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THE MEDICAID EXPANSION OF 2014

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THE GREAT MEDICAID EXPANSION OF 2014

WHAT IT IS AND HOW TO MAKE IT SUCCEED

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When President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010, advocates for those of low income rejoiced over the Act's promise to bring affordable health coverage to the thirty-two million uninsured Americans.[1] The Act's extension of Medicaid eligibility to everyone at or below 133 percent of the federal poverty level may be the most crucial provision if this promise is to be fulfilled. This expansion, effective in 2014, potentially insures sixteen million (or half of the uninsured), increases access to quality health care for vulnerable populations, and decreases health disparities. Before 2014, advocates, policymakers, and other stakeholders have an opportunity to influence the states' implementation of the Act to help ensure the expansion's success.

Right now, states are designing their eligibility, verification, and enrollment systems to align with the Act's standards; states are exploring ways to increase efficiency in their Medicaid programs and strategizing on outreach and enrollment. The federal government is proposing regulations on the benefits that newly eligible Medicaid enrollees will receive and the extent to which states' eligibility verification and enrollment must accommodate the special needs of vulnerable populations. Simultaneously states choosing to operate their own health insurance exchanges—through which individuals and small businesses will be able to shop for affordable health insurance and obtain federal financial help to purchase insurance or, if under 133 percent of the poverty level, be enrolled in Medicaid—are moving to make these exchanges operational on January 1, 2014. Advocates, legal aid attorneys, and direct service providers who work with this newly eligible population can help shape policy decisions. Here, for advocates who are not Medicaid specialists, we identify the issues essential to understanding the population that stands to benefit from Medicaid expansion, and we offer a blueprint for successful implementation.

Medicaid Today

Medicaid was enacted in 1965 to provide health insurance to low-income U.S. residents who lacked access to quality, affordable coverage.[2] This safety net program covers nearly sixty million individuals—thus the third largest source of health insurance in the United States.[3] Still, many low-income and uninsured individuals are ineligible be-

[1]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (May 30, 2010).

[2]See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

[3]See Kaiser Commission on Medicaid and the Uninsured, Medicaid Matters: Understanding Medicaid's Role in Our Health Care System 1 (March 2011), http://bit.ly/vrZVEP; Almanac of Policy Issues, Medicaid (n.d.), http://bit.ly/sALUsb.

cause Medicaid traditionally covers only certain categories of people—those who are both poor *and* disabled, blind, over 65, pregnant, a child, or a parent of an eligible child.[4] Most childless adults and many custodial parents are left out.[5] The Patient Protection and Affordable Care Act reforms these federal eligibility requirements.[6] It sets in motion the biggest expansion in Medicaid history.[7]

The Medicaid Expansion

Starting January 1, 2014, the Patient Protection and Affordable Care Act requires states to extend Medicaid eligibility to almost everyone between 19 and 65 living at or below 133 percent of the federal poverty level.[8] Any person who was not eligible for Medicaid on December 1, 2009, and meets these and citizenship requirements will qualify.[9] This will create a more consistent and cohesive policy throughout the country and will extend eligibility to an estimated sixteen million.[10]

Financing

Funding for Medicaid has always been a federal-and-state shared responsibility. A "federal medical assistance percentage" is calculated annually for each state to determine the federal government's share of the state's Medicaid costs.[11] The Patient Protection and Affordable Care Act mitigates the Medicaid expansion's financial implications for states by enhancing the percentage for the newly eligible population.[12] From 2014 through 2016, the federal government will pay 100 percent of

[4]42 U.S.C. § 1396d(a).

[5]We use the term "childless adult" to mean adults without children as well as noncustodial parents or parents of adult children (see Martha Heberlein et al., Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010–2011 3 (Jan. 2011), http://bit.ly/rLj8B5 ("as of January 1, 2011, only seven states (AZ, CT, DE, DC, HI, NY, and VT) provide Medicaid or Medicaid-equivalent benefits to adults without dependent children" and "[a]dditional states offer more limited coverage to these adults, but in most states, low-income adults without children do not have access to public coverage regardless of their income"); *id.* (as of January 1, 2011, thirty-three states did not cover parents up to 100 percent, median eligibility threshold for parents was 64 percent, and sixteen states limited eligibility for parents to below 50 percent, of federal poverty level).

[6]See Patient Protection and Affordable Care Act § 2001(a)(1)(C) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)) (2011) (expanding Medicaid coverage to include persons "who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Part A of title XVIII [of the Social Security Act]; or enrolled for benefits under part B of title XVIII [of the Social Security Act], and are not described in a previous subclause of this clause, and whose income (as determined under [42 U.S.C. § 1396a](e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5) [of the Social Security Act]) applicable to a family of the size involved, subject to [42 U.S.C. § 1396a](k)").

[7]See Kaiser Commission on Medicaid and the Uninsured, Expanding Coverage to Adults Through Medicaid Under Health Reform 1 (Sept. 2010), http://bit.ly/vtO95t.

[8]Patient Protection and Affordable Care Act § 2001(a)(1)(C) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)) (expanding Medicaid coverage). For the 2011 poverty guidelines, see Annual Update of the HHS Poverty Guidelines, 76 Fed. Reg. 3637–38 (Jan. 20, 2011). The poverty level for a family of four in the forty-eight contiguous states and the District of Columbia is $22,350; 133 percent of that is $29,725. In 2010 an estimated 17.1 million uninsured adults had family incomes at or below 133 percent of the poverty level (Kaiser Commission on Medicaid and the Uninsured, *supra* note 7, at 3).

[9]See Patient Protection and Affordable Care Act § 2001(a)(3)(B), as amended by *id.* § 10201(c)(3)(B) (2010) (adding 42 U.S.C. § 1396d(y)(2)(A)) (defining "newly eligible" to mean, "with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full"). Current eligibility policies for immigrants will continue (Letter from Cindy Mann, Director, Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services, to State Health Official and State Medicaid Director 3 (April 9, 2010) ("All rules applicable under the Medicaid program in general apply to this new eligibility group, including rules relating to cost sharing and immigration status."); see generally National Health Law Program, The Advocate's Guide to the Medicaid Program pt. III(I) (2011) (Medicaid eligibility based on citizenship or immigration status).

[10]See Patient Protection and Affordable Care Act § 2001(a)(3)(B), as amended by *id.* § 10201(c)(3)(B) (2010) (adding 42 U.S.C. § 1396d(y)(2)(A)) (defining "newly eligible"); Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to Nancy Pelosi, Speaker of the U.S. House of Representatives, tbl.4 (March 20, 2010), http://1.usa.gov/vPZhi9 (estimating that Patient Protection and Affordable Care Act will extend Medicaid and Children's Health Insurance Program (CHIP) coverage to sixteen million nonelderly people).

[11]See 42 U.S.C. §§ 1396b(a)(1), 42 U.S.C. § 1396d(b).

[12]See Patient Protection and Affordable Care Act § 2001(a)(3)(B) (adding 42 U.S.C. § 1396d(y)).

the costs associated with the Medicaid expansion; in 2017 the rate will decrease to 95 percent and continue to taper until it levels off at 90 percent in 2020.[13]

The enhanced federal share will apply only to newly eligible Medicaid beneficiaries. Traditional rates, which range from 50 percent to 83 percent, will continue to be administered for traditionally eligible Medicaid beneficiaries.[14] States will need to distinguish who is part of the newly eligible population and draw down this enhanced federal funding.[15]

"Benchmark" Benefits Package

Under the Patient Protection and Affordable Care Act the benefits package for new Medicaid beneficiaries must meet "benchmark" or "benchmark-equivalent" standards for "essential health benefits."[16] The standard package must cover at least

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.[17]

While this list is fairly comprehensive, it is not as robust as the traditional Medicaid benefits plan.[18] It thus raises concern about the quality of coverage that newly eligible individuals will receive.

New Enrollment and Verification Procedures

The Patient Protection and Affordable Care Act requires each state to have simplified, coordinated, and streamlined electronic Medicaid enrollment, verification, and eligibility—commonly known as EVE—procedures for easy access to coverage.[19] Following the Act's guidelines, states must update their systems by 2014 as a front door for enrolling in Medicaid via the health insurance exchanges.[20] The U.S. Department of Health and Human Services (HHS) guided states on designing procedures, and the federal government has offered

[13]*Id.* § 2001(a)(3)(B) (adding 42 U.S.C. §§ 1396d(y)(1)(A), (B), (E)).

[14]National Health Law Program, *supra* note 9, pt. II(C); Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51173 (proposed Aug. 17, 2011) ("newly eligible [federal medical assistance percentage] is only available for those members of the adult group who are determined to be newly eligible as discussed in this regulation").

[15]CMS recognizes that a dual eligibility system would be "burdensome and costly to States and the Federal government, a barrier to enrollment for eligible individuals and families, and would likely lead to inaccurate determinations" (Medicaid Program, 76 Fed. Reg. at 51173). CMS proposed three alternative ways for states to determine the appropriate federal share (*id.* at 51173–74).

[16]Patient Protection and Affordable Care Act §§ 2001(a)(2)(A), (c) (adding 42 U.S.C. § 1396a(k)(1) and amending 42 U.S.C. § 1396u-7(b)) (requiring that Medicaid benchmark benefits consist of at least minimum essential coverage as described in Patient Protection and Affordable Care Act § 1302(b)).

[17]*Id.* § 1302(b) (adding 42 U.S.C. § 18021(b)).

[18]See 42 U.S.C. § 1396d(a)(2) (mandatory care and services under traditional Medicaid benefit plans include, *inter alia*, inpatient and outpatient hospital services; laboratory and X-ray services; nursing facility services for adults; health screenings for children and treatment if medical problems are identified; comprehensive dental and vision services for children; family planning services and supplies; medical and surgical dental services for adults; private-duty nursing services; prescription drugs; pediatric and family-nurse practitioner services; nurse-midwife services; and home health care services).

[19]See Patient Protection and Affordable Care Act § 2201 (adding 42 § U.S.C. 1396w-3) (requiring simplified enrollment and coordination with health insurance exchanges as condition for state participation in Medicaid); *id.* § 1413 (adding 42 U.S.C. § 18063) (governing streamlining of enrollment procedures through exchange and state Medicaid, CHIP, and health subsidy programs).

[20]See Patient Protection and Affordable Care Act § 1311(b) (adding 42 U.S.C. § 13031(b)) (requiring that each state, no later than January 1, 2014, establish American Health Benefit Exchange for state that "(A) facilitates the purchase of qualified health plans; (B) provides for the establishment of a Small Business Health Options Program … that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and (C) meets the requirements of" the Patient Protection and Affordable Care Act § 1311(d)); *id.* § 1311(d) (adding 42 U.S.C. § 13031(d)) (detailing requirements for state exchanges).

to match 90 percent of states' costs of system development through 2015 and 75 percent of continuing operational expenses.[21] By 2014, through their health insurance exchanges, states must have a functioning, one-stop-shop Web-based portal integrating enrollment, verification, and eligibility for individuals enrolling in Medicaid or the children's health insurance program or purchasing private insurance.[22] The Web portal must be easy to navigate and use plain language to describe coverage options.[23]

More specific, applicants must be able to apply via the Internet (on the exchange), telephone, mail, or in-person, using one standardized application form.[24] Each state must build its system's capacity to conduct electronic data matching in enrollment and renewal eligibility verification.[25] The federal government will help states in data matching by offering information from various agencies, such as the Social Security Administration and the Department of Homeland Security.[26] The federal government has proposed a rule to require states to modernize policies so that renewals are conducted annually unless a change in income is reported.[27] The Patient Protection and Affordable Care Act requires, as part of enrollment simplification and streamlining, that every state use modified adjusted gross income to calculate household income.[28] The Act allows for a 5 percent income disregard when income eligibility is determined in this way; this means in practice that enrollees with household incomes up to 138 percent of the federal

[21]Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Guidance for Exchange and Medicaid Information Technology (IT) Systems (May 2011), http://bit.ly/rIQtmf; 42 C.F.R. §§ 433.112(c), 433.116(j) (2011).

[22]See Patient Protection and Affordable Care Act § 2201(b)(1)(A) (adding 42 U.S.C. § 1396w-3(b)(1)(A)) (requiring states to establish procedures for "enabling individuals, through an Internet website that meets the requirements of [Patient Protection and Affordable Care Act § 2201(b)(4)], to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature"); *id.* § 2201(b)(4) (adding 42 U.S.C. § 1396w-3(b)(4)) (stating enrollment website requirements); see also Medicaid Program, 76 Fed. Reg. at 51195 (to be codified at 42 C.F.R. § 435.1200(d)) (setting forth proposed rules related to website). Some states already have Web portals that function as electronic enrollment systems; others have yet to create such systems (see generally Kaiser Commission on Medicaid and the Uninsured, Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement (June 2011), http://bit.ly/rWMPJR; see also Medicaid Program, 76 Fed. Reg. at 51161 (stating that single, streamlined application to be used for all insurance affordability programs "will build on the successes many States have had in developing simplified applications")).

[23]See Medicaid Program, 76 Fed. Reg. at 51195 (to be codified at 42 C.F.R. § 435.1200(d)(2)) (proposing that state Medicaid agencies make available to current and prospective applicants and beneficiaries a website that "[i]s accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons who are limited English proficient"); see also *id.* at 51161 (noting that CMS "intend[s] to address the readability and accessibility of applications, forms and other communications with applicants and beneficiaries in future guidance").

[24]The secretary of health and human services must provide each state with a single, streamlined form (Patient Protection and Affordable Care Act § 1413(b)(1)(A), adding 42 U.S.C. § 18063(b)(1)(A)), but states may develop and use their own form (*id.* § 1413(b)(1)(B) (2010), adding 42 U.S.C. § 18063(b)(1)(B)).

[25]See *id.* § 1413(c)(2) (adding 42 U.S.C. § 18063(c)(2)).

[26]See *id.* § 1413(c)(3)(A)(ii) (adding 42 U.S.C. § 18063(c)(3)(A)(ii)) (requiring states to determine eligibility for state health subsidy programs, such as Medicaid, "on the basis of reliable, third party data, information" from, *inter alia*, tax records, quarterly earnings, new hires' reports, and other public benefit programs); see also Medicaid Program, 76 Fed. Reg. at 51191 (to be codified at 42 C.F.R. § 435.949) (proposing rules related to verification of certain information through electronic service).

[27]See Medicaid Program, 76 Fed. Reg. at 51192 (to be codified at 42 C.F.R. § 435.916(a)(1)) (proposing that states schedule redeterminations or renewals for Medicaid beneficiaries whose eligibility is based on modified adjusted gross income once annually and that state Medicaid agency redetermine "eligibility without requiring information from the individual if able to so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under § 435.948, § 435.949 and § 435.956 of this part").

[28]Patient Protection and Affordable Care Act § 2002(a) (adding 42 U.S.C. § 1396a(e)(14)(A)); see Medicaid Program, 76 Fed. Reg. at 51190–91 (to be codified at 42 C.F.R. § 435.603) (proposing rules related to using modified adjusted gross income in determining financial eligibility for Medicaid). Certain traditionally eligible populations and services are not subject to the modified adjusted gross income method but remain subject to current income rules (see Patient Protection and Affordable Care Act § 2002(a) (adding 42 U.S.C. § 1396a(e)(14)(D)(i)) (setting forth exceptions to rule that income is determined by using modified adjusted gross income).

poverty level will be eligible for Medicaid in 2014.[29]

The Newly Eligibles

Several groups newly eligible for Medicaid have unique social circumstances and health needs: childless adults, young adults, older adults, the homeless, minorities, and parents. Understanding their characteristics will help advocates meet their needs and employ effective outreach and enrollment.

Childless Adults. According to 2008 data, 69 percent of uninsured adults living below 133 percent of the federal poverty level are childless—they have no children, they are noncustodial parents, or their children are adults.[30] Of this group, 61 percent are male, 87 percent are unmarried, almost half are white, and 27 percent lack a high school diploma.[31] The unemployment rate of this population is 45 percent; more than 50 percent have incomes *less than half* the federal poverty level.[32] While relatively few childless adults living at or below 133 percent of the federal poverty level acknowledge poor or fair health, most lack a usual source of care.[33] In fact, almost half of the 33 percent of uninsured childless adults diagnosed with a chronic condition have gone without seeing a doctor for at least a year.[34]

These data can inform outreach and enrollment strategies by, for example, helping local community organizations and government agencies locate where many childless adults live and work and shedding light on this population's likely access to media and technology. Childless adults' low education levels suggest that they may lack literacy and technological skills, and so outreach methods should adopt non-Internet-based approaches.

Lessons from states that already offer Medicaid coverage to childless adults reveal that many such adults have fluctuating incomes, lack connections to or familiarity with public programs in general, report negative associations with or misunderstandings of Medicaid, and may not fully understand they should obtain health insurance.[35] Awareness campaigns should educate childless adults about Medicaid eligibility and enrollment and remove any stigma and misunderstandings associated with Medicaid. Note that some members of this group do not want to come forward at all. Some may fear arrest for nonpayment of child support or on an outstanding criminal warrant if they apply for benefits. Others may have lived under multiple aliases and fear revealing themselves to authorities. Outreach efforts must credibly assure potential applicants that they will not be penalized for seeking to enroll.

Young Adults. Often referred to as members of the "young invincible" population, many uninsured young adults think they do not need health coverage.[36] Enrollment efforts for this population must therefore focus on teaching the value of health care. Young adults between 19 and 25 account for almost one-third of uninsured adults with household incomes below 133 percent of

[29]Patient Protection and Affordable Care Act § 2002(a) (adding 42 U.S.C. § 1396a(e)(14)(I)(i)). Under the 2011 poverty guidelines, 138 percent of the federal poverty level for a single adult in the forty-eight contiguous states and the District of Columbia is $15,028.20; for a family of four in this region, 138 percent of the federal poverty level is $30,843 (see Annual Update of the HHS Poverty Guidelines, 76 Fed. Reg. at 3637–38 (establishing 2011 federal poverty guidelines)).

[30]Kaiser Family Foundation, *Expanding Medicaid Under Health Reform: A Look at Adults at or below 133% of Poverty* 1, fig.1 (April 2010), http://bit.ly/tBEVGW.

[31]*Id.* at 5.

[32]*Id.*

[33]See Matthew Broaddus, Center on Budget and Policy Priorities, Childless Adults who Become Eligible for Medicaid in 2014 Should Receive Standard Benefits Package: Federal Government Will Assume Large Majority of Cost 2 (July 6, 2010), http://bit.ly/sxM2Yq; Kaiser Family Foundation, *supra* note 30, at 3.

[34]See Kaiser Family Foundation, *supra* note 30.

[35]Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons from State Experiences* 6–7 (July 2010), http://bit.ly/vJeBQB.

[36]*Id.*

the federal poverty level.[37] Approximately 20 percent of uninsured young adults are unemployed and have not completed high school.[38] Even though more than half lack a usual source of care, 93 percent report being in good to excellent health.[39] As young adults age out of Medicaid or a parent's private insurance plan, they find themselves without access to affordable health insurance.[40] In 2014 low-income young adults will no longer "age out" of Medicaid at 19; rather, they will transition into the newly eligible population.[41] Effective outreach and enrollment, as well as avoiding gaps in coverage, are tasks for advocates and policymakers alike.

Older Adults. Many low-income adults 55 to 64 are unemployed and uninsured.[42] Due to cost, they often forgo filling prescriptions, seeking necessary medical treatment, and getting timely preventive screening.[43] Chronic ailments such as diabetes, cardiovascular disease, and high blood pressure are most common in this age group; almost two-thirds report having at least one diagnosed chronic condition.[44] Older adults are likely to understand the value of health coverage; outreach to them should focus on awareness of their new eligibility status. And, in light of their complex health needs, ensuring that they have a complete set of benefits and access to primary and preventive care as soon as possible is vital.[45]

Homeless Population. Typically composed of single, male, and childless adults, this subgroup has unique social circumstances and unmet health needs.[46] Many suffer from chronic and acute physical and mental health conditions, as well as substance abuse problems, and do not have a usual source of care.[47] Homelessness barriers to Medicaid enrollment are due to homeless individuals tending to be transient and unaware or distrustful of public programs and government institutions. Homeless individuals' circumstances make the documentation necessary to navigate program enrollment difficult to keep. The only contact some have with institutions is through homeless shelters and emergency rooms. Homeless individuals may not prioritize health coverage when other needs such as food and shelter are not met. Their literacy skills and their access to conventional media outlets such as the Internet and television are often limited. Strategies for reaching and enrolling homeless individuals need to be innovative, coordinated with trusted community groups and public service organizations, and heavily reliant on in-person communication.

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[37]Kaiser Family Foundation, *supra* note 30, at 4.

[38]Karyn Schwartz & Tanya Schwartz, Kaiser Commission on Medicaid and the Uninsured, *How Will Health Reform Impact Young Adults?* 9 (May 2010), http://bit.ly/tswzkD.

[39]*Id.* at 9, 2.

[40]*Id*. at 2. Before the Patient Protection and Affordable Care Act, coverage through a parent's plan typically terminated for children when they turned 19, although some states required continued coverage under certain circumstances, such as the young adult's college attendance. As of September 2010 young adults may remain on a parent's private insurance plan until they turn 26 (Patient Protection and Affordable Care Act § 1001, adding 42 U.S.C. § 300gg-14(a)).

[41]Patient Protection and Affordable Care Act § 2001(a)(3)(B), as amended by *id.* § 10201(c)(3)(B) (adding 42 U.S.C. § 1396d(y)(2)(A)).

[42]See Sara R. Collins et al., Commonwealth Fund, *Realizing Health Reform's Potential: Adults Ages 50–64 and the Affordable Care Act of 2010*, at 1–2 (Dec. 2010), http://bit.ly/uSBcHA (in 2009 of 8.6 million 50-to-64-year-olds who were uninsured, 3.3 million were in families earning less than 133 percent of federal poverty level, and "record high unemployment" for this age group has driven losses in insurance coverage).

[43]*Id*. at 3.

[44]*Id*. at 2.

[45]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 3.

[46]See Steve Eiken & Sara Galantowicz, U.S. Department of Health and Human Services, Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples 4 (March 29, 2004), http://go.cms.gov/uUlbqg ("The majority of people experiencing chronic homelessness are childless, single adult males or non-custodial parents under age 65.").

[47]See National Coalition for the Homeless, Health Care and Homelessness 1 (June 2006), http://bit.ly/sKdXht ("Many homeless people have multiple health problems. For example, frostbite, leg ulcers and upper respiratory infections are frequent, often the direct result of homelessness. Homeless people are also at greater risk of trauma resulting from muggings, beatings, and rape. Homelessness precludes good nutrition, good personal hygiene, and basic first aid, adding to the complex health needs of homeless people.").

Minority Populations. In 2008 minority populations made up 51 percent of uninsured adults with incomes less than 133 percent of the federal poverty level; Hispanics alone account for 26 percent of this group.[48] Problems such as limited English proficiency and low literacy rates can make navigating the health care system and understanding coverage options difficult.[49] Because of cultural differences, immigrant populations may not easily understand the value of obtaining health coverage.[50] Minorities, especially those who are immigrants, often distrust or misunderstand government programs such as Medicaid.[51] Families with mixed immigration status may experience complications. Individuals whose undocumented status renders them ineligible must nonetheless be able to enter the health care marketplace Internet portal and enroll eligible family members into Medicaid. In order for this to be feasible, documentation such as a social security number must not be required of the individual filling out the application.[52] Minority populations thus require specific outreach and enrollment efforts. Information on new eligibility standards and enrollment must be in multiple languages.[53] Awareness campaigns need to educate minority populations about the value of health coverage and overcoming skepticism toward enrolling in government programs.[54] Participation in outreach and enrollment by trusted community organizations will be indispensable.[55]

Parents. Low-income parents who have dependent children in their households and who do not meet the current Medicaid eligibility requirements will be newly eligible in 2014. Parents are 31 percent of uninsured adults at or below 133 percent of the federal poverty level.[56] By small margins, uninsured parents have better health than uninsured childless adults but have similar problems with access to care.[57] Unlike childless adults, parents are likely to be familiar with the health care system and to understand the signif-

[48]Kaiser Family Foundation, *supra* note 30, at 5.

[49]Leighton Ku & Timothy Waidmann, Kaiser Commission on Medicaid and the Uninsured, How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population 9 (Aug. 2003), http://bit.ly/vR3SFx.

[50]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 7.

[51]See Shawn Fremstad & Laura Cox, Kaiser Commission on Medicaid and the Uninsured, *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance* 21, 24–25 (Nov. 2004), http://bit.ly/vHRfyQ (immigrants are often concerned "that receiving Medicaid or [State Children Health Insurance Program] will have adverse immigration consequences … or that benefit receipt will prevent an immigrant from sponsoring a relative seeking to immigrate to the United States"; ways to limit these concerns).

[52]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 7 ("Families that have mixed immigration status where some may be eligible for coverage while others are not also may be harder to reach [for purposes of Medicaid enrollment].").

[53]*Id*. ("studies of the low-income Hispanic population have shown that not having program materials printed in Spanish and not having access to Spanish-speaking providers are commonly-perceived barriers to obtaining health insurance"); Fremstad & Cox, *supra* note 51, at 22 ("Language barriers can prevent immigrants from learning that [public insurance] coverage is available or understanding how to apply for it, and can also make it difficult for immigrants to retain coverage, particularly if renewal notices are not available in their primary language.").

[54]Fremstad & Cox, *supra* note 51, at iii (some states have facilitated enrollment in state-funded insurance programs for immigrants by undertaking "efforts to address immigrant confusion surrounding eligibility, to reduce language barriers, and to alleviate immigrant concerns around the impact of enrolling in coverage on immigration status"); National Immigration Law Center, Immigrant-Friendly Health Coverage Outreach and Enrollment 1–5 (June 2002), http://bit.ly/AzcF7C (common concerns among immigrants about seeking public health coverage and ways in which outreach workers, application assisters, and advocates can deal with these concerns and increase enrollment).

[55]See National Immigration Law Center, *supra* note 54, at 4 (recommending, for purposes of immigrant-friendly health coverage outreach, recruitment of "workers who are bilingual, bicultural, and have relationships with immigrant and refugee communities").

[56]Kaiser Family Foundation, *supra* note 30.

[57]*Id*. at 7 (of uninsured parents at or below 133 percent of federal poverty level, 15.7 percent are in fair or poor general health and 8.4 percent are in fair or poor mental health; 16.7 percent of childless adults at or below 133 percent of federal poverty level are in fair or poor general health and 10.7 percent are in fair or poor mental health); *id.* at 3 ("Uninsured parents and uninsured childless adults at or below 133 percent [of federal poverty level] have similar levels of access problems, and these problems could potentially put their health at risk.").

icance of obtaining health insurance because of their children's doctor's visits.[58] Having children in a school system and being enrolled in other public programs makes parents likely to be connected to social institutions. Thus avenues such as schools and public benefit programs, such as TANF (Temporary Assistance for Needy Families) and SNAP (Supplemental Nutrition Assistance Program), will be useful for reaching parents. Awareness campaigns should focus on ensuring that parents know about the changes in eligibility; the campaigns should help with enrollment.

Advocacy Opportunities

The Patient Protection and Affordable Care Act's guidelines serve as a floor for expansion outreach and enrollment. Each state administration may go beyond this floor to enroll as many newly eligible individuals into Medicaid as possible and get them access to quality care. Policy decisions now will inform the success of the Medicaid expansion in each state, and advocates can help shape and inform the design and implementation of states' (1) outreach and enrollment strategies and (2) enrollment, verification, and eligibility systems.[59] The following advocacy blueprint offers some helpful suggestions as advocates partner with policymakers and other stakeholders in this work.

Outreach Strategies. Start now to design an effective strategy that casts a wide net to reach the newly eligible population. To begin, partner with trusted community-based organizations and educate them on finding and enrolling hard-to-reach populations.[60] People who are not well connected to governmental institutions or society at large are likely nonetheless to have contact with a community organization. For example, to reach homeless individuals, involve shelters and food banks in identifying those who will be newly eligible and in helping in their enrollment. Trusted community organizations, such as religious groups, should lead in outreach and enrollment to overcome barriers such as distrust or skepticism of government programs. Community health care providers will be vital to effective outreach because, even when adults are uninsured, they are likely to seek care at a community health center, hospital emergency room, or drug treatment center. Other avenues for outreach are unemployment offices, job-training centers or career fairs, community colleges, food stamp offices, the Social Security Administration's Supplemental Security Income offices, charity care organizations such as food banks and domestic violence shelters, and local businesses.

A state strategy for effective outreach should involve community-based organizations functioning as "navigators" (created by the Patient Protection and Affordable Care Act to conduct public education activities raising awareness of qualified health plans being available via exchanges), facilitate enrollment into these plans, and obtain, for qualified individuals, access to the federal financial help for households with incomes less than 400 percent of the federal poverty level.[61] The role of navigators, as defined for the private small group market, should be mimicked to assist low-income individuals and families in enrolling in Medicaid through the new health care marketplace Web

[58]Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 6.

[59]See Patient Protection and Affordable Care Act § 2201 (adding 42 U.S.C. § 1396w-3(b)(1)(F)) (requiring states to establish procedures for "conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under … title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS").

[60]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 9 ("[Study] [p]articipants noted that marketing and outreach is generally most effective if coming from people with whom uninsured adults can identify and/or organizations they trust. The more that messaging comes through community-based organizations and non-government agencies, the more it may resonate with the target population and help overcome linguistic and cultural barriers.").

[61]Patient Protection and Affordable Care Act § 1311(i)(2)(B) (adding 42 U.S.C. § 13031(i)(2)(B)).

portals.[62] Even if organizations are not "navigators," their caseworkers should be trained to identify and enroll newly eligible individuals into Medicaid and be able to explain the benefits and importance of seeking a primary care provider to meet the individuals' health needs.[63]

An outreach strategy should prioritize finding and enrolling the most needy of the newly eligibles, particularly those with chronic conditions. The states will benefit from enrolling this population immediately in 2014.[64] The federal government will fully fund benefits for the newly eligible Medicaid population for the first three years of the expansion; states should take advantage of this opportunity to provide this population with health coverage and a medical home and in many cases to get expensive medical care to improve the health of this population.[65]

To eliminate any stigma from Medicaid being a "welfare" program, advocates and policymakers should consider rebranding it as a public health insurance program for which low-income people qualify and in which they should enroll. Advocates should inform a state's health literacy campaign so that newly eligibles are taught about the value of obtaining health coverage and available benefits.[66] The campaign should disseminate consistent messaging and information; the state Medicaid agency could lead the campaign.

To reach non-English-speaking populations, advocates should tap into culturally specific media with culturally relevant messaging. Radio and television can help raise awareness among people who have limited English proficiency or individuals who have low literacy rates and who may not normally gather information from written sources or the Internet.[67] Advocates should have materials written clearly, in multiple languages.[68] Advocates should get trusted community organizations to act as an effective and informed link between the newly eligible population and the expanded Medicaid program.[69]

Enrollment and Retention. States now have an enormous opportunity to update Medicaid eligibility verification and renewal and to coordinate their data-matching capacity with other public benefit programs.[70] Advocates can tap their expertise from years of enrolling

[62]See Stan Dorn, Urban Institute, Implementing National Health Reform: A Five-Part Strategy for Reaching the Eligible Uninsured: Timely Analysis of Immediate Health Policy Issues 6 & n.47 (May 2011), http://bit.ly/uZ3yc0 (how "navigators" can facilitate individual enrollment of low-income consumers into subsidized coverage).

[63]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 10 (study participants suggest that outreach efforts to enroll childless adults explore new avenues, "such as unemployment offices, assisted housing programs, job training programs, homeless and domestic violence shelters, food stamp offices and food banks, programs serving migrants or seasonal hires, child support enforcement agencies, one-stop career centers, community colleges, literacy/GED programs, and employer/employee organizations").

[64]See Kaiser Family Foundation, Glossary of Key Health Reform Terms (n.d.), http://bit.ly/vQxfqH ("People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.").

[65]Patient Protection and Affordable Care Act § 2001(a)(3)(B) (adding 42 U.S.C. § 1396d(y)(1)(A)).

[66]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 8 (why "[c]lear messaging about coverage opportunities and the value of coverage is imperative" in reaching and enrolling childless adults in Medicaid); see generally Stephen A. Somers & Roopa Mahadevan, Center for Health Care Strategies, Health Literacy Implications of the Affordable Care Act 10–11 (Nov. 2010), http://bit.ly/utEqD6.

[67]See Somers & Mahadevan, *supra* note 66 ("Research shows that a higher percentage of adults with low literacy receive their information about health issues from radio and television than through written sources, the internet, or social contacts.").

[68]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 7 ("[Study] participants commented that program applications and resource materials that are written at or above a 9th grade level and use legalese often create enrollment difficulties for populations with limited English proficiency or lower education.").

[69]*Id.* at 9 ("[Study] [p]articipants noted that marketing and outreach is generally most effective if coming from people with whom uninsured adults can identify and/or organizations they trust. The more that messaging comes through community-based organizations and non-government agencies, the more it may resonate with the target population and help overcome linguistic and cultural barriers.").

[70]*Id.* at 6 (states covering childless adults reported using "data matches with other administrative systems to verify income"); see generally Dorn, *supra* note 62, at 2–6 (best practices for eligibility verification data-matching procedures).

low-income individuals into public benefit programs—especially in states with online enrollment—to inform and shape enrollment. Advocates can use their relationships with staff members of state Medicaid agencies, many of which are already holding open meetings on system redesign or as part of meetings about the states' Medicaid programs or the design of the states' exchange health insurance marketplace.

Advocates must see that the state's enrollment, verification, and eligibility system is designed to overcome linguistic barriers to enrollment for people who have limited English proficiency and who are newly eligible and that a sufficient number of multilingual navigators and community organizations will assist in enrollment. Advocates have to ascertain that vulnerable populations can access and navigate the system and enroll eligible family members into Medicaid.

Advocates can educate Medicaid agency staff on the detriment of multiple reporting requirements for changes in income during an eligibility cycle.[71] Updating these policies will help avert income documentation and administrative verification problems due to the high prevalence of low-income people with fluctuating incomes and irregular paychecks.[72] Advocates can help get states to design a seamless transition between Medicaid and the private insurance plans so that individuals do not have gaps in coverage or care due to income fluctuation and that qualified individuals receive federal subsidies.[73] Advocates can exhort states to adopt the Patient Protection and Affordable Care Act's twelve-month continuous eligibility policy, which will keep newly eligible Medicaid beneficiaries enrolled.[74]

Now is a critical time for advocates to participate in determining the benefits available to newly eligible Medicaid beneficiaries. Proposed regulations defining "essential health benefits"—expected by early 2012—will determine the range of services required in the Medicaid benchmark packages.[75] Advocates can inform policymakers about the need for newly eligible Medicaid enrollees to have a benefits package at least equivalent to the traditional set of benefits for those eligible for Medicaid.[76]

■ ■ ■

The Patient Protection and Affordable Care Act sets in motion the largest Medicaid expansion in the history of the program. Now is the time for advocates, legal aid attorneys, and direct service providers who work with newly eligibles to urge on their behalf policy decisions before the 2014 expansion to fulfill health reform's promise of providing affordable, quality health care to the low-income millions.

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[71]See Aviva Goldstein, National Center for Law and Economic Justice, Childless Adults: Barriers to Enrollment in Public Health Insurance 18 (April 2010), http://bit.ly/skaOIh (recommending that policymakers "[a]dvocate for the elimination of reporting requirements for changes in eligibility during year of continuous coverage"); see also Medicaid Program, 76 Fed. Reg. at 51191 (to be codified at 42 C.F.R. § 435.603(h)(2)) (proposing that states have option to base financial eligibility for Medicaid "either on current monthly household income and family size or projected annual household income for the current calendar year"); *id.* at 51156 (proposing 42 C.F.R. § 435.603(h)(2) "[t]o promote flexibility, administrative simplification and continuity of coverage for beneficiaries already enrolled in Medicaid" and "to minimize the extent to which individuals experiencing relatively small fluctuations in income bounce back and forth between programs").

[72]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 35, at 6–7 (challenges fluctuating incomes of low-income individuals pose to enrollment).

[73]Kaiser Family Foundation, Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries 5 (Aug. 2010), http://bit.ly/rMLblH.

[74]See Medicaid Program, 76 Fed. Reg. at 51192 (to be codified at 42 C.F.R. § 435.916(a)(1)) (proposing that states schedule redeterminations or renewals for Medicaid beneficiaries whose eligibility is based on modified adjusted gross income once every twelve months).

[75]See Patient Protection and Affordable Care Act § 2001(c) (amending 42 U.S.C. § 1396u-7(b)) (requiring that Medicaid benchmark benefits consist of at least minimum essential coverage, as described in Patient Protection and Affordable Care Act § 1302(b)); *id.* § 2001(a)(2)(A) (adding 42 U.S.C. 1396a(k)(1)) (requiring that Medicaid coverage includes benchmark coverage described in Section 1937(b)(1) of the Social Security Act or benchmark equivalent coverage, as described in Section 1937(b)(2) of the Social Security Act).

[76]Kaiser Family Foundation, *supra* note 73, at 5; see *supra* note 19 and accompanying text.

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