

GIH

CONNECTING
CONSUMERS TO
COVERAGE:

*Foundations Learn from the
Past and Look to the Future*

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EXECUTIVE SUMMARY

CONNECTING CONSUMERS TO COVERAGE:

Foundations Learn from the Past and Look to the Future

Foundations at the national, state, and local levels have played a pivotal role in improving the health of generations of Americans through thoughtful investments designed to ensure access to affordable health insurance coverage. With the passage of the Patient Protection and Affordable Care Act (ACA) in March 2010, the landscape for foundation investment has shifted dramatically. This is particularly true of investments targeted at streamlining eligibility and enrollment processes for publicly supported health insurance programs. The ACA and implementing regulations mandate potentially transformative eligibility and enrollment improvements and provide substantial funding to implement these new rules. Yet the need for foundation support has not abated. While new coverage options and streamlining rules take effect on January 1, 2014, the vision outlined in the ACA for a seamless continuum of coverage across all insurance affordability programs (IAPs)—Medicaid, the Children’s Health Insurance Program (CHIP), Advanced Premium Tax Credits (APTCs), and Cost Sharing Reductions (CSRs)—will not be a reality in most states on day one. Indeed, whether this vision is ever fully realized will depend in part upon the resources provided to help ensure that the ACA’s sweeping coverage changes become a reality on the ground. The purpose of this report is to inform foundations of the opportunity presented by federal health reform to improve participation in comprehensive, affordable health insurance coverage; reduce the number of uninsured; and, ultimately, improve the health and financial security of millions of uninsured Americans.

LESSONS LEARNED FROM PAST FOUNDATION INVESTMENT

Foundations have invested over \$200 million over the past 15 years in efforts to streamline eligibility and enrollment processes and to elevate the importance of health insurance coverage as a national priority. These investments offer lessons for the future.

- **People matter.** Foundations have helped develop a small community of individuals with highly specialized knowledge who collectively have had an enormous impact on state and federal eligibility and enrollment rules and systems, and, ultimately, on coverage.
- **Federal legislation serves as a catalyst for innovation.** The passage of federal legislation, such as the creation of CHIP, can create momentum even beyond the specific legislative mandates, enabling signifi-

LOOKING BACK, LOOKING FORWARD

This report examines:

- **Looking Back.** What has catalyzed progress with respect to improvement of eligibility and enrollment processes in the past and where have obstacles arisen? When speaking of eligibility and enrollment processes, not only are the policies that govern eligibility and enrollment (statute, regulations, and sub-regulatory guidance) included, but also the systems and staffing deployed to determine eligibility for and effectuate enrollment into coverage. What has been the role of foundations in this progress and what has contributed to the success or failure of those efforts? How does this inform future investment?
- **Looking Forward.** How has the policy environment changed with respect to efforts to expand coverage for low-income populations and improve eligibility and enrollment processes for public health insurance programs in light of the requirements and associated funding of the ACA? What are the strategic opportunities or leverage points where limited foundation resources might be effectively invested to ensure that the eligibility and enrollment processes for existing and new health insurance coverage options under the ACA facilitate coverage of eligible individuals and, ultimately, increase coverage?

cant leaps forward in reforming public coverage policies and systems and providing symbiotic opportunities for foundation investment.

- ***Investments in states drive change.*** Because so much policy is determined and implemented at the state level for Medicaid, CHIP, and soon for many Marketplaces, foundation investments in states are critical in driving policy change and supporting implementation.
- ***Implementation is where the real action is.*** Legislative and regulatory victories at either the state or federal level are not enough. Establishing an effective eligibility and enrollment process is first and foremost about implementation—the practical and often tedious work of translating policy and law into action.
- ***External factors slow, but do not necessarily prevent, progress.*** Change is possible even in environments with significant external barriers, including political opposition.

POTENTIAL FOUNDATION INVESTMENT PRIORITIES FOR 2014 AND 2015

These lessons suggest several potential investment priorities for foundations, all of which could advance a continuum of coverage across Medicaid, CHIP, APTCs/CSRs, and, where applicable, the Basic Health Program, enabling eligible individuals to obtain and keep coverage.

- ***Medicaid Expansion*** – About half the states, including those with the highest percentages of uninsured residents, are not implementing the Medicaid expansion under the ACA, leaving nearly 10 million low-income Americans without coverage. Foundation investment could be brought to bear in these states to document the impact of expansion choices, to support state-based organizations positioned to translate data into policy change, and through initiatives aimed at increasing the take-up of subsidized coverage in the Marketplace to reinforce the value of coverage made available under the ACA.
- ***Enrollment Policies Facilitating Access to Coverage*** – The ACA provides a host of policy changes designed to improve the eligibility and enrollment process. Foundation investment in research and thought leadership could help advance implementation of these ACA policies and develop new streamlining policies to simplify eligibility and enrollment further.
- ***Outreach, Education, and Mobilization*** – The ACA’s delayed implementation and continued political divisiveness have created widespread confusion, and government funding for outreach and education will vary drastically among states. Foundation investment could complement government spending, strategically targeting particular states, communities, and/or strategies to supplement state and federal efforts. Specific strategies could include education and training targeted to state legislators, local officials, and state and local eligibility workers; grassroots mobilization efforts for education and enrollment; and efforts to “rebrand” Medicaid.
- ***Technical Assistance (TA) to States*** – Even the most committed and sophisticated state officials are overwhelmed by the scale of change required to implement the ACA. TA to states could come in the form of funded staff extenders, as well as specialized expertise from organizations and consultants working across multiple states. Effective TA providers engage committed state leaders, address problems that are meaningful from states’ perspectives, and connect federal and state officials to inform both state work and federal thinking.
- ***Feedback Loop*** – An ACA feedback loop bringing together state officials and advocates working “on the ground” in key states could help track ACA implementation, identify obstacles and possible solutions, and organize and transmit the information to key federal and state officials. The goal would be to convene knowledgeable individuals and organizations, issue-spot quickly, and collaborate with federal and state officials to address issues in a timely manner.
- ***Information Technology (IT) Infrastructure*** – After decades without significant investments, states are funding long-overdue improvements to their Medicaid information systems. Foundations could complement federal and state investments in IT infrastructure by documenting and disseminating best

practices in IT systems and tools, seeding experts to identify areas to improve usability, and driving market competition among IT vendors by performing competitive analyses and convening industry leaders to innovate and recruit new talent.

- ***“Second Wave” Eligibility and Enrollment Simplification*** – Eligibility and enrollment processes remain enormously complex and require continued investment to further streamline the consumer experience. Foundations could convene state and federal officials, consumer advocates, and policy experts to identify the technical differences between IAPs and opportunities for simplification. With ACA implementation consuming current government resources, foundation support is critical to keep the momentum for continued streamlining alive.

CONCLUSION

Foundations, especially those with a long track record of investment in health care coverage and access, are well-positioned to advance ACA implementation. While the ACA rollout faces significant challenges, it also provides an opportunity to expand coverage and propel forward streamlined eligibility and enrollment processes. Building on lessons learned from past investments, foundations are poised to help realize a vision of seamless, continuous, and affordable health coverage for millions of low-income Americans.

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INTRODUCTION AND BACKGROUND

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) became law and established a new coverage paradigm promising all Americans access to comprehensive, affordable health insurance coverage. The ACA creates a continuum of coverage across insurance affordability programs (IAPs), providing individuals with incomes up to 400 percent of the federal poverty level (FPL) with financial assistance through Medicaid, the Children's Health Insurance Program (CHIP), or advanced premium tax credits and cost-sharing reductions (APTCs/CSRs) available in the Marketplace. The magnitude of this accomplishment is historic, providing more than 32 million Americans with access to affordable coverage through Medicaid and new state and federal Marketplaces. The ACA also provides an opportunity to dramatically advance consumer-friendly eligibility and enrollment processes so that low- and modest-income Americans eligible for IAPs are able to obtain and keep coverage. Since the passage of the ACA, however, it has become clear that it will take a great deal of work and ingenuity to ensure that the law delivers on its promise.

The purpose of this paper is to assist foundations seeking to take full advantage of the opportunity presented by federal health reform to reduce the number of uninsured; improve participation in comprehensive, affordable health insurance coverage; and, ultimately, improve the health and financial security of millions of uninsured Americans. The findings in this paper stem from a review of over 60 reports and policy papers on public health insurance eligibility and enrollment improvement efforts; documentation of past foundation investments; and interviews with some of the leading funders, government officials, and experts on both current and historic efforts to streamline eligibility and enrollment processes.

Specifically, the authors examine the following:

- **Looking Back.** What has catalyzed progress with respect to improvement of eligibility and enrollment processes in the past and where have obstacles arisen? When speaking of eligibility and enrollment

POTENTIAL INVESTMENT PRIORITIES FOR 2014 AND 2015

There are several potential investment priorities for foundations, all of which could advance a continuum of coverage across Medicaid, CHIP, APTCs/CSRs and, where applicable, the Basic Health Program, enabling eligible individuals to obtain and keep coverage.

- **Medicaid Expansion:** Invest in research, education, and advocacy efforts to document the impact and implications of states' expansion choices.
- **Enrollment Policies Facilitating Access to Coverage:** Support the implementation of strategies to enroll Medicaid-eligible individuals quickly and efficiently into the coverage options for which they are eligible.
- **Outreach, Education, and Mobilization:** Invest in public education, messaging development, and mobilization strategies targeting consumers, state legislators, local officials, and state and local eligibility workers.
- **Technical Assistance (TA) to States:** Provide TA to states on designing and implementing streamlined eligibility and enrollment processes.
- **Feedback Loop:** Bring together federal and state officials and advocates to track implementation, identify obstacles and solutions, and share information.
- **Information Technology Infrastructure:** Advance innovation and build state capacity by promoting best practices, seeding innovation, and affecting market dynamics.
- **“Second Wave” of Eligibility and Enrollment Simplification:** Invest in analyses, convening, and collaboration to promote further rule simplification and to identify additional options and implications for program alignment.

processes, not only are the policies that govern eligibility and enrollment (statute, regulations, and sub-regulatory guidance) included, but also the systems and staffing deployed to determine eligibility for and effectuate enrollment into coverage. What has been the role of foundations in this progress and what has contributed to the success or failure of those efforts? How does this inform future investment?

- **Looking Forward.** How has the policy environment changed with respect to efforts to expand coverage for low-income populations and improve eligibility and enrollment processes for public health insurance programs in light of the requirements and associated funding of the ACA? What are the strategic opportunities or leverage points where limited foundation resources might be effectively invested to ensure that the eligibility and enrollment processes for existing and new health insurance coverage options under the ACA facilitate coverage of eligible individuals and, ultimately, increase coverage?

This paper starts with defining the characteristics of an effective eligibility and enrollment process, and documents the mandates and investments under federal health reform intended to improve the consumer experience of applying for or renewing publicly subsidized health insurance coverage. Focus is on the full continuum of IAPs, Medicaid/CHIP, APTCs/CSRs, and, where applicable, the Basic Health Program. The paper then explores how foundations have supported improvements in the eligibility and enrollment processes for Medicaid/CHIP in the past and critical “lessons learned” from these efforts. The paper concludes with potential foundation investment priorities for the next two years targeted to ensure full utilization of the coverage continuum.

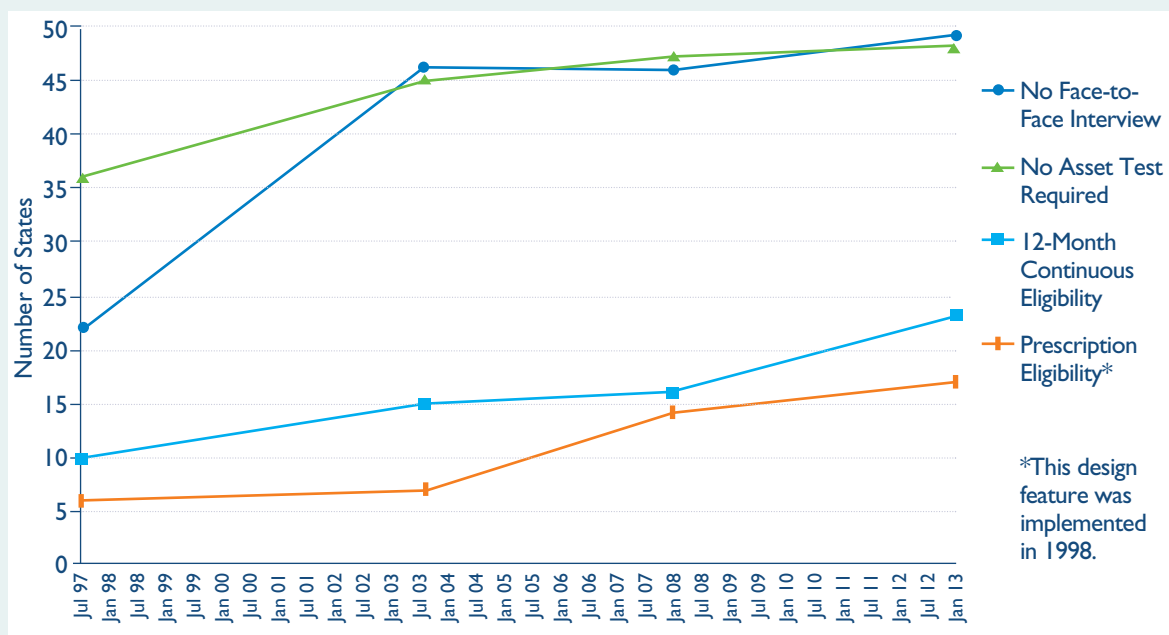
ELIGIBILITY AND ENROLLMENT: TODAY AND UNDER THE ACA

STREAMLINED ELIGIBILITY AND ENROLLMENT PROCESSES DEFINED

An effective eligibility and enrollment process includes features that both affirmatively facilitate the consumer's ability to apply for and maintain health insurance coverage and also minimize bureaucratic barriers or burdens to application and enrollment of eligible individuals. Because subsidized health insurance programs are based on need, it is necessary to determine who qualifies and who does not based on factors, including income, residency, immigration status, and household size.

Historically, the burden for seeking Medicaid coverage, including gathering the information necessary to verify eligibility, has fallen on the consumer. Stemming from its roots as a welfare program, application and enrollment processes were designed to weed out the ineligible, with little consideration for barriers posed for the eligible. Over the past two decades, consumer and health care advocates, foundations, and some policy-makers have doggedly pursued a wide range of policies aimed at changing this paradigm, much of it spurred by passage of CHIP and strong nationwide interest in insuring children. Recognizing the critical importance of health insurance coverage not only to improve health outcomes, but also to improve worker productivity, school attendance, and financial stability, the eligibility and enrollment movement has studied, identified, and advocated for a host of policy and systems changes that have resulted in slow but incremental progress. For example, in 1997, 29 states required a face-to-face interview as a condition of Medicaid eligibility – essentially requiring applicants for public coverage programs to take a day off of work and spend an afternoon in the local welfare office to obtain health insurance coverage (Georgetown Center for Children and Families and KFF 2013). At the time of the ACA's passage, 14 states continued to require a personal interview for parents applying for Medicaid coverage while two states maintained the requirement for children (Georgetown Center for Children and Families and KFF 2013).

FIGURE I. TRENDS IN SIMPLIFYING ELIGIBILITY AND ENROLLMENT FEATURES IN MEDICAID, JULY 1997-JANUARY 2013



Source: KFF 2013b

While the ACA simplifies the criteria for determining who is eligible for which program, it does not eliminate the standards altogether. Unlike Medicare, which provides universal coverage based on minimal criteria, IAPs (including Medicaid, CHIP, APTCs/CSRs in the Marketplace, and the Basic Health Program) under the ACA require sorting individuals into multiple programs and subsidy levels based on a complex set of standards. Virtually everyone is entitled to affordable coverage, but how much people pay and under which program they are covered depend on their income, household composition, age, citizenship or immigration status, and other factors. To make that coverage continuum meaningful, the ACA mandates new federal enrollment standards, eliminating roadblocks, such as face-to-face interview requirements and asset tests, and requiring electronic, real-time verification, the gold standard for a streamlined application process that many have long pursued. Overnight, the slow march toward an effective Medicaid eligibility and enrollment process took a leap forward, creating the potential for transformative change.

ACA CHANGES TARGETED TO THE ELIGIBILITY AND ENROLLMENT PROCESS

The ACA and implementing regulations read like a road map for eligibility and enrollment improvements advanced over the past decade. Specifically, the law provides as follows:

- Most of the income-counting rules are aligned across all IAPs, and all are based on modified adjusted gross income.
- Asset tests and face-to-face interview requirements are prohibited.
- Complex income rules that “disregard” certain expenses are eliminated and replaced with a standard 5 percent deduction for Medicaid and CHIP (ACA 2012a).
- Applicants can apply for coverage for all IAPs on a single streamlined application (ACA 2012b). Regardless of whether an application is submitted to the Medicaid agency or the Marketplace, an applicant will be considered for eligibility for all IAPs (ACA 2012c).
- The application must require only the minimum information needed to determine IAP eligibility (ACA 2012d).
- The consumer must have the option to submit the application on-line, by telephone, through the mail, or in person to the Marketplace or to any agency administering an IAP (ACA 2012e).
- To the maximum extent possible, information must be verified through the use of electronic data sources so that the consumer is not asked to provide paper documents to prove information already available in electronic databases (ACA 2012f; ACA 2012g; ACA 2012h; ACA 2012i).
- The renewal process is simplified; states must tap into electronic data sources to administratively verify continuing eligibility for coverage (ACA 2012j).
- State Medicaid/CHIP agencies and Marketplaces must enter into agreements delineating each of their roles, responsibilities, and timelines to ensure coordination of all IAP eligibility and enrollment processes (ACA 2012k).

The federal government also provides funding to implement these new rules. State Medicaid agencies may receive 90 percent federal matching dollars until December 31, 2015, for the design, development, and installation or enhancement of eligibility systems, and 75 percent federal matching dollars thereafter to operate the system. As a condition of receiving the enhanced federal match, state eligibility systems must meet timeliness, accuracy, efficiency, and integrity standards. The systems must ensure seamless coordination and integration with the Marketplace and provide for interoperability with health information exchanges and other state agencies and programs (42 CFR §433.112, 2013). To date, 48 states and the District of Columbia¹ have received approval to spend more than \$3.09 billion to upgrade Medicaid eligibility and

¹ The U.S. Virgin Islands also received \$421,000, which is included in the \$3.09 billion total spending.

enrollment systems (CMS 2013a).

Additional federal funding is being made available to state Marketplaces to build streamlined systems. The funds require no state match. To date, more than \$3.9 billion has been distributed to Marketplaces, much of it to support the information technology (IT) necessary to enroll IAP-eligible individuals (Center for Consumer Information and Oversight 2013). Furthermore, the ACA provides funding for outreach and education efforts to ensure that eligible individuals understand their coverage options and how to enroll.

While the new coverage options go into effect on January 1, 2014, the vision outlined in the ACA for a seamless, consumer-friendly application and enrollment process will not be a reality in most states on day one. The continuum of coverage across IAPs will have multiple crevices, requiring interagency “handoffs” and manual work-arounds, even in the most advanced states. Whether these crevices can ultimately be bridged remains to be seen and will depend in part upon the resources and support provided to help ensure that the sweeping changes to eligibility and enrollment included in the ACA become a reality on the ground for people in need of coverage.

With these funds, states are moving to implement the ACA requirements – aligning their rules, modernizing their Medicaid eligibility systems, and integrating with Marketplace eligibility systems (a handful of states are using the same eligibility system). Federal officials have identified seven eligibility and enrollment “critical success factors” that state Medicaid/CHIP agencies must address on or before January 1, 2014, including the ability to (1) accept a single streamlined application; (2) interface with the federal data services hub, which will enable states to electronically verify tax information, social security number, and citizenship or immigration status; and (3) interface with the Federally Facilitated Marketplace (FFM) (in FFM states), transferring consumer accounts electronically and verifying current Medicaid/CHIP enrollment for FFM applicants (CMS 2011; CMS 2013b). Notably, these systems requirements, as well as all streamlining mandates outlined above and the enhanced federal matching dollars, apply whether or not a state expands its Medicaid program.

While few states will have fully compliant systems by the start of open enrollment on October 1, 2013, most are expected to come into compliance during 2014. (The Centers for Medicare and Medicaid Services (CMS) is working with states to develop “mitigation” strategies in the interim.)

Despite this progress, considerable implementation challenges remain. While the new coverage options go into effect on January 1, 2014, the vision outlined in the ACA for a seamless, consumer-friendly application and enrollment process will not be a reality in most states on day one. The continuum of coverage across IAPs will have multiple crevices, requiring interagency “handoffs” and manual work-arounds, even in the most advanced states. Whether these crevices can ultimately be bridged remains to be seen and will depend in part upon the resources provided to help ensure that the sweeping changes to eligibility and enrollment included in the ACA become a reality on the ground for people in need of coverage.

LOOKING BACK: LESSONS LEARNED FROM FOUNDATION INVESTMENTS IN ELIGIBILITY AND ENROLLMENT PROCESSES

Foundations committed to improving the health and welfare of vulnerable communities have long been critical partners in the effort to provide health insurance to the uninsured. Through investments in thought leadership, research and evaluation, policy development and advocacy, technical support and innovation development, and outreach and public education, foundations at the state and national levels have helped elevate the importance of health insurance coverage as a public priority and promoted the evolution in public coverage programs from a welfare paradigm to the vision established in health reform today. These investments have been considerable: a nonexhaustive survey of major foundation initiatives in the past 15 years revealed over \$200 million in investment alone. Foundations' past experiences with investing in streamlining efforts offer crosscutting lessons that inform a post-ACA investment strategy across the full range of potential future investments.

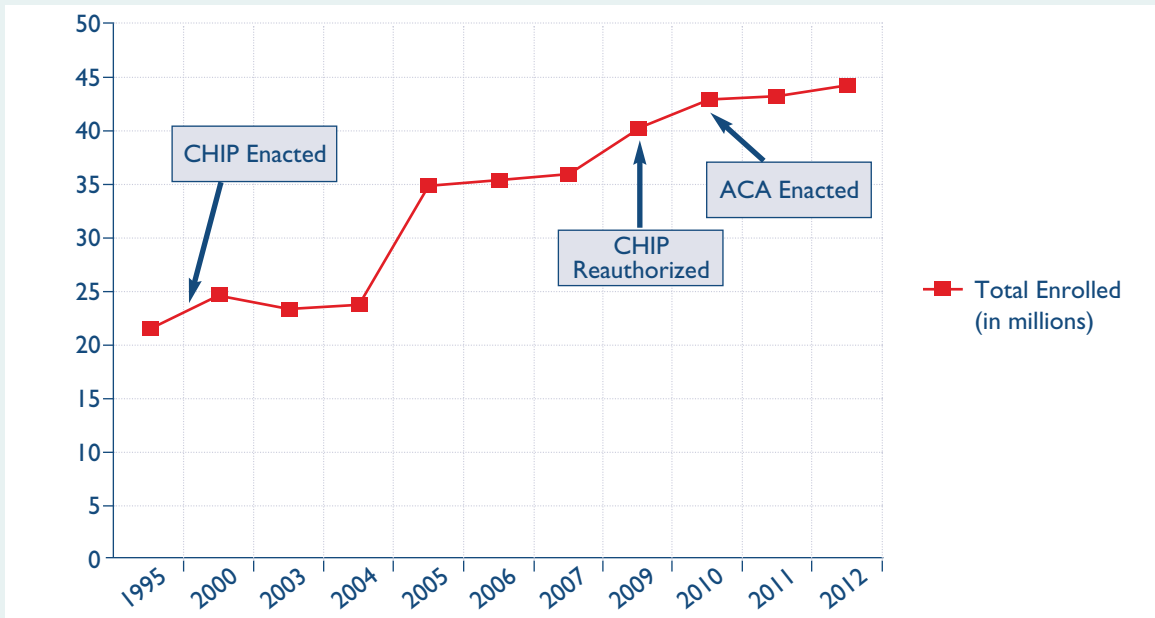
PEOPLE MATTER

At the outset, it is worth noting that the ability to marshal human capital – at the foundation, government, and/or grantee level – is likely the single strongest predictor of the success or failure of efforts to improve the eligibility and enrollment process. Identifying and supporting dynamic leaders or a small community of individuals with collective commitment, knowledge, and skill can have an enormous impact on state and federal systems and rules, and, ultimately, on coverage. At the same time, foundation investments in building this human capital have value far beyond any single grant or initiative. Many of the foundation-supported authors of the reports referenced in this paper went on to help with drafting the eligibility and enrollment provisions of the ACA and/or are leading implementation efforts in government, foundations, advocacy groups, and private industry. While difficult to define or measure, and not unique to this effort, the importance of human capital should not be overlooked. Strategies to target investments to individuals and organizations with a proven track record, as well as those aimed at developing emerging talent, will likely pay off in the short and long term.

FEDERAL LEGISLATION SERVES AS A CATALYST FOR INNOVATION

Major federal legislation – such as the passage of CHIP – creates momentum that can cause bursts of innovation and dramatic leaps forward in reforming public coverage policies and systems, even beyond the specific mandates of the legislation. Foundations can play a critical role in effectuating implementation and accelerating innovation, and in forming and shaping their direction. For example, shortly after the passage of CHIP, the Robert Wood Johnson Foundation (RWJF) invested more than \$150 million over 10 years (1997-2007) in two initiatives, *Covering Kids* and *Covering Kids and Families*, to build and support state-based coalitions to enroll eligible, but unenrolled, children. While impossible to measure precisely, it appears that these efforts contributed to the decrease in the number of uninsured children by nearly 3 million between 1997 and 2005 (*Covering Kids and Families* 2013).

This lesson is particularly resonant given the coverage and streamlining provisions in the ACA. There are, however, important differences between the passage of CHIP and the ACA, most notably the gap between enactment of the legislation and implementation, the magnitude and complexity of the effort, and perhaps most critically, the contentious political debate about the ACA.

FIGURE 2. CHILDREN ENROLLED IN MEDICAID AND CHIP, 1995-2012

Source: CMS 2013b

INVESTMENTS IN STATES DRIVE CHANGE

Investments within the states – whether in technical assistance (TA) to government agencies or seed funding for grassroots groups – have been critical to driving policy change but also to supporting implementation. Because so much policy is determined and implemented at the state level for Medicaid, CHIP, and soon for many Marketplaces, initiatives that are confined to groups and efforts in Washington, DC, will have limited impact. Funding at the state level is important at any time but critically so with respect to ACA implementation.

To the extent that state funding is coordinated with investments at the national level, this can magnify the impact. State and federal collaborations – among government, advocates, and funders themselves – are likely to be increasingly predictive of success. For example, the RWJF State Health Reform Assistance Network (State Network) provides TA on ACA implementation to 11 states. Through hands-on TA to state agencies and convening of state and federal policymakers on key implementation issues, the State Network has accelerated the flow of information to states and created a feedback loop to federal officials, ultimately informing implementation of the ACA (State Network 2013). Notably, state officials attribute the success of the State Network initiative in part to the fact that it tailored the TA to the different needs of each state. By contrast, while the RWJF Covering Kids and Families initiative was generally considered successful, several state officials and advocates note that it would have benefited from being less prescriptive and allowing greater flexibility for individual states and their coalition partners to be responsive to the needs of their diverse state environments.

IMPLEMENTATION IS WHERE THE REAL ACTION IS

Legislative and regulatory victories at either the state or federal level are not enough. Establishing an effective eligibility and enrollment process is first and foremost about implementation – the practical and often tedious work of translating policy and law into action. Foundation support for this work can stretch over years, and can range from funding consumer organizations to advocate from the outside for progress, to TA to states, to the development of IT tools for states' use in implementation. For example, the Enroll UX

2014 initiative, funded by a coalition of health foundations led by the California HealthCare Foundation (CHCF), developed a model enrollment portal design for use by the FFM and states. An earlier effort funded primarily by CHCF, the One-e-App initiative, produced an integrated electronic application for health insurance and human services programs. Both initiatives involved retaining leading IT firms to develop tools that could be deployed by government agencies to support a streamlined eligibility and enrollment system. These initiatives went far beyond telling officials why streamlining was important or what policies to adopt; they helped government implement the policies themselves.

While both CHCF initiatives produced state-of-the-art enrollment tools, the adoption of Enroll UX 2014 is proving to be on a scale that eluded One-e-App, which is now used in five states.² This may be attributable to fundamental differences in the initiatives. Enroll UX 2014 is a design prototype targeted to new systems under development at the state and federal levels. These new systems are mandated by federal law and paid for with federal funding. One-e-App, in contrast, is an IT installation that requires states to replace existing systems. The improvements offered by One-e-App are not federally mandated, and states must contribute to the implementation cost. Finally, while both initiatives involved public officials in product development, Enroll UX 2014 did so on a national scale and with a level of intensity unmatched by One-e-App. This collaboration has helped to spur high levels of interest among many states and augers well for broad-scale adoption.

EXTERNAL FACTORS SLOW, BUT DO NOT NECESSARILY PREVENT, PROGRESS

Finally, it is perhaps obvious that external factors have enormous influence on the impact of foundation investments. The political environment and administration and agency leadership at the state and federal levels are primary predictors of success. Changing that political environment is beyond the control of foundations and those they support. But this is not to say that progress cannot be made.

While it may be tempting, and sometimes even prudent, to pursue the low-hanging fruit, foundation investment in the context of a contentious external environment can pay off. One example is the Texas Well and Healthy Campaign, where a coalition of children's advocacy groups supported by The Atlantic Philanthropies, Cover Texas Now, and The David and Lucile Packard Foundation came together to expand access to affordable health coverage for children and families. The campaign successfully advocated for improvements in enrollment, renewal legislation, and staffing and procedural changes at the Health and Human Services Commission. Despite long-standing debate about expanding public insurance programs in Texas, since 2007 the campaign's collaborative efforts resulted in implementation of streamlined eligibility processes that contributed to securing health coverage for more than 800,000 uninsured children (Children's Defense Fund-Texas 2013). While the Texas experience illustrates that success is possible despite external factors, the climb is far steeper and the victories much more modest when the political climate is charged and/or the budget outlook is austere.

With these lessons in mind, the next section outlines opportunities for foundation support of streamlined eligibility and enrollment processes in a post-ACA world.

² At least 11 states have leveraged Enroll UX 2014 design materials or used the design specifications to inform their Exchange and/or Medicaid eligibility and enrollment portals, pending final implementation decisions. Other states are also evaluating the design. (Additional details are available on the Enroll UX 2014 Web site: <http://www.ux2014.org/implementation/november-update>.)

OPPORTUNITIES FOR STRATEGIC INVESTMENT IN 2014 AND 2015

The ACA provides a road map for nearly universal coverage, providing the opportunity to expand Medicaid to nondisabled adults with incomes below 133 percent of the FPL; financial assistance for consumers with incomes between 133 percent FPL and 400 percent FPL; policy reform and funding to improve the eligibility and enrollment process across Medicaid, CHIP, and the Marketplace; and new resources for outreach, education, and enrollment assistance. Despite new federal mandates and funding, foundation support remains essential to realizing the goal of expanded access and coverage, enabled by effective eligibility and enrollment policies and systems. Foundation funding offers flexibility that government resources lack. Unlike government dollars, foundation dollars do not have to be appropriated by state legislatures and are not subject to state procurement rules that can delay investments for months or even years. Because they exist outside the political process and leverage private funds, foundation investments could interject credible and neutral voices and information that could help defuse polarization and create room for objective discussion. Finally, foundations support a wider range of actors. Relatively few government dollars are targeted to community-based organizations, for example, and yet grassroots groups are critical to enrollment efforts.

The following section examines potential foundation investment priorities. Each section starts with a statement of the challenge at hand and then identifies investments that, based on past experience and current need, are likely to have the greatest impact. It bears noting that state-focused investments must be tailored to reflect a particular state's landscape, including the state's Marketplace model – federal, partnership, or state-based – and whether the state has expanded its Medicaid program to new adults. Finally, some of the proposed investments could be made by one foundation focused on one state; others would benefit from a multistate strategy, potentially engaging multiple state-based foundations. Some could involve one or more foundations targeting resources to national organizations.

Since passage of the ACA, a considerable amount of work has been done to implement the law's new coverage provisions. In all states, at least some of these new coverage provisions will go into effect on January 1, 2014. Despite this, the continuum of coverage will not be seamless on day one. In many states, there will be gaps in the availability of coverage. In all states, there will be system challenges and policy obstacles that will need to be addressed. And these challenges will exist in a polarized environment, where routine glitches may be fodder for criticism. Thus, the immediate challenge is to solidify the progress that has been made while highlighting and addressing what remains to be done to bridge remaining coverage gaps, encourage take-up, and implement a continuum of coverage.

SUPPORTING THE MEDICAID EXPANSION

The U.S. Supreme Court decision effectively making the Medicaid expansion voluntary will leave many low-income Americans without access to affordable health insurance coverage in 2014. To date, it appears that half the states will *not* expand in 2014, including states that have among the highest percentages of uninsured residents (and lowest current Medicaid eligibility levels) in the country, such as Texas (28.8 percent), Louisiana (24 percent), Florida (22.8 percent), and Mississippi (21.7 percent). By one estimate, 9.7 million Americans out of the 15 million potentially eligible low-income adults live in states that will not expand Medicaid (The Washington Post 2013). It is certainly possible that more states will take up the expansion after 2014. It bears noting that it was 17 years after the initial passage of Medicaid in 1965 before all states had Medicaid programs. (By 1972, all states but Arizona had joined Medicaid; Arizona joined in 1982.)

Among the possibilities for investment are the following:

- Support initiatives aimed at increasing the take-up of subsidized coverage in the Marketplace. While not directly an investment in advancing the Medicaid expansion, increased take-up reinforces the value of

coverage made available under the ACA, which is an essential backdrop of expansion and streamlining goals addressed here.

- Support research and publications documenting and comparing the impact of the coverage gap on consumers, providers, and businesses in non-expansion states, and those in expansion states. While Medicaid coverage has always varied widely across states, in 2014 the differences will be stark, as low-income, childless adults gain coverage in some states while the same individuals in neighboring states do not. In addition to documenting the impact of non-expansion, it will be equally critical to document the impact of expansion – what it means for consumers, providers, businesses, and the economy in expansion states.
- Invest in state-based organizations that are positioned to translate the data into policy change. At a minimum, that means investing in organizations that are positioned to work with a wide array of constituencies, including provider and business groups, to explore the social and economic impacts of Medicaid expansion. Informing state legislators will be a key component of these efforts, given their influence in the state decisionmaking process. In some states, an additional or alternative initiative might assist local officials, including mayors, county executives, legislators, and public health officials, as they seek to educate their constituents about emerging coverage options (Pear 2013). The ACA is complex, and it is critically important that those in the private and public sector are positioned to explain the coverage opportunities to their constituents if the continuum of coverage is to have real meaning.

ENROLLMENT POLICIES FACILITATING ACCESS TO COVERAGE

The ACA provides a host of policy changes designed to improve the eligibility and enrollment process; for these policy changes to be effective, however, support for their uptake and implementation will be essential. Foundation-funded thought leadership has fueled incremental progress toward streamlined enrollment. For example, foundation-supported work by the Urban Institute and the Center on Budget and Policy Priorities was cited by the Center for Medicaid and CHIP Services (CMCS) in its State Medicaid Director letter outlining states' authority to extend Medicaid renewals scheduled in the first quarter of 2014 to later in the year; enroll individuals into Medicaid based on their eligibility for the Supplemental Nutrition Assistance Program; enroll parents into Medicaid based on children's income eligibility; and adopt 12-month continuous enrollment (CMS 2013c).

Going forward, it will continue to be important for foundations to fund the research and thought leadership necessary to develop new streamlining policies (see discussion below regarding investment in research on the second wave of eligibility and enrollment simplification), as well as the advocacy necessary to ensure adoption of optional policies and practices that enable people to get and keep health insurance coverage. While the ACA and the more recent policy guidance offer any number of optional strategies to facilitate consumer-friendly enrollment across the continuum of IAPs, on-the-ground advocacy in states will be required to assure that state officials understand them. Both expansion and non-expansion states stand to benefit from the ACA's streamlining requirements, as they offer a vehicle for increasing coverage among currently eligible individuals who are uninsured.

OUTREACH, EDUCATION, AND MOBILIZATION

Perhaps the single biggest obstacle to providing health insurance coverage to the uninsured is the fact that three years after its enactment, the ACA remains a mystery to most Americans. Americans, including uninsured Americans who have the most to gain, report little understanding of the impact the ACA will have on them. In fact, 40 percent of Americans think the law has been repealed (KFF 2013a). No matter how consumer-friendly the eligibility and enrollment process is, consumers will not seek health insurance coverage unless they understand and value what coverage offers.

The political battle over the ACA has obscured plain facts about what the law offers and to whom. And while federal and state investments in outreach and education will gain momentum in the coming months, they will likely be inadequate to fill the knowledge gap. At most, government dollars for outreach and public education will be a partial solution, creating a national “teachable moment” on the value and importance of

EXAMPLES OF FEDERAL INVESTMENTS IN OUTREACH AND EDUCATION

- In April 2013, CMS announced \$54 million in cooperative agreements to fund navigators in both federally facilitated and state-based Marketplaces to help consumers understand and enroll in coverage (CMS 2013e).
- In January 2013, CMS launched its third round of Connecting Kids to Coverage Outreach and Enrollment grants that will provide up to \$32 million to support outreach strategies and to fund activities to help families understand the health coverage options and application procedures for IAPs (Grants.gov 2013).
- In April 2013, CMS awarded \$8 million to Weber Shandwick to launch an awareness effort about the FFM. The initiative will largely target young adults with a two-prong approach, starting with basic education, followed by efforts to enroll young adults from October 2013 through March 2014 (Dickson 2013). This contract builds off of an October 2012, \$3.1-million award from CMS to Weber Shandwick to lay the groundwork for this effort (Dickson 2012).
- In May 2013, U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced and in July awarded \$150 million in new funding for 1,159 community health centers to provide in-person enrollment assistance to help enroll more uninsured in the new health coverage options under the ACA (HHS 2013b). Health centers are expected to hire an additional 2,900 outreach and eligibility assistance workers to assist millions of people nationwide with enrollment into affordable health coverage with these funds.

health insurance coverage offered under the ACA. Federal officials have noted the importance of targeting healthy, young Americans – the “young invincibles” – in order to ensure stable risk pools and keep the cost of coverage down in insurance Marketplaces (Emanuel 2013; Gehrke 2013). Thus, much of the administration’s efforts likely will be targeted with that audience in mind.

States’ spending on outreach and consumer assistance varies widely. For example, California, with 5.3 million uninsured residents, is likely to be among the most resourced states in the nation (California Health Benefit Exchange 2013). In California, the Health Benefit Exchange provided \$43 million for an Outreach and Education Grant Program and also awarded \$14 million to Ogilvy Public Relations Worldwide to develop, implement, and manage the Assistors Program and Marketing Plan. In addition, on May 6, 2013, The California Endowment announced its commitment of \$26.5 million to fund the state’s Medi-Cal expansion outreach under the ACA (Gorn 2013). Florida, on the other hand, is on course to spend \$6 million to reach out to 4 million uninsured individuals. While private entities, including health insurance companies, are also planning outreach and enrollment campaigns, the scale and impact remain unclear (Haberhorn 2013).

While foundation investment in outreach and education to-date is obviously not of the magnitude of the federal government’s, it is often more strategic or targeted to specific states or communities. In addition to the \$26 million committed by The California Endowment, among the more significant foundation investments are the following:

- Since 2008 RWJF has awarded over \$15 million toward its Maximizing Enrollment program, designed to help states increase enrollment and retention of eligible children into Medicaid and CHIP and to establish best practices among states in this area. The initiative focuses on five core areas, including the testing and development of strategies to enroll eligible children. RWJF also awarded \$13.5 million to Enroll America and \$2 million to Community Catalyst to coordinate efforts in 12 states to develop and implement outreach, enrollment, and education strategies to maximize enrollment under the ACA (Maximizing Enrollment 2013).

- The New York State Health Foundation awarded \$1.2 million in December 2012 to the Community Service Society of New York to expand its Small Business Assistance Project (NYSHF 2013). RWJF and CHCF likewise targeted funds to educate and assist small businesses regarding the ACA's coverage options.
- The David and Lucile Packard Foundation (2013) has awarded over \$8.6 million in grant funding through its Insuring America's Children: State's Leading the Way Program. One component of the program, The Getting to the Finish Line Project, initiated in 2011, has awarded grants to advocacy organizations in 12 states that are positioned to help insure more children and families. Grantees include organizations in Arkansas, California, Colorado, Kansas, New Mexico, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, and Wisconsin.
- The Blue Cross and Blue Shield of Minnesota Foundation (2013) awarded \$700,000 to six Minnesota-based organizations to conduct outreach and assist families in completing insurance applications.
- The Atlantic Philanthropies (2013) has long supported campaigns to increase the uptake of health insurance among uninsured children. In addition to grants made to the Children's Defense Fund and 100 Percent Campaign among others, Atlantic awarded \$3.25 million in 2012 to the National League of Cities program, Cities Expanding Children's Access to Health Care, to expand children's health coverage by strengthening the capacity of city officials to serve as champions, educators, and advocates for health insurance for children.

Over the next two years, foundations could build upon these existing efforts by making some of the following strategic investments with potentially long-lasting impacts (Galewitz 2013).

- **Consumer Outreach and Education** – Consumers are in need of clear, objective information about their coverage options under the ACA, how to apply, and the importance of coverage to their health and financial well-being. Foundations, through their grantees, have traditionally served as a credible moral voice in public education efforts, standing above the political fray and providing factual information that educates the public and promotes public health. Specifically, foundations could develop and disseminate educational materials, train community-based organizations and other trusted organizations in the community, and thereafter fund the work of these organizations to educate consumers. Foundations might also consider investing in “back-up” experts available to assist – on close to real-time basis – community organizations as they encounter unanticipated and complicated issues.

Given the federal targeting of “young invincibles,” foundations, with a traditional focus on poor and vulnerable populations, have an important role to play in developing messages targeted to low-income consumers. Foundation support already is being provided to develop methods for population segmentation and targeted marketing. For example, Enroll America, a nonprofit organization working to maximize the number of uninsured Americans who enroll in health coverage, synthesizes and analyzes multiple data sources to create specific outreach maps highlighting areas with uninsured individuals (Enroll America 2013). The organization utilizes the maps to create targeted marketing campaigns to engage hard-to-reach individuals, and couples this strategy with mobilization efforts among a diverse group of stakeholders – health insurers, hospitals, doctors, pharmaceutical companies, employers, consumer groups, faith-based organizations, civic organizations, and foundations – seeking to educate people about health coverage. Further foundation support to develop messaging targeted to vulnerable subpopulations and strategies to engage the minority press would complement federal investments and existing efforts and ensure that outreach and education efforts reach those most in need.

Finally, monitoring and fact-checking public messaging will be critical to countering campaigns that may confuse potentially eligible individuals and families. Again, foundations could invest in state-based and national organizations with the expertise to monitor and quickly disseminate accurate information to consumers and the general public.

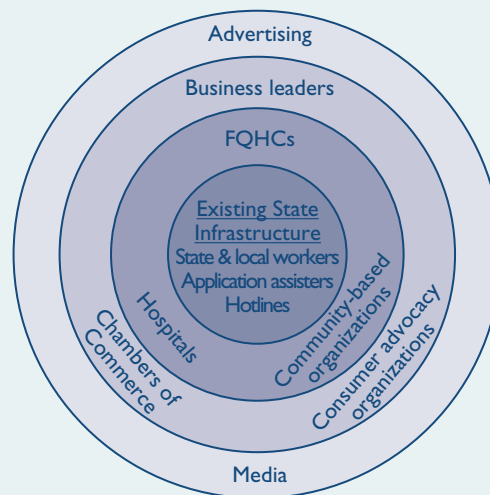
- **Education and Training of State Legislators and Local Officials** – Over the course of the last year, the importance of state legislators in determining whether or not a state expands Medicaid, implements a state-based Marketplace, or adopts streamlined enrollment policies has become increasingly clear. Accordingly, in addition to providing support for consumer organizations, foundations could consider providing TA and educational support to state and local officials. Foundations may support state and local officials in a number of ways. Similar to RWJF’s assistance to members of the executive branch, foundations could provide direct TA, offering ongoing support from external consultants and policy experts to overextended legislative staff and members. For example, CHCF provides regular analyses and updates on federal ACA implementation, which are distributed broadly to state officials in both the administration and the legislature. Foundations also could fund existing organizations that support legislators, such as the National Council of State Legislatures, which provides research and TA for policymakers and facilitates the exchange of ideas on pressing state issues. Foundations also may consider funding groups outside the Beltway such as community-based organizations and think tanks that provide objective information and assistance to state and local officials. In this vein, The Atlantic Philanthropies is currently supporting the National League of Cities, a member organization dedicated to helping municipal leaders build stronger communities by serving as a resource and advocate for its members (National League of Cities 2013). Foundation investments that directly and indirectly provide objective education and TA to state legislators and local officials will be critical.
- **Education and Training of State and Local Workers** – Well-prepared state and local agency staff also is critical to the successful implementation of the new policies and systems. State/local workers have operated under pre-ACA rules for decades. Changing workers’ perceptions about Medicaid requires a fundamental sea change. Moving from a system where eligibility workers made the majority of decisions and used discretion regarding documentation requirements to a system that is rules-based and electronic is monumental. It requires a shift in attitudes and job responsibilities, and may require development of new skill sets.

Early education is critical to prepare state/local workers as they adopt new roles and responsibilities. Many workers are not aware of the changes taking place, and will require training on new IT systems, new Medicaid policies, and new business processes, as well as “soft skills” training in the consumer-centered approach to coverage (Angeles et al. 2012).

The public’s confusion about the vision and details of the ACA extends to state/local eligibility staff. Foundations could play a pivotal role in supporting the education and training of state/local workers. In the area of training, foundations might invest in developing materials, toolkits, and modules in consultation with state officials that could be deployed to meet state-specific needs, including webinars and other on-line trainings that do not require state workers to travel.

- **Mobilization** – Foundations have the opportunity to magnify the impact of education efforts through creating or supporting the infrastructure for a large-scale, grassroots campaign. Marketing and education alone will not be adequate to reach eligible individuals. Like any good campaign, consumers need boots on the ground – distributing information at health fairs, door-to-door, through faith organizations, business groups, and other

FIGURE 3. INVENTORY OF EXISTING OUTREACH AND EDUCATION RESOURCES



venues and channels and providing concrete assistance in navigating the application process. Foundations could start by supporting the development of an inventory of existing outreach, education, and enrollment resources, including state and local workers/assisters/hotlines; federally qualified health centers/hospitals/community-based organizations; business leaders/consumer advocacy organizations/chambers of commerce; and media/advertising. While this infrastructure will be augmented under the ACA through the deployment of Navigators and In-Person Consumer Assisters, these new resources alone will be inadequate to meet the need. With this inventory, foundations could target resources to those organizations best equipped to ratchet up education and enrollment assistance activities.

In addition, foundations could fund research on the best strategies, messages, and messengers for providing assistance, as well as the barriers that deter enrollment. Foundations also could fund TA to assisters, and opportunities to share best practices across regions or states.

Foundations also could underwrite organization and mobilization of networks – from grassroots to grassstops – and support the development of materials, including organizing toolkits that go beyond the educational materials discussed above. Additional efforts will be needed within the states to mobilize state-based coalitions, and to provide enrollment assistance.

- **Medicaid Rebranding** – In the past year, federal officials have invested in consumer testing to develop a brand for the new health insurance marketplaces, which resulted in changing the name of the program from “Exchange” to “Marketplace.” This effort included re-launching www.healthcare.gov to focus more on helping consumers understand their coverage options (Kennedy 2013). Similar investments have not been made in the history of the 40-year-old Medicaid program, despite concerns about perceptions of the program (AP 2011; Lewis 2010).

Research on the prevalence of a Medicaid stigma is mixed – while some studies have indicated that consumers negatively associate Medicaid with welfare programs, polling shows that public support for the program remains high (Smith 2000; KFF 2013b). Yet few would argue that Medicaid as a program has developed a compelling market brand – public support is driven more by the recognized need for the coverage that the program offers than positive associations with its offerings. The Medicaid brand has an impact on consumers’ willingness to enroll in the program, elected officials’ willingness to fund it, and the public’s willingness to get behind the program with tax dollars and other support. It can also affect the culture of the program itself – influencing perceptions among program administrators and staff of the import of their work, as well as attitudes about the people the program is designed to serve. While rebranding alone cannot transform a state’s Medicaid program, it is a critical complement to systemic changes designed to improve the consumer experience and integrate Medicaid into the new coverage continuum.

In the immediate term, foundations could work with state Medicaid agencies to rebrand and redesign Medicaid home pages. With the launch of new federally mandated electronic applications, an increasing number of applicants will view the Medicaid Web site as the front door to the program. Yet the typical state Medicaid agency Web site is not designed with this purpose in mind. Foundations could help states transform these sites to make them welcoming to consumers and to advance a positive Medicaid brand within the state and within the insurance continuum.

Over the longer term, foundations could support work to rebrand Medicaid as health insurance coverage and part of the continuum of IAP coverage. Lake Research Partners and GMMB have done initial testing of Medicaid and CHIP messaging, yet much work remains to be done. Using experiences of families with members in multiple insurance programs (such as Medicaid, CHIP, and qualified health plans with tax credits), foundations could work with state and federal officials, as well as advocates, providers, participating health plans, and other program stakeholders to both better understand the program’s strengths, and develop a plan to transition the program’s identity. Of course, such efforts will only have value if paired with efforts to ensure that the programs are prepared to live up to the promise of the new brand (Betty 2013; GMMB 2013).

PROVIDING TECHNICAL ASSISTANCE TO STATES

Investment in TA to states on the design and implementation of streamlined eligibility and enrollment policies and systems has been identified by streamlining experts and advocates as a high-priority area for foundations. The unprecedented magnitude of the changes mandated under the ACA falls on already-stretched state bureaucracies. Staff shortages, state budget constraints, civil service rules, and procurement laws conspire to tie the hands of Medicaid/CHIP officials, preventing them from hiring or contracting for the staff and expertise they need to effectuate the ACA's eligibility and enrollment mandates. While procurement barriers are not a new issue for states, tight ACA implementation timelines exacerbate the situation. As a result, even the most committed and sophisticated state officials are overwhelmed by the scale of required change – ranging from revising decades-old regulations, statutes, policy manuals, and training materials, to procuring new IT systems and forging new relationships among Medicaid agencies, insurance agencies, and Marketplaces.

RWJF has made considerable investment in state TA, as have state foundations in California, New York, Missouri, and Colorado. These foundations have funded staff extenders, as well as specialized expertise from organizations and consultants working across multiple states. For example, the New York State Health Foundation collaborated with state officials to retain Social Interest Solutions to jump-start their IT gap analysis. Prior to the passage of the ACA, the foundation, again at the request of New York State officials, also retained the Georgetown Center for Children and Families to identify where New York law could be streamlined, consistent with then-existing federal law. Based on that analysis, New York's Medicaid leadership was able to eliminate its asset test and face-to-face interview requirements, as well as some documentation requirements. While not uniformly successful, these state investments can lead to real improvements in the eligibility and enrollment process.

Among the lessons learned from these investments are the following:

- The “right” state officials must be leading and committed to the TA effort from inside the government for the TA to have an impact on state policy. That means involvement of both a high-level official committed to using the TA to advance an identified goal and someone in the trenches who has sufficient credibility to pull in state resources as needed and who has or makes the time to liaise with the outside resources. In short, the TA investment is most effective when the state is positioned to be a good consumer of TA services.
- The “right” TA provider addressing the “right” topic and providing the “right” deliverable are all components of a successful TA project. That means identifying and funding an individual or organization that comes into the state with a level of credibility and deep expertise. The TA must be directly related to the goal the state is trying to advance or the problem the state is trying to solve, providing information, solutions, or products that the state can use.
- A long-term relationship between the funder and the state is a plus in maximizing the effectiveness of the investment in state TA. While states desperately need greater bandwidth, they do not always know how to deploy the TA organization or the tools provided. Over time, the foundation and state officials can build trust and learn how to best develop and deploy resources that the state can use. A longer-term relationship proved valuable in RWJF's multiyear State Network initiative and is likely to be important over the ACA's extended implementation timeline.
- Looping federal officials into the TA work, formally or informally, can enhance the value of the investment in two respects. First, it provides the state with timely input from federal regulators, and second, it provides federal officials with an additional gauge of state implementation issues while providing them with substantive support in the areas of the TA. That is, federal officials are often able to use the work of the TA provider to inform their own thinking. Given the extraordinarily fast pace of ACA implementation, this added benefit should not be underestimated.

The need for TA with respect to ACA implementation generally and the eligibility and enrollment provisions specifically will continue well beyond 2014. For Medicaid, the ACA represents a monumental

paradigm shift, virtually turning on its head 40 years of history, requiring equally significant changes in law, regulation, systems, and culture. For exchanges, the task of building new systems (in state-based Marketplace states) and integrating with federal systems (in FFM states) is vast and complex. In addition to addressing the issues raised above, foundations will want to decide which investments will most contribute to the development of a real continuum of coverage in the particular state.

INVESTING IN A FEEDBACK LOOP

Interviewees from both the public and private sectors discussed the importance of a feedback loop starting with open enrollment. Successful state/federal feedback loops have been part of several major foundation investments, most notably the RWJF State Network and the CHCF Enroll UX 2014 initiative, discussed later. The suggestion here is somewhat different, namely, that foundations consider funding an initiative that would bring trusted and informed state officials and advocates working “on the ground” in key states together to track implementation; identify obstacles; identify possible solutions (preferably quick solutions); and organize the information and transmit it as appropriate to key federal officials in CMCS, Center for Consumer Information and Insurance Oversight, or the White House and to key state officials. While the media will focus on high-level successes and on the most visible failures, neither provides a constructive basis on which to take action. A past example occurred in New York shortly after the passage of CHIP when the United Hospital Fund, the Robin Hood Foundation, and The New York Community Trust funded the Children’s Defense Fund-New York to convene community-based facilitated enrollers to monitor the impact of policy changes on enrollment and retention and establish a feedback loop to state Medicaid and CHIP officials. More recently, RWJF funded a collaboration among more than a dozen state and national consumer advocacy groups, collectively called the “Gateways” group, to provide joint feedback to federal officials on various aspects of ACA implementation. Recent topics for feedback include the new single streamlined application, enrollment policies and process flows, and draft model eligibility notices.³ Similarly, the goal of an ACA feedback loop would be to organize and convene knowledgeable individuals and organizations and issue-spot quickly and work with federal and state officials to address issues equally quickly. The goal is to put information from the field into the hands of officials who can make use of it in a timely manner.

INVESTING IN INFORMATION TECHNOLOGY

The IT infrastructure that underlies state eligibility and enrollment systems has, by all accounts, been an enduring barrier to streamlined and consumer-friendly enrollment processes in the states. The rules laid out in the ACA increase reliability on electronic data and processes, such that more sophisticated systems are essential. Yet state eligibility systems typically have been minimally improved over the last 30 years (42 CFR §433.112, 2013). Most state Medicaid agencies rely on antiquated systems, many of which continue to rely on COBOL, a computer language written in the 1950s that is notorious for lengthy coding (Neff 2012). Further, many state Medicaid information systems are administered by other state agencies, such as welfare agencies or centralized administrative or IT agencies. This requires Medicaid agencies to compete with other state priorities for routine programming requests, as well as for broader-scale innovation.

Prior to passage of the ACA, efforts to update state systems focused primarily on claims payment, rather than eligibility or the consumer interface, driven in part by the fact that enhanced federal matching funds have been limited to the former (CMS 2013d). The ACA’s requirements for an electronic eligibility system, coupled with recent change in policy (mentioned above) permitting states to use enhanced funds to build (90 percent federal match) and operate (75 percent federal match) streamlined eligibility systems, have prompted a wave of investment across the country.

³ This “Gateways” group includes Center for Public Policy Priorities; Center on Budget and Policy Priorities; Children’s Defense Fund-New York; Colorado Center on Law and Policy; Economic Progress Institute; Florida Legal Services; Georgetown University Center for Children and Families; Health Care For All Massachusetts; Illinois Maternal and Child Health Coalition; Legal Services of Southern Piedmont; Maine Equal Justice Partners; Pennsylvania Health Law Project; Tennessee Justice Center; and Virginia Poverty Law Center.

Foundations traditionally have played a limited, but critical, role in supporting improvements in Medicaid information systems. Most notable are the efforts of CHCF, which seeded the creation of an integrated electronic application for health insurance and human services programs (One-e-App), and more recently managed a coalition of funding partners in the creation of a reference model for a first-class user experience design for health insurance exchanges (Enroll UX 2014). One-e-App is currently in use in several states. It appears that most states and the federal government are relying on Enroll UX 2014 to design a consumer-friendly Marketplace Web site and enrollment process.

With new mandates and hundreds of millions of dollars in enhanced federal funding on the table, it is reasonable to question whether additional private investment is needed. Past and current experience with Medicaid IT, however, indicates that there is still a potential role for foundations in advancing innovation and supporting state capacity.

- **Promoting Best Practices** – With the enormous investment currently being made in deploying new and improving existing IT systems and tools, there is a critical need to identify and promote innovations that bring value across state lines. A small number of vendors are developing and managing multiple state projects across the country (State Health Access Data Assistance Center 2012). While the vendors all operate within a competitive environment, federal funds have been conditioned on open use of artifacts developed with those funds, to minimize duplication of resources and support shared learning. Federal officials have been directly involved in these efforts – counseling states and vendors on federal requirements, posting artifacts in a central location on-line, and hosting multiple forums for state and federal officials to exchange information. Nevertheless, the pace of deployment, inevitable given pressing statutory deadlines, has forced states and federal officials to develop IT solutions on somewhat parallel paths – condensing the development cycle and limiting opportunities to leverage work across projects.

Most states will enter 2014 with dramatically improved (but still far from ideal) IT tools, including streamlined eligibility and enrollment systems, streamlined electronic application forms, and data sharing and matching agreements and interfaces (HHS 2013a). Virtually all states will continue with new deployment well into 2014, and beyond, including integrating IAPs with other Medicaid offerings and human services programs. And all states (and federal officials) will have upgraded their newly deployed IAP enrollment systems, adding additional features that were abandoned in an effort to meet the demands of the commencement of open enrollment on October 1, 2013, and making adjustments as unanticipated problems and opportunities for improvement are revealed.

Foundations could play a supportive role in documenting and disseminating best practices in IT systems and tools. For example, foundations could provide support for tracking systems issues and specific solutions, convening state and federal officials and industry vendors, and encouraging reuse of successful solutions.

- **Seeding Innovation** – The experience with One-e-App and Enroll UX 2014 illustrates the value that foundations can bring in stimulating innovation in the eligibility and enrollment IT market. While 2014 will be a watershed year for IT development for publicly funded health insurance programs, IT is a dynamic field, and continued innovation will be necessary to meet rising consumer expectations for a state-of-the-art application and enrollment experience. It is not yet clear what the next major opportunity for innovation will be. However, given that the FFM will be the central hub where people first go for coverage, foundations could fund experts to evaluate its usability and provide recommendations on features that can easily be improved. Such efforts could reveal further innovation opportunities.
- **Shifting Market Dynamics** – Finally, multiple market dynamics currently conspire to disadvantage eligibility and enrollment IT development. The market of IT vendors for government health insurance programs is highly consolidated. Complex and burdensome procurement rules incentivize states to maintain incumbent relationships, and scarcity of funding forces piecemeal upgrades and work-arounds rather than full-scale redesign. State staff is often stretched thin and poorly equipped to manage complex engagements with multiple points of accountability and sophisticated vendors. The lack of competition

and innovation in Medicaid is particularly present in eligibility, the core of the new IT systems, compared to payment or plan selection. Foundations could seek to shift these dynamics to create more competition in the market by performing a competitive analysis and making policy recommendations that, if adopted, would bring in a larger and more diverse group of players into the eligibility and enrollment IT space. Foundations could also convene industry leaders to discuss the need for innovation and/or engage industry experts to recruit new talent – including start-up firms – to compete for eligibility and enrollment dollars. Finally, foundations could help states become better consumers of IT services by providing training and support in procurement, project management, and oversight and accountability.

“SECOND WAVE” OF ELIGIBILITY AND ENROLLMENT SIMPLIFICATION

While the eligibility and enrollment reforms mandated under the ACA and subsequent implementing regulation represent a significant philosophical, legal, and operational shift toward streamlined eligibility and enrollment for public health insurance programs, there can be little debate that the process remains extraordinarily complex. Needs-based programs, by definition, require rules and processes to sort the eligible from the ineligible, and while the ACA created a continuum of coverage, it also left in place differences in eligibility rules for programs across that continuum. Even the most committed efforts to streamline and ensure a seamless continuum of coverage are bumping up against old Medicaid rules and new ACA requirements that are proving more difficult to implement than when conceived.

Some of these differences are structural. For example, benefit packages vary across coverage vehicles, resulting in differing levels and types of benefits across coverage groups; eligibility levels and maintenance-of-effort requirements for children and pregnant women result in individuals in the same household being eligible for different programs; and offers of or coverage under employer health insurance have different eligibility consequences across IAPs. Other differences are more process-based. For example, requirements that eligibility workers be merit-based employees, rules related to counting grandparent income, and medical support obligations for absent parents are different across IAPs.

Many of these disparities reflect policy choices aimed at preserving aspects of the existing Medicaid program – sometimes to hold harmless vulnerable populations currently eligible for Medicaid, sometimes to preserve Medicaid practices or systems. Some disparities are rooted in law and require a statutory change to create alignment. Some, like rules on other coverage, go to fundamental differences in the design of the coverage vehicles and may be unlikely or even impossible to change.

While the merits of each disparity could be the subject of reasonable debate, there is no question that their cumulative result is to create complexity in the application process itself, resulting in longer applications, lengthy and confusing notices, and making it harder for staff and consumers to understand programmatic options and rules. This complexity makes it impossible, for example, to create a mobile application form, a tool that is increasingly market standard for on-line transactions.

A second wave of streamlining is necessary to further reduce this complexity and further streamline eligibility processes. Foundations could, for example, support analyses resulting in a comprehensive accounting of differences in the rules governing IAPs, identify where rules can be simplified, and document options and implications for alignment.⁴ Existing CHIP waiting periods are an example of a policy that will not be simplified in this first round of reform but could be the focus of future efforts. This work would be best served by convening state and federal officials, along with consumer advocates and policy experts, to hash through the technical differences between programs and the relative merits of maintaining or eliminating these differences. CHIP reauthorization in 2014 may provide an opportunity and a vehicle to introduce additional streamlining requirements and eliminate lingering barriers to implementation of a continuum of coverage across all IAPs, and this effort could be timed with that vehicle in mind. Given the volume of demands on state and federal officials' time, without foundation support, such an effort is unlikely to happen.

⁴ Similar work was conducted after the passage of CHIP. See The Commonwealth Fund, *Creating a Seamless Health Insurance System for New York's Children* (New York, NY: February 2001).

CONCLUSION

The ACA articulates a vision that embodies more than a decade of work to simplify Medicaid's eligibility and enrollment process by foundations, consumers, and policymakers. However, three years after passage of the ACA, and only months away from implementation, the vision is still far from becoming a reality. Half the states will not take up the Medicaid expansion, leaving millions of their lowest-income citizens without access to subsidized coverage. While most states are moving forward to upgrade their Medicaid eligibility systems, establish interconnectivity with the Marketplace, and amend their laws and regulations to comply with the ACA's eligibility and enrollment rules, they are confronting considerable challenges – legal, practical, and political – that put at risk the vision of seamless and continuous coverage.

There is little doubt that, in the years ahead, the rollout of the ACA will face many challenges. Prior to passage of the ACA, a decade of education and advocacy seeking to advance streamlined eligibility rules and processes – often supported by foundations – had an impact on coverage rates. The impact was not consistent across states and progress was often slow, but there can be little doubt that over time the nation experienced dramatic improvements in children's access to coverage, and it became somewhat easier for adults to obtain and maintain coverage. The ACA provides an opportunity to expand coverage and propel forward streamlined eligibility and enrollment processes and firmly ground Medicaid in the insurance continuum. However, it will likely take years, perhaps a decade or more, to fully capitalize on this vision of continuous coverage. And, for all the reasons discussed in this paper, 2014 will be extremely bumpy. As the rollouts of CHIP and Medicare Part D programs show, early problems are not predictors of long-term success. Foundations, especially those with a long track record of investment in health care coverage and access, are well-positioned to leverage implementation and ensure the provision of affordable health care to low-income Americans.

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