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The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage

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EXECUTIVE SUMMARY

Less than two years after Massachusetts' 2006 reform law went into effect, only 2.6 percent of residents were uninsured – the lowest proportion ever recorded by an American state. Fully 56 percent of the state's increase in coverage took place through Medicaid and Commonwealth Care (CommCare), the state's new subsidy program for uninsured adults with incomes at or below 300 percent of the Federal Poverty Level (FPL).

By itself, the state's well-known individual mandate does not explain this result since it is not enforced against adults with incomes at or below 150 percent FPL and does not apply to children. And while Massachusetts generously subsidizes low-income residents to enroll in comprehensive coverage, the same is true of many other programs that have reached a much smaller proportion of eligible, low-income consumers.

Based on interviews with policymakers, stakeholders, advocates, and others, as well as a review of published reports, we find that the following factors have played a central role in helping Massachusetts enroll so many eligible, low-income uninsured:

- **Data-driven eligibility.** When data available from the state's previous Uncompensated Care Pool (UCP) showed that uninsured individuals qualified for CommCare, they were automatically "converted" to CommCare coverage, without any need to submit new applications. By June 2007 (eight months into the new program), such "auto-converted" members represented more than 80 percent of CommCare participants. By December 2007, former UCP enrollees, most of whom were presumably auto-converted to CommCare, numbered nearly 100,000 out of 158,000 CommCare members, or roughly a quarter of all newly insured state residents.
- **An integrated eligibility system that serves multiple programs.** A single application is used for Medicaid, CommCare, the UCP, and other subsidy programs. The form is processed by a single statewide unit within the Medicaid agency, using automated procedures to determine eligibility. As a result, consumers submit just one application to learn the program for which they qualify; they are not required to go from agency to agency, submitting multiple applications until they find the right program.
- **Health care providers and community-based organizations (CBOs) completing application forms on behalf of consumers.** Through the state's "Virtual Gateway," trained and deputized staff from these agencies complete application forms online. As consumers' authorized representatives, the agencies receive copies of state requests for additional documentation needed to establish eligibility. This lets them educate consumers about applicable procedural requirements and ensure necessary follow-through.

KEY FINDINGS

- Less than two years after Massachusetts passed reform legislation, more than 97 percent of state residents were insured.
- Within 15 months after implementation began, roughly one out of four newly insured state residents received subsidized coverage based on state data about household income, without any need to file traditional application forms.
- A single application form and a single system of eligibility determination served multiple subsidy programs, making enrollment simple and seamless for consumers.
- More than half of all successful applications for subsidized coverage were completed for consumers by community-based organizations and health care providers.

The state denies providers full reimbursement when a patient does not fully complete the application for health coverage. As a result, safety-net hospitals and community health centers devote significant staff resources to completing applications for patients through the Gateway and ensuring that patients follow-up as needed. In addition, CBOs have received "mini-grants," totaling \$2.5 to \$3.5 million a year from the state, plus additional amounts from foundations, enabling these organizations to educate consumers and enroll them into coverage.

As a result of these combined factors (the Virtual Gateway, incentives for providers to complete applications on behalf of their patients, and mini-grants to CBOs to help people enroll), more than half of all successful Medicaid and CommCare applications since the 2006 reforms have come via the Virtual Gateway. *Between this system for application assistance and the above-described data-driven eligibility, most uninsured residents enrolling in Medicaid and CommCare had their eligibility determined without the consumers needing to fill out application forms.*

- **An intensive public education campaign.** State residents were informed about both new assistance and the individual mandate through a multi-faceted public education campaign. Low-income households, whose members may not have understood that they were effectively exempt, worried about possible sanctions and therefore paid great attention to health coverage, which helped increase enrollment into Medicaid and CommCare.

While quickly achieving high levels of program participation, the state's approach to eligibility determination also cut administrative costs. The state did not need to process new applications for people who qualified for CommCare based on data from the UCP; CBOs and safety-net providers implemented patient education and key-data-entry functions that, in a less innovative program, would be performed by publicly funded social-service-office staff; applications submitted by trained CBO and provider staff via the Virtual Gateway, which incorporates automatic checks to spot problems and require corrections, had many fewer errors and were therefore less costly to process than applications directly submitted by consumers; and compared to traditional administrative procedures, a single statewide office determining eligibility used less labor-intensive methods to process applications while achieving economies of scale.

As health reform is considered at the federal and state levels, policymakers wishing to enroll large proportions of the low-income uninsured into subsidized coverage may wish to consider policies like those used by Massachusetts, including the following components:

- Whenever possible, eligibility for subsidies could be determined based on available data, without requiring unnecessary application forms. Such data could include information on tax returns, which are filed for more than six out of seven uninsured Americans (86.3 percent).
- Eligibility for all subsidy programs (including Medicaid, the Children's Health Insurance Program, and any new subsidies established by reform legislation) could be decided by an integrated eligibility system that uses a single, common application form. The form could be processed by either one government agency or several agencies working in coordination. With both of these approaches, an integrated system would ensure that, after consumers file a single form, they are placed in the appropriate program without any need to submit additional applications.
- Trained community- and provider-based staff could provide hands-on application assistance using a single online application system for all subsidy programs. Providers and CBOs could be given grants or financial incentives to successfully complete applications on behalf of low-income consumers.
- An individual mandate could be widely publicized, along with information about available subsidies.

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INTRODUCTION

By the summer of 2008—less than two years after Massachusetts' health care reform law became effective—only 2.6 percent of Massachusetts residents were uninsured (Long, Cook and Stockley 2008). This was the lowest proportion ever recorded in an American state.

The state's gains in coverage were particularly large for adults with incomes low enough to qualify for subsidies—that is, at or below 300 percent of the federal poverty level (FPL).¹ For them, the percentage without coverage dropped from 23.8 percent in 2006 to just 7.6 percent in 2008 (Long and Stockley 2009).

How did the state accomplish this result? The usual explanations are insufficient. The state mandates insurance coverage for adults, but the mandate does not apply to children and is not enforced against adults with incomes below 150 percent FPL. These two groups represent nearly half of the increase in coverage since 2006, as we discuss below.

The state provides hefty subsidies for uninsured residents with low incomes, but other states have taken similar steps without achieving remotely comparable participation by eligible households (Maine School of Public Service Institute for Health Policy 2006). To borrow the familiar "Field of Dreams" cliché, other states built systems of health coverage subsidies, but the uninsured didn't come. How did Massachusetts get them to come?

Based on state administrative data, a review of existing studies, a site visit to Boston in July 2009, and follow-up interviews, this report explains the innovative administrative strategies that caused an unprecedented proportion of eligible, low-income residents to participate in Massachusetts' subsidized health coverage programs.

National policymakers structuring health reform legislation have already learned much from Massachusetts' groundbreaking efforts. Key features of both Massachusetts reform and proposed national legislation include generous subsidies for uninsured residents with incomes too high to qualify for Medicaid but too low to afford coverage on their own, an individual mandate to purchase coverage whenever it is affordable, and a health insurance "exchange" in which consumers can choose from among competing plans.²

But none of these well-known policies, either alone or in combination, would have yielded the state's extraordinary results placing the low-income uninsured into subsidized health coverage. Innovative outreach and enrollment strategies, which this paper describes for the first time to a national audience, also played a central role. For future reforms at either the national or state level to accomplish the basic objective of enrolling the low-income uninsured into health insurance, it will be important to incorporate these additional lessons from Massachusetts into the design of coverage expansion.³

This study was completed under a grant from the Robert Wood Johnson Foundation's State Health Access Reform Evaluation (SHARE) initiative.

I. AN OVERVIEW OF MASSACHUSETTS REFORMS

Massachusetts' reform legislation was signed into law in April 2006. For purposes of this report, the most important elements of the new policy involve subsidies, the individual mandate, and reimbursement for uncompensated care. After describing key features of the 2006 Massachusetts reforms,⁴ this section of our paper identifies some of the major dates in the state's implementation of the new law.

Subsidies

- The 2006 legislation extends coverage of children through Medicaid (dubbed "MassHealth" in Massachusetts) to 300 percent FPL. Before the bill, eligibility stopped at 200 percent FPL.⁵
- A new subsidy program, Commonwealth Care (CommCare), provides comprehensive benefits to adults who are ineligible for Medicaid and whose incomes are at or below 300 percent FPL. Beneficiaries include poor adults who fell outside the state's previous categories for adult Medicaid eligibility. CommCare members with incomes below 100 percent FPL were not charged premiums initially; later, that threshold was raised to 150 percent FPL. Between the "zero-premium" income threshold and 300 percent FPL, premiums are charged on a sliding scale, based on income.

- A newly created, independent state agency known as the Commonwealth Health Insurance Connector Authority (“Connector”) administers CommCare as well as certain other aspects of the reform law.
- Both Medicaid and CommCare provide coverage primarily through private managed care organizations (MCOs). Under reform legislation, the same four MCOs served both Medicaid and CommCare beneficiaries through June 2009, when the Connector gained the ability to contract with additional MCOs.

Individual mandate

- All adults in Massachusetts are legally required to have health insurance, unless they cannot afford it.
- Children are not subject to the mandate.
- The mandate is enforced through the state income tax system. However, the mandate is not enforced against adults with incomes at or below 150 percent FPL.⁶

Uncompensated care

- Before the 2006 reform legislation, the state ran an Uncompensated Care Pool (UCP) for low-income uninsured patients ineligible for subsidized coverage. The UCP reimbursed both hospitals and community health centers throughout Massachusetts.
- To help finance the state’s coverage expansion, the UCP was substantially reduced in size and scope. The UCP has been replaced by a similar program, the Health Safety Net (HSN), which continues to pay for uncompensated care, albeit subject to stricter limits.

Key dates in implementing reform

- April 2006: Governor Romney signs Chapter 58 of the Acts of 2006, the reform legislation, into law.
- October 2006: CommCare begins enrolling eligible individuals with incomes at or below 100 percent FPL. They receive premium-free coverage.

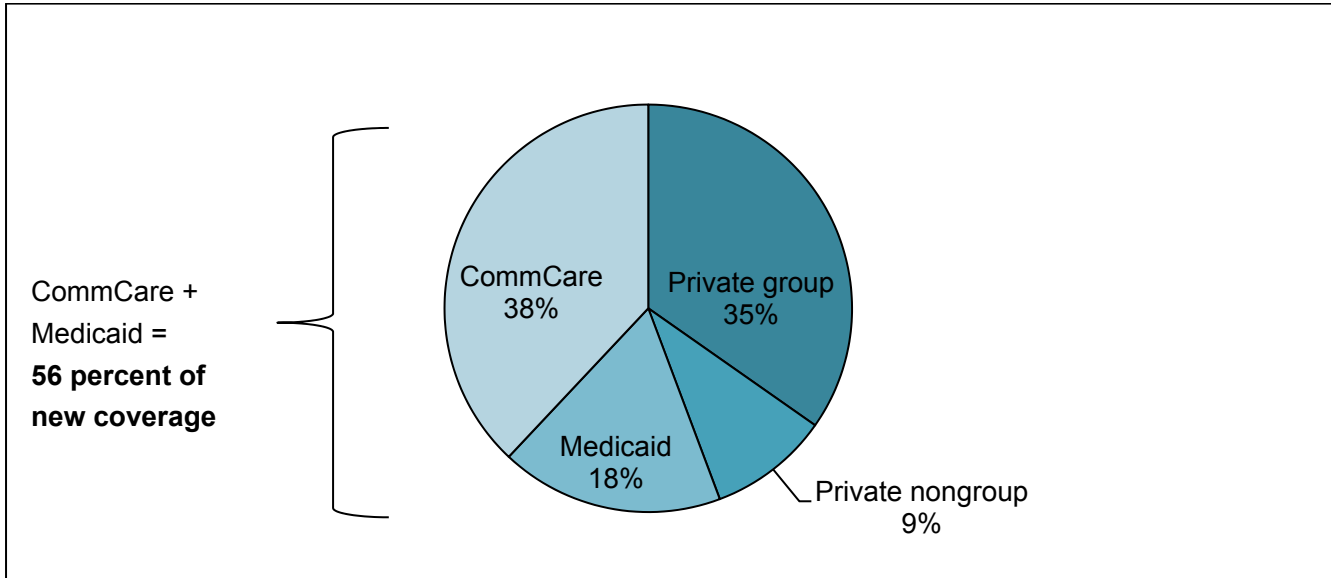
- January 2007: CommCare is open to all eligible individuals, including those with incomes between 100 and 300 percent FPL, who are charged premiums on a sliding scale.
- July 2007: Premiums are eliminated for CommCare enrollees with incomes between 100 and 150 percent FPL.
- July 2007: Expanded Medicaid eligibility becomes effective.
- October 1, 2007: The HSN replaces the UCP.
- December 31, 2007: A consumer’s compliance with the individual mandate for 2007 (the mandate’s first year) is based on coverage as of this date.
- April 15, 2008: State income tax returns are due for 2007. Adults must report their coverage as of December 31, 2007. The uninsured pay a \$219 penalty (Cronin 2009).
- April 15, 2009: State income tax returns are due for 2008. Each uninsured adult is subject to a penalty between \$17 and \$912, depending on household income and the number of months without coverage.

II. CHANGES IN MASSACHUSETTS INSURANCE COVERAGE SINCE THE 2006 LEGISLATION

From 2006 to 2008, the proportion of state residents without insurance coverage fell from 6.4 percent to 2.6 percent (Division of Health Care Finance and Policy 2009).⁷ More than half of the increase in coverage (56 percent) took place through Medicaid and CommCare (Figure 1).

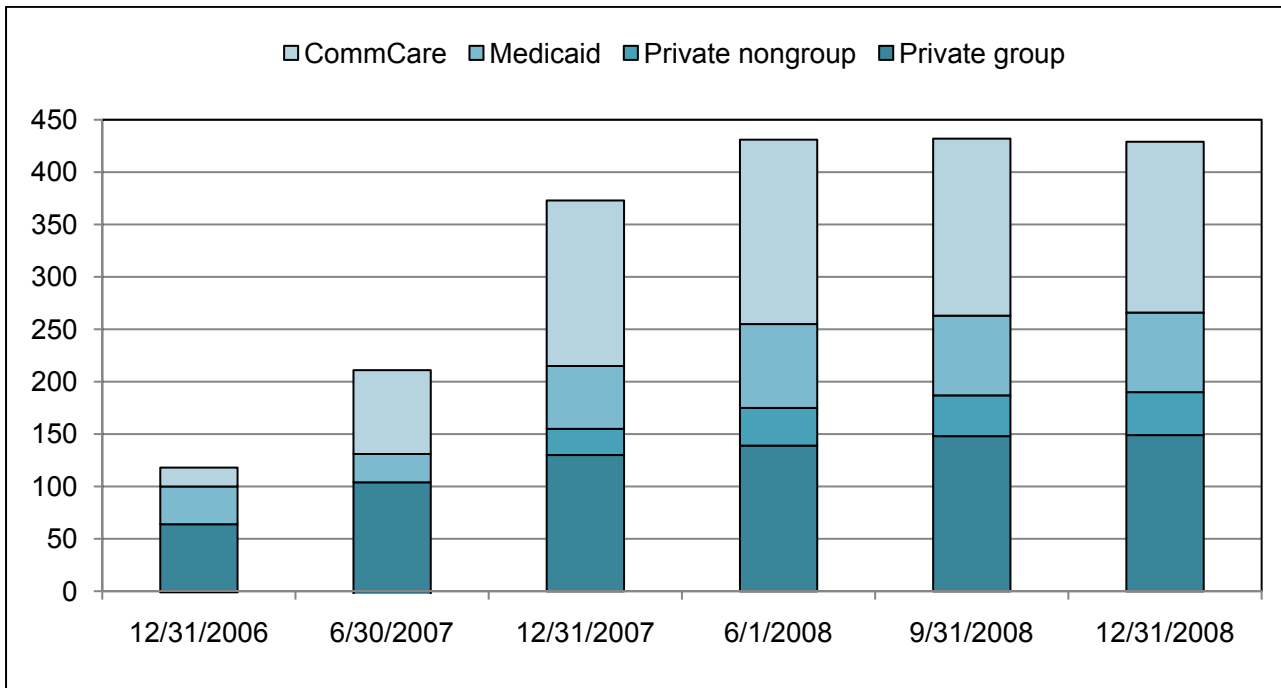
Since the end of 2007, CommCare enrollment has been the single largest contributor to the increase in health coverage (Figure 2).

Figure 1. Net increase in the number of Massachusetts residents with health insurance, by coverage type: June 30, 2006, to December 31, 2008



Source: Authors' calculations, Massachusetts Division of Health Care Finance and Policy, May 2009.

Figure 2. Increases in the number of Massachusetts residents with health insurance, by coverage type, since June 30, 2006: Various points in time (thousands of people)



Source: Authors' calculations, Massachusetts Division of Health Care Finance and Policy, May 2009.

III. RESEARCH METHODOLOGY

To learn more about Massachusetts' implementation of health care reform and to investigate how the state succeeded in enrolling so many low-income uninsured into subsidized coverage, we conducted a site visit to Boston in July 2009. During the site visit, evaluators met with more than 15 key informants representing a broad range of perspectives, including the MassHealth and Commonwealth Care programs, public and private providers (including hospitals and community health centers), health plan administrators, health care advocates, health policy researchers, and community-based outreach agencies. (See Appendix A for a complete list of all site visit informants.) All interviews were conducted using structured protocols by evaluation team members from the Urban Institute. To supplement information gathered during the site visit, we also drew upon a range of published reports and analyses of the state's programs.

IV. WHAT WORKED?

To stimulate high participation levels, the state provided subsidies that made it affordable for low-income people to enroll in comprehensive coverage. A vigorously enforced individual mandate also played an important role. While these two program characteristics have been widely discussed at the national level (e.g., Kaiser Commission on Medicaid and the Uninsured 2009), the following factors that helped Massachusetts achieve unusually high enrollment into subsidized coverage have received little or no attention:

- Data-driven eligibility for CommCare;
- A single, integrated eligibility system that applied information technology to seamlessly serve multiple health coverage programs;
- Grants to community-based organizations (CBOs) for public education and enrollment; and
- An intensive public education campaign that prominently featured information about the individual mandate.

Combined, these strategies had the further benefit of lowering the state's administrative costs.

Of note, some of the state's key administrative innovations were introduced years before the 2006 reforms. Thus, policymakers planning to replicate similar ap-

proaches nationally or in other states need to take into account the time required for successful implementation.

Data-driven eligibility and automatic enrollment into CommCare

As officials planned the implementation of Massachusetts' reforms, the state's Medicaid agency already had eligibility records for people who received care through the UCP. This included information about household income and the reason for Medicaid ineligibility. Using these data, the Medicaid agency identified UCP beneficiaries who appeared eligible for CommCare, based on income and categorical ineligibility for Medicaid.⁸ The agency ended their eligibility for the UCP⁹ and "auto-converted" them to CommCare, without any need for consumers to complete new application forms.¹⁰

This auto-conversion occurred in two waves. From October through December 2006, 48,000 adults¹¹ whose incomes were below 100 percent FPL (based on UCP records) were found eligible for premium-free CommCare and sent written notices explaining their new coverage status. These individuals were given 14 days to select a managed care organization (MCO). Although the notice was complex and difficult to understand,¹² roughly 45 percent of these auto-converted members chose a plan within this brief window, according to state officials.

People failing to select an MCO were assigned to a plan by the state. The auto-assignment process was based primarily on the premium bids submitted by each MCO, with the low bidders receiving the highest share of auto-assigned members; however, in some cases, evidence of prior relationships with an MCO's affiliated providers determined the plan in which an individual was enrolled. Consumers unhappy with their assignments had 60 days in which to change plans, but relatively few people requested such changes. By June 2007 (eight months into the new program), the nearly 50,000 auto-converted individuals who received premium-free coverage represented more than 80 percent of all CommCare enrollees.

A second round of auto-conversion took place from January through March 2007, for approximately 62,000 people who qualified for CommCare based on UCP data showing income between 100 and 300 percent FPL. As with the first set of auto-converted members, the second group was sent notices explaining their CommCare eligibility. However, because they qualified for coverage that required premium payments, they were not enrolled in

CommCare until they selected an MCO and paid their first month's premium. By December 2007, nearly 100,000 out of 158,000 total CommCare enrollees—roughly a quarter of all newly insured residents—were former UCP patients (Sullivan 2007), most of whom were presumably auto-converted based on UCP data. None of the auto-converted had to complete a new application form to establish their CommCare eligibility.

An integrated system that uses information technology to seamlessly determine eligibility for multiple health subsidy programs

Well before the 2006 reforms, Massachusetts developed a system through which a single eligibility system was used for the following programs:

- Medicaid;
- The Children's Health Insurance Program (CHIP), which is part of Medicaid in Massachusetts;
- A premium subsidy program for certain low-income workers offered employer-sponsored insurance, which is also part of the state's Medicaid program;
- The UCP; and
- The Children's Medical Security Program, a state-funded program for low-income, immigrant children ineligible for federal matching funds under Medicaid and CHIP.

All of these programs employed a single, common application form—called the Medical Benefit Request—and enrollee eligibility was determined by the state Medicaid agency. After passage of the 2006 legislation, this integrated system expanded to include the new CommCare and HSN programs.

With this system, a single statewide Medicaid office determines eligibility for all programs by applying one set of income methodologies. Eligibility is determined based on a computerized, logic-driven decision tree, rather than the state's previous, traditional approach, which required local public welfare staff to manually determine each applicant's eligibility case-by-case.¹³

From the beneficiary's perspective, such an integrated eligibility system greatly simplifies the enrollment process. Only one form must be completed, after which the consumer learns which program (if any) will provide coverage. By contrast, in many other states that operate multiple health coverage programs, consumers may need to file applications with one agency after another before they finally qualify for the right program.

The Massachusetts system is further streamlined through the state's "Virtual Gateway." Operational since

2004, this system allows deputized, state-trained staff of safety net providers and CBOs to fill out and file applications for consumers over a secure, internet portal. Such "application assisters" also obtain consumer signatures on necessary forms as well as eligibility documentation required by state policy, forwarding completed paper documents to the state. In addition, consumers authorize providers or CBOs to act as their representatives for eligibility purposes. This means that the application assister receives a copy of the state's notices requiring consumers to take various steps to qualify for coverage, such as providing a missing item of documentation. This facilitates follow-through and helps avoid denials for failure to meet procedural requirements.¹⁴

A key part of the Massachusetts system is that a provider cannot receive full reimbursement for a patient—under any system of coverage—unless an application form is successfully completed.¹⁵ As a result of this incentive, the staff of safety net hospitals and health centers complete forms online for patients, frequently following up to make sure all procedural requirements are met, using their status as authorized representatives of the patients in question. While this requirement was originally initiated to prevent providers from tapping the UCP for patients who should have received Medicaid, it has also had the effect of increasing enrollment into health coverage under the state's new, reformed system. According to state officials, application forms completed by providers or CBOs (but not by consumers) and submitted via the Virtual Gateway have resulted in more than 50 percent of all Medicaid and CommCare enrollment since the enactment of reform legislation.

Outreach and enrollment grants to CBOs

For several years before the 2006 legislation, Massachusetts extended grants to CBOs—totaling between \$2.5 and \$3.5 million annually—to support outreach and enrollment efforts. These grants were supplemented by the Blue Cross and Blue Shield of Massachusetts Foundation. Typically, they were provided to organizations that had a long history of working in underserved communities and that had developed strong trust relationships within those communities. Ranging from \$5,000 to \$20,000 per organization,¹⁶ these "mini-grants" helped develop a cadre of agencies and individuals who were knowledgeable about the state's health coverage programs, trained in using the Virtual Gateway to complete applications on behalf of consumers, and skilled in culturally and linguistically competent strategies for working with diverse, low-income families.

The mini-grants continued after the enactment of reform legislation in 2006. Recipient organizations obtained extensive, ongoing briefings about the reforms' imple-

mentation, positioning them to provide accurate information to their communities, both proactively and in response to questions from consumers. This effort continues presently through a regular training program, with an event held each quarter at five locations throughout the state. These briefings are well-attended by the staff of providers and CBOs and remain an important and ongoing resource in keeping CBOs and providers informed about the state's evolving health coverage programs.

As noted above, CBOs joined with safety net hospitals and clinics to complete more than 50 percent of all Medicaid and CommCare applications via the Virtual Gateway. According to many of our interviewees, CBOs have been particularly important in reaching members of ethnic minority groups and people with limited English proficiency. Consumer advocates suggest that a trusted adviser from the consumer's own community can be critically important in giving people the confidence to seek coverage.

Public education (including information about the individual mandate)

Following passage of health care reform legislation in 2006, Massachusetts carried out a massive public education campaign leading up to the December 2007 implementation of the individual mandate (Anthony, et al., 2009; Commonwealth Connector 2008). The state partnered with the Boston Red Sox baseball team on television, radio, and game time advertisements. CommCare-contracted health plans, though barred from marketing directly to individuals, bought advertisements on buses and subway trains and conducted targeted media outreach in ethnic communities. CBOs, funded by mini-grants, also worked with nearby health centers and hospitals to conduct public education at local health fairs, churches, and even door-to-door. Bank of America, CVS, and other major corporations partnered with the state in educating the public. Not only did news outlets cover the state's reforms, the Connector purchased mass media advertisements and sent millions of postcards to taxpayers and hundreds of thousands of mailings to employers explaining the new law.

A key part of the state's public education effort was informing residents about the individual mandate to obtain health coverage. Public opinion research conducted before the state's main public education campaign showed that, while most residents were aware of the reforms, very few knew even such basic facts as the date on which the individual mandate would go into effect (Kaiser Family Foundation, et al., 2007). According to the majority of key informants interviewed for this study, most low-income residents were unaware that

they were exempt from the individual mandate. Rather, because of the widespread publicity around the mandate, these residents paid keen attention to health reform implementation, fearing that inaction or the wrong decision could trigger penalties. When state notices about health coverage reached such households, consumers frequently reached out to CBOs to learn the meaning and implications of such correspondence. As explained above, many CBOs could respond to the queries with well-informed, useful advice, since they had received both training and funding to conduct outreach, public education, and enrollment. The combination of household awareness of the individual mandate and CBOs' readiness to offer guidance contributed significantly to 45 percent of auto-converted CommCare enrollees selecting an MCO in late 2006, despite having only two weeks in which to choose a health plan.

Notably, most of the increase in subsidized coverage took place among people for whom the mandate was not enforced. This included children, who were exempt from the mandate, and adults with incomes below 150 percent FPL, who comprised 72.5 percent of CommCare members.¹⁷ The vast majority of new Medicaid enrollees also fell outside the mandate.¹⁸ Nevertheless, public warnings about the individual mandate were important in achieving these enrollment gains, according to informants. Unlike most state coverage expansions, Massachusetts reforms involved a public education message that stressed not just new benefits, but also new penalties. The effectiveness of this message in galvanizing action is consistent with behavioral economics research showing that people are more likely to take advantage of available benefits if the issue is framed as preventing loss rather than achieving gain, even if there is no substantive difference between the two (Bertrand, et al., 2006).

Effect on the state's per capita administrative costs

The policies described above lowered the per capita administrative cost of determining eligibility and enrolling people into subsidized coverage, due to several factors:

- When eligibility was established based on existing UCP data, rather than requiring consumers to complete new application forms, the state was spared the cost of processing such new forms.
- When application forms came via the Virtual Gateway, safety net providers and CBOs did much of the consumer interviewing and key-data entry that, in a traditional enrollment system, is handled by publicly-funded social-service-agency staff.

- Errors were substantially less likely with the Virtual Gateway than when consumers completed application forms, for two reasons. First, the Virtual Gateway was programmed to flag errors and to require corrections before an application form could be submitted. Second, CBO and provider staff were required to complete state training before they were authorized to use the Virtual Gateway. Because these applications contained fewer errors and irregularities than forms completed by consumers, they could be processed more rapidly and less expensively.
- The Medicaid agency's shift to a computerized eligibility determination system reduced the operating costs of eligibility determination, compared to the previous, more labor-intensive model that featured substantial exercise of discretion by local welfare workers.
- The use of a single statewide agency to determine eligibility for multiple programs achieved economies of scale.

Quantified estimates of the magnitude of administrative savings were not available for this analysis. However, state officials noted the following indicator of increased efficiency well before the 2006 reforms: after implementing its revised approach to eligibility determination, the Medicaid agency more than doubled the number of annual eligibility determinations while increasing staff by less than 10 percent.

Of course, changing the eligibility determination system required up-front investment in information technology as well as cultural changes and other transition costs. But according to state officials with whom we spoke, the administrative cost-savings of more efficient ongoing operations exceeded the cost of one-time investments in an improved administrative infrastructure.

V. LIMITATIONS TO THE MASSACHUSETTS APPROACH

Despite the state's accomplishments, the enrollment strategies described above have encountered several challenges. The first resulted from a combination of unexpected success and greater need for assistance than the state originally anticipated. Because of the data-driven enrollment into CommCare described above, in addition to the state's underestimate of the number of uninsured residents before reforms were implemented, early enrollment totals went beyond state expectations. As a result, initial subsidy costs likewise exceeded the anticipated amounts. However, after several years,

enrollment and costs remained within the range of original projections, according to Massachusetts observers.

Second, the state's eligibility system is not entirely integrated and data-driven:

- **One significant health coverage program is outside the state's integrated eligibility system.** The Medical Security Program (MSP) subsidizes health coverage for laid-off workers who receive unemployment insurance and whose incomes are at or below 400 percent FPL. Individuals who qualify for MSP are ineligible for Medicaid and CommCare. Unlike the latter subsidy programs, MSP eligibility is determined outside Medicaid, by the same agency that runs the state's unemployment insurance program, using its own application form. According to advocates, consumers can remain uninsured for months as they attempt to transition from the state's integrated eligibility system to the MSP program.
- **Medicaid and CommCare have different rules for when eligibility starts and stops.** While Medicaid eligibility can end at any point on the calendar, CommCare's does not begin until the first day of a calendar month. As a result, if someone transitions from Medicaid to CommCare eligibility because of a mid-month change in household circumstances—for example, a new job or marriage—the person experiences a gap in coverage, which can last for several months if the Connector has to wait for the individual to select a plan or pay the first month's premium.
- **Some non-safety-net hospitals do not complete application forms for all uninsured patients.** Rather than seek reimbursement from the state in all cases, these hospitals bill some of their uninsured patients. The resulting charges, some or all of which could have been covered by Medicaid, CommCare, or the HSN, can be significant (Pryor and Cohen 2009).
- **Coverage can end for procedural reasons at re-determination, even if members remain eligible.** After a year on the program, each CommCare member's eligibility is reviewed. The state sends the member a form requesting updated demographic, income, and employment information. If that form is not returned, eligibility ends. This renewal process does not include the data-driven eligibility and application-assistance components that make initial enrollment so user-friendly.¹⁹ As a result, many CommCare members have their coverage terminated for failure to complete and return these forms at redetermination. During an average quarter between October 2007 to December 2008, 47,433

people joined CommCare, but 37,771 members saw their coverage end because of the redetermination process (authors' calculations from Boudreault 2008 and Commonwealth Connector 2009a). Within five months of losing coverage, 21 percent of these CommCare members re-enrolled into the program. (Commonwealth Connector 2009b).²⁰

In a sense, the strength of the state's general enrollment and eligibility strategies are illustrated by these gaps. Such lapses in coverage result precisely because they involve circumstances not governed by the state's usual strategies of (a) applying an integrated eligibility system to serve multiple programs and (b) using data-driven eligibility and application assistance to avoid the need for consumers to fill out forms before they receive coverage.

VI. LESSONS FOR NATIONAL AND STATE POLICYMAKERS

The combination of innovative strategies in Massachusetts—namely, data-driven eligibility, a single application for all programs that is processed by a single state agency, an online portal using provider and community resources to enroll consumers, and intensive use of multiple media tools to convey a message that included warnings about the individual mandate—yielded unprecedented results in lowering the number of uninsured. Sadly, most health subsidy programs achieve participation levels far below those reached in Massachusetts. For example:

- In bills passed from 1986 through 1990, Congress enacted Medicare Savings Programs²¹ providing Medicaid coverage of Medicare premiums and, in some cases, deductibles and co-insurance for seniors with incomes up to 120 percent FPL (Carpenter 1998). By 2001—over a decade later—fewer than one-third of eligible beneficiaries were enrolled (Federman, et al., 2005).
- In 1997, Congress passed the State Children's Health Insurance Program (recently renamed the Children's Health Insurance Program, or CHIP). Despite extensive outreach and streamlining of application procedures, fully five years after CHIP became effective only 60 percent of eligible children had enrolled (Selden, et al., 2004).²²
- When the Health Coverage Tax Credit (HCTC) for trade-affected displaced workers and certain early retirees was enacted by Congress in 2002, policymakers predicted that hundreds of thousands might

benefit. By 2006, only 28,000 households received health coverage through HCTC—an estimated 12 to 15 percent of the eligible population (Dorn 2008). For the first three years of implementation, HCTC subsidy payments were less than 30 percent of the level forecast when the legislation was enacted (Dorn 2006).

To avoid similar problems with new coverage expansions, federal policymakers crafting national health reform (as well as state lawmakers designing coverage expansions), could adopt policies similar to those implemented in Massachusetts.

Federal implications

For national health reform legislation to achieve its basic goal of covering the low-income uninsured, federal lawmakers could consider incorporating the following policy elements:

- **Data-driven eligibility.** No nationwide Uncompensated Care Pool contains data from which uninsured individuals can have their eligibility determined for an expanded Medicaid program or for new subsidies created by national reform legislation. But other sources of such data exist. In particular, more than six out of seven uninsured individuals (86.3 percent) file federal income tax returns (Dorn 2009). Reform legislation could allow the uninsured to use tax returns to indicate their lack of insurance coverage; such legislation could also authorize the use of those returns to determine eligibility for subsidized health coverage. If so, tax information could frequently establish eligibility without any need for consumers to complete additional application forms.²³
- **A single, integrated system for applications and eligibility determination that applies to all major subsidy programs.** In each state, one agency could determine eligibility for Medicaid, the Children's Health Insurance Program (CHIP), and new subsidies enacted through national reform, applying a common methodology for calculating income and determining enrollment periods, thus avoiding any gaps. Within each state, a single application form would apply to all three programs.

The entity determining eligibility could be the Medicaid agency,²⁴ if it applies a computerized, logic-driven eligibility model at the state rather than local level.²⁵ State Medicaid agencies would most likely require enhanced federal matching funds to cover the cost of developing and operating the information technology needed under this new approach to eligibility determination.²⁶ If a state chose not to as-

sume this role, it could be performed by the Social Security Administration, which has experience determining income and eligibility for the Supplemental Security Income (SSI) program.²⁷ Congress could require the Secretary of HHS to establish continuous and integrated eligibility methodologies for Medicaid, CHIP, and new subsidies created by reform legislation.

- **A single online application system for all subsidy programs within each state, with strong financial incentives for providers to use that system for uninsured patients.** The Secretary of HHS could establish incentives for providers to complete application forms for their patients, develop training programs so staff of providers can use the online system effectively, and create procedures through which patients authorize providers to receive correspondence related to eligibility issues and help the families meet requirements needed to enroll and to retain coverage.
- **Grants for community-based organizations (CBOs) to enroll uninsured individuals into subsidized health coverage.** Along with grants would come training and access to the online enrollment system described above.
- **An extensive public education effort,** with participation from major national corporations, that includes information about coverage mandates.

State implications

In many states, policies and practices resemble those in Massachusetts, but additional refinements may be needed to maximize enrollment. For example:

- With the enactment of Express Lane Eligibility (ELE) in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states have greatly expanded flexibility under federal law to use data from state income tax records and the files of other public benefit programs to grant eligibility for children's health coverage, notwithstanding differences between program methodologies. While this flexibility is limited to children, states may be able to obtain Medicaid waivers under Section 1115 of the Social Security Act to extend similar strategies to the determination of eligibility for parents and other adults.
- Many states have at least partially integrated the application processes for Medicaid and separate CHIP programs by using a single application form for both programs and creating a "single point of entry" for reviewing and determining eligibility. Under

the latter policy, when the CHIP agency denies eligibility because a child appears eligible for Medicaid, the file is transferred to the Medicaid agency for further processing.

While such systems represent a major step forward, the approach does not reach the full integration achieved by Massachusetts. After a family has fulfilled all procedural requirements for CHIP, if the application is transferred to the Medicaid agency, the family may need to meet additional procedural requirements for the child to receive coverage. With two sets of procedural requirements to fulfill (rather than a single set), there are more opportunities for enrollees to fall between the cracks, so eligible children are more likely to remain uninsured.

This problem would be avoided if a state modified its eligibility determination system so that a single agency—under federal law, the Medicaid agency—determined eligibility both for Medicaid and CHIP, using the kind of statewide, automated processing employed by Massachusetts. Alternatively, if a state chose not to make such a move, it could instead work to align its Medicaid and CHIP eligibility rules and procedures so that, invisible to the applicant, the two programs would work in concert to determine which program (if any) covers the child, without requiring the completion of any additional application forms. For example, through ELE, a Medicaid and CHIP program could each base a child's eligibility on the other program's determinations.²⁸

- As part of implementing CHIPRA, the Centers for Medicare and Medicaid Services (CMS) are allocating \$80 million in grants to community-based organizations and providers to conduct outreach and enrollment for children. This builds on existing state efforts (Hill et al. 2004), such as New York's "Facilitated Enrollment" model (Fairbrother, et al., 2004; Hill and Hawkes 2002a) and California's "Certified Application Assistance" approach (Jacobson and Buchmueller 2007; Sullivan et al. 2005; Hill and Hawkes 2002b). To achieve the full benefit of such strategies, states need to train and fund the staff of providers and CBOs to complete application forms rather than just educate consumers about available coverage. Ideally, state procedures could encourage consumers to appoint these staff to act as their authorized representatives for eligibility purposes, thus facilitating necessary follow-through after the original application form is filed.
- States could take additional steps to increase providers' involvement in helping consumers enroll.

States could follow Massachusetts' lead by establishing requirements or financial incentives for community health centers and hospitals to help their uninsured patients complete applications for health coverage. For example, such consumer assistance could be required as a condition of licensure, receiving Disproportionate Share Hospital payments, or reimbursement from Medicaid or health insurance covering state employees.

- Several states have developed online application forms for Medicaid and CHIP; in some cases, these forms serve other populations and programs as well. In many states, however, applicants need to print out and mail in the forms that are completed online. States would achieve administrative efficiencies and increase enrollment if data could also be *submitted* online and automatically transferred to the state's eligibility files for further processing. Moreover, states could improve the quality of applications received online by training application assistants and programming the online form to reject applications that have clear errors.

Obviously, states can take different approaches to achieving coverage results like those realized in Massachusetts. One important aspect of the Massachusetts system is that many different administrative features combine to maximize enrollment and reduce administrative costs. However, the strategies applied by Massachusetts deserve serious consideration as potential models by states that seek either to reach large numbers of uninsured, eligible residents or to lower the operating costs of eligibility determination.

CONCLUSION

Innovative administrative strategies that were essential to Massachusetts' substantial reduction in the number of uninsured are surprisingly unknown to health policy analysts outside the state. Through interviews with state policymakers and stakeholders, we learned that most low-income uninsured who enrolled in subsidized coverage did not need to fill out application forms. Instead, many qualified for assistance based on data already in the state's possession. Others had application forms completed by trained staff of safety-net providers or

CBOs, using the state's online enrollment system. Even though the state sponsors multiple programs to subsidize health care and to reimburse providers for uncompensated care, a single state agency determines eligibility for almost all programs, based on a single, common application form. By leveraging information technology, private-sector involvement in completing application forms, and centralized data processing, the state reduced the administrative costs of eligibility determination below the levels characteristic of traditional public benefit programs. Finally, a major public education campaign gained consumers' attention by describing the subsidies and individual mandates included in the state's reform.

If federal or state policymakers wish to enroll a large number of eligible uninsured individuals into subsidized coverage under proposed reforms, they could learn from Massachusetts by designing policies to accomplish the following goals:

- Use available data, whenever possible, to establish eligibility, without requiring uninsured consumers to file new application forms before receiving coverage for which they qualify;
- Let consumers apply for all possible sources of subsidized health coverage by filing a single application form;
- Use an integrated and seamless system to process the single application form and determine eligibility for all available subsidies, without requiring the consumer to complete additional paperwork;
- Enlist help from trained staff of providers and CBOs by funding them and providing incentives to complete online applications on behalf of consumers and to help consumers follow through meeting applicable procedural requirements;
- Determine eligibility using a single statewide agency that employs logic-driven and automated routines to identify missing documentation and establish eligibility; and
- Conduct an intensive public education campaign that educates consumers about both new assistance and legal requirements to obtain health coverage.

REFERENCES

- Anthony, Stephanie, Robert W. Seifert, and Jean C. Sullivan. 2009. *The MassHealth Waiver: 2009-2011...and Beyond*. Prepared by the Center for Health Law and Economics, University of Massachusetts Medical School, for the Massachusetts Medicaid Policy Institute and the Massachusetts Health Policy Forum. Boston, MA.
- Bertrand, Marianne, Sendhil Mullainathan, and Eldar Shafir. 2006. "Behavioral Economics and Marketing in Aid of Decision Making Among the Poor." *Journal of Public Policy & Marketing*, Spring; 25(1):8-23.
- Boudreault, Melissa. *Commonwealth Care Quarterly Program Update: Board of Directors Meeting, Friday, October 17, 2008*. Commonwealth Connector. Boston, MA.
- Carpenter, Letty. 1998. "Evolution of Medicaid Coverage of Medicare Cost Sharing," *Health Care Financing Review*, Winter; 20(2): 11-18.
- Commonwealth Connector. 2009a. *Quarterly Update: January 15, 2009*. Boston, MA.
- — — 2009b. *Quarterly Update: April 9, 2009*. Boston, MA.
- — — 2008. *Report to the Massachusetts Legislature: Implementation of the Health Care Reform Law, Chapter 58, 2006-2008*. Boston, MA.
- — — 2007. *Board Update: March 9, 2007*. Boston, MA.
- Cronin, Neil. 2009. *All Aboard: Making Coverage Truly Available to All*. Presentation at Health Action 2009, Families USA. January 31, 2009. http://www.familiesusa.org/conference/health-action-2009/conference-materials/thursday_ppt/cronin-thurs-pm-all-aboard.ppt.
- Division of Health Care Finance and Policy. 2009. *Health Care in Massachusetts: Key Indicators: May 2009*. Boston, MA.
- Dorn, Stan. 2009. *Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform*. Prepared by the Urban Institute for the Pharmaceutical Researchers and Manufacturers of America. Washington, DC. (Publication pending)
- — — 2008. *Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons*. Prepared by the Urban Institute for the Robert Wood Johnson Foundation. Washington, DC.
- — — 2006. *Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment*. Prepared by the Urban Institute for The Commonwealth Fund. Washington, DC.
- Hudson, J.L., and T.M. Selden. 2007. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead," *Health Affairs*, September/October; 26(5): w618-w629
- Fairbrother, Gerry, Jennifer Stuber, Melinda Dutton, Roberta Scheinmann, and Rachel Cooper. 2004. "An Examination of Enrollment of Children in Public Health Insurance in New York City through Facilitated Enrollment," *Journal of Urban Health*, June; 81(2):1099-3460.
- Federman, Alex D., Bruce C. Vladeck, and Albert L. Siu. 2005. "Avoidance of Health Care Services Because of Cost: Impact of The Medicare Savings Program," *Health Affairs*, January/February; 24(1): 263-270.
- Hill, Ian, Mary Harrington, Corinna Hawkes. 2004. *Final Cross-Cutting Report on the Findings from Ten State Site Visits: Congressionally Mandated Evaluation of SCHIP*. December 2003. (Revised May 2004) Mathematica Policy Research, Inc. Princeton, New Jersey
- Hill, Ian, and Corinna Hawkes. 2002a. *The State of New York's Child Health Plus Program: Site Visit Report from the Congressionally Mandated Evaluation of the State Children's Health Insurance Program*. December 2002. Mathematica Policy Research, Inc. Princeton, New Jersey
- — — 2002b. *The State of California's Healthy Families Program: Site Visit Report from the Congressionally Mandated Evaluation of the State Children's Health Insurance Program*. November 2002. Mathematica Policy Research, Inc. Princeton, New Jersey.

- Jacobson, Mireille, and Thomas C. Buchmueller. 2007. "Can Private Companies Contribute To Public Programs' Outreach Efforts? Evidence From California," *Health Affairs*, March/April; 26(2): 538-548.
- Kaiser Commission on Medicaid and the Uninsured. 2009. *Massachusetts Health Care Reform: Three Years Later*. Washington, DC.
- Kaiser Family Foundation, Harvard School of Public Health, Blue Cross Blue Shield of Massachusetts Foundation. 2007. *Massachusetts Health Reform Tracking Survey*.
- Long, Sharon K., Allison Cook, and Karen Stockley. 2008. *Estimates from the 2008 Massachusetts Health Insurance Survey*. Urban Institute, Washington, DC.
- Long, Sharon K., and Karen Stockley. 2009. *Health Reform in Massachusetts: An Update on Insurance Coverage and Support for Reform as of Fall 2008*. Urban Institute, Washington, DC.
- Maine School of Public Service Institute for Health Policy. 2006. *Comparing the Dirigo Choice Program Experience with Other State Initiatives Targeted to Small Businesses and Individuals*. August. Prepared for the State Health Planning Program, Health Resources and Services Administration, U.S. Department of Health and Human Services, Portland, ME.
- Pryor, Carol, and Andrew Cohen. 2009. *Consumers' Experience in Massachusetts: Lessons for National Health Reform*. Prepared by the Access Project for the Kaiser Commission on Medicaid and the Uninsured.
- Seifert, Robert W. 2008. *The Basics of MassHealth*. Massachusetts Medicaid Policy Institute. (Updated September 2008) Boston, MA.
- Selden, Thomas M., Julie L. Hudson, and Jessica S. Banthin. 2004. "Tracking Changes in Eligibility And Coverage Among Children, 1996–2002," *Health Affairs*, September/October; 23(5):39-50
- Sullivan, Gregory W. 2007. *Status Report on Issues Related to Health Care Reform Implementation Raised by the Joint Committee on Health Care Financing*. Office of the Inspector General, The Commonwealth of Massachusetts. Boston, MA.
- Sullivan, Jennifer, Ian Hill, and Christopher Trenholm. 2005. "Links Between New Enrollment, Outreach, and Policy Changes: Case Study of California." September 2005. Mathematica Policy Research, Inc. Princeton, New Jersey.

APPENDIX A: KEY INFORMANT INTERVIEWS (IN ALPHABETICAL ORDER)

- Stephanie Anthony, Principal Associate, The University of Massachusetts Medical School Center for Law and Health Economics
- Leanne Berge, Vice President of Strategic Planning and Business Development, Network Health
- Kate Bicego, Consumer Education & Enrollment Manager, Massachusetts Health Care for All
- Melissa Boudreault, Director of Commonwealth Care Health Plan, Massachusetts Health Insurance Connector Authority
- Robin Callahan, Director of Member Policy and Program Development, Office of Medicaid, Massachusetts Executive Office of Health and Human Services
- John Cragin, Senior Director of Commonwealth Care, Boston Medical Center HealthNet Plan
- Neil Cronin, Policy Analyst/Advocate, Massachusetts Law Reform Institute
- Patricia Edraos, Policy Director, Massachusetts League of Community Health Centers
- Donna Fox, Vice President of Government Affairs, Cambridge Health Alliance
- Kaitlyn Kenney, Manager of Policy and Research, Massachusetts Health Insurance Connector Authority
- Meg Kroeplin, Executive Director, Community Partners, Inc.
- Members of the ACT!! Health Care for All Coalition Policy and Program Committee
- Caroline Minkin, Deputy Director for the Health Safety Net
- Brian Rosman, Research Director, Massachusetts Health Care for All
- Bob Seifert, Principal Associate, The University of Massachusetts Medical School Center for Law and Health Economics
- Lindsay Tucker, Health Reform Policy Manager, Massachusetts Health Care for All

NOTES

- ¹ In 2009, the FPL is \$18,310 per year for a three-person household, \$22,050 for a household of four, etc.
- ² Under some pending national proposals, subsidies are significantly smaller for both premiums and out-of-pocket costs than is the case in Massachusetts. While important, that subject is outside the parameters of this paper.
- ³ This topic could also be important for other states for reasons that go beyond the maximizing enrollment of eligible individuals. Proposed national legislation may impose significant new administrative burdens on states. The 2009 House Tri-Committee bill (HR 3200), for example, requires that all uninsured must be screened for potential Medicaid eligibility (and enrolled, if they qualify) before their eligibility for other subsidies is assessed. As explained below, Massachusetts' administrative innovations substantially lower the per capita cost of eligibility determination. Such efficiencies may be important for other states to replicate if national legislation substantially increases the number of eligibility determinations required of Medicaid agencies. Those efficiencies also provide an important signal to national policymakers that, done right, reforms can slim rather than fatten public-sector bureaucracies, even as the number of uninsured declines.
- ⁴ Features of the law not described here include employer responsibilities, insurance reforms, and the Commonwealth Choice program (the state's health insurance exchange, which offers unsubsidized coverage).
- ⁵ The reform legislation made other changes to Medicaid as well. For example, the bill expanded eligibility for certain categories of adult coverage, increased Medicaid reimbursement rates, and restored certain adult benefits that had previously been eliminated.
- ⁶ The reason for this exemption is that these adults have access to premium-free CommCare. As a result, they have no financial incentive to delay coverage until they need care. In addition, the penalty for uninsurance is set at half the cost of coverage; since CommCare is free to these adults, no penalty applies.
- ⁷ Survey methodologies changed from 2006 to 2008, so results may not be fully comparable. However, other surveys conducted in 2006, 2007, and 2008 that applied consistent methodologies confirm the magnitude of the decline in uninsurance (Long and Stockley 2009).
- ⁸ Some people fall outside Medicaid's eligibility categories and so do not qualify, no matter how low their income.
- ⁹ For each auto-converted member, the UCP continued to be available for 90 days after eligibility for CommCare was established.
- ¹⁰ This conversion took place even though, with some individuals, eligibility data for the UCP had not been updated for over a year. This did not pose a problem for the Centers for Medicare and Medicaid Services (CMS), because these enrollees' eligibility would be redetermined a year after their CommCare enrollment. This issue received a small amount of attention as the state and CMS negotiated the terms of the state's 2006 Medicaid waiver under Section 1115 of the Social Security Act.
- ¹¹ The number of auto-converted individuals in each category (up to 100 percent FPL and above 100 percent FPL) is taken from the Connector's estimate of the number of UCP members who qualified for CommCare (Commonwealth Connector 2007).
- ¹² The notice of CommCare eligibility was contained in the middle of a lengthy UCP eligibility notice, written in technical language, the main nominal topic of which was the termination of UCP eligibility and the consumer's resulting appeal rights.
- ¹³ Each hospital and community health center determined eligibility for the UCP, applying state standards.
- ¹⁴ The state is planning to implement a "public facing" Virtual Gateway through which consumers can complete applications online.
- ¹⁵ If such a form is not filled out, the only source of compensation is the "medical hardship" program, which pays uncompensated care costs once expenses have exceeded a specified percentage of the patient's income; the percentage varies based on the applicable FPL. 114.6 CMR §13.05.
- ¹⁶ Some grants were for significantly larger amounts. The recipients were responsible for subcontracting with and providing training and technical support to multiple local agencies.
- ¹⁷ Authors' calculations from Commonwealth Connector 2009a.
- ¹⁸ Medicaid children are exempt from the mandate, and most adults have incomes below 150 percent FPL. However, a small number of adults under age 65 receive Medicaid even though their incomes exceed this threshold. For example, these adults may qualify because of pregnancy or HIV/AIDS, for which eligibility extends to 200 percent FPL, a diagnosis of breast or cervical cancer, which confers eligibility up to 250 percent FPL, and employment at certain companies for which Medicaid provides premium subsidies up to 300 percent FPL (Seifert 2008).
- ¹⁹ As we go to press, CommCare administrators are working to improve the redetermination process by including a "CommCare-specific" insert with redetermination paperwork; pre-populating redetermination forms with information available to the state; and permitting consumers to complete forms for both enrollment and renewal on-line (Commonwealth Connector 2009b).
- ²⁰ The latter estimate is for February 2008 through March 2009.
- ²¹ At the time, the eligibility categories were known as Qualified Medicare Beneficiaries (QMBs) or Specified Low-Income Medicare Beneficiaries (SLMBs).
- ²² By 2004-2005, participation rates reached 80 percent. Authors' calculations, Hudson and Selden 2007.
- ²³ For a relatively detailed discussion of how such eligibility could be structured, see Dorn 2009.
- ²⁴ If eligibility were to be determined instead by private contractors, as takes place under many CHIP programs, it may prove challenging to maintain high performance with strong institutional memory over time. State competitive bidding laws often require selecting the least costly contractor. After the initial contract ends, that standard can require a transition to a new contractor, which can cause substantial dislocation that harms beneficiaries as a new contractor comes up to speed.
- ²⁵ Determining eligibility at the county level, as takes place in several states, makes it substantially more difficult to implement major reforms. It also reduces the likelihood of adherence to data security and privacy safeguards, which are critically important under the data-based approach described here.
- ²⁶ One possible approach would extend the current Medicaid Management Information System (MMIS) enhanced match to eligibility improvements needed to carry out the kind of expanded responsibility described in the text. Such match pays 90 percent of initial IT development and 75 percent of operating costs. Under a regulation dating back to the 1970s, MMIS match is available only for systems that process provider claims, not IT that determines eligibility. 42 CFR 433.112(c) and 42 CFR 433.111(b)(3).
- ²⁷ Problems during early implementation may be lessened if administrative duties are assigned to agencies that currently have similar responsibilities. For this reason, we do not suggest vesting health insurance exchanges with the responsibility for determining subsidy eligibility. Such exchanges will bear a great enough burden without assuming the complex duties involved in determining eligibility for subsidies.
- ²⁸ New Social Security Act § 1902(e)(13)(F)(ii)(I)(cc) and (dd) [42 U.S.C. 1396a(e)(13) (F)(ii)(I)(cc) and (dd)], added by CHIPRA Section 203(a).

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Stan Dorn is a senior research associate, Ian Hill is a senior fellow, and Sara Hogan is a research associate at the Health Policy Center of the Urban Institute.

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The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

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