine Medicaid and CHIP eligibility, transferring files to Medicaid or CHIP for further processing.

The remaining 36 states use the federal healthcare.gov enrollment platform. Out of those 36 states, 29 have assessment and file transfer systems.[13] Only seven use determination and enrollment systems (Figure 1, page 7).[14]

Figure 1. Eligibility determination in states and the District Columbia, by degree of fragmentation: January 2021



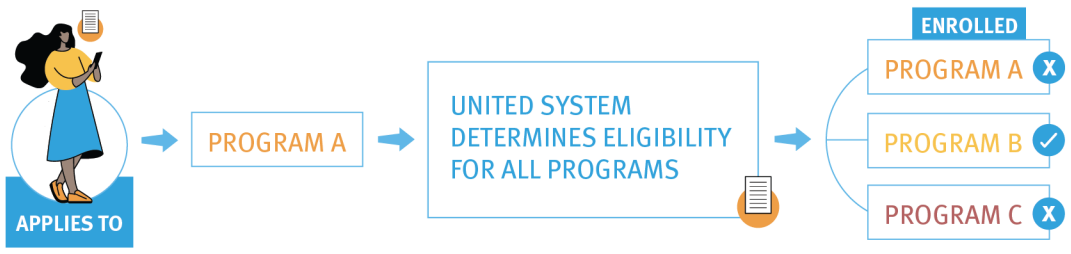
- Assessment and file transfer states that use healthcare.gov
- Determination and enrollment states that use healthcare.gov
- Assessment and file transfer states that operate their own marketplaces
- State-based marketplaces with largely integrated eligibility determination

What Happens When Someone Applies for Health Coverage?

Amber is uninsured. She applies to program A, seeking health care, but it turns out that she qualifies for program B. Her fate depends on her state.

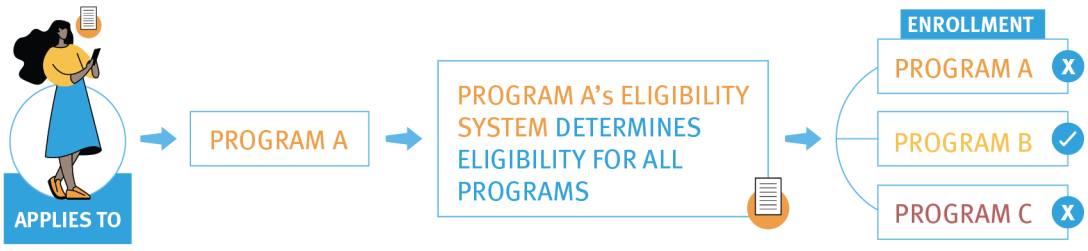
IF AMBER LIVES IN A STATE WITH A UNIFIED ELIGIBILITY SYSTEM OR SERVICE:

Regardless of where she applies, the same eligibility system or service determines her eligibility, enrolling her in the program for which she qualifies. *Amber is covered.*



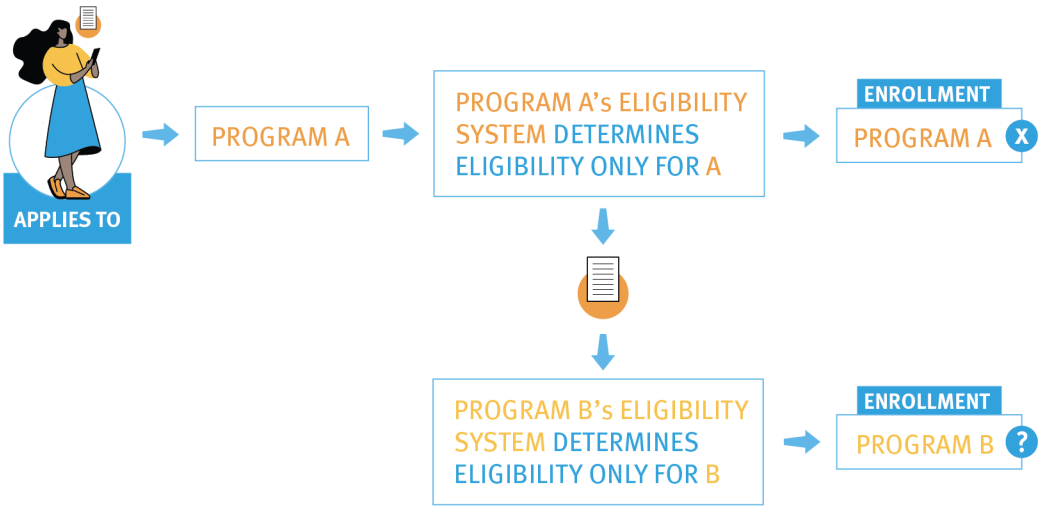
IF AMBER LIVES IN A DETERMINATION AND ENROLLMENT STATE:

Amber can apply to one health program and automatically be enrolled into any program for which she qualifies. Even though health programs have separate eligibility systems, one program's system can determine eligibility for other programs and enroll applicants into the program for which they qualify.* *Amber is covered.*



IF AMBER LIVES IN AN ASSESSMENT AND FILE TRANSFER STATE:

Amber applies to a health program and is denied. That program is not allowed to determine her eligibility for other programs. Instead, the program to which she applies merely "assesses" her as potentially qualifying for a different program, sending Amber's application and file to the other program. Amber must wait to hear whether the other program finds her eligible, and will need to provide it with any additional paperwork it requests. In the meantime, *Amber remains uncovered.*

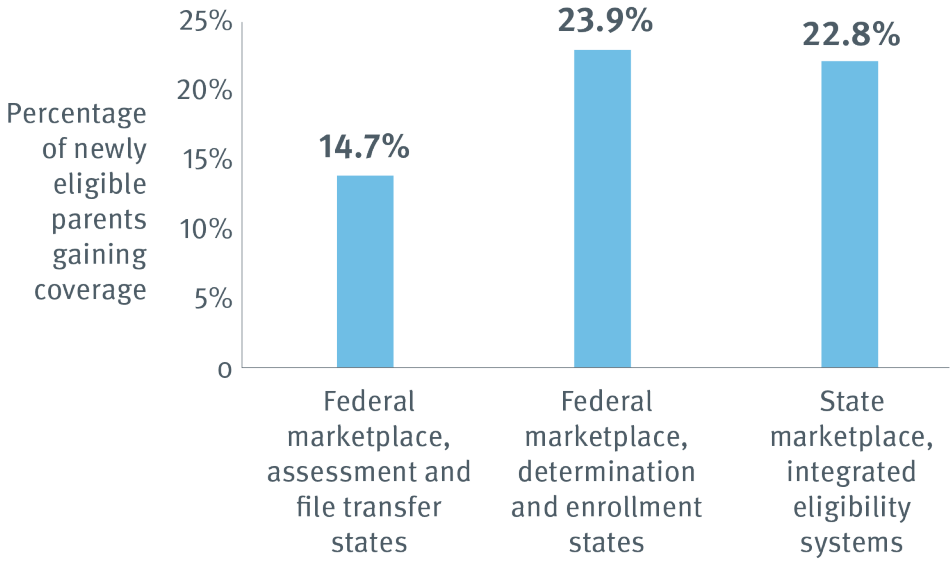


* Determination and enrollment processes apply only when someone seeks coverage at the marketplace and qualifies for Medicaid or CHIP.

Prior research

Published evidence shows that fragmented eligibility systems prevent many eligible people from receiving health coverage. One study[15] examined parents who newly qualified for Medicaid under the ACA. From 2013 (the year before the ACA's Medicaid expansion became effective) to 2015 (the year after it took effect), Medicaid enrollment among newly eligible parents was more than a third lower in states where the federal marketplace operated assessment and file transfer systems than in states where the marketplace (whether state or federal) determined Medicaid and CHIP eligibility. For example, in states served by the federal marketplace, 23.9% of newly eligible parents gained coverage in states with determination and enrollment systems, compared with 14.7% in states with assessment and file transfer systems (Figure 2).

Figure 2. Increased Medicaid coverage for newly eligible parents, by marketplace category: Changes from 2013 to 2015



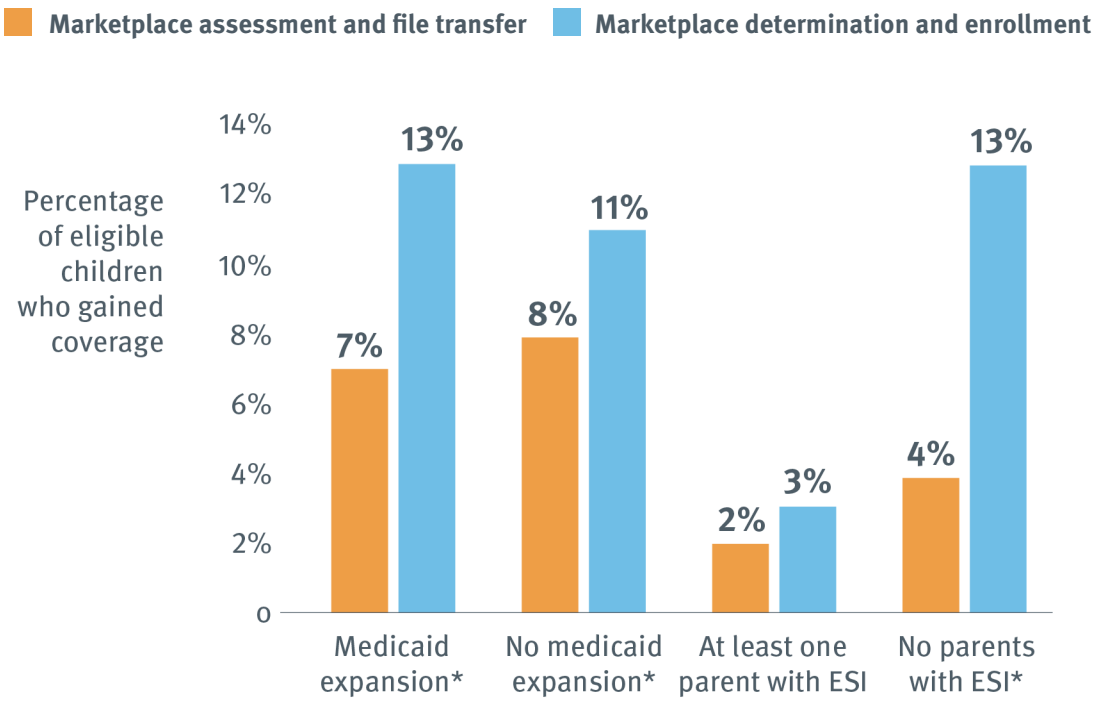
Source: Julie L. Hudson and Asako S. Moriya, "Association Between Marketplace Policy and Public Coverage Among Medicaid or Children's Health Insurance Program-Eligible Children and Parents," JAMA Pediatrics 172, no. 9 (2018): 881–882, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2687008.

Note: Researchers reported a statistically significant difference between states with assessment and file transfer systems and states in the other two categories. Researchers did not find a statistically significant difference between states served by the federal marketplace with determination and enrollment systems and states that operate their own marketplaces with integrated eligibility systems. Newly eligible parents are those who qualified for Medicaid due to expanded eligibility under the ACA. The percentage of newly eligible parents who gained health coverage refers to the percentage-point change in Medicaid coverage among newly eligible parents from 2013 to 2015.

A second study[16] examined changes in children's health coverage from 2013 to 2018. In Medicaid expansion states that either operated integrated systems or let the federal marketplace determine Medicaid and CHIP eligibility, 13% of eligible children gained coverage. By contrast, in expansion states that used assessment and file transfer policies, just 7% of eligible children gained coverage (Figure 3). Put differently, children's coverage gains were cut nearly in half under assessment and file transfer policies.

For families who were particularly dependent on the marketplace because parents did not receive employer-sponsored insurance, children's health coverage gains were lower by an order of magnitude when states did not fully implement "no wrong door" eligibility. Only 4% of eligible children gained health coverage in expansion states with assessment and file transfer systems, compared with 13% of children who gained health coverage in expansion states with determination and enrollment systems (Figure 3).

Figure 3. Increased Medicaid and CHIP coverage for eligible children, by marketplace role in determining Medicaid and CHIP eligibility, Medicaid expansion status, and parental coverage: Changes from 2013 to 2018



Source: Julie L. Hudson and Asako S. Moriya, "The Role of Marketplace Policy on Welcome Mat Effects for Children Eligible for Medicaid or the Children's Health Insurance Program," INQUIRY 57 (2020), https://pubmed.ncbi.nlm.nih.gov/33161820/.

*Indicates a statistically significant difference between states with marketplace assessment and file transfer systems and states with marketplace determination and enrollment systems.

Note: Estimates were for children with family income between 139% and 250% of the federal poverty level. Marketplace assessment and file transfer states have healthcare.gov assess rather than determine eligibility for Medicaid and CHIP and, in cases where such eligibility appears likely, transfer the applicant's file to the state Medicaid or CHIP program for further processing. Marketplace determination and enrollment states include (a) states that operate their own marketplaces with integrated eligibility systems that serve all programs and (b) states where the healthcare.gov enrollment platform determines Medicaid and CHIP eligibility, after which eligible people are enrolled in Medicaid and CHIP. The percentage of eligible children who gained health coverage refers to the percentage-point increase in Medicaid and CHIP coverage among eligible children from 2013 to 2018. Medicaid expansion states expanded adult eligibility to at least 138% of the federal poverty level, as provided in the ACA.

New research findings: Consumers experience serious problems in fragmented eligibility systems

To understand how the current limited approach to "no wrong door" was affecting consumers, we interviewed consumer assistance programs in 16 states that used assessment and file transfer systems and were served by the federally facilitated marketplace: Arizona, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah and Wisconsin.[17] Each organization we interviewed either helped residents enroll in health coverage or was a statewide consumer advocacy group that regularly partnered with local consumer assistance programs.[¶] In all but one state, these programs reported widespread and serious problems.

In most assessment and file transfer states, required file transfers did not appear to be taking place. Consumer assistance programs reported that, in nine of the 16 states, state agencies did not appear to be making any file transfers to the federally facilitated marketplace for use in determining APTC eligibility. In three states, Medicaid and CHIP agencies did not appear to be collecting and using file transfers from the marketplace to determine eligibility. In such cases, the interviewed organizations that work directly with consumers had never seen a client whose case file had been transferred between federal and state agencies, who obtained any notice of such transfers, or who received other follow-up communications from the agency that was supposed to get the file (Figure 4, page 12).

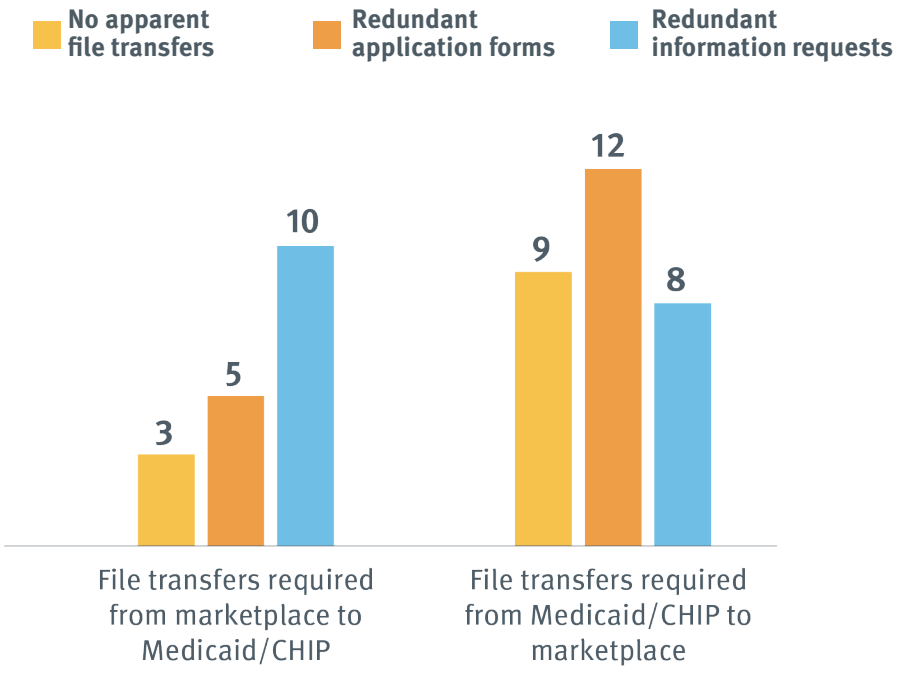
In most assessment and file transfer states, families were required to complete and file the same application form with two separate agencies. In 12 of the 16 states, consumers who applied to Medicaid or CHIP and were found ineligible had to submit redundant applications to the marketplace to be considered for APTC eligibility. In five states, consumers who applied at the marketplace and were assessed as qualifying for Medicaid or CHIP could not get health coverage until they filled out and provided the Medicaid or CHIP program with the same application they already completed for the marketplace (Figure 4, page 12).

[¶] We held one interview per state, asking questions over Zoom using semi-structured protocols, with follow-up questions asked via email. We conducted all hour-long interviews between March and May of 2021.

In most assessment and file transfer states, consumers had to provide the second agency with information or documents they already gave the first agency. In 10 states, consumers who began their applications at the marketplace and were referred to Medicaid or CHIP had to give the latter programs answers to the same questions or eligibility documentation the consumers already provided to the marketplace. In eight states, consumers whose files were transferred from Medicaid or CHIP to the marketplace were required to give the latter agency some of the same answers or documents they already provided to Medicaid or CHIP (Figure 4).

In the majority of assessment and file transfer states, families encountered obstacles whether they began their application at the marketplace or at a Medicaid or CHIP program. In nine states, regardless of the direction in which families' files had to be transferred — marketplace to Medicaid or CHIP, or Medicaid or CHIP to marketplace — consumer assistance programs reported that health programs had one or more of the following problems: failing to make a file transfer, requiring redundant applications, or asking for information already provided to the program that received the initial application (Table 1, page 14). In six states, consumer assistance programs reported problems in a single direction. In only one state did an interviewee find no problems in either direction.

Figure 4. Enrollment problems in 16 assessment and file transfer states, by nature of problem and direction of required file transfer: 2021



Note: For more details about the distribution of these problems by state, see Appendix Table 1.

In several assessment and file transfer states, applications could be subject to prolonged delays while moving back and forth between state and federal agencies. In six states, consumer assistance organizations reported that it was common for applications to be repeatedly transferred between the marketplace and the state Medicaid or CHIP program, resulting in prolonged delays (data not shown in figure or table). Interviewees described income and immigration status as the issues that most frequently led to repeated referrals.

Families whose files were transferred from the marketplace to state Medicaid or CHIP programs often could not find out what happened to their applications. Consumer assistance programs in multiple states described the frustrations that resulted when people who applied at the marketplace were not told what happened to their applications after they were assessed as potentially eligible for Medicaid or CHIP and their files were supposed to be transferred to the state. At best, prolonged delays resulted as applicants struggled to learn their status. At worst, families did not know their files were transferred and never heard from either the federal exchange or the state. In such cases, even experienced and trained consumer assisters often found it impossible to learn the status of those applications.

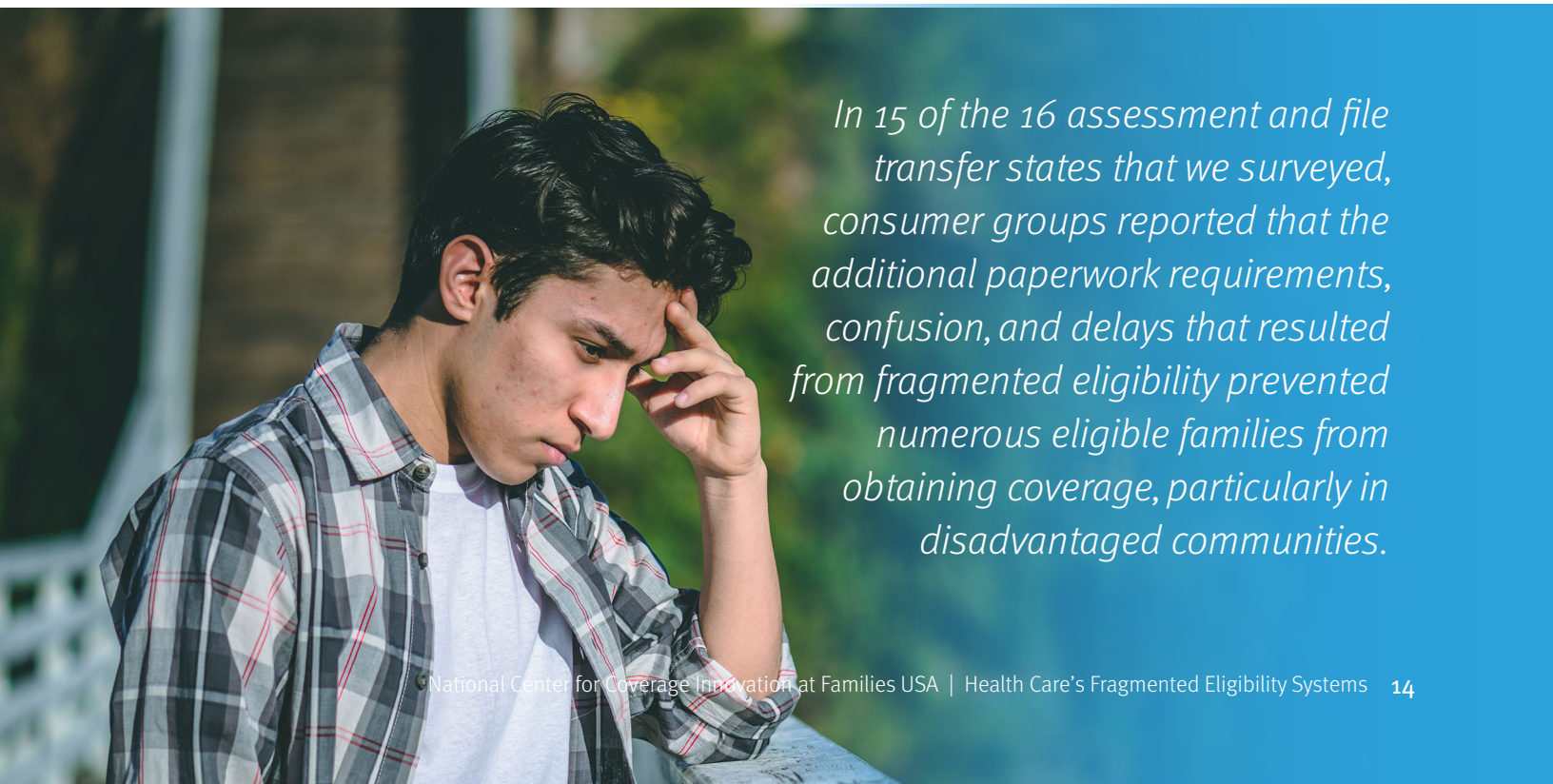
Table 1. Number of states with "no wrong door" problems reported by consumer assistance programs in 16 assessment and file transfer states, by direction of required file transfer: 2021

		Number of States
Direction of required file transfer	Problems only when file transfers are required from Medicaid/CHIP to healthcare.gov	4
	Problems only when files file transfers are required from healthcare.gov to Medicaid/CHIP	2
	Problems in both directions	9
	Problems in neither direction	1
Total states where consumer assistance programs were interviewed		16

Note: A No Wrong Door problem listed in this table is either (1) the apparent absence of file transfers that come from one agency and are used by the other in determining eligibility; (2) the need for families to complete and file a new application form with the second agency, even though they already completed the same form and filed it with the first agency; or (3) a requirement to provide the second agency with answers to questions or with documents the applicant already provided the first agency.

In 15 of the 16 assessment and file transfer states that we surveyed, consumer groups reported one or more of the problems described above: an apparent failure to make file transfers, requirements to file duplicative applications, requests for duplicative information, or applications that could not be tracked after file transfer was required. **In each of those 15 states, interviewees agreed that the additional paperwork requirements, confusion, and delays that resulted from fragmented eligibility prevented numerous eligible families from obtaining coverage, particularly in disadvantaged communities.** The consumers who most frequently remained uninsured as a result of fragmented eligibility systems were people with limited English proficiency (disproportionate impact noted in 11 states), residents of rural areas (noted in five states) and immigrants eligible for IAPs (noted in three states) (data not shown in figure and table).

These consistent and troubling interviews suggest that, nearly a decade after their enactment, the regulatory guardrails for assessment and file transfer systems have not come close to achieving their goals, and eligible families' enrollment in coverage is being obstructed as a result. Substantial behavioral science research shows that, as a general rule, small procedural requirements can substantially cut participation in public and private benefit programs.[18] **But enrollment is damaged especially deeply when economic or social stresses impose cognitive and emotional burdens** that make it hard to process information about complex benefit programs and then complete required paperwork.[19] Those stresses are particularly widespread in low-income, disadvantaged communities that rely on insurance affordability programs for health coverage. Broader research findings are thus consistent with consumer assistance programs' reports that procedural requirements imposed due to fragmented eligibility have prevented numerous eligible people from receiving coverage.

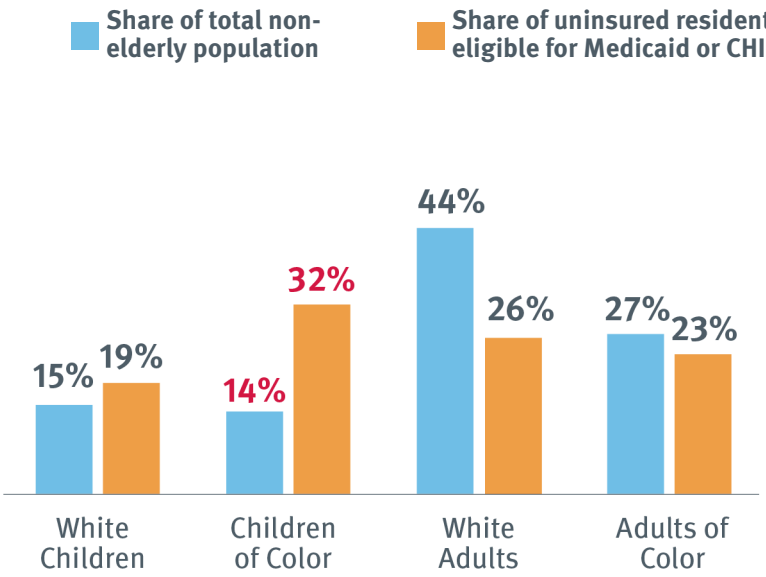


In 15 of the 16 assessment and file transfer states that we surveyed, consumer groups reported that the additional paperwork requirements, confusion, and delays that resulted from fragmented eligibility prevented numerous eligible families from obtaining coverage, particularly in disadvantaged communities.

New research findings: Fragmented eligibility systems pose particularly serious risks to children of color

To understand the demographic characteristics of people whose coverage is affected by states' failure to implement "no wrong door" policy, we analyzed U.S. Census Bureau data, and we found that two groups are disproportionately likely to be uninsured but eligible for Medicaid or CHIP: (1) children; and (2) people of color.[21] When those groups intersect in African American children, Latino children and other children of color, the net impact is quite troubling. Only 14% of people who live in assessment and file transfer states are children of color, but they comprise fully 32% of all uninsured residents who qualify for Medicaid or CHIP (Figure 5). They are thus the single group most at risk of remaining uninsured, despite eligibility for assistance, if their families seek coverage through the healthcare.gov enrollment platform.

Figure 5. Percentage of nonelderly population in assessment and file transfer states versus percentage of state residents who are uninsured and eligible for Medicaid or CHIP, by age, race and ethnicity: 2019



Source: Families USA analysis of 2019 American Community Survey data, available through IPUMS USA, University of Minnesota, www.ipums.org.

Note: Children are ages 0-18, the age range for Medicaid and CHIP eligibility. White people are not described in U.S. Census Bureau data as Hispanic. People of color include people of all races and ethnicities except white non-Hispanics.

Texas Children Harmed by Fragmented Eligibility Systems

Starting in 2014, the Texas Medicaid program's computers misread files sent by the federal marketplace, mistakenly classifying children as adults. Instead of evaluating children's eligibility based on the state's income standard for children (206% of the federal poverty level), the state used the income standard for parents (19% of the federal poverty level).[20] This error was not discovered until 2019. At the time of our 2021 interview, consumer-serving organizations in Texas had not received any confirmation that the problem had been fixed. It is impossible to know how many eligible children have been wrongly denied health coverage in Texas as a result. It is also impossible to know what other communication failures between incompatible federal and state computer systems remain undiscovered and are denying coverage to eligible people today, either in Texas or in other states.

Florida Children Harmed by Fragmented Eligibility Systems

In Florida, the state's Medicaid program and separate CHIP program do not share a common eligibility system or service, nor do they use the same methodology to calculate financial eligibility. As a result, when families apply at one of these programs seeking health coverage for their children, their applications are often transferred back and forth between programs, leading to delays and sometimes causing applications to seemingly disappear. These problems worsened when the CHIP program's system was hacked and went offline in December 2020, a problem that had not been fixed by the time of our spring 2021 interview. According to the consumer assistance program we interviewed, many families with CHIP-eligible children must file Medicaid applications and complete the Medicaid eligibility determination process, which has deterred enrollment for many families who clearly have incomes too high for Medicaid but low enough for CHIP. This state-level disjunction between child health programs has been amplified by the additional disjunction between federal and state agencies resulting from incomplete implementation of "no wrong door" requirements. According to consumer assistance groups, fragmented eligibility systems prevent children from receiving coverage for which they qualify due to excessive and unnecessary paperwork requirements, delays, mistaken eligibility denials, and lost applications.

A Call to Action: The Biden Administration Should Fully Implement the ACA's "No Wrong Door" Requirements

Full implementation of "no wrong door" requires administrative action in two areas.

1. **Establish a clear pathway for each state to develop a single eligibility system or service that serves all IAPs**

   The administration should move toward having a single eligibility system or service in each state determine all IAP eligibility, regardless of the agency where residents first seek help. As noted earlier, ACA statutory language explicitly states this requirement, and research suggests that fully integrated systems may yield the greatest coverage gains. Living up to this requirement will require time and significant effort in many states, but federal funding is available. Regulations enacted more than a decade ago authorize 90% federal funding for all information technology (IT) development and 75% federal funding for IT operations needed for Medicaid to determine eligibility.[22] Marketplaces could also apply user fee revenues or other administrative funding to cover their share of IT development costs, under standard federal cost allocation principles.[23]

   To address the challenges of creating integrated eligibility systems in states where the healthcare.gov platform determines APTC eligibility, the U.S. Department of Health and Human Services could begin by working with select "early adopter" states, gaining experience to inform the development of templates and tools that other states could use. The administration could also consider a learning collaborative approach to implementation, using methods like those deployed soon after ACA enactment to help state Medicaid programs implement ACA eligibility reforms.[24]

   As an immediate and actionable step in this direction, the administration should require each state-based marketplace to work with Medicaid and CHIP programs to operate an integrated eligibility system or service that determines eligibility for all IAPs. Most states that operate their own marketplaces already do this, but newly created marketplaces in Nevada, New Jersey and Pennsylvania do not. Without such action by the federal Centers for Medicare & Medicaid Services, new state-based marketplaces coming online in other states may needlessly obstruct families' enrollment in coverage by operating eligibility systems that are bifurcated between the marketplace and state Medicaid and CHIP programs.

2. Require each agency to determine eligibility and initiate coverage when a person who applies to that agency qualifies for a health program sponsored by a different agency

During the transition to fully integrated eligibility systems in each state, the administration should take immediate action to require agencies with which applications are initially filed to determine eligibility when applicants qualify for insurance affordability programs sponsored by a different agency, as required by the ACA. This approach has two elements.

First, the administration should immediately require the healthcare.gov marketplace to determine Medicaid and CHIP eligibility based on modified adjusted gross income for people who apply at the marketplace and have incomes too low for APTCs. After finding a family eligible for Medicaid or CHIP, the marketplace should convey applicant files to the state agency, but only for enrollment purposes. This policy would make all states determination and enrollment states, reinstating a key feature of the Obama administration's original proposed rule.

Second, the administration should require state Medicaid and CHIP programs to determine eligibility for APTCs and cost-sharing reductions, whenever possible, when applicants appear to qualify for the latter assistance. This may require Medicaid and CHIP programs to access federal income tax records, either directly or through an intermediary, to determine financial eligibility for APTCs.[25] States will also need to obtain information about access to employer-sponsored insurance to verify whether applicants qualify for APTCs because they are not offered employer-sponsored insurance that meets the ACA's standards for affordability and comprehensiveness. However, compared with marketplaces, state Medicaid programs are already better equipped to verify such eligibility since Medicaid programs are legally required to obtain information about all state residents with employer-sponsored insurance for purposes of third-party-liability enforcement.[26] Implementing this measure sooner rather than later could minimize the number of Medicaid beneficiaries who lose coverage when "maintenance of effort" requirements related to the public health emergency end, since Medicaid programs could automatically transition people to the marketplace when eligibility shifts from one program to the other.[27]

Conclusion

Dividing eligibility determination between marketplaces and state Medicaid and CHIP programs imposes needless procedural burdens that prevent eligible people from obtaining health coverage. Those obstructions and the associated delays and confusion mean that eligible families are denied the health coverage they need to thrive. Such procedural barriers have the greatest adverse impact on those who need help the most.

During his first few weeks in office, President Joe Biden signed executive orders that are directly relevant to this issue. One such order directed federal agencies to reverse "policies or practices that may present unnecessary barriers to individuals and families attempting to access Medicaid or ACA coverage."[28] Another prioritized removing obstacles that disproportionately affect "underserved communities and individuals."[29] A third executive order called for "actions that facilitate better use of data and other means to improve access to, reduce unnecessary barriers to, and improve coordination among programs funded in whole or in part by the Federal Government."[30]

To keep those promises, the Biden administration should take immediate steps to fully implement the ACA's "no wrong door" requirements. The Obama administration's attempt at partial implementation — with the hope that regulatory guardrails could prevent fragmented eligibility systems from denying health care to eligible families — failed to provide necessary protection. It is time to finally ensure that families' eligibility for all health programs is determined swiftly, without their applications being bounced from program to program, and regardless of which "door" families enter to enroll in coverage. Such steps are essential for millions of uninsured people in America to finally obtain the high-quality, affordable health coverage they are promised under federal law.

It is time to finally ensure that families' eligibility for all health programs is determined swiftly, without their applications being bounced from program to program, and regardless of which "door" families enter to enroll in coverage. Such steps are essential for millions of uninsured people in America to finally obtain the high-quality, affordable health coverage they are promised under federal law.

Appendix

Supplementing the findings displayed in Figure 4, Appendix Table 1 provides more detailed information about the distribution of problems reported by the consumer assistance programs we interviewed.

Appendix Table 1. Number of assessment and file transfer states with various problems reported by consumer assistance programs: 2021

		A. Consumers must fill out, for the second agency, the application form they already completed for the first agency	B. Consumers must provide the second agency with other information they already gave the first agency	Must consumers do both A&B, one of them, or none?			Total number of states in row
				Both	One	None	
Consumer applies to healthcare.gov, file transfer to Medicaid/CHIP is required	File transfers completed	2	7	1	7	5	13
	File transfers apparently not completed	3	3	3	0	0	3
	Total number of States	5	10	4	7	5	16
Consumer applies to Medicaid/CHIP, file transfer to healthcare.gov is required	File transfers completed	4	2	2	2	3	7
	File transfers apparently not completed	8	6	6	2	1	9
	Total number of States	12	8	8	4	4	16

How to read this table. For example, the first row provides information about states where file transfers are typically completed after a consumer applies at healthcare.gov and their application must be transferred to the state Medicaid program. In 2 of these states, consumers must submit new applications to Medicaid or CHIP, and in 7 states they must provide the Medicaid or CHIP program with other information they already furnished to healthcare.gov. In 1 of these states, consumers must do both things; in 7 states, they must do one or the other; and in 5 states, they are not required to take either step. Altogether, consumer assistance groups in 13 of the 16 states reported that file transfers take place when a consumer first applies at healthcare.gov and is assessed as likely eligible for Medicaid or CHIP.

Endnotes

[1] "Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured," Kaiser Family Foundation, 2021, https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Cynthia Cox and Daniel McDermott, "Millions of Uninsured Americans Are Eligible for Free ACA Health Insurance," Kaiser Family Foundation, November 24, 2020, https://www.kff.org/policy-watch/millions-of-uninsured-americans-are-eligible-for-free-aca-health-insurance/.

[2] These states are California, Colorado, Connecticut, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont and Washington.

[3] ACA §1413(b)(1)(A) requires the U.S. Department of Health and Human Services to "develop and provide to each State a single, streamlined form that (i) may be used to apply for all applicable State health subsidy programs within the State … [and] (iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs."

Once the application is submitted, a single eligibility system is supposed to determine the IAP for which the individual qualifies. As explained by §1413(a): "The Secretary shall establish a system … under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs." Subsections (c)(1), (c)(2), and (c)(3)(A) of ACA §1413 similarly require the use of a single electronic interface within each state that allows a determination of eligibility for all IAPs:

> (c)(1): "Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data … that allows a determination of eligibility for all such programs based on a single application."
>
> (c)(2): "Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3)."
>
> (c)(3)(A). "Each applicable State health subsidy program shall, to the maximum extent practicable (i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2)."

Social Security Act Section 1943(b)(1)(D) (42 U.S.C. 1396w-3), added by ACA §2201, reinforces the requirement for each state to use a single, data-driven eligibility system to determine eligibility for all IAPs: "A State shall establish procedures for … (D) ensuring that the State [Medicaid] agency … the State [CHIP] agency, and an Exchange … utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this title, title XXI, or a qualified health plan, as appropriate."

[4] ACA §1413(a) requires that the eligibility and enrollment system for IAPs must "ensure that if an individual applying to an Exchange is found through screening to be eligible for [Medicaid], or eligible for [CHIP], the individual is enrolled for assistance under such plan or program." To the same effect is Social Security Act §1943(b)(1)(B), added by ACA §2201, which requires Medicaid and CHIP programs to enroll people whom an exchange has identified as eligible for Medicaid and CHIP: "A State shall establish procedures for … (B) enrolling [into Medicaid or CHIP], without any further determination by the State … individuals who are identified by an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act as being eligible for [Medicaid or CHIP]."

Applying the identical approach when applications move in the opposite direction, Social Security Act §1943(b)(1)(C) requires Medicaid and CHIP programs to ensure that ineligible applicants are screened for APTC and cost-sharing reduction (CSR) eligibility and, if they qualify, are enrolled in exchange coverage without the need to submit a new application: "A State shall establish procedures for … (C) ensuring that individuals who apply for but are determined to be ineligible for [Medicaid and CHIP] are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, [APTCs and CSRs], and, if eligible, enrolled in such a [qualified health] plan without having to submit an additional or separate application."

[5] According to ACA §1413(b)(2): "[A]n applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable [insurance affordability] program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification … or is otherwise insufficient to determine eligibility."

[6] Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010: Proposed Rule," *Federal Register* 76, no. 159 (August 17, 2011), https://www.govinfo.gov/content/pkg/FR-2011-08-17/pdf/2011-20756.pdf.

[7] Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule," *Federal Register* 77, no. 57 (March 23, 2012), https://www.govinfo.gov/content/pkg/FR-2012-03-23/pdf/2012-6560.pdf.

[8] This requirement was limited to beneficiaries whose financial eligibility was based on modified adjusted gross income, the same general income definition used in determining APTC eligibility.

[9] The regulation itself refers to "determination" and "assessment" states. We have added language to clarify the full import of this

distinction.

[10] Vikki Wachino et al., "CMCS Webinar Series: Coordination Across Medicaid, CHIP, and the Affordable Insurance Exchanges," Centers for Medicare & Medicaid Services, April 5, 2012, https://www.medicaid.gov/state-resource-center/downloads/4-5-12-eligibility-webinar-transcript.pdf.

[11] California, Colorado, Connecticut, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont and Washington operate their own marketplaces.

[12] "State Health Insurance Marketplace Types, 2021," Kaiser Family Foundation. 2021 results are no longer posted on line. For 2022 results, showing that several additional states are planning to begin operating their own marketplaces next year, see https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[13] These states are Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah and Wisconsin. One state, South Carolina, did not respond to the survey that gathered these results. We classify it as an assessment and file transfer state, based on interviews with consumer advocates.

https://www.kff.org/health-reform/state-indicator/medicaid-and-health-insurance-marketplace-coordination/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[14] Alabama, Alaska, Louisiana, Montana, Virginia, West Virginia, and Wyoming are "determination and enrollment" states; One state, South Carolina, did not respond to the survey that gathered these results. We classify it as an assessment and file transfer state, based on interviews with consumer advocates. See "Medicaid and Health Insurance Marketplace Coordination," Kaiser Family Foundation, 2020, https://www.kff.org/health-reform/state-indicator/medicaid-and-health-insurance-marketplace-coordination/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[15] Julie L. Hudson and Asako S. Moriya, "Association Between Marketplace Policy and Public Coverage Among Medicaid or Children's Health Insurance Program-Eligible Children and Parents," *JAMA Pediatrics* 172, no. 9 (2018): 881–882, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2687008.

[16] Julie L. Hudson and Asako S. Moriya, "The Role of Marketplace Policy on Welcome Mat Effects for Children Eligible for Medicaid or the Children's Health Insurance Program," INQUIRY 57 (2020), https://pubmed.ncbi.nlm.nih.gov/33161820/.

[17] We also interviewed state officials in one assessment and file transfer state and consumer assistance staff in one determination and enrollment state. These informants' findings differed from what consumer assistance groups told us in assessment and file transfer states. We could not generalize based on a single state's data collection within these two categories (interviews with state officials, rather than consumer assistance programs, in assessment and file transfer states; and interviews with consumer assistance programs in determination and enrollment states, rather than assessment and file transfer states). Results of these two additional interviews are available upon request.

[18] Fredric Blavin, Stan Dorn, and Jay Dev, *Using Behavioral Economics to Inform the Integration of Human Services and Health Programs Under the Affordable Care Act* (Washington, DC: Urban Institute, 2014), https://aspe.hhs.gov/reports/using-behavioral-economics-inform-integration-human-services-health-programs-under-affordable-care-0.

[19] Julian Christensen et al., "Human Capital and Administrative Burden: The Role of Cognitive Resources in Citizen-State Interactions," *Public Administration Review* 80, no. 1 (January/February 2020): 127–136, https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/puar.13134; Marianne Bertrand, Sendhil Mullainathan, and Eldar Shafir, "A Behavioral-Economics View of Poverty," *American Economic Review* 94, no. 2 (May 2004): 419–423, https://www.aeaweb.org/articles?id=10.1257/0002828041302019; Frank Schilbach, Heather Schofield, and Sendhil Mullainathan, "The Psychological Lives of the Poor," *American Economic Review* 106, no. 5 (May 2016): 435–440, https://www.aeaweb.org/articles?id=10.1257/aer.p20161101; Lisa A. Gennetian and Eldar Shafir, "The Persistence of Poverty in the Context of Financial Instability: A Behavioral Perspective," *Journal of Policy Analysis and Management* 34, no. 4 (May 2015): 904–936, https://www.russellsage.org/sites/all/files/conferences/BE_and_Parenting/Gennetian_Shafir_Persistence_of_Poverty.pdf; Emma Boswell Dean, Frank Schilbach, and Healther Schofield, "Poverty and Cognitive Function," National Bureau of Economic Research, December 2018, https://www.nber.org/books-and-chapters/economics-poverty-traps/poverty-and-cognitive-function.

[20] Tricia Brooks et al., *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, January 2015), https://ccf.georgetown.edu/wp-content/uploads/2015/01/Modern-Era-Medicaid-January-2015.pdf.

[21] Children make up 29% of nonelderly residents in assessment and file transfer states but 50% of nonelderly residents who are uninsured and eligible for Medicaid or CHIP. Among residents

under age 65, people of color comprise 40% of the population but 55% of uninsured residents who qualify for Medicaid or CHIP. Families USA's The National Center for Coverage Innovation (NCCI) analysis of 2019 American Community Survey data, accessed through IPUMS.

[22] 42 CFR §§ 433.112, 433.116.

[23] "OMB Circular A-87 Revised," Office of Management and Budget, revised May 10, 2004, https://obamawhitehouse.archives.gov/omb/circulars_a087_2004.

[24] Centers for Medicare & Medicaid Services, "Medicaid and CHIP (MAC) Learning Collaboratives," Medicaid.gov [undated], https://www.medicaid.gov/resources-for-states/medicaid-and-chip-mac-learning-collaboratives/index.html

[25] Although APTC eligibility ultimately reflects expected annual income, financial verification begins (and often ends) by consulting federal income tax records from the past year. Many state Medicaid and CHIP programs do not access federal income tax data that the U.S. Department of Health and Human Services makes available through the federal data services hub, since accessing that data would require compliance with the Internal Revenue Service's cumbersome requirements for data security. A state may be able to address those constraints by having an intermediary receive the data, comply with IRS requirements, and report only final results to the state. Alternatively, a state with a state income tax system could use its own income tax records to determine eligibility. In states where tax return data show only adjusted gross income (AGI) and not modified adjusted gross income (MAGI) used to determine eligibility, states could verify eligibility based on AGI. The components of income that are included in MAGI and not AGI, such as tax-exempt interest and income earned in foreign countries, affect Medicaid eligibility for relatively few low-income people. For example, in 2018, the most recent year for which data are available, among all tax filers earning less than $100,000 a year, fewer than 7% reported any tax-exempt interest or foreign-earned income, which combined amounted to just 0.9% of income for these households. Calculations based on Internal Revenue Service, "Table 2.1: Returns with Itemized Deductions: Sources of Income, Adjustments, Itemized Deductions by Type, Exemptions, and Tax Items, by Size of Adjusted Gross Income, Tax Year 2018 (Filing Year 2019)," *SOI Tax Stats – Individual Income Tax Returns Complete Report (Publication 1304),* September 2020, https://www.irs.gov/pub/irs-soi/18in21id.xls.

[26] Centers for Medicare & Medicaid Services, "Coordination of Benefits & Third Party Liability," Medicaid.gov [undated], https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html.

[27] Matthew Buettgens and Andrew Green, *What Will Happen to Unprecedented High Medicaid Enrollment After the Public Health Emergency?* (Washington, DC: Urban Institute, September 2021), https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf.

[28] Joseph R. Biden Jr., "Executive Order on Strengthening Medicaid and the Affordable Care Act," The White House, January 28, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/?_hsmi=117826243&_hsenc=p2ANqtz-9lz1XtsUOogBAp0pvMMoWkKLg43qE2dkgD2W0bEg4NR_aaHqVvj8kZZ99AJyjrSB8NiLCZJGzyOVgMqyT_TDHKZ903Tg.

[29] Joseph R. Biden Jr., "Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," The White House, January 20, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

[30] Joseph R. Biden Jr., "Executive Order on Economic Relief Related to the COVID-19 Pandemic," The White House, January 22, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/22/executive-order-economic-relief-related-to-the-covid-19-pandemic/.

THE NATIONAL CENTER FOR COVERAGE INNOVATION | AT FAMILIESUSA

The National Center for Coverage Innovation at Families USA is grateful to the Center for Accountability, Modernization and Innovation for its financial support, which made this project possible. Families USA has final independent authority over the contents of all its projects, including this one, and exercises its authority in service of Families USA's vision of a nation where the best health and health care are equally accessible and affordable to all.

1225 New York Avenue NW, Suite 800 | Washington, DC 20005 | 202-628-3030 | info@familiesusa.org
FamiliesUSA.org | facebook / FamiliesUSA | twitter / @FamiliesUSA