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Implementing the Affordable Care Act: Enrollment Strategies and the U.S. Family Planning Effort

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One of the primary goals behind the Patient Protection and Affordable Care Act (ACA)—the sprawling health care reform law enacted in 2010—is to dramatically increase the number of people in the United States who have health insurance. Today, 50 million Americans are without health insurance, including 13 million women aged 15–44, amounting to 22% of reproductive-age women (related article, page 27).[1] To address that serious problem, the law relies on two major coverage expansions, both scheduled to be implemented in 2014. First, states will be required to extend Medicaid eligibility to all citizens (as well as immigrants after five years of legal residence) in families with incomes at or below 133% of the federal poverty level—a threshold far higher than the income eligibility ceilings in most states today. Second, individuals and small employers will be able to purchase private insurance through new marketplaces called exchanges; most who are currently uninsured will be eligible for federal subsidies to make that coverage affordable. The Congressional Budget Office projects that these two expansions will result in 32 million fewer uninsured Americans in 2016 than would otherwise be the case (see chart).[2]

The extent to which the promise of the ACA is fulfilled depends in large part on how many people actually avail themselves of their new options for health coverage. Thus, the law itself and a series of regulations in the process of being finalized by the Department of Health and Human Services (DHHS) have laid out a number of interrelated strategies for streamlining the enrollment process, coordinating it across programs and helping women and men learn about and choose from among their options.[3–5]

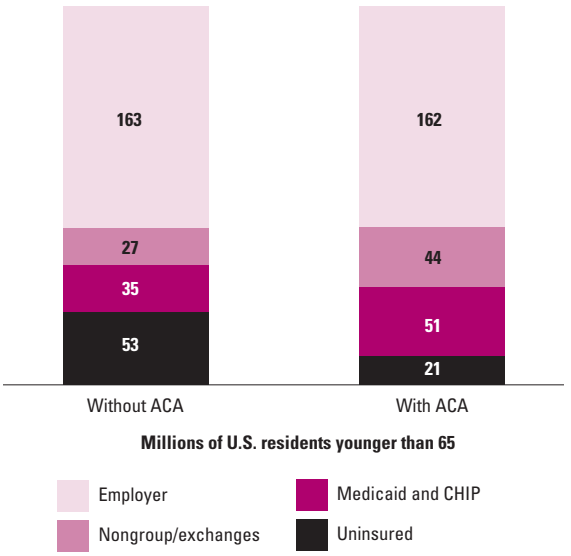
Efforts at streamlining enrollment are vital not only for individuals and families in need of coverage and care, but also for the U.S. health care safety-net system, including the network of more than 8,000 family planning centers throughout the country.[6] More clients with insurance coverage means fewer clients that family planning centers must subsidize in full using their limited supply of flexible grant funds, such as Title X. At the same time, the government officials and health providers who operate the national family planning effort have a unique contribution to make, drawing on the considerable expertise they have developed over the past two decades in implementing state-level expansions for family planning services under Medicaid. For these reasons, it would be to everyone's benefit if family planning officials and providers are at the table as states work to maximize enrollment under the ACA.

Enrollment Strategies under the ACA

Medicaid is a cautionary tale in terms of enrollment challenges. Historically, because of its close ties to welfare cash assistance, Medicaid had placed a strong priority on keeping ineligible people off the program, embodied by numerous bureaucratic requirements, such as requiring extensive written documentation and rechecking eligibility on a frequent basis. That Medicaid-welfare link was broken in the mid-1990s, but even today, after considerable work to address these problems, the rate of Medicaid enrollment among currently eligible adults averages only 62% across the states.[7] The Massachusetts effort

ACA=MORE COVERAGE

Thirty-two million fewer Americans are projected to be uninsured in 2016 than would have been the case under prior law, because of expanded coverage through Medicaid and the new health insurance exchanges.



Notes: Exchange coverage would only exist under the "with ACA" scenario. The nongroup category also includes other types of coverage, such as Medicare. *Source:* Reference 2.

at health reform, which was enacted in 2006, has faced similar issues. Despite remarkable success in expanding insurance coverage in the state, the complexity of the new system has led to problems for Massachusetts residents in learning about available coverage options, moving between these options and keeping up with the paperwork needed to stay enrolled.[8]

In recognition of these types of problems, the health reform legislation and regulations envision a streamlined process for enrolling Americans into either Medicaid or private plans offered through the exchanges. (Also included in this effort is Medicaid's sister program, the Children's Health Insurance Program, as well as potentially other state-run options to subsidize health coverage.) Underlying that streamlined process are several intertwined strategies: coordination among the various programs, accessibility of the application and enrollment process, simplification of that process, minimization of gaps in coverage, and proactive outreach and assistance for enrollees.

Coordination

One of the most important strategies under the ACA to encourage enrollment is to coordinate that process between Medicaid and the exchanges. For example, the law requires eligibility for Medicaid and the exchange subsidies to be measured based on the same definition of income (meaning, that they count and exclude the same items), and prohibits states from also basing eligibility on families' financial assets (which had traditionally been allowed under Medicaid). In addition, states will be required to use a single form to collect the information needed for enrollment in Medicaid and the exchange plans, and to coordinate enrollment across these options. States could accomplish this by having separate application systems that share information or via a single, integrated application system. The goal for all of these measures is to ensure that there is, as many experts describe it, "no wrong door" for an applicant: Regardless of what system individuals use or program they start off applying for, they will be screened for eligibility under all available options and enrolled in the correct one.

Accessibility

Another aspect of the "no wrong door" approach is an emphasis on convenience. Under the ACA, people will be able to apply for coverage in a number of ways: online, by mail, by phone, in person and potentially through other options not yet fully developed. The ACA places a particular emphasis on completing applications remotely, requiring that states set up Web sites for their programs, and prohibiting states from requiring in-person interviews (another traditional Medicaid practice that states have been gradually phasing out). And DHHS emphasizes a goal of ensuring real-time eligibility determination—on any day, at any time—for most applicants.

Even the in-person application process should be more accessible. For example, the law gives states expanded authority to use a technique called "outstationing," under which state employees enroll patients on site at hospitals and other health facilities. This form of enrollment is designed to be more convenient and less stigmatizing than applying at a social services office.

Simplification

Closely tied to the principle of accessibility is the principle of simplification. For applicants, a simplified process is necessary to maximize enrollment and minimize confusion. For states, a simplified process should improve coordination across programs and agencies, and reduce administrative costs.

To these ends, the ACA and its regulations emphasize that applicants be required to provide the minimum slate of information necessary to determine eligibility, while still combating fraud and minimizing errors. The key to making that work is data matching: Rather than requiring applicants to pull together a wide array of documentation on their own, the application system will instead, as a first choice, use federal and state-level databases to automatically locate needed information and verify what applicants have reported. That means, for example, verifying household income via the Internal Revenue Service, citizenship status via the Social Security Administration and immigration status via the Department of Homeland Security—all through a single inquiry routed through DHHS. Eligibility information will also be verified by checking for enrollment in other public assistance programs.

States would still have to request additional documentation when this type of data matching fails. Yet, DHHS has made it clear that in general, applicants should be given the benefit of the doubt, with small discrepancies not being used as an excuse for requiring additional paperwork or delaying enrollment.

Continuity

Policymakers have also taken pains to encourage continuity of coverage under the ACA, building on efforts by most states in recent years to knock down bureaucratic walls under Medicaid that had often led to individuals losing coverage intermittently. For example, proposed regulations require states to first attempt to renew Medicaid eligibility automatically using data matching, with enrollees being sent a notice after the fact requiring no further action on their part. When additional information is needed from an enrollee, DHHS would require states to provide renewal forms prepopulated with all the information already available. The exchanges are expected to be run under similar procedures.

Continuity of coverage also draws on the ACA's efforts to coordinate eligibility across the subsidized coverage options. By minimizing how often enrollees' income and other eligibility information is checked, the ACA aims to prevent individuals from having to switch back and forth among different programs as, for example, small changes to income place them above or below the threshold for Medicaid coverage. And the process of shifting is itself simplified; new rules for Medicaid, for example, would require the program to automatically assess eligibility in other coverage options when enrollees lose their Medicaid eligibility.

Outreach and Assistance

Although all of these steps should go a long way toward encouraging initial and continued enrollment in subsidized coverage options, many Americans will still need help learning about the options available to them and navigating even a simplified enrollment process. In recognition of those needs, the ACA places responsibilities on Medicaid agencies and the exchanges to provide information, conduct outreach and provide assistance to potential and current enrollees.

Notably, the exchanges are given a series of explicit responsibilities in this arena, including maintaining a Web site with a wide array of information for consumers, running a toll-free call center for assistance and, more generally, performing education and outreach to maximize enrollment. DHHS is encouraging states to coordinate or consolidate these types of resources between the exchanges and Medicaid.

The ACA also requires and provides funding for states to establish or improve health insurance consumer assistance programs, such as ombudsmen to help consumers with their grievances. It establishes a "navigator" program, through which the exchanges will provide funding to public or private groups, such as professional associations or consumer groups, to raise public awareness, provide impartial information and facilitate enrollment. DHHS is also encouraging

exchanges to help navigators, along with brokers, caseworkers and others who assist with the application process, to keep track of their clients' records.

Family Planning's Experience

The national family planning effort has helped to pioneer and normalize all of these strategies to varying degrees. Since the mid-1990s, 22 states have implemented broad-based expansions for family planning services under their Medicaid programs (see map).[9,10] (Two additional expansions have been recently approved; related article, page 26.) In those states, Medicaid and health department officials, with assistance from family planning centers themselves, have worked with considerable success to streamline enrollment and reach out to new clients, as documented by a new report from the Guttmacher Institute, *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future.*[11]

As described in the report, most of the states have worked to coordinate the application process for their family planning expansion with other public programs. In Wisconsin, for example, residents can use the state's online system to be screened simultaneously for eligibility in the family planning expansion, other types of health coverage and programs for long-term care, food and energy subsidies, and tax credits. They can then apply for several of the programs, including family planning, through the same Web site.

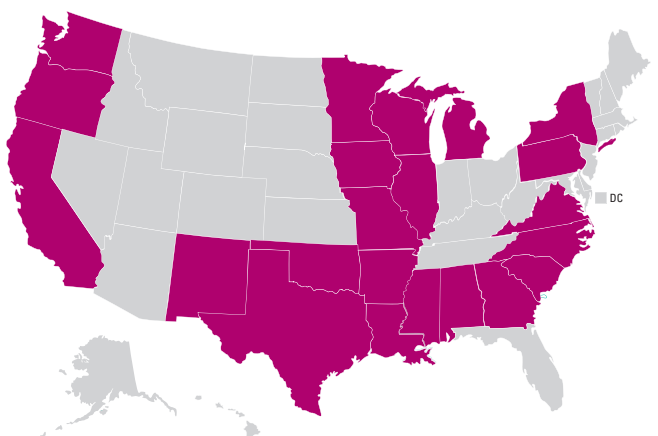
In terms of accessibility, almost all the family planning expansions allow for remote applications, without an in-person interview, and several report that they can achieve real-time eligibility determination. Most of them have also experimented with allowing family planning clients to apply for coverage at the point of service. California and Iowa, in fact, have implemented a groundbreaking enrollment technique that allows clients to sign up for coverage at the point of service, receive services and leave their provider's office officially enrolled in the program. Rather than using outstationed state workers, these states have provided training to clinic personnel to walk their clients through the program application and verify required documentation; the state's computer system then reviews the information provided and issues a notice of decision.

Almost all the family planning expansions have worked to simplify the application process through such steps as using a bare-bones application form, typically one or two pages. The expansions also typically rely on federal, state and even private databases to verify information such as identity, citizenship status, social security number and income.

Many of these same steps—remote application, simplified application forms, data matching—are also used in most family planning expansions to facilitate the renewal process and improve continuity of coverage. At least one of the programs, Missouri's, has already implemented the ACA's approach of automatically renewing a woman's enrollment in the expansion each year, contacting the woman only if information is missing. And at least eight of the states have worked to automate the process of shifting some enrollees between their family planning expansion and other public programs, such as the broader Medicaid program; most commonly, this is done for women who are otherwise losing Medicaid coverage after giving birth.

MEDICAID FAMILY PLANNING EXPANSIONS

Twenty-two states—representing two-thirds of U.S. women of reproductive age—had implemented broad-based Medicaid family planning expansions, as of October 2010.



Sources: References 9 and 10.

Finally, the Medicaid expansions and family planning providers themselves have considerable experience with the types of outreach and enrollment assistance efforts envisioned by the ACA. States have spent considerable effort developing Web sites and telephone hotlines for the family planning expansions to help residents learn about covered services, ask questions about the program and find local providers. States and providers have worked together to conduct community outreach, coordinate outreach across public programs and design educational materials for high-priority populations, such as young adults and Latinas—groups with particularly low rates of insurance.

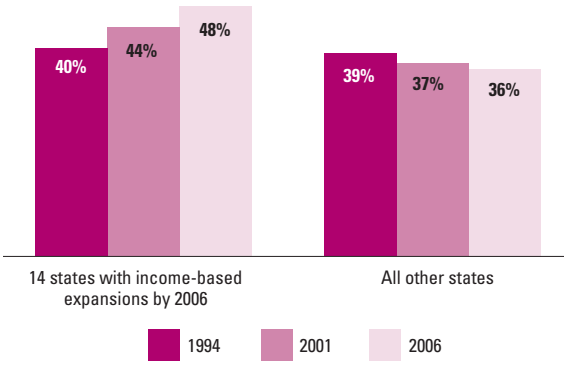
Making the ACA a Success

All this experience makes both state family planning officials and family planning centers natural and valuable partners as states establish and refine their enrollment and outreach systems under the ACA. Family planning officials can bring their experience to internal state deliberations, drawing on what they have seen in their own expansion programs and in those run by other states to inform the broad parameters and the crucial details of these systems. Family planning providers can lend their voice and knowledge to the panoply of health and consumer groups providing comments and feedback to this process.

Perhaps the more important role for providers will come starting in 2014, as states scramble to enroll millions of Americans in Medicaid and the exchanges. Family planning centers could take a wide variety of steps to help this effort, such as providing brochures to their clients, referring them to state hotlines and navigators, and setting up Internet kiosks in their waiting rooms, to allow clients to apply for coverage on site. More ambitiously, they could work with states to station government enrollment staff on site or to train clinic staff to provide application assistance. Centers might even apply to be official navigators for the state's exchange; although the statute does not specifically list health care providers as potential navigators, family planning centers have established relationships with uninsured and underinsured consumers, and many are

MORE COVERAGE, MORE CARE

Family planning centers in states with Medicaid expansions have been able to meet more of the need for publicly supported contraceptive care than those in other states and to expand that share over time.



Notes: Women in need of publicly supported services include those who are sexually active, of reproductive age (13–44), able to become pregnant and not pregnant, postpartum nor trying to become pregnant, and who either have a family income below 250% of the federal poverty level or are younger than age 20 and are therefore assumed to have a low personal income. *Source:* Reference 12.

entirely capable of providing the information and technical assistance required. Their successful experience with point-of-service application for the family planning expansions is evidence of that potential (see "The Role of Family Planning Centers as Gateways to Health Coverage and Care," Spring 2011).

Being part of the navigators program is one potential way for providers to be reimbursed for their efforts to inform and assist their clients, and state officials and providers can work together to identify other sources of funding to support these efforts. Yet, even in the absence of specific funding, it will be in the financial interest of family planning providers to help ensure that the ACA's enrollment efforts are a success. Those providers must rely on scarce grant funding, such as Title X, to subsidize care for uninsured clients. These funds are increasingly under attack, for both ideological and fiscal reasons (see "Wise Investment: Reducing the Steep Cost to Medicaid of Unintended Pregnancy in the United States," Summer 2011). Converting uninsured clients to insured ones—and thereby securing reimbursement for their care—can provide family planning centers with the additional revenue needed to

meet escalating demands, in terms of numbers of uninsured clients, the range of services needed and the cost of new technologies.

Indeed, greater health coverage—in the form of the Medicaid family planning expansions—is the primary reason that public funding for family planning has increased at all in recent years, and it has translated into more clients served. In 2006, a greater proportion of women in need of publicly funded contraceptive care were served by clinics in the 14 states that had implemented Medicaid expansions than by those in all other states (48% vs. 36%; see chart); the proportion served had grown since 1994 in the expansion states (from 40%), but had declined slightly in other states (from 39%).[12]

The lessons learned from the Medicaid family planning expansions will likely be even more salient in a post–health reform America. Helping to ensure that their clients obtain and retain health coverage may be the best chance that family planning programs and providers have to survive and thrive in the decades to come.

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