

Moving to 21st-Century Public Benefits:

Emerging Options,
Great Promise,
and Key Challenges

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May 2012

Coalition for Access and Opportunity



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Executive Summary

Recognizing that many jobs do not pay enough to support a family and that employment is not always possible,

America has developed public benefit programs to meet basic human needs and to help make low-wage employment sustainable. These programs include the Supplemental Nutrition Assistance Program, Medicaid, the Children’s Health Insurance Program, Temporary Assistance for Needy Families, the Child Care and Development Block Grant, and the Low-Income Home Energy Assistance Program. Millions of needy people do not receive the benefits for which they qualify, due in part to burdensome steps that are often required to obtain and retain assistance. Those same bureaucratic complications can increase administrative costs and, in some cases, interfere with the accurate determination of eligibility. As a result, these programs fall short of achieving their promise for the families who need them and for the taxpayers who expect them to function efficiently and effectively.

In many programs, traditional methods of determining eligibility for public benefits were based on interaction between a consumer and a caseworker, often face-to-face across a desk or counter. The consumer applied for assistance and presented supporting documentation, and the caseworker processed the application and evaluated the documents, sometimes by checking with external sources of information.

Innovative states across the country as well as federal policymakers have been departing from this model and moving to 21st-century methods of eligibility determination. These new approaches systemically use existing data sources and information technology—information from outside the one-on-one interaction between consumer and caseworker—to lower administrative costs for states, reduce the burdens placed on consumers, improve access to benefits, and strengthen program integrity.

These 21st-century reforms can change both substantive eligibility rules and procedures for enrollment and retention. New eligibility rules that allow more streamlined operations include—

- Using other programs’ findings to “deem” consumers eligible for assistance without asking one agency to replicate or revise the work already done by a different agency;
- Basing eligibility on prior-year income tax records;
- Providing continuous eligibility by disregarding short-term income fluctuations (e.g., for 6- or 12-month periods); and
- Eliminating eligibility requirements that cannot be documented based on data matches. For example, consumers could opt for standardized rather than itemized deductions or disregards, and asset tests could be eliminated for some or all consumers.

Modernized eligibility procedures include—

- Using data matches, rather than consumer provision of information, to complete application forms and establish eligibility;
- Using electronic case records or data warehouses to serve multiple programs, so that information or documentation already received by one office or program can be used by others;
- “No wrong door” policies through which, when an application is submitted to one agency, data from the application is forwarded to other agencies to see whether consumers qualify for additional assistance—in effect, using an application for one program as an “on ramp” to other programs;
- Streamlining renewal by automatically granting continued eligibility based on data matches and by letting families provide missing information over the phone and online; and
- Default enrollment strategies that provide eligible consumers with assistance unless they affirmatively “opt out.”

Already being implemented in a broad range of states and programs, such modernization should reduce the need for low-wage working families to take time off the job, thereby meeting program objectives related to work support. It can also increase access to benefits, reduce administrative costs, and prevent eligibility errors.

Although there are many advantages of implementing 21st-century eligibility rules and procedures, modernization also brings new challenges. For instance, reforms must be carefully structured to prevent inaccurate, incomplete, or outdated data from leading to erroneous decisions. Increased reliance on data-driven eligibility must be accompanied by strong protections of privacy and data security, with consumers receiving control over whether and when their personal data are shared. Reforms that address multiple programs need to be carefully structured so that they do not import more restrictive rules into programs that are less restrictive. Families that require more individual assistance, including families with limited English proficiency or low literacy levels, need access to such help. If eligibility rules are structured to fit available data, benefits might not be as well targeted to need. If more eligible consumers receive assistance, benefit costs increase. Which modernization initiatives are implemented, how they are structured, and how these trade-offs are evaluated will depend crucially on the specific circumstances facing each benefit program.

Moving to 21st-Century Public Benefits:

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Introduction

Recognizing that many jobs do not provide families with necessary income and that employment is not always possible, America

has developed public benefit programs. These programs seek to meet basic human needs and to make low-wage employment sustainable as families move along the continuum toward self-sufficiency. Such “safety net” programs, including the Supplemental Nutrition Assistance Program (SNAP) (formerly known as food stamps), Medicaid and the Children’s Health Insurance Program (CHIP), the Child Care and Development Block Grant (CCDBG), and Temporary Assistance for Needy Families (TANF), are designed to prevent hunger and destitution, provide access to health care, and support work. They can make a significant difference in low-income peoples’ lives, lifting millions out of poverty and providing children with access to health insurance and quality child care that their parents could not otherwise afford.¹

However, millions of other needy people do not receive the benefits for which they qualify, often because of complex and burdensome steps required for consumers to establish and periodically recertify eligibility.² Those same cumbersome procedures also raise administrative costs, but in the past they have often been essential to accurately determining eligibility.

Our new century offers hope for overcoming the long-standing tension between facilitating enrollment and administrative efficiency, on the one hand, and error-free benefits delivery that safeguards program integrity, on the other. Today, public agencies increasingly have access to reliable, timely data that show whether particular individuals qualify for benefits. Using such data to establish and verify eligibility, rather than basing the eligibility determination process primarily on information furnished by applicants, promises to increase participation and lower administrative costs while preventing mistaken eligibility decisions and detecting and deterring fraudulent applications.

Most public benefit programs operate under federal statutes and regulations that were enacted long before the information technology revolution that made these new approaches possible. Despite legal constraints, innovative state and federal policymakers have been quietly forging a new direction for America’s benefit programs. This paper articulates a framework for thinking

about that new direction in connection with a broad range of need-based assistance. It begins by briefly describing the overall contours of both old and new models for public benefit administration. It then identifies a menu of policy and procedural options that state and federal leaders have been using to increase participation by eligible, low-income households while cutting administrative costs and strengthening program integrity. Finally, it explores some of the challenges presented by the new model. The appendix catalogues a range of modernization efforts that have been undertaken in many different programs.

This paper eschews two goals. First, it does not offer a comprehensive list of useful reforms that increase access to public benefits.³ Rather, this report focuses primarily on reforms that take into account available data to reduce burdens on households and public agencies alike.

Second, even within the latter limited domain, this paper does not pretend to offer final answers to the question of how to modernize eligibility determination for need-based assistance. The report's more modest objective is to construct frameworks and identify promising strategies that will prove helpful in future discussions. ***We hope to show how the diverse strands emerging throughout the country in a broad range of programs and places comprise a fairly well-defined new model for administering need-based assistance programs.*** The paper will succeed if it sparks the further development of ideas that prove effective in achieving a fundamental objective—namely, ensuring that families who seek help during hard times can efficiently and accurately receive the assistance for which they qualify.

Background: General models of eligibility determination

The traditional model of eligibility determination

With important variations based on the applicable program, state, and time period, eligibility determination for assistance in the past was largely paper-driven. The government's job was to educate the public about available assistance, wait for households to seek help, and process written applications by following applicable rules.

Consumers were expected to do most of the work. Applicants needed to determine the programs for which they might qualify. Once they identified a program that seemed promising, low-income families needed to complete paperwork (or answer the questions of a caseworker, who would complete the paperwork) describing their circumstances. Consumers also had to furnish documentary proof of what they asserted on the forms. Applications were filed in person at local social services offices. Public employees reviewed applications, verified eligibility (typically by seeing whether evidence proffered by the applicant met applicable standards), and asked consumers for additional information when necessary. If applicants satisfactorily complied with all requests from agency staff, their eligibility was decided. Caseworkers could obtain additional verification of eligibility from external sources when they felt such steps were warranted. This process often required repeated trips to social services offices, and such trips often entailed long waits to be seen.

Once they qualified for benefits, applicants needed to take other steps to retain assistance. If household circumstances changed, they had to promptly report and document such changes, even if the changes involved only modest fluctuations in earnings. They also needed to file periodic updates with the government, completing forms that again described their circumstances, and in some cases once again making in-person visits to social services offices. Consumers needed to provide additional rounds of documentation at frequent intervals, which had to be verified and analyzed by agency staff for benefits to continue.

Someone requiring more than one type of assistance may have needed to file applications with multiple agencies. In such cases, these repeated applications would present different government offices with similar or even identical information and documentation, which each office would process and evaluate separately. Parallel requirements for retaining assistance had to be satisfied, on an ongoing basis, for each program.

This approach had serious weaknesses. Many eligible people did not know about available programs or mistakenly thought that they were ineligible. Others, particularly those who were employed, could not afford the time required to apply. Some eligible people began applications, but could not complete the process. Still others who qualified for and received assistance soon lost it, even though they remained eligible, because they failed to take the steps needed for renewal. And many people managed to receive one form of assistance but did not obtain other benefits for which they also qualified.

Public agencies also suffered under this system. Administrative resources were wasted in investigating household circumstances that had already been evaluated by other agencies. People who lost assistance would soon cycle back and submit new applications, which public employees needed to process. Social workers objected that, despite their training to work supportively with needy families, they were instead forced to spend much of their time “pushing paper.”

Errors were common. Incorrect decisions could result if a worker transposed digits or an applicant failed to properly translate weekly into monthly earnings, for example. It was often difficult to verify the accuracy of statements on application forms. On occasion, mistakes could have financial consequences for states, as federal auditors exercised 20/20 hindsight to spot and penalize errors, even though they usually resulted from inadvertent mistakes by applicants or staff.

Although these problems were serious, they were largely unavoidable. A generation ago, the Internet and personal computers were science fiction plot devices, not common features of everyday life. Public benefit programs relied on paper applications and manual processing because there was no realistic alternative. And since, until the 1990s, most recipients were not employed, agencies did not prioritize saving them time.

At its best, the traditional model of extended one-on-one interaction between caseworker and client allowed caring, knowledgeable, adequately resourced social workers to help low-income families navigate a confusing maze of multiple public assistance programs to obtain

and retain benefits for which they qualified. But actual practice often fell short of this ideal, and as administrative staff reductions took their toll, caseworkers became increasingly focused on managing the paperwork needed to document eligibility.

In many places and programs, eligibility determination still brings to mind the 1970s. Today's eligibility worker usually has a computer on her desk, but she spends much of her time collecting and processing paperwork provided by clients. Clients often wait for long periods to see a worker. Many programs still experience high levels of churning, with closed cases frequently reopening again within a few months, generating needless administrative costs as families exit and reenter programs for which they qualified all along. In numerous states, programs still exist in separate "silos," requiring consumers to provide similar information to multiple agencies, which spend public dollars analyzing household circumstances that have already been evaluated by other agencies. And even though programs may have access to data establishing eligibility, families are denied benefits until they, in effect, tell the government what it already knows.

It doesn't have to be this way. A new approach is being developed throughout the country, in multiple benefit programs, as explained in the next section.

21st-century eligibility determination

The world has changed, and a new model of public benefit administration is emerging, thanks in significant part to the creativity and persistence of dedicated state officials throughout the country as well as farsighted federal policymakers. The new model uses modern information systems to lower the state's cost of eligibility determination, lighten applicants' burdens, and strengthen program integrity. Typically, 21st-century eligibility methods use data from external sources to help determine whether consumers qualify for need-based assistance, lessening the need for applicants to complete forms and provide documentation that public employees must then evaluate and verify.

Under evolving, 21st-century models of benefit administration, government agencies become more proactive. Rather than passively await applications and reject them if consumers fail to adequately describe and document their

In the old model, eligibility for each individual benefit program was based primarily on a dyad: the consumer, who submitted an application and supporting documentation; and the caseworker, who processed the application and analyzed the proffered documentation, sometimes by consulting external sources of data as a final check on eligibility. The new model emphasizes the routine and early collection of data from outside this dyad to lessen the need to ask consumers for information. This approach seeks to lower the state's cost of eligibility determination, to streamline and simplify enrollment, and to strengthen program integrity.

circumstances, agencies seek out available information to ensure that eligible people who want assistance can receive it, without needless government-created barriers.

This more data-driven approach can increase participation by eligible individuals. More efficient methods for routine eligibility determination can lower administrative costs for government and free up caseworkers to provide more intensive services to the families that are most at risk. At the same time, eligibility errors can become less frequent, as manual procedures (with inevitable attendant mistakes) assume a less prominent role in program administration. And the routine and comprehensive use of reliable data to establish eligibility can both detect and deter fraudulent applications. In short, this approach seeks, at the same time, to increase efficiency, strengthen program integrity, and raise participation levels among eligible individuals. As explained by the Government Accountability Office:

“[P]rogram administrators told us of several strategies that increase access while maintaining and even improving integrity... Improved information systems, sharing of data between programs, and use of new technologies can help programs to better verify eligibility and make the application process more efficient and less error prone. These strategies can improve integrity not only by preventing outright abuse of programs, but also by reducing chances for client or caseworker error or misunderstanding. They can also help programs reach out to populations who may face barriers.”⁴

These strategies also make government more transparent and accountable since 21st-century administrative methods make it harder to implement policies and procedures that prevent eligible households from receiving the help promised by the laws on the books.

Recent technological developments have increased the feasibility of this new model, which would have been all but inconceivable even a decade ago. As leveraging existing data becomes a standard business practice in the commercial marketplace, policymakers and the public increasingly expect similar sophistication from public programs. Public agencies and their contractors are gaining access, often at reduced cost, to ever-increasing amounts of information about household income and other characteristics potentially relevant to eligibility. This makes it more feasible to tap external sources of information systematically instead of episodically.

Using data matches early during the application process can prevent consumers from being required to provide information that agencies already have. Programs can ask consumers to confirm or correct household circumstances as shown by relevant data, rather than delay the use of that same data to “play gotcha” after consumers have completed application forms.

Going beyond technological and commercial factors, intellectual and policy developments have played an important role in this emerging trend. The goal of promoting low-income families’ self-sufficiency through employment has given impetus to policies that make enrollment and retention as streamlined as possible. Many observers now describe benefits like SNAP and child care as “work support,” since such assistance increases bread-earners’ ability to hold low-wage jobs and still meet their families’ basic needs. The target population of benefit programs has thus changed to include more low-wage workers, and many programs now have the dual mission of facilitating movement toward self-sufficiency while meeting basic human needs. If

people must use the work day for gathering documents or visiting social services agencies, they will lose pay and their employment can be jeopardized.

Behavioral economics research has likewise reinforced the common-sense understanding that participation increases when bureaucratic paperwork requirements are reduced. This is true for private as well as public benefits and for middle-class as well as low-income families. In a classic example involving 401(k) retirement savings accounts, 33 percent of new employees sign up if their companies require form completion before enrollment, but participation rises to 90 percent in firms where workers are enrolled unless they complete a form to opt out.⁵

Heightened demand for public benefits during the Great Recession and the harshest state budget climate in generations have also driven modernization efforts. In many states, more residents need and apply for assistance, but fewer caseworkers are available to process those applications, leaving social services agencies increasingly facing the challenge of “doing more with less.” This climate places a premium on strategies to increase the efficiency of eligibility determination. To achieve this efficiency without undermining accuracy or needy families’ access to assistance requires innovative approaches like those explored in the next section of the paper.

Moving to 21st-century eligibility: a range of options

This section describes 21st-century approaches for modernizing eligibility determination to streamline enrollment and

retention. The following menu comes from practices that have been emerging in states and programs across the country, many of which are catalogued in the appendix. Our objective is to help policymakers, stakeholders, analysts, and advocates define a critically important agenda: how can the country systematically update its decades-old public benefit programs—applying information technology to promote program participation, the respectful treatment of families, the efficient use of public resources, program integrity, and transparent and accountable governance—while ensuring the appropriate use and confidentiality of personal information?

Data sharing can improve enrollment and retention procedures, even under current program rules. However, much larger reductions in administrative costs and error rates and much greater increases in participation become possible when eligibility standards are revised to fit available data. In analyzing aid provided by the Earned Income Tax Credit (EITC) and other tax subsidies, the Internal Revenue Service (IRS) Office of the Taxpayer Advocate noted the problematic role played by elements of eligibility that cannot be established based on data, problems that are shared by programs outside the tax system:

“The best-designed tax-based social programs are crafted in a way that eligibility to claim the credit is verifiable with data to which the IRS has access ... Considerations include whether the credit requires information already captured on the income tax return or whether the IRS has direct or indirect access to other data sources that can serve as a proxy for eligibility. Alternatively, an eligibility determination

might require information outside the current reach of the IRS ..., making it difficult for the IRS to screen for noncompliance without requiring the taxpayer to submit additional paperwork and face additional burden....” [Emphasis added]⁶

We thus begin with a discussion of how policymakers can restructure program eligibility rules to fit available data. Changes to substantive eligibility requirements can represent a greater departure from historical practices, but they can also offer the highest potential payoff in streamlining enrollment, reducing administrative costs, reducing eligibility errors, and removing unnecessary barriers to access. We then turn to procedural methods for streamlining eligibility determination.

Eligibility rules

1. Deemed eligibility: Using the findings of other programs to establish eligibility and benefit levels

If one public program has already found that someone is poor enough to qualify for assistance, a “deemed eligibility” approach lets another program automatically grant eligibility based on that earlier finding. The second program relies on the determinations made by the first, even if the two programs have different technical rules for determining eligibility. For example, Medicare beneficiaries who receive Medicaid or Supplemental Security Income (SSI) automatically qualify for Low-Income Subsidies (LIS) for Medicare Part D prescription drug coverage, even in states where Medicaid covers people whose assets would otherwise disqualify them from LIS. As a result, less than six months after the new benefit was first available in 2006, LIS reached nearly three in four of eligible beneficiaries (74 percent)—the highest participation level ever achieved in such a time frame by a need-based program. Four in five enrollees (81 percent) qualified without any need to file applications. Their eligibility was established, and they were enrolled into subsidized coverage, based on the Center for Medicare and Medicaid Services’ (CMS) proactive initiation of data matches with state Medicaid programs and the Social Security Administration (SSA).⁷ Participation rates later reached 81 percent, with data matches (rather than applications) yielding 85 percent of all LIS enrollment.⁸

Depending on the program, this approach may be called many different things, including Direct Certification for the National School Lunch Program (NSLP), adjunctive eligibility for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), categorical eligibility for SNAP, or Express Lane Eligibility (Express Lane) for Medicaid and CHIP. Even with programs that deem eligibility, the full benefits of this approach are not always realized. For example, Express Lane lets states use findings from SNAP to enroll children in Medicaid and CHIP, but states need waivers to do the same for adults.⁹

Not only can deemed eligibility spare households from supplying similar information multiple times to different agencies, it can yield administrative savings. Public agencies are not required to “re-litigate” questions already settled by other offices or to make the often complex calculations needed to match the facts, as found by the earlier agency, to slightly

different eligibility rules used by the second program. Louisiana's implementation of Express Lane, for example, to qualify SNAP-recipient children automatically for Medicaid required upfront investments of almost \$600,000, but it achieved first-year administrative savings between \$1.0 and \$1.1 million for enrollment and between \$8.0 million and \$11.9 million for renewals.¹⁰

It is important to distinguish between true deemed eligibility and more traditional use of data from one program to qualify consumers for other programs. To continue with the Louisiana example, Medicaid in that state classifies children as citizens or qualified immigrants if SNAP made such a finding using the

same or more restrictive rules and procedures than Medicaid's. Such steps were possible under Medicaid law long before the enactment of Express Lane.¹¹ What distinguishes Express Lane and other deemed eligibility strategies is that the findings of one program automatically qualify a household for a different program. Such automatic qualification applies regardless of technical differences in eligibility methodologies (such as the definition of households or countable income) that would otherwise require the new agency to (a) reanalyze each family's circumstances to see how the old agency's findings "fit" into the new agency's eligibility definitions and, in many cases, (b) delay assistance until consumers have provided additional information or documentation.

Deemed eligibility also differs from strategies that bring multiple programs' eligibility rules into conformity with one another. In cases where such conformity would be problematic—for example, where it would eliminate eligibility for some needy households or dramatically increase

Programs that already use deemed eligibility could apply it more broadly. For example, the Medicaid determination of income below a specified percentage of the federal poverty level might establish categorical eligibility for the Low-Income Home Energy Assistance Program. With a waiver, SNAP could likewise automatically aid households whom Medicaid has found to be poor, with a brief period (perhaps 45 days in length) during which SNAP benefits are paid based on Medicaid's income determination. A federally approved demonstration project is already under way that uses Medicaid income determinations to automatically qualify children for free school lunches via NSLP Direct Certification, despite differences in how Medicaid and NSLP define households and countable income.¹² Another precedent for this approach involves SNAP Combined Application Project (CAP) waivers, described in the appendix, which can provide SSI recipients with standardized SNAP benefits based on information in SSI records and limited information about household shelter costs. As with many of the deemed eligibility efforts described in the appendix, a short-term SNAP benefit period based on Medicaid would disregard methodological differences in calculating income, including household composition and income disregards. Regardless of these precedents, however, such a SNAP waiver would need to be constructed carefully to meet budget neutrality requirements.¹³

public sector costs—“deemed” eligibility can allow efficient connections between programs without requiring full-blown multiprogram alignment.

2. Basing initial eligibility and assistance levels on prior-year tax records

Basing initial eligibility and assistance levels on prior-year tax records can effectively reach many low-income people, including those who do not already participate in other need-based programs. In part because of the EITC, a large proportion of low-income households file federal income tax returns. For example, returns are filed by an estimated 86 percent of all uninsured households, including 75 percent of uninsured households with incomes at or below 100 percent of the federal poverty level.¹⁴

This approach allows enormous administrative savings since already-completed tax forms and already-compiled tax data qualify people for benefits. Program integrity can be strengthened, since (a) eligibility criteria are limited to factors that can be verified and (b) data exchanges limit opportunities for manual error. And for consumers, applications can be substantially simplified or even eliminated, making the application and enrollment process faster and easier, thus allowing a major increase in program participation.

Several programs thus already use income tax records to qualify people for need-based assistance. For example, Medicare Part B, which covers doctor visits and certain other outpatient services, uses tax data from two years in the past to establish eligibility for means-tested premiums. Eligibility for Pell Grants and federal student loans is also based, in large part, on the most recent year’s federal income tax return. In both cases, if household circumstances have worsened since the period covered by tax data, consumers can obtain additional assistance.

These programs are typically designed so that improved household circumstances do not reduce assistance until after they have been recorded on tax returns filed at the end of the year. This simplifies administration, but reduces the targeting of aid to current need and increases assistance costs. To avoid those costs, the Patient Protection and Affordable Care Act (ACA) took a slightly different approach. Eligibility for Medicaid will generally be based on income during the month of application, which can sometimes be resolved by prior-year tax return data, but which often requires additional information to establish. Eligibility for premium tax credits and out-of-pocket cost-sharing subsidies, both of which are paid directly to insurers each month, will be based preliminarily on prior-year income tax information, subject to the applicant’s modification based on changed circumstances. If household income turns out to exceed anticipated levels, tax credit recipients will have to repay some or all of their excess subsidies when they file federal income tax returns at the end of the year. This approach reduces net subsidy costs, but it may discourage program participation, as some low-income families could leave tax credits on the table rather than risk unexpected tax liabilities at the end of the year. One reason why the advance payment option was used by no more than 3 percent of low-income workers who received EITC is that many such workers were reluctant

to risk losing their tax refunds or incurring tax debts to IRS if their income turned out to exceed expectations.¹⁵

3. Eliminating eligibility requirements that cannot be verified based on data matches

Many programs have eligibility rules that cannot be easily verified based on data matches. These rules, which require applicants to present documents that establish eligibility, act as “speed bumps” that can delay or prevent the completion of applications. To allow verification based on data matches alone, policymakers could consider policies like those described below.

Expediting eligibility determination when income is far below maximum levels

People could qualify for assistance without furnishing current income documentation if prior-year tax returns and more recent reports available from private contractors and state workforce agencies show income significantly below maximum eligibility levels. For example, if household income shown by recent records is less than 75 of the maximum permitted level, the household could qualify as income-eligible without providing further documentation—a policy already followed by Louisiana’s Medicaid program which, notwithstanding all of the state’s simplification and streamlining efforts, has a federally certified error rate roughly one-fourth the national average.¹⁶

Repealing or limiting asset tests

In contrast to income tax and unemployment insurance programs’ mission-critical monitoring of income, government tracking of information about assets is much more limited. As a result, when eligibility requires information about assets as well as income, application forms become more complex—presenting a major “speed bump” on the path to eligibility, since consumers cannot obtain assistance until they have described their assets and in some cases obtained valuation estimates from third-party sources. Many eligible households do not complete applications, and public-sector administrative costs rise for those who do apply.

To avoid these problems, some benefit programs, such as NSLP and WIC, do not consider assets in determining eligibility, as a matter of national policy. For others, such as Medicaid, CHIP, SNAP, CCDBG, and LIHEAP, states have the option to disregard assets in determining eligibility. Research suggests that such steps can increase enrollment levels by simplifying the application process.¹⁷ Some observers and state officials report that administrative savings from eliminating asset requirements can equal or even exceed the increased benefit costs that result.¹⁸ It is thus not surprising that only 3 states limit children’s eligibility for Medicaid or CHIP based on assets,¹⁹ only 14 states do so for SNAP,²⁰ and only 2 impose such a limit for CCDBG.²¹ In addition, starting in 2014, the ACA made assets irrelevant to eligibility for most forms of Medicaid, for CHIP, and for newly created premium and cost-sharing subsidies.

Other programs retain asset requirements in some form, but limit their application. For example, assets are not considered in determining eligibility for federally funded college student aid if

family income is less than \$50,000 a year and the family either receives a federal means-tested benefit, is eligible to file a 1040EZ or 1040A return, or includes a dislocated worker. In another variant, EITC uses investment income as a proxy for assets. No matter how low their adjusted gross income, taxpayers are ineligible for EITC if they receive more than a specified amount of investment income, which includes interest, dividends, capital gains, rent, and other earnings that show the possession of resources. This approach allows the IRS to dispense with direct asset limitations for EITC, thus lessening the risk of error, lowering IRS administrative costs, and increasing participation by simplifying tax forms.

Such an approach may be an effective way to simplify application procedures, without excessively reducing the targeting of the program to those with the greatest need. For example,

Simplified asset tests

In some states or programs, it may be politically challenging or too expensive to eliminate all asset requirements. In such cases, reforms could eliminate the asset test for people who have (a) income below a specified level (as is currently done with college student aid) or (b) no investment income generated by assets, perhaps as shown on prior-year tax records.²³

recent research finds that if Medicare Savings Programs (MSP) for poor and near-poor seniors were changed so that people could avoid the asset test by showing the absence of investment income, 78 percent of currently eligible seniors could qualify without going through an asset test, and the number of eligible beneficiaries would increase by just 30 percent, compared with more than a doubling of eligibility if the asset test were flatly repealed.²²

Creating alternatives to itemized income deductions or disregards

For some programs, eligibility determinations consider expenses for such things as housing, child care, and medical costs. These costs are deducted from gross income to produce a net income finding that is used to establish both eligibility and benefit levels. This approach serves important policy objectives. It recognizes the effect of household costs, not just earnings, on net disposable income available to meet families' basic needs. However, in some cases, such

disregards may require families to document expenses that cannot be verified based on data matches alone.

Optional alternatives to itemized income disregards

Programs could give consumers alternatives to income disregards that require the presentation of documentation, such as for medical expenses or excess shelter costs. These alternatives would let consumers establish eligibility and benefit levels based on a standard deduction, while retaining the option to use current itemized disregards if such detailed information shows a need for additional assistance. Indexing standard deductions to the Consumer Price Index would prevent their erosion by inflation.

One approach to this issue offers standard deductions as an alternative route to eligibility, permitting families to dispense with disregards that require consumer documentation. A familiar example involves income tax returns, where

taxpayers can either take standard deductions or itemize their deductions. A number of states have received SNAP waivers that let families with elderly or disabled members substitute standard medical deductions for itemized deductions of medical costs. Such waivers permit individuals with unusually high medical expenses to submit documentation that qualifies them for higher disregards, but families with more typical expenses need not do so.

4. Continuous eligibility

One of the most straightforward reforms that can improve access and reduce administrative burdens is to disregard short-term income fluctuations in establishing eligibility, thereby eliminating the need to manually track fluctuations in household circumstances. Historically, many programs required participants to report even minor changes in income. This policy created a major burden for both clients and caseworkers, as low-income workers often experience fluctuations in earnings from month to month. Clients who failed to report even minor changes could be charged with fraud, while states that failed to track and document changes and modify benefits accordingly could be assessed penalties for high error rates.

Several programs now provide continuous eligibility for a defined period of time. During those periods, changed household circumstances do not reduce assistance. Because consumers need not report and agencies need not evaluate interim changes in family circumstances, program participation can increase as administrative costs fall. Clients also obtain more continuous coverage, which is particularly important for benefits like health insurance and child care, where a subsidy's interruption can prevent programs from achieving their goals. Gaps in health coverage, for example, can significantly reduce consumers' receipt of necessary care.²⁴ Consistent and continuous child care arrangements can likewise promote children's healthy development.²⁵ In addition, eligibility errors become less frequent with continuous eligibility, since consumer compliance with required procedures is easier, hence more common.

A less bold approach, for programs where continuous eligibility is not feasible, reduces change reporting requirements. For example, a state might limit such requirements to income growth that exceeds specified thresholds. Such an approach can lessen burdens on households and limit (though not eliminate) interruptions in benefit receipt. The Office of Child Care in the U.S. Department of Health and Human Services (HHS) has issued guidance

Continuous eligibility

Programs could provide stable eligibility for a defined period, based on household circumstances at the time of application. This approach, when used by the NSLP, reduced error rates, as explained in the appendix. Continuous eligibility is also one of the eight best practices for child health coverage of which a state must implement at least five to qualify for performance bonuses under Medicaid and CHIP. In both cases, fluctuating household circumstances during the eligibility period do not affect qualification for benefits, except that households can request additional help based on reduced income or other adverse changes.²⁷

identifying a range of options, short of full continuous eligibility, that reduce interruptions in assistance, using strategies that may be helpful with other benefits as well.²⁶

Eligibility procedures

In addition to changing eligibility rules, programs can implement procedural reforms to facilitate data-driven eligibility determination, thereby streamlining enrollment and retention.

1. Substituting data matches for form completion and applicant documentation

Several programs fully or partially eliminate the need for consumers to file applications before receiving or renewing benefits. In such cases, data matches establish eligibility based on information that is already known or accessible to the agency.

For example, in lowering the proportion of state residents without health coverage to the lowest percentage ever reported, Massachusetts' 2006 health reforms automatically qualified residents for subsidies based on data matches with the state's former free care program, thereby eliminating the need for many consumers to file applications. In a slightly different approach, the ACA envisions using data matches with external sources of data (such as income records and SSA citizenship files) to present applicants with a report describing their circumstances, which applicants can correct, if necessary. Applicants are asked for documentation only if data matches prove insufficient to establish eligibility.

States could consider "triage" strategies in using data-matches to establish eligibility. In some cases, data-matches would establish a reasonable certainty of eligibility, eliminating the need for information from the consumer. In other cases, data-matches would go a long way toward establishing eligibility, but officials may need to follow up with a telephone call to resolve a few open questions. In still other cases, available data would fall well short of establishing eligibility, leaving no alternative but asking the consumer for documentation.

2. Storing eligibility data so multiple programs can use it

When electronic case records or data warehouses store eligibility-related information, multiple programs can access that information. These records can include data provided by reliable third-party sources and consumers themselves. Increasingly, low-income families are gaining the capacity to obtain or even create electronic documentation, such as through cell phone photos of pay stubs or other paper records. Once these electronic records are validated and stored in common electronic case records or shared data warehouses, other programs can reuse them, lessening the need for families to repeatedly present the same or similar information to multiple agencies at both initial application and renewal.

3. Streamlined renewal, including data-based renewals and consumers' telephonic provision of information

At the end of a benefit period, programs could automatically renew eligibility if available data show a reasonable certainty of continued eligibility, using the standards and procedures described above, including “deemed” eligibility based on the receipt of other assistance. If data are not sufficient to renew, households could be contacted and encouraged to provide missing information by phone. Completion of renewal forms could be required only as a last resort. When Louisiana took this approach to child health coverage, it reduced procedural terminations to less than 1 percent of all eligibility redeterminations.

4. “No Wrong Door”

With traditional benefit programs, families may need to go from program to program submitting applications, often providing the same information to multiple agencies. This sometimes happens when people seek several different benefits. It can even happen when they receive a single benefit that is provided by multiple programs. For example, in states that cover the poorest and youngest children through Medicaid and other low-income, uninsured children through separate CHIP programs, at renewal some children may need to shift from one program to the other. Because such “hand-offs” are sometimes fumbled, children are 45 percent more likely to lose coverage at renewal, despite continued eligibility, in a state with two child health programs rather than one.²⁸

To prevent the inconvenience, barriers to program participation, and wasteful administrative costs that result from requiring families to go from agency to agency seeking assistance, a number of programs commit to a “no wrong door” strategy. No matter where a household applies for assistance, applicable government programs work together behind the scenes to provide household members with benefits for which they qualify. Pennsylvania, for example, developed a “Health Care Hand Shake” through which, when children transition between Medicaid and the state’s separate CHIP program because of changed household circumstances, one program’s data system automatically provides data to the other program. State officials report that this approach is “very effective in both facilitating continuity of client coverage and assuring that no one ‘falls through the cracks.’”²⁹ Along similar lines, states like Michigan are planning to let applicants for health coverage have information from their health applications transferred to human services programs to streamline eligibility determination for the latter programs.

In one important variant of “no wrong door” strategies, multiple programs can use the same schedule and procedures for renewal. That allows a family to continue receiving all benefits for which the family qualifies by presenting information about current circumstances once to a single agency. That agency shares the information with other programs, which renew the family’s other benefits at the same time.

5. Default enrollment

The behavioral economics literature documents the powerful impact of defaults, starting with the well-known example, cited above, of how, with 401(k) retirement savings accounts, changing from “opt-in” to “opt-out” enrollment raises participation of new employees from 33 percent to 90 percent.³⁰ A number of benefit programs have thus increased participation by enrolling consumers unless they opt out, thus setting the “default” in favor of participation.

For example, Medicare Part B has historically enrolled seniors automatically when they turn 65, withholding premiums from their Social Security checks, unless beneficiaries complete forms “opting out” of coverage. As a result, 96 percent of eligible seniors have participated.³¹ By contrast, MSPs, which pay premiums and out-of-pocket costs for poor and near-poor Medicare beneficiaries, reach fewer than one-third of eligible seniors;³² to obtain MSP, one must complete the traditional Medicaid application process.

Challenges of the new model

The previous sections describe the potential offered by an emerging 21st-century model of eligibility determination that seeks to improve

access, reduce administrative costs, detect and deter fraud, and prevent error. As with any innovation, these approaches involve tradeoffs, some of which can be reduced through careful attention to the details of policy innovation. In this section we discuss many of the new model’s challenges.

Data quality, security, and privacy

Using inaccurate or incomplete data to determine eligibility can create serious problems. Some ineligible people may receive assistance, while others are denied help for which they qualify. Program designs thus need to take into account data quality and include necessary safeguards. For example, long-standing and significant gaps in data about immigration status have led to safeguards forbidding households from being denied public benefits like Medicaid, TANF, and SNAP while immigration status is being verified.³³ Along similar lines, under the ACA, if data matches show apparent ineligibility for federal subsidies, exchanges may not simply deny coverage; rather, they must give consumers a reasonable period of time in which to explain the inconsistency or provide additional documentation of eligibility.

Enrollment initiatives like those discussed in this paper must thus be structured to accomplish two related goals—

- Identifying and addressing any limitations in the quality and completeness of the data that are being used to establish or verify eligibility; and
- Protecting eligible consumers’ access to benefits when, as sometimes happens with even the highest-quality data source, available information is inaccurate, incomplete, or outdated.

Initiatives to base eligibility determination on data matches also require careful attention to privacy and data security. ACA regulations that implement data-driven eligibility incorporate extensive protections in these areas, which can serve as a model for other programs.³⁴ These regulations identify the following key principles: individual access to personal data; the opportunity for consumers to correct errors in such data; openness and transparency about policies, procedures, and technologies; individual choice about the collection, use, and disclosure of personal data; limits to prevent the excessive or inappropriate collection, use, and disclosure of personal data; safeguards to protect data quality, integrity, and confidentiality; and accountability for breaches. Such policies are important not only in their own terms; by empowering consumers to easily correct errors and omissions, privacy safeguards can improve data quality and accuracy. Consumers' control over personal information also includes advance notice before their personal information is shared and, at a minimum, the ability to opt out of such data-sharing.

Reduced targeting of assistance to need

Shaping eligibility rules to fit available data implies disregarding factors not easily proven through data matches—housing costs or asset values, for example—even if such factors could help focus assistance on the people with the greatest need. Similarly, eligibility that continues for specified periods, regardless of income fluctuations, necessarily prevents the ongoing recalibration of assistance levels to closely match consumers' changing needs.

In these and other cases, policymakers must balance (a) the improved targeting that results from an eligibility restriction, such as a requirement of “real-time” recalibration of benefit levels or the imposition of an asset limit on eligibility, against (b) the more streamlined administration that becomes possible when eligibility rules match available data. In striking an appropriate balance, two questions are central:

1. ***How much does the restriction target assistance to need?*** To answer this question, policymakers could analyze the otherwise ineligible individuals who would receive assistance if the eligibility restriction were eliminated, considering—
 - The number of such individuals who would receive benefits; and
 - How significantly they differ from currently eligible households.
2. ***What are the effects of using manual rather than data-driven methods to determine whether the restriction applies to particular households? To answer this question, policymakers could assess—***
 - The number and circumstances of currently eligible but not participating people who might begin receiving assistance if enrollment were streamlined by moving away from manual procedures;
 - For public agencies, the administrative costs and savings of moving from manual to automated eligibility determination;

- Household time (including the need to take time off work) that could be saved if manual administrative procedures were streamlined; and
- The eligibility errors that would be prevented by simplifying eligibility criteria and using automated rather than manual methods to verify whether the criteria are satisfied.

Of course, quantifying these factors is not easy. The above list of issues may nevertheless be helpful in providing a framework for thinking about whether to modify eligibility rules to facilitate data-driven eligibility.

For example, policymakers in most states long ago decided to eliminate asset requirements in defining children's eligibility for Medicaid and CHIP. On the one hand, such tests contributed only modestly to targeting benefits based on need. Most income-eligible children met asset requirements, and low-income children whose families owned disqualifying assets still needed health insurance but their families could not afford it. Put simply, the children who became newly eligible as a result of eliminating the asset test looked a lot like the children who were already eligible. On the other hand, eliminating asset requirements significantly increased the participation of eligible children; lowered the administrative costs of eligibility determination; reduced burdens on families who sought assistance; and eliminated an important source of eligibility errors—namely, incorrect decisions about the value of household assets. On balance, the advantages of this change outweighed the disadvantages in the minds of most state policymakers.

An alternative simplification strategy permits households to attest to eligibility factors for which confirming data are unavailable, without requiring applicants to provide supporting documentation. This approach avoids the targeting problems that can result from reconstructing eligibility rules to fit available data. However, it may trigger policymaker concerns about erroneous eligibility decisions.

Special issues facing capped programs

Targeting issues have special implications for benefit programs that are capped. These programs have limited amounts of federal funding and a resulting maximum volume of federally funded assistance. Such programs, which include CCDBG, LIHEAP, TANF, and rent subsidies for housing, typically do not offer the possibility of increased total program spending.

However, streamlined procedures that reduce administrative costs can redirect administrative resources to helping more low-income families, allowing an increased total volume of assistance and more efficient use of taxpayer resources. Moreover, changing eligibility rules and procedures to fit available data can lift burdens from households, letting them obtain and retain benefits with substantially reduced effort. That can be particularly important to low-income, working families, as it may spare them the untenable choice between keeping a job and taking the necessary steps to receive essential benefits for which they qualify. Further, strategies

that make participation more continuous can help capped programs like child care achieve important goals that are undermined by needless breaks in assistance, as noted earlier.

Notwithstanding those advantages, policymakers need to think through applicable trade-offs with particular care when it comes to capped programs. If assistance is less tightly targeted to need, this may mean not just that some less needy families receive assistance, but also that some more needy families receive fewer benefits than under current rules.³⁵

Because federal financial exposure is limited, federal laws and regulations for capped programs typically give states great flexibility in defining eligibility. To encourage state action, federal policymakers administering capped programs could provide guidance making clear that modernization strategies like those discussed here can be implemented without running afoul of federal laws and policy goals.

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Increased benefit costs

Modernized eligibility procedures can raise assistance costs for two reasons. First, streamlining enrollment and retention can increase program participation—indeed, this is one of the principal objectives of these reforms. Second, reduced precision in targeting can mean that more people are eligible for assistance. For example, eliminating asset tests for child health coverage, as explained above, qualified some children for assistance who previously were ineligible. Along similar lines, continuous eligibility can increase benefit costs by retaining assistance during continuous eligibility periods, even when incomes rise above eligibility thresholds.

Both factors can increase spending on programs like SNAP, Medicaid, NSLP, and EITC, which guarantee benefits for all who qualify, without any aggregate cap on participants or spending. Although increased benefit costs can be offset by administrative savings, the extent of that offset varies by program and modernization measure. Without a careful analysis of facts and circumstances, one cannot blithely assume that streamlining measures are cost-neutral or better.

In addition, the 21st-century eligibility strategies described here can prevent officials from controlling caseloads by “rationing through inconvenience.”³⁶ One unusually explicit example involved California’s requirement, in the 1990s, for Medicaid beneficiaries to submit status reports every three months, whether or not household circumstances changed in ways that might affect eligibility. During the state’s 2000–2001 budget deliberations, then-Governor Gray Davis persuaded the Legislature to eliminate such reporting, arguing as follows:

“Many [Medicaid] families are discontinued simply because they fail to complete and return these quarterly reports. As a result of eliminating this unnecessary and

burdensome paperwork, an approximate additional 250,000 children and 150,000 adults will retain coverage. The federally required annual redetermination of eligibility will remain in place, and families will continue to be responsible for immediately reporting any change in circumstances which might affect eligibility.”³⁷

A few years later, in his 2003–2004 budget, Governor Davis proposed reinstating quarterly reporting for adults. The goal was to achieve “budget year savings of \$170 million (\$85 million General Fund),” through “reduc[ing] the number of adults receiving [Medicaid] benefits by 193,000.”³⁸ Another example involves supposedly “preventing fraud” by requiring applicants for human services programs to submit fingerprints, even though such requirements detect very little fraud but greatly reduce enrollment of eligible individuals by requiring in-person visits to social services offices.³⁹ Policymakers anxious to retain the fullest possible tool kit for cost control may be loath to surrender the opportunities that traditional eligibility methods provide to inhibit enrollment and retention.

Infrastructure development and other transition costs

Even public officials excited about the opportunities to transform benefits programs may have concerns about transitioning to 21st-century eligibility methods. Operating costs can drop under a more data-driven approach, but significant upfront investments in information technology may be needed, along with reorienting and retraining caseworkers and other staff. If responsibilities move from local to statewide offices, logistical and political difficulties may also emerge.

That said, the implementation of the ACA, which uses a 21st-century approach to eligibility determination for both Medicaid and new tax-based subsidies for individually purchased insurance, will force states to develop the capacity to conduct data matches at an unprecedented scale. As discussed in detail in the companion paper to this report, *How Human Services Programs and Their Clients Can Benefit from National Health Reform Legislation*,⁴⁰ federal officials are offering, for a limited time, greatly elevated federal funding levels to develop information technology (IT) needed to implement the ACA’s more data-driven approach to eligibility. In an exception to usual cost allocation requirements, HHS and the U.S. Department of Agriculture (USDA), which administers the SNAP program, are allowing health

In an exception to usual cost allocation requirements, HHS and USDA are allowing health programs with highly enhanced federal matching rates to pay the full cost of IT development needed for ACA implementation, even if other programs also benefit. This creates a significant but time-limited opportunity to modernize computer systems that serve multiple public benefit programs, at greatly reduced cost to state governments.

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Safeguards to prevent low-income consumers from being inadvertently short-changed

Unless they are carefully structured, streamlined approaches to benefit determination can have the unintended effect of reducing needy households' benefits in harmful ways. For example, one approach discussed earlier lets applicants choose between standardized and itemized deductions. In theory, that strategy should never make families worse off, as it preserves existing benefit levels for families who are willing to go through the previously required, itemized application process. But in practice, some families who would have gone through that process in the past will instead choose the simpler route, even if that means fewer benefits.

Comparable concerns could be triggered by measures that deem eligibility for one program based on the findings already made by another program, even if a family receiving less-than-optimal benefits under the new program can qualify for full benefits by applying through the latter's standard procedures.⁴¹ Such an approach is taken with Express Lane eligibility. If the findings of another need-based program result in a child receiving a form of health coverage with premiums, the family can request an eligibility determination using standard Medicaid methods, to see if the child qualifies for less costly coverage. However, some who would benefit from such a process may not request it.

Similarly, some have suggested that the simplification of the SNAP and Medicaid application processes—without comparable changes to TANF cash assistance—have reduced TANF participation, as families have opted for the easier-to-receive but less-comprehensive package of programs.

Clear communication to consumers and community groups can lessen these adverse effects, and as time passes, understanding will surely grow about how to use new eligibility systems appropriately. Nevertheless, policymakers need to be realistic about the danger that streamlining measures will cause some needy families to receive less than the full benefits for which they qualify.⁴² That risk needs to be considered in deciding whether and, if so, how to undertake the initiatives described in this paper.

Additional considerations for immigrant and mixed-status families

Data-driven models for eligibility determination must be designed carefully to take into account the unique circumstances facing immigrant and mixed-status families. For example, many citizen children who qualify for benefits have immigrant parents who are ineligible or who fear the consequences of seeking assistance. Policymakers who want these children to receive benefits for which they qualify need to ensure that immigrant parents are not discouraged from getting help for their children. Despite above-average need for assistance, children in immigrant families are much less likely than other children to receive benefits.⁴³

For adults, eligibility rules for immigrants are complicated and vary greatly among benefit programs, depending on nuances of immigration status. Mechanisms for granting eligibility

based on data and screening tools that do not include the full details for eligibility determination thus need to state clearly that consumers who do not qualify based on streamlined procedures may nevertheless be eligible and have the right to submit an application using standard procedures. Along similar lines, when receipt of benefits under one program automatically confers eligibility for a second program, if immigration status requirements are less onerous for the second program, consumers need to be informed that they can apply directly to the second program. More broadly, efforts to coordinate enrollment, retention, and eligibility determination among multiple programs that operate differently for immigrants or are perceived differently by the immigrant community need to ensure that immigration status restrictions and information requirements from a more onerous program are not inadvertently transposed into a less onerous program.

Immigrant and mixed-status families often have heightened concerns about the sharing of information among agencies and applying for assistance. Immigrant families may fear risks to sponsors, prevention of future improvements in status and attainment of citizenship, and other potential problems. Data sharing thus needs to be carefully structured to take these factors into account. It should be preceded by a clear statement of the purposes for which data will be used and accompanied by safeguards to ensure that the data will be used only to determine eligibility for stated programs or benefits. Further, consumers need an opportunity to opt out of data-sharing, deemed eligibility, and similar measures. If immigrants learn that seeking one benefit—for example, free school meals—can unknowingly trigger an application for a second program—for example, Medicaid—many may stop applying for the first set of benefits, with potentially grim results. Policymakers should not underestimate the misconceptions about benefit programs in many immigrant communities and the consequent need for clear information and careful program design.⁴⁴

Another important issue involves Social Security numbers (SSNs). Although SSNs are a critical element of most data-matching systems, requesting them from immigrant household members who are not seeking assistance⁴⁵ can deter families from seeking benefits for eligible household members. This reduces participation by citizen children, who often have a great need for the nutrition, health, and other assistance for which they qualify. Accordingly, the “Tri-Agency Guidance” issued by HHS, USDA, and the Department of Justice⁴⁶ restricts the information that Medicaid, CHIP, food stamps, and TANF may require from non-applicant family members, even when such non-applicants are a household’s primary wage earner and taxpayer. Specifically, social services offices may not require non-applicants to provide SSNs, Tax Identification Numbers, or information about immigration or citizenship status. They may request this data, and explain how it will benefit the family to provide it, but they must make clear that its provision is optional.

Finally, immigrant families whose children (and, in some cases, adult members) qualify for benefits tend disproportionately to be working, low-wage families, for whom taking time off work can jeopardize employment. In addition, immigrants often have particular difficulty obtaining documentation of eligibility. Their employers may be reluctant to provide income statements, for example, or immigrant parents may lack the documents needed to obtain a

copy of their children's birth certificates. Language barriers, the absence of a phone for follow-up, and transportation difficulties can make it particularly difficult for immigrants to meet the documentation requirements of traditional public programs.⁴⁷ Measures like those discussed in this paper, which simplify qualification for benefits and seek to reduce reliance on paper documentation, could thus be important in helping immigrants obtain the assistance for which they qualify—so long as policymakers are mindful of the unique issues facing these families.

Keeping the traditional front doors open

Even as the country increasingly develops Internet- and telephone-based enrollment pathways, traditional avenues for seeking assistance in-person will need to remain open. Many low-income people have not filed federal income tax returns and may lack a data trail showing eligibility. Data matches are not perfect, and recorded information may be incomplete, erroneous, or outdated, as noted earlier. People need the opportunity to correct mistakes and report changes since the period covered by data and to supply information not captured in electronic databases. Some individuals may be intimidated by technology, lack the language or literacy skills needed for online applications, or simply prefer in-person contact.⁴⁸ Others may require services or interventions that go beyond simple eligibility determination. As policymakers facilitate enrollment and retention via the Internet, telephone, or mail, it will be essential to retain social services offices as viable doorways to assistance.

Some of the administrative savings that result from less labor-intensive administration could be reinvested in initiatives to provide hands-on assistance to the many consumers who need help obtaining promised benefits, even in highly streamlined systems. For example, improvements to interpretation and translation services can make a significant difference to individuals with limited English proficiency. A substantial body of evidence shows that effective enrollment assistance greatly increases program participation.⁴⁹ Such assistance can be provided by social services agency staff, community agencies, or providers, so long as performance standards ensure that consumers have ready access to trained, knowledgeable, and culturally and linguistically competent staff. Policymakers committed to maximizing enrollment of eligible individuals could thus couple the “high-tech” approaches described in this paper with more “high-touch” strategies that help consumers navigate what many will continue to experience as a confusing and complicated public benefit system, notwithstanding efforts to make enrollment and retention more “user-friendly.”

Such an approach could also help alleviate the concerns of some public-sector unions that have opposed less labor-intensive methods of eligibility determination, reasoning that such strategies could ultimately mean fewer jobs for caseworkers. As a practical matter, elected officials in most states are unlikely, in the foreseeable future, to increase the number of social services agency employees, regardless of the need for more staff. During the current economic downturn, for example, many states have addressed budget shortfalls by reducing the number of caseworkers, even as demands for assistance rose. The effect of 21st-century administrative

methods that increase efficiency could thus be more manageable workloads and more fulfilling employment, rather than fewer public-sector jobs. Social workers trained to help people in need could spend less time processing paperwork and more time working with vulnerable families.

Conclusion

In this new century, public agencies are gaining ever-cheaper access to ever-increasing amounts of personal information.

This presents extraordinary opportunities, but as with most innovation, challenges and risks abound as well. If consumer advocates and policymakers work together carefully, they can use 21st-century information technology to move towards a holistic public benefit system that simultaneously streamlines access to essential work supports, reduces administrative costs, and strengthens program integrity.

Appendix: The emergence of 21st-century eligibility strategies

This appendix documents the emergence, across the country and in multiple programs, of the strategies discussed in the body of the paper. We include both earlier examples (adding citations in some cases) and other examples.

Eligibility rules

Using the findings of other programs to establish eligibility and benefit levels

- Low-income subsidies (LIS) for Medicare Part D prescription drug coverage are automatically provided to Medicare beneficiaries who, based on data matches with state Medicaid programs or the Social Security Administration (SSA), are known to have received Medicaid or Supplemental Security Income (SSI) the previous year. Beneficiaries qualifying through such data matches receive LIS without any need to file application forms. Notwithstanding the federal statute limiting LIS to people with assets under specified levels, this “deemed” eligibility applies even in states that have eliminated asset requirements for their Medicaid programs.

This approach quickly resulted in high participation levels. Less than six months after the new benefit was first available in 2006, LIS reached nearly three in four eligible beneficiaries (74 percent). Four in five enrollees (81 percent) qualified without any need to file applications. Their eligibility was established, and they were enrolled into subsidized coverage, based on the Center for Medicare and Medicaid Services’ (CMS) proactive initiation of data matches with state Medicaid programs and the SSA.⁵⁰ Participation rates later reached 81 percent, with data matches (rather than applications) yielding 85 percent of all LIS enrollment.⁵¹

- Through “direct certification” of eligibility, the National School Lunch Program (NSLP) automatically qualifies children for free school lunches based on their participation in the Supplemental Nutrition Assistance Program (SNAP), their receipt of Temporary Assistance for Needy Families (TANF), or their enrollment in certain other programs. Schools must conduct data matches with SNAP programs at least three times a year. For other programs, schools can either (a) use data matches or (b) have such programs send letters to families proving receipt of benefits and ask the families to provide those letters when they seek NSLP. Either way, families that have already proven low income for purposes of one program are relieved of the need to once again demonstrate their indigence for purposes of a second program. Direct certification applies even in states where TANF and SNAP use different rules than NSLP to calculate household income.

During the 2007–2008 school year, an estimated 46.7 percent of all children receiving free school meals qualified through such deemed eligibility.⁵² According to research sponsored by federal and state agencies, direct certification increases participation by eligible children, lowers public-sector administrative costs, and reduces the proportion of children who receive benefits in error.⁵³ It is thus not surprising that its scope has been increased steadily throughout the past decade, under Administrations and Congresses controlled by both parties.

Federal officials have recently invited states to operate demonstration projects through which direct certification will be granted to children who qualify for Medicaid based on a finding of gross income at or below 133 percent of the federal poverty level.⁵⁴ These demonstrations will proceed even though income is calculated differently by Medicaid and NSLP.

Some observers have expressed the concern that children who would ordinarily qualify for free school meals may instead receive reduced-price meals, because of the different income methodologies used by Medicaid. To address this problem, policymakers could limit deeming to free meals or ensure that families receiving reduced-price meals based on Medicaid data are clearly informed that, by simply completing a standard NSLP application, which will be evaluated using standard NSLP rules, their children may qualify for free meals.

- Through “adjunctive eligibility,” pregnant women and young children who receive Medicaid, SNAP, TANF, or certain other programs automatically qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). As noted by the Government Accountability Office (GAO), “These adjunctive or automatic eligibility policies allow ultimately for simpler applications, which may enhance access and reduce error. In fact, federal administrators at USDA [the U.S. Department of Agriculture] noted that adjunctive eligibility is one of the most important tools now used to address program integrity and access issues in a way that cuts across programs.”⁵⁵
- Through “categorical eligibility,” households may automatically qualify for SNAP based on their participation in TANF, SSI, or general assistance programs. Such eligibility applies even if the latter programs extend eligibility above SNAP’s normal maximum gross income levels or if, unlike standard SNAP rules, they disregard assets in determining eligibility. GAO found that such categorical eligibility lowers administrative costs and reduces error rates,⁵⁶ and the federal agency that administers SNAP has noted that, in addition to these benefits, categorical eligibility also increases program participation.⁵⁷ Note: people who qualify as categorically eligible must still go through a comprehensive assessment of income and household circumstances to determine whether they receive benefits and, if so, the amount of benefits for which they qualify.
 - One specific example of such categorical eligibility involves Combined Application Projects (CAP). As a general rule, to establish the level of food stamp benefits, families who qualify as categorically eligible must estimate and document their

income, even if they already provided similar information to other government programs. However, in a state with a CAP, SSI not only makes cash assistance recipients categorically eligible for SNAP, SNAP benefit amounts can be standardized based on data in SSI records, plus limited information about household shelter costs.⁵⁸ Seniors can obtain additional benefits if they provide additional information showing they qualify under ordinary SNAP rules.

- The Low-Income Home Energy Assistance Program (LIHEAP) likewise permits states to grant automatic “categorical eligibility” to recipients of SSI, TANF, and SNAP, without requiring proof of low income.
- Through Express Lane eligibility, children can qualify for Medicaid or the Children’s Health Insurance Program (CHIP) based on findings of other public programs, notwithstanding different eligibility methodologies used by those programs.⁵⁹

Basing initial eligibility and assistance levels on prior-year tax records

- With Medicare Part B, which covers doctor visits and certain other outpatient services, premiums are subsidized based on income, which is calculated through data matches with federal income tax data from two years in the past. Beneficiaries whose circumstances have worsened can file applications to receive deeper subsidies. Seniors who file no application forms receive subsidies automatically, based on their tax records. If circumstances have improved since the tax year on which subsidy eligibility was based, such improvements are taken into account in subsequent years.
- For federally funded, post-secondary-school student aid, federal income tax data are used to help determine eligibility and assistance levels. For example, grants and loans for the 2010–2011 school year are awarded based largely on information from 2009 tax returns. If a family’s income fell since 2009, it can seek additional help. As with Medicare Part B, increased income is taken into account in a later year’s student aid package.
- For 2008, lawmakers directed IRS to give taxpayers stimulus rebate payments that were means-tested based on federal income tax returns for 2007. If 2008 income fell below 2007 levels, taxpayers could claim additional help on their tax return for 2008, filed in 2009.
- Express Lane Eligibility permits states to qualify children for Medicaid and CHIP based on state income tax records from the prior year. However, if children receive anything but the most generous possible subsidy, families are sent a notice indicating that greater subsidies might be obtained by applying for Medicaid using standard procedures, which include the use of information about recent income.
- One final example involves the Administration’s proposal for further reforms to the eligibility criteria for Pell Grants and college student loans. Many helpful steps have already simplified and streamlined the application process for such assistance, but the process remains sufficiently complex that many low-income families are deterred from participating. In addition, because eligibility often depends on facts that cannot

be verified based on tax information, the current law creates opportunities for error and raises administrative costs. To address these concerns, the Administration has proposed and is working with Congress to reform the aid application requirements and process so that as much information as possible can be drawn directly from tax information supplied by the Internal Revenue Service (IRS) and used to qualify students for assistance. This will help to simplify the application process and provide for more accurate applications. The Council of Economic Advisers found that, in addition to increasing participation by simplifying enrollment, determining eligibility based on available data could prevent fraud, reduce eligibility errors, and retain eligibility targeted to need.⁶⁰

Eligibility rules that disregard short-term income fluctuations

- Until 2004, NSLP required families to report all changes in household income exceeding \$50. The foreseeable failure of beneficiaries to report such changes contributed to findings of high error rates in certifying children for NSLP. In 2004, the program changed its eligibility rules so that income at the start of the school year established eligibility throughout the remainder of the year, regardless of any subsequent changes to household income. This policy adjustment reduced the program's error rate.⁶²
- Medicaid and CHIP can provide children with continuous eligibility for up to 12 months, without regard to changed household circumstances during that period. This option is widely viewed as an effective practice for increasing enrollment, and it is one of several “best practices” of which a state must adopt at least five in order to qualify for child health performance bonuses under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).
- Means-tested premium subsidies for Medicare Part B, LIS for Medicare Part D, and federally funded college student aid are all granted for annual periods, based on records from prior years. As explained earlier, if income rises since the period covered by tax records, reductions are not made until the following year.

Eligibility determination procedures

Substituting data matches for form completion and applicant documentation

- As noted earlier, Medicare avoids the need for tens of millions of seniors and people with disabilities to file applications before they receive need-based premium subsidies for Part B and low-income subsidies for Part D. Instead, federal income tax information automatically establishes eligibility for the former, and data matches with Medicaid and SSA information qualify people for the latter. If federal employees had to verify and process traditional application forms before any beneficiary received subsidies, administrative costs would have been significant, manual errors would have been common, and many fewer eligible seniors would have enrolled.
- One of the most successful state health coverage initiatives was implemented by Massachusetts, through reform legislation passed in 2006. This effort reduced the

proportion of residents without insurance to the lowest level ever recorded in an American state. As one key strategy, the state automatically qualified residents for its new “Commonwealth Care” program through data matches with records from the state’s previous program that paid for hospital uncompensated care. Whenever such matches showed eligibility, consumers did not need to complete new application forms. Roughly one in four newly insured residents received subsidized coverage through these data matches.⁶³

- In renewing children’s eligibility for Medicaid and CHIP, Louisiana has lowered procedural terminations and caseload “churning” to unprecedented levels. As children’s coverage periods come to an end, if data matches show a reasonable certainty of continued eligibility, then coverage is automatically renewed without contacting the family. If additional information is needed, families are encouraged to provide it by phone, if possible. Only if all else fails must families complete paperwork to show their current circumstances. As a result, 19 in 20 children (95.4 percent) have their eligibility continued at renewal, and fewer than 1 in 100 (0.7 percent) loses coverage for procedural reasons.⁶³ By contrast, in the nation as a whole, approximately 29 percent of Medicaid and CHIP children become uninsured at renewal, 44 percent of whom lose coverage despite continued eligibility.⁶⁴ At the same time, federal audits found Louisiana to have an eligibility error rate of 1.54 percent—far below the national average of 6.74 percent.⁶⁵
- Beginning in 2010, families applying for federally-funded college student aid have been able to prepopulate their applications with data that IRS transfers from the families’ federal income tax forms. IRS can now transfer the relevant tax data within two weeks of an electronic filing of a federal income tax return and eight weeks of paper filing. Such IRS data matches constitute full verification of pertinent eligibility elements, relieving families of the need to provide and colleges of the need to verify additional documentation. In the future, families will be expected, as a general rule, to use IRS data in both establishing and updating their eligibility. Federal officials expect these measures to save at least \$340 million by preventing erroneous grants of eligibility.⁶⁶ From January 30 through September 4, 2011—just its second year of operation—this IRS data transfer mechanism was used by more than 3.4 million parents and children, or roughly 21 percent of all applicants for student aid.⁶⁷
- CHIPRA gave Medicaid and CHIP programs the option to verify citizenship based on SSA data matches. During the first three months that states were allowed to exercise this option, 24 states were testing or had adopted it, which successfully confirmed citizenship for 94 percent of applicants.⁶⁸ Even before CHIPRA, citizenship could be established based on data matches with vital records showing birth in the United States. Both data match strategies eliminate the need for consumers to present their original birth certificates or other citizenship documentation before receiving coverage.
- Massachusetts has taken direct steps to allay fears among mixed-status households. The state has implemented an opt-out policy in which some family members can take themselves out of consideration for benefits without affecting the applications of others.

In other words, an unauthorized immigrant parent does not have to provide information about whether he or she is lawfully present when enrolling a child. This opt-out option is conveyed early in the application questions. The Department of Transitional Assistance (DTA), which administers TANF and SNAP, effectively allows immigrant parents to opt out of benefits for some individuals within a household while enrolling others. All local offices now have an opt-out policy. Income and assets for household members who opt out still play a role in eligibility determination, but the state does not delve into their immigration status.⁶⁹

No Wrong Door

- Medicaid, SNAP, and TANF programs have long permitted consumers to file a single application form that allows all three programs to determine eligibility. Such forms can be relatively lengthy and complex, however, since they request information relevant to multiple programs' sometimes distinctive eligibility rules. This complexity has deterred some consumers from completing the combined application form, even though they qualified for help. States are grappling with the challenge of simplifying such joint forms to make them more consumer-friendly.
- Many states permit families to apply for their children's health coverage using a single, simple form that is used for both Medicaid and separate CHIP programs. Regardless of where the form is filed, Medicaid first determines eligibility. If a child is ineligible for that program, the separate CHIP program assesses whether the child qualifies. Each child is placed in the applicable program, without any need for families to submit additional information. This is another best practice that, under CHIPRA, can help a state qualify for performance bonuses.
- Massachusetts' successful health reform initiative, described above, incorporated this procedural reform as a central element. A single application form is used for multiple programs, including Medicaid, CHIP, the state's program to reimburse hospitals and health centers for care furnished to the indigent uninsured, a special state-funded program for immigrant children, and certain other types of health coverage. Regardless of where or how the form is submitted, the Medicaid agency processes the form, uses computerized logic to place each consumer in the program for which he or she qualifies, and informs the family of the results.
- In Rhode Island, applicants for LIHEAP are asked, during their interview, if they want help paying for food expenses. If so, the information they provided for LIHEAP purposes is automatically used to prepopulate an online SNAP application.
- In some states, NSLP application forms ask for permission to share information with the state's health program to see if the children qualify for Medicaid or CHIP. Such permission starts the application process for health coverage, though parents may need to finish the process by giving the health agency additional information.

Default Enrollment

- Historically, Medicare Part B has long enrolled seniors automatically when they turn 65, withholding premiums from their social security checks, unless beneficiaries complete forms “opting out” of coverage. As a result, 96 percent of eligible seniors have participated.⁷⁰ By contrast, Medicare Savings Programs (MSPs), which pay premiums and out-of-pocket costs for poor and near-poor Medicare beneficiaries, reach less than one-third of eligible seniors;⁷¹ to obtain MSP, people must complete the traditional Medicaid application process.
- Medicaid and CHIP programs typically enroll families and children in managed care plans, offering help in selecting a particular plan. However, if consumers fail to make a choice within a defined period, they are enrolled into a plan chosen by the state. Without such a mechanism, eligible people can remain uninsured for months.⁷²
- When beneficiaries qualify for Medicare Part D low-income subsidies, based on Medicaid and SSA data matches, they are asked to select a Part D plan. Those who fail to do so within a defined period of time are assigned to randomly chosen plans. This approach increases participation rates, but it creates problems when the randomly chosen plan is ill-suited to meeting particular beneficiaries’ needs. As a result, many advocates urge shifting from random assignment to default enrollment into Part D plans that, based on available data, appear to be a good fit for beneficiaries.⁷³ Notably, advocates have not proposed re-setting the default to “uninsurance” by delaying enrollment until beneficiaries affirmatively select a plan.
- Some health coverage programs for children have gone beyond the “pre-population” of renewal forms to affirmatively continue eligibility if households fail to correct prepopulated forms. CHIPRA classifies such “administrative renewals” as one of several best practices of which a state must implement at least five to obtain performance bonuses under CHIPRA.⁷⁴ Some state officials report that this strategy increases participation rates and lowers administrative costs without undermining program integrity.⁷⁵
- As noted above, direct certification often qualifies children for free school meals based on data matches with SNAP and TANF programs. When such matches establish eligibility, parents are informed, and unless they opt out, their children are enrolled.

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Stan Dorn is a senior fellow at the Urban Institute's Health Policy Center. Elizabeth Lower-Basch is a Senior Policy Analyst at the Center for Law and Social Policy (CLASP). This report was commissioned by CLASP, First Focus, and Single Stop USA—the co-conveners of the Coalition for Access and Opportunity— and funded by the Annie E. Casey Foundation. The authors are grateful to these organizations for their support and also thank the following individuals for reviewing earlier drafts of this paper: Olivia Golden and Karina Fortuny, Urban Institute; Stacy Dean, Center on Budget and Policy Priorities; Jenny Rejeske, National Immigration Law Center; Julie Kashen, Sarah Fass Hiatt and Ashley Dallman, Single Stop USA and Yuri Kim from Single Stop for his design work; Hannah Matthews, Abigail Newcomer and Helly Lee, Center for Law and Social Policy. Neither those individuals, CLASP, First Focus, Single Stop USA, the Coalition, the Annie E. Casey Foundation, the Urban Institute, nor the Urban Institute's trustees or funders is responsible for the opinions expressed in this report, which are the authors'.

Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. For more information, visit <http://www.urban.org>.

Center for Law and Social Policy

CLASP seeks to improve the lives of low-income people. Through careful research and analysis and effective advocacy, CLASP develops and promotes new ideas, mobilizes others, and directly assists governments and advocates to put in place successful strategies that deliver results that matter to people across America. CLASP is nonpartisan and situated at the intersection of local practice, national research, and state and federal policy, and striving to translate each world to each other.

Coalition for Access and Opportunity

The mission of the Coalition for Access and Opportunity is to share and publicize best practices, identify federal opportunities and promote policy reforms that will strengthen the safety net by removing barriers to participation. Our goals are to improve individual and family financial security, to advance health and well-being, to protect against material hardship and to promote opportunity

and pathways to the middle class. The Coalition for Access and Opportunity is a collaboration of advocates, researchers, and practitioners working to improve access to and better coordination of the range of federal income and work supports.

First Focus

First Focus is a bipartisan advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. First Focus takes a unique approach to children's advocacy, engaging both traditional and nontraditional partners in a broad range of efforts to increase federal investments in programs that address the needs of our nation's children. In all of its work, First Focus seeks to raise awareness regarding public policies impacting children and families and to ensure that related programs have the resources necessary to help children grow up in a healthy and nurturing environment.

Single Stop USA

Single Stop USA is a national nonprofit organization dedicated to helping millions of families move up and out of poverty, toward long-term economic self-sufficiency. Single Stop currently operates sites at community-based organizations and community colleges across the country.

Single Stop's national expansion focuses on partnering with community colleges, integrating its successful economic empowerment model with student service centers and financial aid offices to harness two of the country's most effective anti-poverty tools—coordinated access to America's safety net and a postsecondary education. The aim is to increase the financial security of vulnerable students so they can complete degrees and ultimately to ensure that communities have access to the qualified workforce they need to meet growing labor demands.

Endnotes

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2. See Mills, et al., op cit.
3. Useful papers addressing these broader issues include Shelley Waters-Boots, *Improving Access To Public Benefits: Helping Eligible Individuals and Families Get the Income Supports They Need*, prepared by the Ford Foundation, the Special Fund for Poverty Alleviation of the Open Society Institute, and the Annie E. Casey Foundation, 2009; and Dottie Rosenbaum and Stacy Dean, *Improving the Delivery of Key Work Supports Policy & Practice Opportunities at a Critical Moment*, prepared by the Center on Budget and Policy Priorities for the Ford Foundation, February 24, 2011.
4. Government Accountability Office, *Means-Tested Programs: Information on Program Access Can Be an Important Management Tool* (GAO-05-221), March 2005.
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11. For example, in 2000, CMS (then known as the Health Care Financing Administration) explained, "When an eligibility requirement under another program applies equally to the Medicaid program, the State may accept the other program's determination with respect to this particular eligibility requirement. For example, if the resource standard and method for determining countable assets under the State's TANF program were the same or more restrictive than the asset rules in the Medicaid program, the Medicaid agency may accept [the] TANF agency's determination that a family's assets fall below the Medicaid asset standard without any further assessment on its own part regarding this requirement." CMS, "Questions About the April 7, 2000 Letter to State Medicaid Directors," <https://www.cms.gov/smdl/downloads/smdo40700a.pdf>.
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13. Budget neutrality requires savings to offset the costs of (a) otherwise ineligible individuals receiving benefits and (b) eligible people receiving benefits that exceed those for which they would have qualified without a waiver. In this case, one could structure a "deemed eligibility" waiver to meet those requirements, perhaps as follows. (1) The deeming would enroll few people who are otherwise ineligible, thereby limiting the costs that must be offset. For example, if one deemed eligible for SNAP only Medicaid recipients with gross income below 100 percent of the federal poverty level, as found by Medicaid, few such recipients would be otherwise ineligible for SNAP. (2) Costs could perhaps be offset by reducing the interim benefit levels that "deemed" individuals receive for the 45-day period, not by reducing benefits provided to other SNAP households. So long as that reduction is limited to people who did not previously receive SNAP, and participants in the initiative can seek a standard SNAP determination of eligibility at any time, without waiting for the end of the 45-day period, benefits would not fall for anyone who otherwise would have obtained ordinary SNAP benefits.
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50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011, Georgetown University Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured, January 2011.

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27. For programs where this is problematic, a "second-best" strategy would automatically use reports of new hires and changed earnings to adjust benefit levels for households who receive only employment earnings and unearned income, while providing households with advance notice and an opportunity to challenge benefit reductions. People with independent contractor income do not have income changes during the year reported to the IRS, state workforce agencies, or private contractors that track earnings for public benefit programs. Accordingly, this "second-best" alternative to continuous eligibility would need to be limited to households without significant contractor income. Unearned income poses less of a problem, as by far the most significant source of income fluctuation for low-income households involves changed wage levels and hours of employment. Constance Newman, "Income Volatility Complicates Food Assistance," *Amber Waves*, USDA Economic Research Service, Vol. 4, No. 4 (September 2006): 16–21.
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 40. The paper is available at <http://www.urban.org/UploadedPDF/412446-National-Health-Reform-Legislation.pdf>.
 41. Along similar lines, a consumer whom the Exchange finds ineligible for purely income-based Medicaid immediately receives coverage with subsidies in the health insurance exchange, along with notice of the opportunity to seek a Medicaid determination on other grounds. A consumer seeking such a determination shifts from the exchange to Medicaid after he or she is found to qualify for the latter program.
 42. An example of this challenge is presented by application forms for health coverage under the ACA. Some people will qualify for more benefits under Medicaid based on disability than if they qualify through the new eligibility category that covers adults up to 138 percent of the federal poverty level, regardless of age, disability, pregnancy, or parenthood. If application forms request all information needed to determine disability, the tens of millions of poor and near-poor adults who qualify under the new category will face a more complex enrollment process, and some will fail to complete an application. However, if such forms ignore disability, many who would have received broad Medicaid benefits, without the ACA, would instead receive the narrower benefits that the ACA reserves for newly eligible adults. In its final Medicaid rule, CMS tried to take a middle course. Application forms will request some information about disability; and if those “screening questions” suggest the potential for disability-based eligibility under pre-ACA rules, consumers will be asked to answer additional questions to establish such eligibility.
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