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Medicaid: Compliance With Eligibility Requirements Testimony of Judith Solomon, Senior Fellow, Before the Senate Finance Subcommittee on Health Care

Chairman Toomey, Ranking Member Stabenow, and members of the Health Subcommittee of the Finance Committee, thank you for today's opportunity to testify. My name is Judith Solomon. I am a Senior Fellow on the health team at the Center on Budget and Policy Priorities, a nonprofit, nonpartisan policy institute located here in Washington. The Center conducts research and analysis on a range of federal and state policy issues affecting low- and moderate-income families. The Center's health work focuses on Medicaid, the Children's Health Insurance Program (CHIP), the Affordable Care Act (ACA), and Medicare. I have spent over 40 years working on Medicaid, beginning as a legal services attorney and in several positions focusing on Medicaid policy issues affecting children, seniors, and people with disabilities.

The ACA provides a continuum of coverage for low-income adults, including an expansion of Medicaid for adults with incomes below 138 percent of the poverty line and subsidized individual market coverage for those with incomes above that level. The ACA also includes provisions intended to create a seamless, no wrong door, coordinated eligibility system that allows people to enroll in and move between Medicaid, CHIP, and marketplace coverage depending on their circumstances. Streamlined enrollment is particularly important for low-wage workers, who had high rates of uninsurance before enactment of the ACA.

The audits that are the focus of today's hearing illustrate the challenge of implementing a streamlined enrollment system that gets people enrolled in the right program at initial application and when their circumstances change. But we shouldn't let that challenge detract from how the coverage expansions under the ACA have achieved their goals of reducing uninsured rates and improving access to care, financial security, and health, especially in the states that have implemented Medicaid expansion.

Medicaid expansion has led to significant coverage gains and reductions in uninsurance among low-income people. Most studies show Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security for low-income people. And an increasing number of studies show improved self-reported health following expansion and an association

between expansion and certain positive health outcomes.¹ But the ACA’s vision hasn’t been entirely realized in the 14 states yet to expand, and as this hearing shows there is still work to do to streamline enrollment and avoid gaps in coverage.

Today’s hearing concerns eligibility errors in Medicaid, primarily whether people are being properly enrolled and whether they are remaining enrolled after they are no longer eligible. But we shouldn’t limit our definition of program integrity to the occurrence and likelihood of these types of errors. We should also be concerned that there are many eligible people who aren’t enrolled in coverage and others whose coverage is incorrectly being taken away because of barriers in the eligibility and enrollment process, including excessive paperwork, inadequate communication, and other factors. In 2017, 25 percent of uninsured people, 7.5 million in total, were eligible for Medicaid, according to the Urban Institute.²

In large part, both the eligibility errors that are the focus of today’s hearing and the processes that leave many eligible people uninsured stem from the challenges of operationalizing precise eligibility limits based on income and household circumstances for people whose situations frequently change. Focusing only on the potential for errors in one direction rather than also addressing what’s needed to ensure people can easily enroll, stay enrolled, and transition to other forms of coverage when their situations change will likely exacerbate the recent rise in uninsurance among both children and adults.

States Face Multiple Challenges in Determining Medicaid Eligibility

As noted, the ACA created a continuum of coverage for low-income people based on their income as a percentage of the poverty line, which takes into account both household income and household size. But income and household size aren’t static. Children grow up and leave the home. People get married and divorced. And income changes over the course of a year are especially prevalent among low-income people. Low-wage jobs are often unstable, with frequent job losses and work hours that can fluctuate from month to month. Many Medicaid enrollees also work seasonal jobs in industries such as retail or tourism. A study looking at participation of working-age adults in the Supplemental Nutrition Assistance Program (SNAP), which has federal income limits close to those of the Medicaid expansion, found that workers earning low wages are frequently in and out of work and on and off SNAP as their earnings fall and rise.³ A similar study looking at Medicaid showed similar income volatility.⁴

¹ Larissa Antonisse *et al.*, “The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review,” Kaiser Family Foundation, August 15, 2019, <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/>.

² Linda J. Blumberg *et al.*, “Characteristics of the Remaining Uninsured: An Update,” Urban Institute, July 2018, https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf.

³ Brynne Keith-Jennings and Raheem Chaudry, “Most Working-Age SNAP Participants Work, But Often in Unstable Jobs,” Center on Budget and Policy Priorities, March 15, 2018, <https://www.cbpp.org/research/food-assistance/most-working-age-snap-participants-work-but-often-in-unstable-jobs>.

⁴ Aviva Aron-Dine, Raheem Chaudry, and Matt Broaddus, “Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements,” Center on Budget and Policy Priorities, April 11, 2018,

Another study completed soon after enactment of the ACA showed the majority of people with income below 138 percent of the poverty line at the beginning of a 12-month period had income above 138 percent of the poverty line at some point during those 12 months. Conversely, about 40 percent of people with income between 138 and 200 percent of the poverty line saw their income fall below 138 percent of the poverty line at some point over the course of a year.⁵ Thus, it was clear from the outset that the low-income adults gaining coverage under the ACA would experience frequent changes in eligibility for Medicaid and subsidized coverage.

There are other factors that continue to make it challenging for states to ensure that eligible people get enrolled, stay enrolled when they are eligible, and move to other coverage when their incomes or other circumstances change:

- **Replacing and modernizing state eligibility and enrollment systems to accommodate the ACA’s vision of streamlined enrollment.** Upgrading enrollment systems and adopting new business processes was a huge undertaking for states, and the audits that are the subject of this hearing reflect system and caseworker errors, particularly in the first years of implementation, that continue to be addressed.
- **Requiring that states use income levels for claiming enhanced match different from those used to determine eligibility.** Most expansion states must not only determine whether peoples’ income is below 138 percent of the poverty line, but also must determine whether they can claim enhanced federal matching funds for the costs of their care. Determining the right match rate requires a separate assessment of whether an individual would be eligible under the state’s pre-ACA rules or whether they are newly eligible under the expansion. This determination requires a precision that is often difficult to attain and is reflected in some of the audit findings where states claimed the higher match for people who were eligible under pre-ACA rules. For example, a state may correctly determine that a parent’s income is below 138 percent of the poverty line but incorrectly claim enhanced match if it makes a mistake in finding that her income is above the pre-ACA eligibility level for parents. The error is in the match the state claims, not in eligibility of the person being covered.
- **Training eligibility workers on brand new tax-based rules for determining Medicaid eligibility.** The use of “Modified Adjusted Gross Income” to determine eligibility was a sea change for states, significantly changing prior rules on what income counts and who is considered in a household. Caseworkers had to learn the rules on tax treatment of income, including complex rules on how dependents’ income is treated and who is considered a dependent under tax rules.
- **Limitations on the utility of tax data and other electronic data to verify income of low-wage workers who are self-employed, often change jobs, work on a seasonal basis, and have variable hours.** Verifying income largely through electronic data as the ACA suggests has been difficult to do for some low-wage workers although helpful for many others who no

<https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>.

⁵ Benjamin D. Sommers and Sara Rosenbaum, “Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges,” *Health Affairs*, February 2011, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.1000>.

longer must submit pay stubs or other documentation. Medicaid eligibility depends on monthly income, which can change frequently. Electronic data sources and state wage databases often don't reflect people's current circumstances, because the data aren't up to date, or people's circumstances have changed since the data match, leading to requests for documentation that are difficult to fulfill. And electronic data aren't available for people who are self-employed.

- **Difficulties in effectively communicating complex eligibility rules.** Medicaid rules require that people notify the state Medicaid agency when their situations change to the extent that they are no longer eligible for coverage. This assumes people know that small changes in income or changes in their household composition may make them ineligible and that they should report these changes. Proper reporting is especially difficult for people with frequent income changes based on seasonal employment or variable hours.

Challenges Lead Eligible People to Lose Coverage

The audits by the Government Accountability Office, Health and Human Services Office of Inspector General (OIG), and the state of Louisiana find errors in eligibility determination due to caseworker error, inadequate system capacity, and lack of documentation in case files. Most of these errors reflect the challenges inherent in determining eligibility. In some of the cases, enrollees may have failed to make timely reports of income changes, but variable income and difficulty knowing when to report make timely reporting difficult. For example, a parent who works extra hours in a month or two may not report knowing her hours will soon return to a lower level.

Meanwhile, the audits don't measure whether eligible people are unable to enroll or are losing their coverage when they remain eligible. Recent declines in Medicaid coverage for children and adults are due in part to a greater emphasis on frequent wage checks, more stringent documentation requirements, and terminations based on returned mail.⁶ When state wage checks show income above the eligibility level, states require people to respond and prove they are still eligible within 10 days of the date of the notice, which sometimes reaches them just a few days before the deadline. In addition to short deadlines, the notices are difficult to understand, and people often don't know how to show they remain eligible if, for example, the increase in wages was just temporary.

Research and decades of experience in enrolling low-income children and adults in coverage show that increasing paperwork can lead to loss of coverage among eligible people due to difficulties completing processes and providing documentation.⁷ Behavioral science helps explain why this is the case, teaching that everyone has limited attention and cognitive bandwidth, but people living in poverty face chronic scarcity, which forces them simultaneously to manage multiple challenging problems and requires enormous mental effort.⁸

⁶ Robin Rudowitz *et al.*, "Medicaid Enrollment & Spending Growth: FY 2019 & 2020," Kaiser Family Foundation, October 2019, <http://files.kff.org/attachment/Issue-Brief-Medicaid-Enrollment-and-Spending-Growth-FY-2019-2020>.

⁷ Samantha Artiga and Olivia Pham, "Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage," Kaiser Family Foundation, September 24, 2019, <https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/>.

⁸ Harrison Neuert *et al.*, "Work Requirements Don't Work: A behavioral science perspective," Ideas 42, March 2019, <http://www.ideas42.org/wp-content/uploads/2019/04/ideas42-Work-Requirements-Paper.pdf>.

The story of a Texas family in a recent *New York Times* story is a stark illustration of the consequences of increased paperwork for families facing multiple challenges. A baby’s mother didn’t respond quickly enough to a notice from the state to show her baby was still eligible and didn’t even know her son lost coverage until she took him to the hospital. Her other two children had previously lost coverage for reasons she didn’t understand, and she had given up trying to re-enroll them because it was so hard.⁹

Frequent changes in income and household composition, the complexity of rules governing whose income counts, and the need to make separate determinations of who is eligible for enhanced match make errors inevitable. The types of errors identified in the audits can be reduced but not eliminated. But a sole focus on improving accuracy by more frequent wage checks, increased documentation requirements, and terminating coverage when mail is returned will result in further declines in enrollment and will significantly increase errors in the other direction — taking coverage away from people who are eligible.

We’ve seen the impact of paperwork and the difficulty of reaching people to effectively explain complex rules in the implementation of work requirements in Arkansas and New Hampshire, where large numbers of eligible people lost coverage or were at risk of losing it. About 3 or 4 percent of those subject to the Arkansas work requirement were not working and did not qualify for exemptions, studies estimated.¹⁰ Yet each month, 8 to 29 percent of those subject to the requirement failed to report sufficient work hours; many didn’t report any hours. And over 75 percent of those required to report hours (that is, those not automatically exempted by the state) failed to do so each month.¹¹ Likewise, a study estimates that all but a small minority of Medicaid expansion beneficiaries in New Hampshire are either working or ill or disabled (and therefore should qualify for exemptions), yet 40 percent of those subject to the work requirement were set to lose coverage had the state not put the policy on hold.¹²

Frequent Changes in Eligibility Are Costly

Frequent changes in eligibility, often referred to as “churn,” disrupt the continuity of care and coverage. Coverage changes are associated with changes in physicians, increased use of the emergency room, and decreased medication adherence even for many who don’t experience gaps in

⁹ Abby Goodnough and Margot Sanger-Katz, “Medicaid Covers a Million Fewer Children. Baby Elijah Was One of Them,” *New York Times*, October 22, 2019, <https://www.nytimes.com/2019/10/22/upshot/medicaid-uninsured-children.html?action=click&module=Top%20Stories&pgtype=Homepage>.

¹⁰ Anuj Gangopadhyaya *et al.*, “Medicaid Work Requirements in Arkansas,” Urban Institute, May 24, 2018, <https://www.urban.org/research/publication/medicaid-work-requirements-arkansas>.

¹¹ Arkansas Department of Human Services, “ARWorks Reports,” <https://humanservices.arkansas.gov/newsroom/toolkits>.

¹² Rachel Garfield *et al.*, “Understanding the Intersection of Medicaid and Work: What Does the Data Say?” Kaiser Family Foundation, August 8, 2019, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/>.

coverage.¹³ Churn also creates problems for health care providers and Medicaid managed care organizations, limiting their ability to provide effective care and increasing their administrative costs as people cycle in and out of coverage. People who churn in and out of coverage have higher health care costs, some studies suggest.¹⁴ Churn is also costly for states, creating extra work to process new applications for people who remain eligible after losing coverage.

Frequent changes in eligibility work at cross-purposes with efforts to better manage care in order to lower costs and improve health outcomes. Federal and state programs, including Medicaid, are increasingly shifting to value-based care models that reward providers for managing patients' care and providing low-cost, high-value services. Value-based payment models are intended to give providers greater incentive to reduce costs and improve care by strengthening care coordination, avoiding duplicative or low-value care, and helping patients obtain high-value, low-cost services, such as preventive and primary care and medications to manage chronic conditions. But it's difficult for providers to coordinate and manage their patients' care if they are not continuously enrolled in health coverage.¹⁵

States Can Decrease Churn

Some states have decided churn is so counterproductive that they have changed their eligibility rules to limit the frequency with which households need to change coverage due to changes in income. States have the option to provide children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) with "continuous eligibility" — a full year of coverage regardless of changes in their family's income. States can also elect to provide continuous eligibility to adults through a Medicaid waiver. To date, 24 states have adopted continuous eligibility for children in Medicaid, and 26 have adopted it for CHIP. So far, Montana and New York are the only states with continuous eligibility for adults. Utah has a proposal pending.

In states that have not adopted continuous eligibility, it's likely that some people still remain enrolled in Medicaid for a period after their income rises; similarly, it's likely that some people remain enrolled in the marketplaces for a period after their income falls. But while the audits being considered today have led some to claim that the federal government is spending large sums on people who are inappropriately enrolled in Medicaid, the reality is that the fiscal impact of these mistakes is often limited. Medicaid expansion enrollees whose incomes rise modestly above 138 percent of the poverty line are generally eligible for subsidized marketplace coverage. And for people

¹³ Benjamin D. Sommers *et al.*, "Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many," *Health Affairs*, October 2016, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455>.

¹⁴ Anthem Public Policy Institute, "Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States," June 2018, https://www.communityplans.net/wp-content/uploads/2019/04/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf.

¹⁵ Hannah Katch, "Restrictive Medicaid Policies Will Impede Innovation to Improve Care and Reduce Costs," Center on Budget and Policy Priorities, March 14, 2019, <https://www.cbpp.org/research/health/restrictive-medicaid-policies-will-impede-innovation-to-improve-care-and-reduce>.

with low incomes, the federal cost for subsidized marketplace coverage is similar to (or sometimes greater than) the federal cost for Medicaid.¹⁶

While continuous eligibility is the best approach, states can take other steps to decrease churn without increasing the number of ineligible people receiving coverage:

- **Improve communication with enrollees.** Written notices are often lengthy and complex without clear directions on what people must do to stay covered. In addition to improving enrollee notices, states can use phone calls, text messaging, and email to reach enrollees. Text messages are commonly used by low-income people, can reach them more quickly than traditional mail, can remind enrollees about needed verification documents, and can even collect information.¹⁷ States should also use online and case management portals, through which enrollees can report changes in income and household size, view notices, and see when their renewal paperwork is due.¹⁸
- **Streamline verification of eligibility through self-attestation and use of electronic data to verify eligibility factors.** Part of the ACA’s approach to streamline eligibility relies on electronic data sources to verify eligibility at application and renewal. When verifying income, state Medicaid agencies compare the sworn attestations that clients make on their application and renewal forms to available electronic data. The attestation and data source are considered “reasonably compatible” if they are both below the eligibility threshold, even if the amount of income in the attestation is different from the amount in the electronic data source. Under reasonable compatibility, states require documentation only when the difference between the attestation and data source affects eligibility. There are best practices states can take to fully implement reasonable compatibility policy and minimize the need for paper documentation.¹⁹

¹⁶ The Congressional Budget Office (CBO) estimates the 2019 annual average federal cost of covering an individual in Medicaid or CHIP at \$4,620, compared to \$6,490 for covering an individual in the ACA marketplace. While these cost estimates are not directly comparable due to differences in the people who are eligible for coverage in these programs, they are suggestive evidence that coverage through Medicaid is not more costly to the federal government than coverage through the marketplace. Additional Treasury Department data show that ACA marketplace subsidies for those between 150 percent and 200 percent of poverty — those just above the Medicaid expansion level — are greater than the average subsidy, further suggesting that the federal government pays a similar amount, or perhaps less, for people with incomes modestly above 138 percent of the poverty line who remain enrolled in Medicaid. See, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029,” Congressional Budget Office, May 2019, https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf; and, “Health Tax Provisions and Analysis, Table 3, Premium Tax Credit, 2018,” U.S. Department of the Treasury, accessed September 2019, <https://home.treasury.gov/policy-issues/tax-policy/office-of-tax-analysis>.

¹⁷ Jennifer Wagner, “Leveraging Text Messaging to Improve Communications in Safety Net Programs,” Center on Budget and Policy Priorities, May 8, 2019, <https://www.cbpp.org/research/poverty-and-inequality/leveraging-text-messaging-to-improve-communications-in-safety-net>.

¹⁸ Sonal Ambegaokar, Rachael Podesfinski, and Jennifer Wagner, “Improving Customer Service in Health and Human Services Through Technology,” Social Interest Solutions and Center on Budget and Policy Priorities, August 23, 2018, <https://www.cbpp.org/research/health/improving-customer-service-in-health-and-human-services-through-technology>.

¹⁹ Jennifer Wagner, “Reasonable Compatibility Policy Presents an Opportunity to Streamline Medicaid Determinations,” Center on Budget and Policy Priorities, August 16, 2016, <https://www.cbpp.org/research/reasonable-compatibility-policy-presents-an-opportunity-to-streamline-medicaid>.

States can, and most do, allow sworn self-attestation of eligibility factors such as age, household size, and tax filing status to reduce paperwork.

- **Use information collected and verified from other programs such as SNAP to determine eligibility.** About three-quarters of households receiving SNAP benefits in 2014 had at least one member receiving health coverage through Medicaid or CHIP. States can use data that SNAP programs collect and verify at application and renewal to renew Medicaid eligibility, among other strategies.²⁰
- **Follow up on returned mail.** Arkansas is an example of a state that terminates people's coverage based on just one piece of returned mail. That's a big reason the state saw enrollment decline by 60,000 people over an 18-month period even before it started taking coverage away from people who didn't comply with a work requirement.²¹ Many low-income people move frequently within a state, so rather than assume they moved out of state when mail is returned, which Arkansas appears to do, states can use the postal service's National Change of Address system and use text, mail, or phone to reach people before taking their coverage away.

Adopting continuous eligibility and these other measures would decrease errors in both directions, increasing the accuracy of eligibility determination while also making it easier for people to enroll, stay enrolled, and transition to other coverage when their eligibility changes. Focusing just on increased wage checks and documentation may reduce the number of *ineligible* people who receive Medicaid, but it will likely end up taking coverage away from a greater number of *eligible* people.

Recent Claims of Widespread Eligibility Error Based on Faulty Analysis

Some opponents of Medicaid expansion have relied on a recent study finding that significant numbers of people who reported in census surveys that they have annual income above the Medicaid cutoff appeared to have gained coverage through the expansion.²² But those reporting survey income above 138 percent of poverty could be eligible for the Medicaid expansion for many legitimate reasons. They could, for example, be eligible for part of the year because they had low income in some months due to temporary unemployment or unstable hours; Medicaid eligibility is generally based on monthly, not annual, income. Or, they could have income from child support or other sources that don't count toward Medicaid eligibility. Or, in their responses to the census questions, they could have provided rough estimates of their incomes rather than precise answers. The census surveys don't verify income, while Medicaid does.

In addition, some higher-income people whom surveys record as enrolled in Medicaid may be enrolled in other coverage (such as marketplace coverage), either because they responded incorrectly

²⁰ Jennifer Wagner and Alicia Huguélet, "Opportunities for States to Coordinate Medicaid and SNAP Renewals," Center on Budget and Policy Priorities, February 5, 2016, <https://www.cbpp.org/research/health/opportunities-for-states-to-coordinate-medicaid-and-snap-renewals>.

²¹ Benjamin Hardy, "Scrubbed from the system," *Arkansas Times*, August 9, 2018, <https://arktimes.com/news/covers-stories/2018/08/09/scrubbed-from-the-system>.

²² Brian Blase, "Health Reform Progress: Beyond Repeal and Replace," Galen Institute, September 2019, https://galen.org/assets/Health-Reform-Progress-Brian_Blase.pdf; and Brian Blase and Aaron Yelowitz, "Medicaid Deception," *Wall Street Journal*, August 14, 2019, <https://www.wsj.com/articles/obamacares-medicaid-deception-11565822360>.

to the survey questions or because of the way that census studies infer Medicaid enrollment for those who don't answer the relevant survey question.

Moreover, the OIG audits — particularly those from Kentucky, which was the subject of an earlier study based on survey data with similar findings — don't show widespread enrollment of people with incomes over the poverty line, further debunking the attempt to use survey data as a proxy for improper enrollment.

Conclusion

Thank you for the opportunity to testify. I look forward to responding to your questions.