An Enrollment Checklist for 2012

By
Jennifer Sullivan

Enroll America's

Best Practices Institute

March 2012

Although open enrollment for exchange coverage and the beginning of the Medicaid expansion may seem to be a long way away, important deadlines are right around the corner. States creating their own exchanges must get their plans approved by the Department of Health and Human Services (HHS) by January 2013, open enrollment for all exchanges is slated to begin October 1, 2013, and the Medicaid expansion will take effect January 1, 2014. There is no time to waste in preparing for these deadlines. Ensuring maximum, optimal enrollment in 2014 means starting work now, despite challenges facing the Affordable Care Act (ACA).

Anyone interested in ensuring that as many eligible Americans as possible get enrolled has a role to play in paving the way this year. The enrollment checklist below is designed to help guide stakeholders' enrollment-related work in 2012. Activities that will take the most planning or prolonged effort are listed first.

1. Take advantage of opportunities for federal funding.
2. Develop an effective outreach plan.
3. Automate enrollment whenever possible.
4. Adopt enrollment policies that minimize documentation requirements.
5. Promote data-driven, integrated eligibility systems.
6. Ensure a comprehensive approach to consumer assistance.
7. Create materials that are easy to read and understand for the target audience.

2012 Enrollment Checklist

Take advantage of opportunities for federal funding.

Federal funding is available to streamline enrollment and to conduct outreach to let uninsured consumers know that new coverage is available.

There are two streams of funding available:

1. Exchange Establishment Grants for states' costs associated with the development of health insurance exchanges; and

2. Enhanced federal Medicaid matching dollars to help states improve their Medicaid computer systems in preparation for the Medicaid expansion in 2014.

Developing a health insurance exchange may be a political football in your state, but this should not stand in the way of urging your state to take full advantage of federal funding to help people get enrolled in health coverage.

- **Exchange Establishment Grants**

  States do not need to pass exchange legislation or make decisions about how to operate their exchange before they apply for these grants. Even states that have decided to implement a partnership exchange or allow a federally operated exchange are eligible for establishment grants to support their role in establishing an exchange. All states should take advantage of this opportunity to invest in the technology infrastructure, outreach campaigns, and consumer assistance functions that will be necessary to support enrollment in coverage through exchanges.

  There are two levels of funding states can apply to receive. "Level 1" grants are designed to support one year's worth of planning for the state's role in operating a health insurance exchange. States can apply for multiple Level 1 grants to focus on different exchange establishment objectives. States that have developed longer-term plans for implementation and that have successfully completed establishment milestones in their Level 1 grant can apply for a "Level 2" grant. Level 2 grants are designed to provide enough funding to see the state through exchange implementation until December 31, 2014.[1] HHS announces new grant awards on a quarterly basis. States choose how to design their Establishment Grant proposals and the activities funded through these grants.

As of February 2012, 33 states and the District of Columbia have been awarded a total of $608.8 million in Level 1 Establishment Grants.[2] The grants range in size from $1.6 million (Tennessee) to $57.8 million (Kentucky), and the average grant is $15.6 million. The amount a state receives depends on what it is proposing to do with the funds and how much progress it has already made in establishing its exchange. States are using these grants for many different kinds of activities, including technology investments (both "front-end" technology, such as exchange websites and online applications, and "back-end" functions, like data verification and coordination between programs and agencies); hiring exchange staff; creating stakeholder groups; developing outreach and education plans; and setting up the consumer assistance functions of an exchange, like call centers and Navigator programs.

- **Enhanced Federal Medicaid Matching Dollars**

In November 2010, the Centers for Medicare and Medicaid Services (CMS) announced that until December 31, 2015, it will match state investments in Medicaid computer systems at a rate of 90 percent. In other words, for every dollar a state spends on these systems improvements, the federal government will contribute nine dollars. This is commonly referred to as a "90/10 match." States that are distancing themselves from health reform implementation can nonetheless take advantage of these federal dollars to make much-needed

This funding was made available through federal regulations that are separate from the health reform law.

improvements to their existing Medicaid eligibility systems. This funding was made available through federal regulations that are separate from the health reform law.

Medicaid computer systems, including both eligibility systems and medical claims systems, are woefully out of date in most states. The 90/10 match is a unique and important opportunity for states to modernize their computer systems. States should use this chance to prepare their systems for the Medicaid expansion and the new eligibility rules coming in 2014. Modernizing will also make it easier for Medicaid to coordinate with health insurance exchanges when they are implemented and will promise more efficient enrollment.

All but three states are already taking advantage of the 90/10 match or are planning to, so for stakeholders in most states, the important thing to do now is to ensure that policy is driving the technology and not the opposite.[3] For example, decisions like which databases to connect with for eligibility verification and the ability to

add or change databases in the future have real consequences for consumers. Although technology is at the heart of these decisions, they must be made with the consumer's perspective and the state policy context in mind, not arbitrarily or solely by technology vendors.

Now is the time to find out what your state is planning and to urge state officials to take maximum advantage of the opportunity to modernize systems. Stakeholders should ensure that Medicaid systems improvements are building in the capacity to do the following:
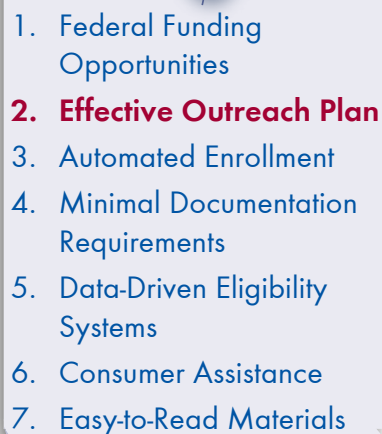
- verify eligibility electronically;
- accept minimal documentation;
- accept documentation in electronic formats (such as photos or documents via text message or email);
- connect with a health insurance exchange (whether it is state or federally operated); and
- provide interfaces where community partners can get eligibility information (which is crucial to ensuring that those providing enrollment assistance can be as helpful as possible).

To qualify for the 90/10 match, a state needs to apply to CMS with a system plan that meets certain standards and conditions.[4] A 75 percent matching rate is also available to states on an ongoing basis for operating and maintaining Medicaid systems that meet these requirements.

Urge state officials to take maximum advantage of federal funding to help people get enrolled.

1. Federal Funding Opportunities
2. **Effective Outreach Plan**
3. Automated Enrollment
4. Minimal Documentation Requirements
5. Data-Driven Eligibility Systems
6. Consumer Assistance
7. Easy-to-Read Materials

Develop an effective outreach plan.

Although the new health coverage through health insurance exchanges and Medicaid will not be available until January 1, 2014, it is important to start thinking about outreach this year.

This effort will be several times bigger than previous health coverage outreach efforts for the Children's Health Insurance Program (CHIP) or for seniors at the outset of the new Medicare Part D benefit. Some 40 million people nationwide will be eligible for new health coverage, and most of them are unaware that this coverage is coming.[5] Over the next year, there are several ways for stakeholders to help lay the groundwork for an effective outreach plan.

- **Convene—or strengthen—state and local coalitions.**
  An effort of this magnitude will require a partnership among many different stakeholders. Many diverse voices should be at the table, including those representing hospitals; community health centers and safety-net providers; doctors, nurses and other providers; consumer groups; groups representing communities of color; health insurance plans; pharmacies; agents and brokers; members of the business community; faith-based organizations; community colleges and universities; and even groups involved in tax preparation services. These groups can work together to establish an outreach strategy that leverages the strengths and connections each partner brings.

- **Encourage the state to invest in outreach.**
  There is no federal funding explicitly earmarked for outreach, but states can include funding for outreach in their Exchange Establishment Grant requests. Stakeholders should urge their states to develop a plan for outreach this year and to include significant resources in their grant requests to accomplish this task.

- **Identify segments of the uninsured to target.**
  The uninsured are not a homogenous group, and different populations will require different messages and different outreach strategies. In order to develop the most appropriate and effective outreach campaign, it will be important to know who the uninsured are in your state or region and to pick specific segments of that population to target in an outreach campaign.

At a national level, more than half of the uninsured are under age 35, most work either full- or part-time, the vast majority have income less than four times the federal poverty level, approximately one-third are Hispanic, and slightly more than half are men.[6] These breakdowns may be very different in your state, however. There isn't one message or messenger that will effectively reach all of these groups *en masse*. Some groups will respond better to a mass media campaign, while others may prefer personal, one-on-one outreach, such as a conversation with a trusted community partner, before they will feel comfortable taking steps to enroll. Understanding the demographics of the uninsured in your state will help your state or coalition design an outreach campaign that uses resources and media effectively to reach the target populations, educate them about their new coverage options, and activate them to enroll.

- **Design an outreach campaign.**
  This is where the rubber meets the road. Here are some questions to start thinking about: What will the campaign look like? Will there be television, radio, or print advertisements? What written materials or social media presence will you need to create to educate the public? What action steps will you ask your audience to take (visit a website, call a hotline, come to an enrollment event, etc.)? Will there be enrollment events held throughout your state? Where and when will these events be held? Will there be one unified statewide enrollment campaign or multiple local campaigns? These questions and many more must be grappled with and answered as soon as possible to get the campaign(s) on track.

- **What can your organization do?**
  If creating a coalition, leveraging resources, or designing a statewide campaign are beyond the scope of your organization, your organization should still begin planning for its role in raising awareness about new health coverage availability in your community. Can your organization help conduct "train the trainer" programs to expand the number of people in your community who can share accurate information about the new coverage options and when and how to apply? Think about which communities your organization or company already has relationships with and start spreading the word about when coverage is coming and how to apply.

Establish an outreach strategy that leverages the strengths and connections each partner brings.

Automate enrollment whenever possible.

Outreach campaigns will require significant time and resources. States have an opportunity to make the outreach task easier by proactively engaging those people who are already known to the system. These include two different kinds of people:

1. Uninsured people whose income information is already known as a result of their connection to other programs. This includes people like parents of children already enrolled in Medicaid or CHIP, adults already enrolled in the Supplementation Nutrition Assistance Program (SNAP, formerly food stamps), and individuals who are receiving support through state-funded mental or behavioral health programs, assistance for the homeless, or other state or local "means-tested" programs.[7]

2. People already enrolled in coverage whose coverage will change in 2014. For these groups, it will be important that coverage transitions are smooth, so that no one who is already covered loses coverage or notifying them of changes on the horizon. This includes people enrolled in a Pre-existing Condition Insurance Plan, who will need to transition to coverage through a health insurance exchange, and children enrolled in CHIP who, as a result of the Medicaid expansion, will become eligible for Medicaid instead.[8]

At a minimum, states have extensive information about these individuals and families that can be used to conduct targeted outreach, such as mailings or phone calls inviting them to apply for health coverage or notifying them of changes on the horizon. However, it may be more efficient to take it a step further and create connections between federal, state, and private databases so that the uninsured can automatically be enrolled in coverage if they are eligible. For example, a state could use the information in its records from other programs to figure out whether an individual or his or her family members are eligible, or are likely to be eligible, for Medicaid or a premium tax credit. If they are found to be eligible (or likely to be eligible), the state could send them a notice of "pre-approval," letting them know which coverage option could be available to them if they decided to apply or to notify the state that they are interested in coverage. States could begin this identification process several months in advance and initiate the enrollment process on a rolling basis so that people get connected to coverage as soon as it is available.

This kind of proactive outreach strategy is not without precedent. States have made tremendous progress in recent years helping children enroll in and retain Medicaid or CHIP coverage by taking advantage of Express Lane Eligibility.[9] This federal policy option lets states use information from programs like SNAP to help make an eligibility determination for Medicaid or CHIP. The state can pull specific information, like a family's income, from other programs instead of collecting information directly from an applicant. This gives states the ability to get a complete picture of a child's eligibility based entirely on data from other programs and to then make an eligibility determination without ever requiring a family to complete an application.[10] They can do this one by one, as people enroll in other programs, or they can enroll an entire category of people all at once. Louisiana enrolled thousands of children in Medicaid in a single batch by automatically enrolling children who were already enrolled in SNAP.[11]

Automating enrollment and renewal also reduces the amount of manual data entry and verification that eligibility workers need to do. South Carolina estimates that it will save 50,000 hours of worker time and $1 million per year with its program to automate children's Medicaid renewals based on data from SNAP and Temporary Assistance to Needy Families (TANF).[12] In the first year Louisiana used automated enrollment and renewal, the state saved between $8 and $12 million compared to what it would have spent to manually enroll the same number of children.[13]

Although the Express Lane Eligibility option currently only applies to children's coverage, the Affordable Care Act provides tools so that states can automate enrollment and renewal in similar ways for adults.[14] In 2011, CMS approved a Medicaid waiver request from Massachusetts that includes authority to begin automating parent and caretaker Medicaid renewals based on SNAP eligibility.[15] But for automated enrollment and renewal in 2014 and beyond, states may not need a Medicaid waiver because language in the Affordable Care Act supports an automated approach. This will allow states to enroll and renew large numbers of people quickly and achieve considerable administrative savings.

Adopt enrollment policies that minimize documentation requirements.

Proposed federal regulations were issued in August 2011 outlining states' options for verifying eligibility for various forms of coverage.[16] These regulations mark a departure from the old way of verifying eligibility for Medicaid—they describe a tiered approach to verification, starting with the process that will be simplest for the consumer. For most eligibility criteria, states have the option to accept the applicant's attestation rather than require the applicant to provide documentation.

If a state does not accept attestation for one or more eligibility criteria, it must first rely on electronic verification, including connecting to the federal data hub and other state and private databases.[17] When data from these sources are "reasonably compatible" with information the applicant provides, the state can accept the data and continue the determination. This makes it easy for the applicant, as long as his or her data exist in the databases being tapped and those data accurately reflect their situation. The state's definition of reasonable compatibility will be very important; in cases where an applicant's attestation and information from a database are different, but both suggest eligibility, eligibility should be granted without requiring the applicant to provide additional documentation.

If information either cannot be found in electronic databases or is not reasonably compatible with the information provided by the applicant, the state may request additional documentation from the applicant. This is more burdensome for the applicant, but there are still opportunities to make it easier. Instead of requiring the applicant to mail or fax hard copies of documents, states could accept electronic forms of documentation, such as portable document format (pdf) files that can be attached to an email and sent to the state agency or even photographs of documentation that the applicant, or the applicant assister, can take with a mobile device and send to the agency by email or text message. This may be a viable option for many of the uninsured—83 percent of Americans own a cell phone and of these, 36 percent already use their phone to send photos or videos.[18] These numbers are only expected to rise in the future.

Start with the process that will be simplest for the consumer.

1. Federal Funding Opportunities
2. Effective Outreach Plan
3. Automated Enrollment
4. Minimal Documentation Requirements
5. **Data-Driven Eligibility Systems**
6. Consumer Assistance
7. Easy-to-Read Materials

Promote data-driven, integrated eligibility systems.

If your state is already taking advantage of the federal funding opportunities to modernize eligibility systems, then the next step is to ensure that these new or improved systems are designed with the consumer in mind. Without a background in IT systems, though, it may be difficult to know how to evaluate proposals or provide meaningful input. The following are key principles that can serve as a guide to focus proposals.

- **Data-driven eligibility.**

   One of the most important things that a new IT system must support is a true data-driven eligibility system. The system needs to establish real-time connections with a range of federal, state, and private databases that contain information relevant to eligibility for exchange coverage, Basic Health (where applicable), Medicaid, and CHIP. There are different ways to use the available data to make an eligibility determination, and states will likely take different approaches. But any time data suggest that an individual qualifies for a given health coverage program, the data should suffice to establish eligibility. Data should actually drive the eligibility decision, not simply be used as verification for information an applicant provides. In fact, consumers should never have to provide documentation for information a state or exchange already has access to. Exchanges and Medicaid and CHIP agencies should develop clear and consistent rules for the thresholds that determine when additional documentation will be needed and the rules for what to do when data do not accurately reflect an applicant's situation.

- **Coordination between health coverage programs.**

   It is also critically important that the exchange, Medicaid, and other health programs (including Small Business Health Option, or SHOP, exchanges) coordinate their eligibility processes. Although agencies may connect to the databases in different ways and prioritize the data they receive differently, agencies should establish aggreements that detail the hierarchy of various data sources and the business rules that will be used to ensure that consumers are not erroneously denied eligibility because of administrative coordination glitches. This is essential to make the enrollment experience truly seamless. Although this may require more work and coordination at the outset, it will make the enrollment system more efficient, reducing administrative duplication and costs in the long run.

- **Seamlessness as family circumstances change.**
Over time, the kind of coverage an individual is eligible for is likely to change as people enter and leave the household, gain or lose jobs, or move from one location to another. The eligibility system must be seamless not only at the initial point of entry, but also in an ongoing way that accommodates individuals and families as their circumstances change. Experts estimate that within one year, more than half of all adults with family incomes below twice the federal poverty level ($38,180 a year for a family of three) will experience a shift in eligibility from Medicaid to an exchange, or the reverse.[19] If the eligibility systems are not designed to handle these fluctuations and coverage transitions smoothly, some eligible people will almost certainly lose coverage.

- **A centralized "my account" feature.**
Enrollees should have access to their health coverage enrollment information online and by phone. This will allow them to easily see which coverage each member of the household is enrolled in and what assistance they are eligible to receive (Medicaid, CHIP, Basic Health, and/or premium tax credit and cost-sharing subsidy amounts), report changes in household circumstance that might affect eligibility, and receive notices pertaining to their eligibility. Enrollees should be able to keep the same account and account access information even if the kind of coverage they are eligible for changes. Providing consumers—or those assisting them—with a single portal to keep track of coverage and eligibility will make it easier to ensure continuous, seamless coverage.
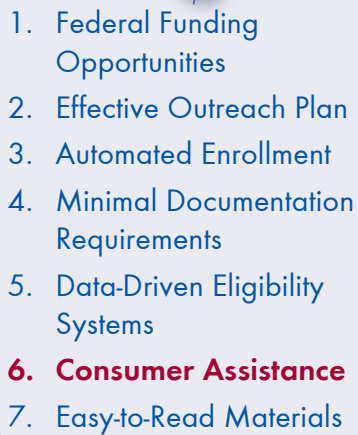
- **Coordination with other human services programs.**
An additional consideration when designing the data-driven, integrated eligibility system will be whether and how to integrate eligibility for other human services programs, like SNAP, child care assistance, and Temporary Assistance for Needy Families. Each state will need to determine whether and to what extent it wants to pursue this degree of coordination. CMS has indicated that states that receive the 90/10 match for Medicaid systems improvements may use this funding to create systems that integrate eligibility determination functions across multiple federally funded human services programs.[20] This funding is available until December 31, 2015. (See pages 1- 3 for more information).

*The eligibility system must
accommodate individuals and families
as their circumstances change.*

1. Federal Funding Opportunities
2. Effective Outreach Plan
3. Automated Enrollment
4. Minimal Documentation Requirements
5. Data-Driven Eligibility Systems
6. **Consumer Assistance**
7. Easy-to-Read Materials

Ensure a comprehensive approach to consumer assistance.

Technology will make it easier for consumers to apply for coverage on their own, but it can never replace the need for personalized human assistance. In fact, consumer assistance needs will only grow as more people become eligible for coverage and need help understanding their options. In most states, health insurance exchanges are an entirely new way of providing assistance with the cost of coverage. It will be particularly important that there are well-trained assisters available to help explain how the exchange, premium tax credit, and cost-sharing subsidy work and the implications of consumers' choices on their tax liability. Assistance will need to be tailored to the needs of different segments of the uninsured to account for language preferences, literacy and health insurance literacy, and any physical or developmental disabilities people may have.

As states plan the various functions of their exchanges, it is of paramount importance that a robust consumer assistance function be built in. This includes creating and staffing a call center that can either provide direct consumer assistance or connect with the appropriate resources in the community that can provide the assistance (such as other community-based organizations' consumer helplines or benefits assistance programs), creating a Navigator program (as described in the Affordable Care Act and related regulations),[21] and making it easy to connect with sources of assistance from the exchange's website (like chat functions and emails to customer service). Consumers will need help with the application and eligibility process. They will also need help choosing a health plan that meets their needs and learning how to use their coverage once they have it.

It will be important that those providing assistance are well versed in all of the programs in the coverage continuum, since members of some households will be eligible for different programs and their eligibility for programs may fluctuate throughout the year, particularly for consumers with lower incomes.[22] Those providing assistance will also need to be familiar with the tax policies involved in the advance payment of the premium tax credit, as these policies are complicated and will likely be a source of confusion for many consumers.

Stakeholders interested in working with their states to ensure adequate consumer assistance should think about some key questions:

- Is the state appropriately matching the assistance that will be provided to the anticipated needs of the uninsured population in the state? Different segments of the uninsured will require different kinds of assistance.
- What range of skills will assisters need to have? Different kinds of assisters will be better suited for different duties, from outreach and public education, to assisting with complicated application and eligibility situations, to helping with premium tax credit decisions and health plan selection.
- These different duties may require different training modules. Who will design these modules and how will they be administered?
- What sources of funding will be available to support assistance?
- Will assisters have access to the eligibility system(s) in the state so that they can provide real-time assistance to consumers about the status of an application or renewal or other information concerning eligibility?
- How will assisters' performance be measured over time?

It will also be important to establish connections between those providing assistance and the relevant state and federal agencies and to build mutual trust between these players. Assisters can serve as "canaries in the coal mine," spotting problems early and working together with the relevant administrative partners to correct problems on an ongoing basis. This feedback loop is an incredibly valuable part of ensuring continuous quality improvement in enrollment processes, particularly in the first few enrollment and renewal cycles.

Consumer assistance needs will only grow as more people become eligible for coverage.

1. Federal Funding Opportunities
2. Effective Outreach Plan
3. Automated Enrollment
4. Minimal Documentation Requirements
5. Data-Driven Eligibility Systems
6. Consumer Assistance
7. **Easy-to-Read Materials**

Create materials that are easy to read and understand for the target audience.

Making materials easy to read and understand helps make enrollment easier for everyone, regardless of their literacy skills. However, given that a large portion of the uninsured face significant literacy challenges, it will be particularly important that outreach materials, websites, and applications are designed with the consumer in mind.[23] The following are some key points to consider, which are described in greater depth in a separate issue brief series.[24]

- Plain language—Write in a conversational tone, using words that are easy to understand and free of jargon. Use short sentences written in the active voice and describe processes in a logical, step-by-step way.

- Clear design—Make ample use of white space, align margins to avoid a cluttered page or confusion about instructions and steps, and don't use more than two different fonts in the same document.

- Appropriately adapted translations—Write materials in the language in which they will be published, rather than translating from English.

- Focus groups and usability testing—Always test new materials with the target audience(s) before they "go live." Solicit participation from diverse groups, including people of different ages and different racial and ethnic backgrounds (including in languages other than English, when appropriate), people with different physical and developmental disabilities, and people with limited literacy skills. Make adjustments based on the feedback received.

Making materials easy to read and understand helps make enrollment easier for everyone . . .

Conclusion

This is an important and busy year for health reform implementation work, especially enrollment issues. Paving a smooth, simple, and streamlined path to coverage is not something that can be accomplished after the exchange has been established or after other key implementation decisions have been made. It must be integrated into the work already being done this year to prepare for coverage expansions, and it must be taken on by a range of stakeholders, not just state and federal government agencies. Ensuring enrollment success in 2014 and beyond will require all enrollment stakeholders to work collaboratively. Following the 2012 enrollment checklist will help keep these efforts on target.

2012 Enrollment Checklist

1. Take advantage of opportunities for federal funding.

2. Develop an effective outreach plan.

3. Automate enrollment whenever possible.

4. Adopt enrollment policies that minimize documentation requirements.

5. Promote data-driven, integrated eligibility systems.

6. Ensure a comprehensive approach to consumer assistance.

7. Create materials that are easy to read and understand for the target audience.

Endnotes

[1] To qualify for a Level 2 grant, a state must have certain elements of its exchange in place: legal authority to establish and operate an exchange compliant with federal requirements; a governance structure; a budget and initial plan for financial sustainability by 2015; a plan for how to prevent fraud, waste, and abuse; and a plan describing how consumer assistance capacity will be created, continued, and/or expanded, including a provision for a call center.

[2] One state (Rhode Island) was awarded both Level 1 and Level 2 Establishment Grants.

[3] Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, and Jessica Stephens, *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2012). The three states not yet receiving or planning to request the match are Florida, Maine, and Utah.

[4] To receive the 90/10 match, a state's proposed Medicaid system must promote the sharing or reuse of Medicaid technology and systems within and among states, support timely eligibility determinations, produce reports that can be used for program evaluation, ensure seamless coordination with the exchange and interoperability with other health and human services programs.

[5] Kaiser Familiy Foundation, *Kaiser Health Tracking Poll—August 2011* (Washington: Kaiser Family Foundation, August 2011), available online at http://www.kff.org/kaiserpolls/8217.cfm, accessed on February 23, 2012.

[6] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer* (Washington: Kaiser Family Foundation, October 2011), available online at http://kff.org/uninsured/7451.cfm, accessed on March 9, 2012.

[7] "Means-tested" programs are available only to people who have incomes under a certain limit. That means that the state or locality already has information about the individual's income, as well as their address or other contact information, and can be very proactive about helping them get health coverage once it becomes available.

[8] Currently, the minimum eligibility level for children ages 6-18 in Medicaid is 100 percent of the federal poverty level ($18,530 for a family of three). This will increase to 133 percent of the federal poverty level (for all children and non-elderly adults) by 2014. When the expansion takes effect, children with household income between 100-133 percent of the federal poverty level who are currently eligible for CHIP will become eligible for Medicaid instead.

[9] Jennifer Sullivan and Laura Parisi, *Express Lane Eligibility: Early State Experiences and Lessons for Health Reform* (Washington: Families USA, January 2011), available online at http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf, accessed on February 24, 2012.

[10] Centers for Medicare and Medicaid Services, *Letter to State Health Officials: Express Lane Eligibility Option, SHO#10-003/CHIPRA #14* (Baltimore: CMS, February 4, 2010).

[11] Urban Institute, *Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility* (Washington: Urban Institute, February 2012), available online at http://www.shadac.org/publications/louisiana-breaks-new-ground-nations-first-use-automatic-enrollment-through-express-lane, accessed on March 5, 2012.

[12] Center for Medicaid and CHIP Services Information Bulletin, January 12, 2012.

[13] Urban Institute, op. cit.

[14] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Subtitle E, Part I, Subpart B, Section 1413, and Subtitle G, Section 1561.

[15] Letter from Marilyn Tavenner, Acting Administrator of the Centers for Medicare and Medicaid Services to JudyAnne Bigby, Secretary, Massachusetts Executive Office of Health & Human Services, December 20, 2011, available online at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/MassHealthCurrentApprovalDocuments.pdf, accessed on February 24, 2012.

[16] Centers for Medicare and Medicaid Services, *Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010, Proposed Rule* (Baltimore: CMS, August 17, 2011). Centers for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, Proposed Rule* (Baltimore: CMS, August 17, 2011). Final and interim final exchange eligibility regulations were issued on March 12, 2012, and final and interim final Medicaid and CHIP eligibility regulations were issued March 16, 2012.

[17] The Centers for Medicare and Medicaid Services is establishing a federal data services hub that will give state exchanges and Medicaid and CHIP agencies electronic access to federal data relevant to making eligibility determinations.

[18] Aaron Smith, *Americans and Their Cell Phones* (Washington: Pew Research Center, August 2011), available online at http://pewinternet.org/Reports/2011/Cell-Phones.aspx, accessed January 28, 2012.

[19] 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* 30, no. 2 (February 2011): 232.

[20] The enhanced federal matching rate is available for the integration of systems across multiple federally funded human services programs as long as the costs would have been incurred anyway to develop systems for health coverage programs. Centers for Medicare and Medicaid Services, Administration for Children and Families, and Food and Nutrition Service, *Tri-Agency letter from CMS, ACF, and FNS Regarding Exemptions to Cost Allocation Policy for IT Systems*, August 10, 2011, available online at http://www.fns.usda.gov/snap/rules/Memo/2011/081011.pdf, accessed on February 24, 2012.

[21] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle E, Section 1311(i).

[22] Benjamin D. Sommers and Sara Rosenbaum, op. cit.

[23] Nicole Donnelly, Penny Lane, Joan Winchester, Christina Powell, *An Introduction to Health Literacy and Enrollment* (Washington: Enroll America, December 2011), available online at http://files.www.enrollamerica.org/best-practices-institute/publications-and-resources/2011/Health_Literacy_and_Enrollment.pdf.

[24] See Enroll America's Health Literacy Series, written by experts from the MAXIMUS Center for Health Literacy, available at http://www.enrollamerica.org.

Acknowledgments

Enrollment Checklist for 2012

© March 2012 Enroll America

Available online at
www.enrollamerica.org