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Ms. Shalanda Young  
Acting Director  
Office of Management and Budget  
Executive Office of the President

**Re: Docket No. OMB-2021-0005, “Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government”**

Dear Ms. Young:

On behalf of The Enrollment Coalition, the following comments are in response to the Office of Management and Budget’s (OMB) Request for Information (RFI) regarding Executive Order 13985. We appreciate the opportunity to respond to this RFI and share our thoughts on ways the federal health safety net can be leveraged to help promote health equity and reduce racial disparities in health care services and outcomes.

The Enrollment Coalition is a group of organizations across the health care community, including consumer advocates, patient advocates, health plans, health care providers, employers, technology and data organizations, and researchers. Our mission is to collaboratively identify, develop, and advance actionable policy recommendations for federal policymakers aimed at improving enrollment data, systems, and processes to foster the enrollment of uninsured Americans under age 65 into existing health coverage plans and programs for which they are eligible. Our collective effort respects and builds on the roles of the public and private sector to enable uninsured Americans to enroll into existing coverage sources for which they are eligible, such as Medicaid, CHIP, Marketplace, and employer-sponsored coverage.

According to 2020 analysis by the Congressional Budget Office, “in 2019, about 12 percent of people under 65 were not enrolled in a health insurance plan or a government program that provides financial protection from major medical risks.” CBO noted that “many uninsured people do not enroll in coverage because of the cost; others may not know that they are eligible for subsidized coverage or may be deterred by the complexity of enrolling.” As CBO suggested, the reasons for this gap in coverage are diverse and multi-faceted – ranging from affordability to personal choice...from changes in jobs to changes in economic status...from linguistic or cultural barriers to missed opportunities to leverage data systems. Of the individuals uninsured in CBO’s analysis, 67 percent were eligible for subsidized coverage, with 36 percent of individuals being eligible for federally-subsidized health coverage (Medicaid, CHIP, or Marketplace coverage).<sup>1</sup>

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<sup>1</sup> Congressional Budget Office, Who Went Without Health Insurance in 2019, and Why? <https://www.cbo.gov/publication/56504>.

More recently, the Kaiser Family Foundation found that 63 percent of the uninsured now qualify for financial assistance to help purchase coverage, with more than 4 out of 10 uninsured people being eligible for free or nearly free coverage through Medicaid, CHIP, or health insurance Marketplaces. Among uninsured consumers eligible for zero-net-premium Marketplace coverage:

- 32 percent are Latino, compared to 20 percent of the non-elderly U.S. population;
- 62 percent have a high-school education or less, compared to 36 percent of U.S. residents under age 65;
- 13 percent lack internet access at home, compared to 6 percent of the non-elderly population; and
- 35 percent speak a language other than English at home.<sup>2</sup>

The COVID-19 public health emergency has further highlighted the longstanding challenges millions of Americans face in health care—whether due to racial inequities, health disparities, socio-economic differences, or social determinants of health. Thus, coverage efforts also need to acknowledge and help address the real hurdles and challenges many face to receiving equitable access and care. In addition, there are other factors, known as the social determinants of health (SDOH), in places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. These may include factors such as lack of access to healthy food or increased economic stresses, which studies show can result in reduced participation in health and other public programs.<sup>3</sup>

Black Americans were 1.5 times more likely to be uninsured than Whites from 2010 to 2018. The Hispanic uninsured rate remained over 2.5 times higher than the rate for Whites during that same timeframe.<sup>4</sup> People of color who do have coverage are also more likely to be underinsured. The Enrollment Coalition provides the following recommendations for reducing barriers and burdens to enrolling in coverage, and to reduce racial disparities.

### **Barrier and Burden Reduction**

The Enrollment Coalition specifically responds to the following questions related to Area 2 on barrier and burden reduction:

- *How can agencies address known burdens or barriers to accessing benefits programs in their assessments of benefits delivery?*
- *Are there specific requirements or processes (e.g., in-person visits, frequency of recertification of eligibility) that have been shown in rigorous research to cause*

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<sup>2</sup> How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured, March 25, 2021, <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>.

<sup>3</sup> Human Capital and Administrative Burden: The Role of Cognitive Resources in Citizen-State Interactions, <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/puar.13134>.

<sup>4</sup> Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018. (2020, March 05). Retrieved from: <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>

- program drop-off or churn by underserved individuals and communities? Similarly, is there rigorous evidence available that certain requirements or processes have little actual effect on program integrity?*
- *How might agencies incorporate into their equity assessments barriers or duplicative burdens a participant is likely to experience when seeking services from multiple agencies?*

## Fully implement the “no wrong door” enrollment approach

Section 1413 of the Affordable Care Act and Section 1943 of the Social Security Act require the use of a single, streamlined form for all insurance affordability programs; mandate data matches, whenever possible, to establish eligibility for both initial and renewed coverage, rather than deny health coverage unless consumers provide documents; forbid state inquiries that are not essential to determining eligibility; and require initial eligibility for all insurance affordability programs (IAPs) to be determined at the point of application – no matter where the application is filed (with Medicaid or the exchange) or how it is filed (telephonically, electronically, in-person, or by mail). In recent years, states have faced enormous challenges in rapidly modernizing state Medicaid systems and creating new health insurance exchanges.

In most states, Medicaid-eligible people who file applications with an exchange or people eligible for exchange premium tax credits who submit an application to the Medicaid agency remain uninsured until their files are transferred to another agency and it processes the files, potentially reaching out to the family for additional information. Coverage gains have been an order of magnitude lower in states with such bifurcated eligibility systems.<sup>5</sup> Immediate determination of eligibility for all IAPs, drawing on all available data sources, wherever an application is submitted, would address this problem.

In the 29 states<sup>6</sup> that require file transfers instead of allowing the federally-facilitated exchange to determine Medicaid and CHIP eligibility, 14 percent of residents under age 65 are non-White children. Children of color comprise 32 percent of all uninsured residents who qualify for Medicaid or CHIP in those states and are disproportionately hurt by not receiving immediate determinations when their families apply for coverage through Healthcare.gov.<sup>7</sup>

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<sup>5</sup> Association Between Marketplace Policy and Public Coverage Among Medicaid or Children’s Health Insurance Program–Eligible Children and Parents, [https://jamanetwork.com/journals/jamapediatrics/fullarticle/2687008?utm\\_campaign=articlePDF&utm\\_medium=articlePDFlink&utm\\_source=articlePDF&utm\\_content=jamapediatrics.2018.1497](https://jamanetwork.com/journals/jamapediatrics/fullarticle/2687008?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamapediatrics.2018.1497).

<sup>6</sup> Medicaid and Health Insurance Marketplace Coordination, <https://www.kff.org/health-reform/state-indicator/medicaid-and-health-insurance-marketplace-coordination/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>7</sup> Among adults, people of color comprise 38 percent of these states’ total non-elderly adult population but 47 percent of uninsured adults who qualify for Medicaid. National Center for Coverage Innovation at Families USA. (NCCI) unpublished analysis of 2019 American Community Survey data, made available through IPUMS USA, University of Minnesota, [www.ipums.org](http://www.ipums.org). Eligibility estimates were based on income thresholds reported by the Kaiser Family Foundation for [adults](#) and [children](#), with imputations of satisfactory immigration status to non-citizens.

## Reissue an exception to the cost allocation requirements in OMB Circular A-87

In 2011, HHS and the U.S. Department of Agriculture issued an exception to the cost allocation requirements set forth in the OMB Circular A-87<sup>8</sup> to encourage states to leverage the technology investments and advances in streamlined enrollment required under law for modernizing eligibility and enrollment for other safety-net benefits. Reviving this time-limited tool would be an important step enabling the creation of data connections between public agencies that make major contributions to enrolling the eligible uninsured and preventing coverage losses among people who are currently enrolled. Reissuing a previous exception to the cost allocation requirements in OMB Circular A-87 would allow states to do more to integrate the eligibility determination and enrollment functions across health and human services programs, realizing efficiencies for States and serving individuals and families. Integrated eligibility systems would allow individuals and families to access critical safety-net services without having to complete multiple enrollment processes and without government workers processing the same information again and again. Additional information on this can be found in Appendix I.

## Encourage the Use of Enhanced Enrollment Strategies

During the COVID-19 Public Health Emergency, many states have taken steps to streamline Medicaid enrollment and eligibility processes. States have employed several strategies to support Medicaid enrollment during COVID-19, including waiving requirements for an interview (in-person or via telephone), accepting self-attestation of information for criteria besides citizenship/immigration, and adopting simplified application forms.<sup>9</sup> States could also extend the timeframe by which an individual must provide all required application documentation.<sup>10</sup> For example, Florida “extended the timeframe allowed to complete a Medicaid application, providing individuals more time to submit paperwork, while still using the initial application date as the basis for the start date for coverage.”<sup>11</sup> CMS should issue guidance on these strategies to increase enrollment in Medicaid and CHIP, including information, guidance, and best practices for states to continue and expand the use of these strategies.

Currently, states have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP. According to CMS, 27 states provide 12-month continuous eligibility for CHIP (some states include exceptions to their continuous eligibility period and may also limit it to a subgroup of their CHIP eligible population), and 25 states provide 12-month continuous eligibility for Medicaid.<sup>12</sup> Current federal law gives states the option to extend continuous

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<sup>8</sup> OMB CIRCULAR A-87 REVISED, [https://obamawhitehouse.archives.gov/omb/circulars\\_a087\\_2004](https://obamawhitehouse.archives.gov/omb/circulars_a087_2004).

<sup>9</sup> How States Are Facilitating Medicaid Enrollment During COVID-19—And How They Can Do Even More, <https://www.healthaffairs.org/doi/10.1377/hblog20200612.887360/full/>.

<sup>10</sup> How States Are Facilitating Medicaid Enrollment During COVID-19—And How They Can Do Even More, <https://www.healthaffairs.org/doi/10.1377/hblog20200612.887360/full/>.

<sup>11</sup> State Actions to Facilitate Access to Medicaid and CHIP Coverage in Response to COVID-19, May 22, 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/state-actions-to-facilitate-access-to-medicaid-and-chip-coverage-in-response-to-covid-19/>.

<sup>12</sup> Continuous Eligibility for Medicaid and CHIP Coverage, <https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html>.

coverage to Medicaid and CHIP pregnant enrollees through one full year after the birth of the child. This option is available to states starting on April 2022.

Under Section 1115 of the Social Security Act, New York and Montana have received waivers from CMS to provide continuous eligibility to nonelderly adults on Medicaid. Such waivers require states to assume the increased cost of continuous rather than periodic eligibility, which can be a barrier preventing other states from enacting similar policies. The resulting churn of Medicaid adults on and off the program is disproportionately felt by people of color, as documented in a recent issue brief published by the Assistant Secretary for Planning and Evaluation.<sup>13</sup> To equip states to address this problem, CMS could expand the permitted scope of waiver authority in two ways. CMS could permit states to provide 12-months continuous eligibility to adults through two waivers authorities under Social Security Act §1902(e)(14)(A) [42 U.S.C. 1396a]. This waiver authority, unlike Section 1115, does not impose federal budget neutrality requirements. CMS could also permit states to obtain federal pass-through funds through waivers under ACA §1332.

CMS could also issue guidance describing how waiver authority can be employed to provide continuous eligibility to other vulnerable populations who see only minor and modest changes in income over time, including model waivers for states. Guidance from CMS on continuous eligibility following the end of the COVID-19 public health emergency and adopting continuous eligibility for additional populations would assist states in addressing Medicaid churn with the goal of promoting continuity of care.

### **Medicaid and CHIP programs could be tapping into all reliable and relevant data sources in qualifying eligible families for health coverage**

Section 1413(c)(3) of the ACA requires states to determine eligibility “on the basis of reliable, third party data,”<sup>14</sup> except for data sources where HHS finds that the cost of data use outweighs the “expected gains in accuracy, efficiency, and program participation.” CMS currently allows each state’s Medicaid and CHIP programs to make their own decisions about the data sources they choose to use. However, many states are not using sources of data that could prove beneficial in preventing losses of coverage, including when current Medicaid maintenance-of-effort requirements expire at the end of the public health emergency. Several examples illustrate the importance of fully implementing Section 1413:

- **Change of address data.** At the start of this year, only 19 states planned to link to U.S.-Postal-Service change-of-address data.<sup>15</sup> Without that data, many who move will lose

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<sup>13</sup> ASPE Issue Brief: Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic, <https://aspe.hhs.gov/system/files/pdf/265366/medicaid-churning-ib.pdf>.

<sup>14</sup> In addition to this general requirement, ACA §1413(c)(3)(A) calls on states to connect to specific data sources, unless HHS finds the cost of using those sources exceeds their likely gains. Those sources include quarterly wage data and unemployment insurance records maintained by state labor agencies, wage and income information from the Social Security Administration and Internal Revenue Service, eligibility records from other public programs, and state income-tax records and returns.

<sup>15</sup> Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey, <https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/>

coverage as a result, because their state's notices will be sent to the wrong address. Disadvantaged populations tend to move more frequently than other people, so this preventable and foreseeable loss of coverage could further exacerbate existing inequities.

- **State income tax data.** Very few states use income tax data to renew eligibility, even though 72 percent of all Medicaid beneficiaries are in households that file tax returns, including 81 percent of children.<sup>16</sup> Such income-tax data, combined with quarterly-wage data accessible to states, can establish an 85 percent or greater likelihood of continued Medicaid eligibility for more than half of all Medicaid-eligible people.<sup>17</sup>
- **SNAP data.** Most state Medicaid agencies have access to SNAP data and CMS could promote the effective use of such data. SNAP receipt establishes more than a 90 percent likelihood of continuing eligibility for Medicaid.<sup>18</sup> Thus, data matching showing that a Medicaid beneficiary receives SNAP can help provide reliable information showing continued eligibility.

### **Highlight for states the challenge of terminating Medicaid and CHIP eligibility unless clear evidence demonstrates that beneficiaries no longer qualify**

States implementing periodic income checks routinely match their Medicaid beneficiary records to past quarterly wage records. If those records show wages above applicable income thresholds, beneficiaries are generally terminated unless they come forward to document continued eligibility.

One challenge with this widespread practice is that it ignores the routine income fluctuations lower-wage workers experience when engaging in the gig economy, part-time work, and seasonal labor. For example, one recent study found that nearly half of all low-income, working-age adults experience, each year, at least one month's spike in income that exceeds average monthly income by 25 percent or more. According to another study,<sup>19</sup> the average low and moderate-income household experiences an average of 2.6 months per year in which income exceeds the family's annual income by 25 percent or more. While persistent and ongoing change in income can clearly disqualify an individual from Medicaid, occasional or periodic income fluctuations, by themselves, do not demonstrate ineligibility. They can result in individuals being disenrolled in manner that disrupts their source of health coverage, continuity of care, and adds extra administrative and human costs for the disenrollment and reenrollment processes. Periodic income checks can inadvertently disrupt the care and coverage of individuals who

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<sup>16</sup> NCCI unpublished analysis of Current Population Survey data for 2019, made available through IPUMS USA, University of Minnesota, [www.ipums.org](http://www.ipums.org).

<sup>17</sup> Using Past Income Data to Verify Current Medicaid Eligibility, <https://www.urban.org/sites/default/files/publication/24026/412920-Using-Past-Income-Data-to-Verify-Current-Medicaid-Eligibility.PDF>.

<sup>18</sup> Using Past Income Data to Verify Current Medicaid Eligibility, <https://www.urban.org/sites/default/files/publication/24026/412920-Using-Past-Income-Data-to-Verify-Current-Medicaid-Eligibility.PDF>.

<sup>19</sup> Income Gains and Month-to-Month Income Volatility: Household evidence from the US Financial Diaries, <https://www.usfinancialdiaries.org/paper-1/>.

remain eligible despite income fluctuations that are increasingly characteristic of low-wage work, and that have disproportionate effects among families of color.

Evidence of occasional or periodic income fluctuation, without more comprehensive data, thus can be a misleading basis of terminating coverage before a beneficiary's 12-month eligibility period has run its course. We encourage CMS to sponsor research that uses longitudinal survey data to establish validated rules for states to identify income changes that signify likely ineligibility. Based on accessible information, such rules would help states distinguish income fluctuations that demonstrate likely ineligibility from those that are consistent with continued eligibility, taking into account not just a single quarter's income spike, but other relevant indicators as well (such as patterns over multiple quarters of wage records, the extent to which quarterly wages exceed applicable eligibility thresholds, past income fluctuations, etc.).

### **Integrate funding streams to support all-payor application assistance**

Application assistance is often divided between navigator services, funded through exchange administrative resources, and consumer assistance provided to Medicaid applicants, funded through Medicaid administrative funding. CMS could encourage states to leverage current Medicaid Managed Care Organizations (MCOs) to help assist beneficiaries in redeterminations and renewals or with assistance navigating disenrolled individuals' access to marketplace coverage, or use cost-allocation agreements between Medicaid agencies and exchanges to fund integrated, one-stop systems of application and consumer assistance, with each program paying costs in proportion to the benefits it receives. That guidance could also remind states that, whenever the consumer assistance furnished for Medicaid purposes involves a direct interaction between the application assister – whether a state employee, state contractor, or community-based organization – and the state's eligibility and enrollment system, the federal government's share of cost is 75 percent.<sup>20</sup>

Thank you for the opportunity to comment.

Sincerely,

The Enrollment Coalition

**Alliance of Community Health Plans**  
**Alluma**  
**American Academy of Family Physicians**  
**Association for Community Affiliated Plans**  
**Centene Corporation**

**Community Catalyst**  
**Families USA**  
**Health Care Service Corporation**  
**Healthcare Leadership Council**  
**March of Dimes**

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<sup>20</sup> State Medicaid Letter: RE: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding, <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16004.pdf>.