ELIGIBILITY AND ENROLLMENT IN NATIONAL HEALTH REFORM

REPORT #1

Prepared for

The Robert Wood Johnson Foundation

Sarah Shuptrine & Associates

May 1994

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by

Sarah C. Shuptrine
Vicki C. Grant

Sarah Shuptrine and Associates
P.O. Box 5345
Columbia, SC 29250
(803) 779-2607

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Introduction

Under any national health reform measure which passes Congress and is signed by the President, whether public or private, mandatory or voluntary, the first step for Americans will be to gain entry by enrolling. An important objective for policy makers will be to assure that enrollment procedures do not impede access to health coverage.

Complicated and inaccessible enrollment or application forms, verification requirements, lack of transportation and unfriendly application environments pose serious obstacles for individuals and families with limited resources, low educational levels and disabling conditions. It would be shortsighted for policy makers to assume that public or private sector administrators will be sensitive to these and other factors which affect an individual's ability to complete all enrollment or application requirements.

This report is the first of three special reports which will examine eligibility and enrollment issues related to the major health reform bills and proposals before Congress. The reports will focus primarily on the process and the requirements faced by persons who need to enroll in a newly created program. The reports will examine the issues from the perspective of the individual or family with special attention given to those individuals who may require special assistance to enroll, e.g., poor and low income families with children, the elderly, the disabled, the unemployed and the homeless. The reports will not address access to service issues.

The second report will be published in September 1994 and will include analysis of the major committee proposals. The final report will be published in November 1994 and will be a synthesis of eligibility and enrollment issues related to health reform. The reports will include specific policy recommendations related to enrollment, particularly for individuals and families who may have difficulty in complying with all requirements.

This report presents an analysis of selected health reform bills and includes examination of the following questions:

- Is enrollment compulsory or voluntary?
- Who is eligible?
- What are the major Medicaid eligibility changes?
- Is Medicare continued?
- What are the eligibility requirements related to income or resources?
- What provisions relate to disability?
- What is the enrollment process?
- What provisions relate to enrollment/application forms?
- What provisions relate to enrollment/application sites?
- What provisions relate to verification requirements for income, resources, citizenship and other eligibility criteria?
- What provisions relate to outreach for enrollment?
- What provisions relate to undocumented aliens?
- What provisions relate to portability?

The bills included in the analysis are:

Managed Competition Act
Cooper/Breaux
HR 3222; S 1579

Health Security Act
Administration Bill
Gephardt/Mitchell
HR 3600; S 1757

American Health Security Act
McDermott/Wellstone
HR 1200; S 491

Affordable Health Care Act Now
Michel/Lott
HR 3080; S 1533

Consumer Choice Health Security Act
Stearns/Nickles
HR 3698; S 1743

Health Equity and Access Reform Today Act
Thomas/Chafee
HR 3704; S 1770

The following section provides an analysis of each bill on the questions listed above. The final section presents a discussion of the issues identified during the analysis and includes recommendations to assure that enrollment or application procedures do not erect barriers to health coverage.

ANALYSIS OF SELECTED HEALTH REFORM BILLS

IS ENROLLMENT COMPULSORY OR VOLUNTARY?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
Voluntary—Coverage available to US citizens and legal residents through competitively priced accountable health plans purchased through Health Plan Purchasing Cooperatives. [2]	Compulsory—Coverage of a comprehensive set of benefits and a "health security card" [1001(a) & (b)], or Medicare for Medicare eligible individuals [1001(d)]. Effective date would be January 1, 1988. [1006] Individuals can voluntarily apply for home and community based treatment for the disabled [2101], eligibility determination for nursing home care [4211 & 4212] and for care as a qualified child with special needs. [4222]	Compulsory—Coverage of comprehensive set of benefits, including long term and chronic care services under the appropriate state health security program. [102] Effective date would be January 1, 1995. [106]	Voluntary—Coverage of private health insurance for eligible employees who voluntarily purchase a plan. [101] Effective date would be after December 31, 1996. [1022] Voluntary coverage under a new Medicaid program called the State Health Allowance Programs, effective on or after January 1, 1994. [1601]	Voluntary—Coverage of a federally qualified health insurance plan for qualified individuals who voluntarily purchase the plan or a compulsory state health insurance program for the uninsured. [101 and 131] Effective date would be after December 31, 1996. [101]	Compulsory—Coverage of citizens and lawful permanent residents of the US through qualified health plan or equivalent health care program. Effective date would be January 1, 2005. [1501]

WHO IS ELIGIBLE?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
All individuals regardless of employment status. [2] These individuals are: 1) An employee of a small employer 2) Eligible family members of employees, such as the spouse, unmarried dependent child younger than 22, including adopted children, stepchildren and foster children, or unmarried dependent child regardless of age who is incapable of self-support due to a disability which existed before age 22. Eligible family members must be a citizen or national of the US, alien lawfully admitted for permanent residence or alien lawfully residing permanently under color of law.	1) All US citizens or nationals; 2) Permanently residing alien under color of law; and 3) Long-term nonimmigrant [1001(c)] Premium discounts and cost sharing reductions based on income are available. [3171(a) and 6104(a) & (c)]	1) All US resident citizens or nationals; 2) Lawful resident alien [102(a)] Authority is provided so that classes of nonimmigrants may be entitled. [102(b)] The American Health Security Standards Board may make other individuals eligible, in order to: 1) Preserve the public health of communities; 2) Compensate states for the additional health care financing burdens created by such individuals; and 3) Prevent adverse financial and medical consequences of uncompensated care. [102(c)]	Each employer except employers of less than two years and employers with two or fewer employees must offer eligible employees and their dependents a group health plan and to have premiums collected through payroll deduction. [1001] Employers are not required to contribute toward premiums. Eligible employees are those who normally work 30 hours per week on a monthly basis. [1023(a)(2)] A new Medicaid program is available to current Medicaid eligibility groups, as well as low-income individuals to allow payments for premiums to group health plans. [1601 & 1602]	1) Taxpayers, spouses of taxpayers and each dependent of taxpayers enrolled in a federally qualified health insurance plan. [101] 2) Each state is required to establish a health insurance plan to enroll uninsured individuals. [131]	All US citizens and lawful permanent residents. [1001 and 1501] The bill provides for an application process for low income families to obtain a voucher for premium assistance. [1003(a)]

WHO IS ELIGIBLE?					
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3) Residents who are not covered under an AHP, including part-time, seasonal or temporary employees working an average of less than 25 hours per week and who is employed for 8 weeks or less in a 12 month period for an employer. [1701] Premium and cost sharing assistance is available for low-income individuals. [2001]					

WHAT ARE THE MAJOR MEDICAID ELIGIBILITY CHANGES?

Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)	American Health Security Act McDermott - HR 1200 and Wellstone - S 491	Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533	Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743	Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770
Repeals Medicaid effective January 1, 1995. [2301]	AFDC and SSI recipients continue to qualify for Medicaid services not covered by the comprehensive benefit package. [4221] A new grant program to cover home and community based care for severely disabled persons of all ages is established. [2101] A new mandate requiring states to allow nursing home residents to have higher income and resource disregards [4211] and to spend down and become eligible for Medicaid is created. [4212]	Medicaid is eliminated effective December 31, 1994, except in cases of inpatient hospital stays and extended care services during a continuous period which began prior to January 1, 1995. [106(a)]	Changes are not made to current Medicaid eligibility groups, except that some or all of a person's assets can be disregarded when attributable to qualified long term care insurance. [3101] A new Medicaid program is available to current Medicaid eligibility groups , as well as low-income individuals to allow payments for premiums to group health plans. [1601 and 1602]	Medicaid eligibility groups are left intact. An additional Medicaid eligibility group is added via an amendment to provide for grants to serve uninsured individuals with incomes below 150% of the poverty level. [131 and 214]	Changes are not made to current Medicaid eligibility groups.

IS MEDICARE CONTINUED?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
Medicare is continued.	Medicare is continued.	Medicare is eliminated effective December 31, 1994, except in cases of inpatient hospital stays and extended care services during a continuous period which began prior to January 1, 1995. [106(a)]	Medicare is continued.	Medicare is continued.	Medicare is continued.

WHAT ARE THE ELIGIBILITY REQUIREMENTS RELATED TO INCOME OR RESOURCES?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
The bill specifies three groups of low-income individuals who can apply for assistance with premium payments and cost sharing requirements [2001]: 1) Very Low-Income Individual is a state resident whose family adjusted total income is less than 100% of the state adjusted poverty level; 2) Moderately Low-Income Individual is a state resident whose family adjusted total income is 100% or more and less than 200% of the state adjusted poverty level. 3) A Medicare-eligible state resident whose family adjusted total income is less than 120% of the state adjusted poverty level.	1) Reductions in cost sharing amounts are available to families who file applications and are approved. Families entitled to a reduction are enrolled in regional alliances and are either: a) An AFDC or SSI family, or b) A family with a family adjusted income below 150% of the applicable poverty level. [3171(a)] Each family enrolled with a regional alliance is entitled to a premium discount, if the family is: a) An AFDC or SSI family, b) A family with a family adjusted income below 150% of the applicable poverty level, or c) A family for which the family obligation amount	There are no eligibility requirements beyond those specified regarding who is eligible. For low income elderly persons receiving long term health care, the Secretary shall provide a process whereby individuals with an adjusted gross income which does not exceed $8,500 (or $10,700 in the case of joint adjusted gross income for a married individual) are not liable for the $65 per month premium for long term/health care. [837]	Eligibility requirements are not specified for purchase of group health insurance through employers. The bill creates a new Medicaid program called the State Health Allowance programs. The following individuals are eligible to participate: 1) All Medicaid categorically eligible individuals automatically eligible. 2) State residents with family income equal to or below 100% of the poverty level, except if the state sets a lower income level due to excess costs. 3) States can opt to include lawful state residents with family incomes greater than 100% of the poverty level and equal	The bill does not specify any eligibility requirements, except for a new program under Medicaid established by section 1933 for uninsured individuals with incomes below 150% of the poverty level would be provided health insurance coverage. [131(c)(1)]	Low-income families can apply for vouchers to use as assistance with premiums for a qualified health plan. Families eligible to apply, called qualified families, have family income which does not exceed the phase-in eligibility percentage of the poverty level. Beginning in 1997, family incomes cannot exceed 90% of the poverty level. Over the next several years, the percentage of the poverty level increases by 20 points each year until it reaches 240% of the poverty level in the year 2005. [1003(a) & (b)] A family is not qualified for a voucher if it is receiving Medicaid coverage. [1003(b)]

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State adjusted poverty levels are the federal poverty level adjusted for the cost of living in each state. [2009]	would exceed 3.9% of family adjusted income. The limitation applies to families with less than $40,000 adjusted family income. [6104(a) & (c)] 2) Qualified children with special needs can apply for Medicaid covered services, excluding long term care, which are not in the comprehensive benefit package. A qualified child must be younger than 19, be income eligible and for years prior to 1998 when all states are participating, be a resident of a participating state. [4222] The financial requirements of qualified children with special needs are: a) An AFDC (includes foster care and adopted children) or SSI recipient, or		to or less than 200% of the poverty. [1601] The bill provides states with the option of using a resource standard as a condition of eligibility only if the Secretary approves the state's use of such a standard. [1601] Elderly Medicare-eligible individuals are not eligible to participate in the new Medicaid program. [1601]		

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	b) Eligible for Medicaid under a Medically Needy program, or c) Family income between 133% and 185% of the poverty level for children younger than 1, or d) Family income less than or equal to 133% of the poverty level for children age 1 through 5, or e) Family income less than or equal to 100% of the poverty level for children born after September 30, 1993 and attained age 6. [4222] Qualified children must also meet circumstances under which the additional benefits will be considered medically necessary, as defined by the Secretary in regulations. [4222] 3) Financial eligibility criteria for nursing facility residents would be expanded				

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	by allowing spend-down of incurred medical expenses. [4211] For determining eligibility for nursing facility residents, income disregards are increased to the first $50 of income and, at state option, resource disregards are increased to $12,000 for unmarried individuals. [4212 & 4301] 4) At state option, home and community based services will be available for individuals with disabilities. [2102 & 2103] The state plan for home and community based services must assure that low income individuals with disabilities are served in proportion to the population of the state that represents individuals who are low income. [2102(a)(2)(E)]				

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	The bill specifies that there will be no or nominal cost sharing for individuals with incomes less than 150% of the poverty level. A sliding scale for individuals with incomes equal to or more than 150% of the poverty level is specified. [2105]				

WHAT PROVISIONS RELATE TO DISABILITY?					
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The bill does not make specific provisions for the disabled.	1) Qualified children with special needs can apply for Medicaid covered services, excluding long term care, which are not in the comprehensive benefit package. A qualified child must be younger than 19, be income eligible and for years prior to 1998 when all states are participating, be a resident of a participating state. Qualified children must also meet circumstances under which the additional benefits will be considered medically necessary, as defined by the Secretary in regulations. [4222] 2) A new grant program to cover home and community based care for severely disabled persons of all ages is established. [2101]	The bill does not make specific provisions for the disabled.	The bill does not make specific provisions for the disabled.	The bill does not make specific provisions for the disabled.	The bill does not make specific provisions for the disabled.

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	3) A new mandate requiring states to allow nursing home residents to have higher income and resource disregards [4211] and to spend down and become eligible for Medicaid is created. [4212]				

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The Health Care Standards Commission shall provide for enrollment as follows: 1) Initial enrollment periods of not less than 30 days during which new employees are offered enrollment. 2) Annual open enrollment of not less than 30 days when employees can choose among plans. 3) Special enrollment periods when an employee can change plans, because of a change in family situation, such as marriage, birth or adoption of a child, divorce, separation or death. [1005(b)] Each small employer, defined as an employer that normally employs fewer than	1) Each regional alliance is required to assure that each regional alliance eligible individual who lives in the alliance area is enrolled in a health plan. All covered individuals are to enroll in a regional or corporate alliance which provides coverage via a health plan. Regional alliances are required to establish methods and procedures to ensure enrollment when an individual first becomes eligible, including at the time of birth, at the time of moving into an alliance area and at the time of reaching the age of eligibility as an individual. [3123(a)] The enrollment process can be initiated when a nonenrolled individual seeks services from a provider and the provider can be paid for delivering services to a	The American Health Security Standards Board is required to develop policies, procedures, guidelines, and requirements to carry out the Act, including those related to eligibility and enrollment. [401(f)(1)(A) & (B)] Each state health security program must provide a mechanism to enroll individuals entitled or eligible for benefits. The mechanism must: 1) Provide a process for automatic enrollment at the time of birth in the US and at the time of immigration into the US or other acquisition of lawful resident status in the US. 2) Provide for enrollment of all eligible individuals by January 1, 1995. 3) Provide for a process to	The bill does not specify an enrollment process for health insurance plans. Insurers must accept every small employer in the state that applies for coverage under a MedAccess plan and must accept for enrollment under the plan every eligible individual and dependent who applies on a timely basis and the insurer cannot place restrictions on the eligibility of an individual to enroll. [1101] Enrollment may be considered not to be timely if the eligible employee or dependent fails to enroll during an initial enrollment period, if the period is at least 30 days. Exceptions to timeliness are allowed for: 1) Declining enrollment during the enrollment period and then losing coverage under another	An enrollment process is not specified for a federally qualified health insurance plan for which individuals voluntarily enroll. After December 31, 1996, as a condition of receiving federal funds for health care programs, each state is required to have established a health insurance plan, at least equal to the federally qualified health insurance plan, which is for the purpose of enrolling individuals who are uninsured because they refuse to voluntarily purchase insurance coverage privately. Coverage can be provided under a state Medicaid program, an existing or new state health care program (established under a new Medicaid amendment), a private insurer the state contracts	By meeting certain conditions, a health plan can be certified as a qualified general access plan which is made available to eligible employees or eligible individuals in a Health Care Coverage Area. [1101 & 1113(b)] A qualified general access plan must offer the following enrollment procedures: 1) Initial enrollment period of not less than 30 days when an individual becomes eligible; 2) Open enrollment period of not less than 30 days; 3) Special enrollment periods due to a change in family composition, change in employment status and change in residence to another health care coverage area. [1115]

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101 employees on a typical day, is required to offer accountable health plans through a health plan purchasing cooperative. [1005(a)] Large employers are required to offer each employee enrollment in a qualifying Accountable Health Plan on an individual or on a family basis. A health plan purchasing cooperative, on behalf of an accountable health plan, is required to enroll eligible individuals. In doing so, the HPPC is required to conduct activities, including outreach, as is necessary to actively seek enrollment of eligible individuals, including those who are low-income or who reside in	nonenrolled individual. [1323(b)] Each regional alliance is required to hold an annual open enrollment period during which eligible individuals can choose among plans. Each regional alliance is required to have procedures for eligible individuals to change plans for good cause during the year and procedures are required to be implemented in a manner that assures continuity of coverage during the year. [1323(d)] 2) Individuals desiring assistance with cost sharing requirements, e.g., premium contributions or copayments can apply. [1371] In no case will a family or individual	enroll lawful aliens and other groups as added by the Board. [103(a)]	plan; 2) Court ordered coverage of a spouse or child; and 3) Within 30 days of marriage, birth or adoption or when family coverage is first made available. [1101] The bill does not specify the enrollment process for persons eligible for the new Medicaid program, the State Health Allowance Program. [1601] Specific provisions are not made on enrollment, other than timely enrollment of employees into group health insurance plans offered by employers. [1101]	with or any health insurance plan available to the resident. If a state has established a state program under a grant received in accordance with a new section 1933 of the Medicaid law as provided by this bill, individuals with incomes below 150% of the poverty level would be provided health insurance coverage. [131(c)1)] Such a state program is required to give priority to coverage of benefits to individuals who are: 1) Ineligible for Medicaid, 2) Are eligible for the tax credits created by this Act, and 3) Has unreimbursed expenses for health	Each employer is required to make available directly or through a purchasing group, enrollment in a qualified health plan to each eligible employee, defined as normally working 30 hours per week. A small employer must make available a qualified insured health plan. [1004] The bill provides for an application process for low income families to obtain a voucher for premium assistance. [1003(a)] A family may file an application for a voucher at any point in time. [1003(e)(1)] The Secretary will prescribe the manner in which to submit applications for vouchers. To the extent possible, the Secretary is

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medically underserved areas. [1102(b)] The Health Care Standards Commission is required to develop performance standards for health plan purchasing cooperatives which include measures of the effectiveness of the HPPC in enrolling individuals who are eligible for low-income assistance or who reside in medically underserved areas. [1101(e)] For individuals seeking assistance with premium and cost sharing amounts, the bill specifies an application process. The Health Care Standards Commission is required to prescribe the application form and contents in order to provide information for a	lose coverage for failure to pay cost sharing amounts owed. [1344(d)] A regional alliance eligible family may apply for a determination of the family adjusted income for the purpose of establishing cost sharing reductions. An application may be filed at times provided by the Secretary, including during any open enrollment period, at the time of a move, or after a change in life circumstances (such as unemployment or divorce) affecting class of enrollment or amount of family share or repayment amount. Each regional alliance will approve or disapprove an application and notify the applicant of the decision, within such period as specified by the			insurance coverage and medical care which exceed 5% of adjusted gross income and are not otherwise taken into account in determining the tax credit. [214] In the case of uninsured individuals who are not eligible for coverage under the new Medicaid program established under section 1933 of this bill, the state is to identify them and automatically enroll them in a state program. The individual enrolled may be charged a premium for coverage based on the cost of coverage and the individual's ability to pay. [131(c)(2)]	required to provide for an option to enroll in a qualified health plan as part of the application and approval process. [1003(e)] At the time of submitting an application, the family can elect to have income determined on the basis of the three month period preceding the month of application or based upon estimated income for the entire year. [1003(f)] Families receiving vouchers are required to reconcile income statements on the application with income reported on tax returns. [1003(h)] Families receiving vouchers will receive a notice from the Secretary by January 31 of the following year and the family must

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determination of assistance, information on the accountable health plan and to provide for assignment of rights to assistance. [2006(c)] Written applications are to be filed by person or mail to the Health Care Standards Commission. Applications can be filed at any time and may be resubmitted not more frequently than every 3 months based on a change in family composition. Applications to reduce the amount of assistance based on an increase in income can be filed at any time. [2006(d)] Individuals receiving assistance in September of a year who wish to remain eligible for assistance beginning with January of the following year must file an application in October.	Secretary after filing the application. The application will be approved if it is demonstrated that the family adjusted income is (or is expected to be) less than 150% of the applicable poverty level. A regional alliance will take into account income for the previous 3 month period and current wages from employment, consistent with rules specified by the Secretary. At the option of the individual, a family may include (and not be required to separate out) the income of other individuals who are claimed as dependent for income tax purposes, but such individuals cannot be counted as part of the family size. The continued eligibility of a family is conditioned upon the family's eligibility being confirmed				attach its tax return and forward to the Secretary for reconciliation. Penalties are provided for families failing to file without good cause or for providing false information. [1003(h)]

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Such an application cannot be filed during November or December. [2006(d)] An application is considered filed on the date on which all documentation required is included. [2006(i)] Families eligible for benefits under title IV part A or E (AFDC or foster care) or for SSI are deemed to have adjusted total income below 100% of the state adjusted poverty level and are not required to file an application. Such families are not required to submit statements verifying income for a taxable year for reconciliation purposes. [2008]	periodically by the regional alliance and verified (through the filing of a new application) by the regional alliance at the time income reconciliation statements are required to be filed. Each approved family must promptly notify the regional alliance of any material increase (as defined by the Secretary) in the family adjusted income. If the regional alliance receives information of a significant change in employment status or increase in income, the alliance must promptly take steps to reconfirm eligibility. [1372(a)-(e)] Applications for AFDC and SSI families are not required. [1372(g)]				

WHAT IS THE ENROLLMENT PROCESS?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
	Any regional alliance family may apply for a determination of the family adjusted income to establish eligibility for a premium discount or a reduction in liability (repayment amounts). Individuals eligible for a discount must have family adjusted income less than 150% of the applicable poverty level and individuals eligible for a reduction in liability must have a wage adjusted income less than 250% of the applicable poverty level. Applications may be filed during open enrollment, at the time of a move, or after a change in life circumstances (such an unemployment of divorce) affecting class of enrollment or amount of family share or repayment amount.				

WHAT IS THE ENROLLMENT PROCESS?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
	In making a determination, a regional alliance must take into account the income for the previous 3 month period and current wages from employment and the statement of estimated income for the year, consistent with rules specified by the Secretary. [1373(a)-(c)] Each approved family must promptly notify the regional alliance of any material increase (as defined by the Secretary) in the wage adjusted income. If the regional alliance receives information of a significant change in employment status or increase in income, the alliance must promptly take steps to reconfirm eligibility. [1373(d)]				

WHAT IS THE ENROLLMENT PROCESS?					
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	The bill specifies general provisions related to the application process for premium discounts and cost sharing reductions. Regional alliances must distribute applications directly to consumers through employers, banks and designated public agencies. Applications must be filed by person or mail with a regional alliance or an agency designated by the State for this purpose. The application may be submitted with an application to enroll with a health plan or separately. Each application must include a declaration of estimated annual income for the year involved. The Secretary is required to specify the form and manner of applications and shall				

WHAT IS THE ENROLLMENT PROCESS?					
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	require the provision of information necessary to make a determination. An application may be filed at any time during the year and during the reconciliation process. For AFDC and SSI recipients, the date of approval of benefits shall be considered the date of approval of an application. The Secretary must provide for verification, on a sample basis or other basis, of the information supplied in applications. This verification must be separate from reconciliation. The bill specifies that each regional alliance must assist individuals in the filing of applications and income reconciliation statements. Penalties are provided for individuals who knowingly underestimate income or				

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	misrepresents material information. [1374] Families approved for premium discounts or reductions in liability must file, at a time specified by the Secretary, with the regional alliance an income reconciliation statement to verify the family's adjusted income or wage adjusted income for the year in which the approval was effective. The statement must contain information as the Secretary may specify. AFDC and SSI families are not required to reconcile. [1375] 3) For qualified children with special needs, the bill specifies that the Secretary shall promulgate regulations not later than July 1, 1995 which include procedures for the periodic redetermination				

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Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
	of an individual's eligibility for benefits. [4222(c)] The bill specifies that not later than July 1, 1995, the Secretary shall establish procedures for enrolling qualified children under which essential community providers serve as enrollment sites and any forms used for enrollment purposes are designed to make the enrollment as simple as practicable. [4222(b)(3)(A)] The Secretary is required to establish a process under which an individual who is a qualified child and is enrolled in a health plan shall automatically be deemed to have met any enrollment requirements. [4222(b)(3)(B)]				

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Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
	4) For home and community based services, the determination of whether an individual is an individual with disabilities shall be made, by persons or entities specified under the State plan, using a uniform protocol consisting of an initial screening and assessment specified by the Secretary. A state may collect additional information, at the time of obtaining information to make such a determination, in order to provide for the assessment and plan of care or for other purposes. [2103(b)]				

WHAT PROVISIONS RELATE TO ENROLLMENT/APPLICATION FORMS?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
An application for low income assistance must be in a form and manner specified by the Health Care Standards Commission and shall require the provision of information necessary to make a determination and the assignment of rights to assistance. Additionally, the form must include notice that the subsidies will be made as a direct reduction of premiums and cost sharing under the Accountable Health Plan involved. [2006(c)]	Application forms to be used in applying for premium discounts and cost sharing reductions shall include information determined by the regional alliance (consistent with rules developed by the Secretary) and shall include at least information about the family's employment status and income. [1372(a)(2)] Each application must include a declaration of estimated annual income for the year. [1372(c)] The Secretary is required to prescribe the form and manner of filing applications and shall require the provision of information necessary to make a determination of eligibility. [1374(c) & (d)]	The bill specifies that each state must make available applications for enrollment. [103(b)]	None are specified.	None are specified.	The Secretary shall use an application which should be as simple in form as possible and understandable to the average individual. The application can require attachment of documentation as deemed necessary by the Secretary. The bill directs the Secretary to use any existing forms used for federal income tax filing as an application if deemed practicable. The Secretary is required to make application forms available through health care providers and plans, public assistance offices, public libraries, post offices and at other locations accessible to a broad cross-section of families. [1003(e)]

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	For qualified children with special needs, the Secretary is required to establish procedures for the enrollment of children under which any forms used for enrollment purposes are designed to make the enrollment as simple as practicable. [4222(b)(3)(A)]				

WHAT PROVISIONS RELATE TO ENROLLMENT/APPLICATION SITES?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
Applications for premium and cost sharing assistance must be filed with the Health Care Standards Commission. The Commission is required to make grants that will make available assistance in filing applications. Grants are to be made in a manner that provides assistance at a variety of sites that are readily accessible to individuals and families eligible for assistance, such as low-income housing projects and shelters for homeless individuals. [2006(g)]	1) Applications filed for premium discounts and cost sharing reductions are to be filed by person or mail with a regional alliance or an agency designated by the state. [1374(b)] 2) For qualified children with special needs, the bill specifies that not later than July 1, 1995, the Secretary shall establish procedures for enrolling qualified children under which essential community providers shall serve as enrollment sites. [4222(b)(3)] Essential community providers are any health care provider or organization meeting certification standards, which can be community and migrant health centers, federally qualified health centers and rural health	Each state is required to make enrollment applications available at the following locations: 1) Local offices of the Social Security Administration, 2) Social services locations, 3) Outreach sites, such as provider and practitioner sites, and 4) Other locations, including post offices and schools which are accessible to a broad cross-section of individuals eligible to enroll. [103(b)]	Enrollment sites are not specified.	Enrollment sites are not specified.	Enrollment sites are not specified.

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	centers, homeless and public program providers, family planning clinics, Indian Health programs, AIDS providers, maternal and child health providers, school health services providers, community practice network and health professionals. [1582(a)] 3) Enrollment sites are not specified for nursing home residents and for the new home and community based services program.				

WHAT PROVISIONS RELATE TO VERIFICATION REQUIREMENTS FOR INCOME, RESOURCES, CITIZENSHIP AND OTHER ELIGIBILITY CRITERIA?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
The Health Care Standards Commission is required to provide for verification, on a sample basis or other basis, of information supplied in applications for assistance. This verification is separate from verification for reconciliation purposes. [2006(f)] For reconciliation of low income assistance, families (other than cash assistance related families) must file with the Commission by April 15 of each year a statement that verifies the family's total adjusted family income for the previous taxable year. The statement should provide information necessary to determine the family adjusted total income during the year and the number of family members as of the last day of the year.	1) For persons applying for premium discounts and cost sharing reductions, the Secretary is required to provide for verification, on a sample basis or other basis, of the information supplied in applications. Verification of this information is separate from reconciliation. [1374(g)] Each state must assure that eligibility determinations for cost sharing assistance are made by regional alliances on the basis of the best information available to the state. [1202(e)] 2) For qualified children with special needs, the bill does not specify verification requirements. 3) For nursing home residents and home and community based care, the	None are specified.	None are specified.	None are specified.	The Secretary may require documentation of information provided on the application for a voucher. [1003(e)]

WHAT PROVISIONS RELATE TO VERIFICATION REQUIREMENTS FOR INCOME, RESOURCES, CITIZENSHIP AND OTHER ELIGIBILITY CRITERIA?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
The Commission is required to provide a process under which filing of a federal income tax return shall constitute the filing of an income statement. Failure to file a statement without good cause can result in the loss of assistance. [2007]	bill does not specify verification requirements.				

WHAT PROVISIONS RELATE TO OUTREACH FOR ENROLLMENT?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
In offering enrollment in Accountable Health Plans, a Health Plan Purchasing Cooperative is required to perform such activities, including outreach, as may be necessary to seek actively the enrollment of eligible individuals, including individuals who are eligible for low income assistance or who reside in medically underserved areas. [1102(b)(3)] The Health Care Standards Commission shall make grants to public or private nonprofit entities that will make available assistance to individuals and families in filing applications for low income assistance. The Commission shall make grants in a manner that provides such assistance at a variety of sites, such as low income housing projects and	As part of a state's responsibilities related to health plans, a state may provide for an adjustment to the risk adjustment methodology and or financial incentives to plans to assure that such plans enroll individuals of disadvantaged groups. A state may provide for appropriate extra services, such as outreach to encourage enrollment and transportation and interpreting services to ensure access to care, for certain population groups that face barriers to access because of geographic location, income levels, or racial or cultural differences. [1203(e)(3)] Each regional alliance is required to assist individuals in filing applications and income reconciliation statements. [1374(h)]	None are specified.	None are specified.	None are specified.	The Secretary is required to make application forms available through health care providers and plans, public assistance offices, public libraries, post offices and at other locations accessible to a broad cross-section of families. [1003(e)]

WHAT PROVISIONS RELATE TO OUTREACH FOR ENROLLMENT?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
shelters for homeless individuals, that are readily accessible to individuals and families eligible for low income assistance. [2006(g)]					

WHAT PROVISIONS RELATE TO UNDOCUMENTED ALIENS?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
No provision specified.	Undocumented aliens are not entitled to the comprehensive benefit package or to a health security card. [1005(a)] Medicaid will continue to be available in the case of emergency services. [4201(a)]	The American Health Security Standards Board may make individuals, not otherwise entitled under the Act, eligible for health care services under the appropriate state health security program and regulate the nature of the eligibility of such individuals in order to: 1) preserve the public health of communities, 2) compensate states for the additional health care financing burdens created by such individuals, and 3) prevent adverse financial and medical consequences of uncompensated care, while inhibiting travel and immigration to the US for the sole purpose of obtaining health care services. [102(c)(1)]	No provision specified.	All aliens, except for specified refugees and lawfully admitted aliens older than 75 years, who have lived in the US for at least five years, are ineligible for a range of health and social services, including Medicaid and AFDC. Medicaid emergency services may continue to be provided to eligible aliens. [801]	No provision specified.

WHAT PROVISIONS RELATE TO UNDOCUMENTED ALIENS?					
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		Any state health security program may make individuals described in the paragraph above eligible for benefits at the expense of the State. [102(c)(2)]			

WHAT PROVISIONS RELATE TO PORTABILITY?					
Managed Competition Act Cooper - HR 3222 and Breaux - S 1579	**Health Care Security Act Gephardt - HR 3600 and Mitchell - S 1757 (for the Administration)**	**American Health Security Act McDermott - HR 1200 and Wellstone - S 491**	**Affordable Health Care Now Act Michel - HR 3080 and Lott - S 1533**	**Consumer Choice Health Security Act Stearns - HR 3698 and Nickles - S 1743**	**Health Equity and Access Reform Today Act Thomas - HR 3704 and Chafee - S 1770**
Guarantees portability with limitations on preexisting conditions which are conditions which have been diagnosed or treated during the 3 month period ending on the day before coverage under a plan is to begin. Any exclusion of preexisting conditions may not exceed 6 months and cannot apply to services furnished to newborns and pregnant women. Any period of exclusion must be reduced by one month for each month in a period of continuous coverage of 3 months or more. [1204] The bill provides for a transitional period, such that each individual who enrolls in an accountable health plan prior to July 1, 1995 is considered to have had a period of continuous coverage during the 6 months ending January 1, 1995. [1204]	The design of the plan guarantees benefits through private insurance provided by either a regional or corporate alliance, Medicaid or Medicare. Changes in who provides coverage can be made without loss of coverage of universally guaranteed benefits. [1001 & 1402]	A state can impose a residency requirement or waiting period up to three months, but an individual can continue to receive benefits under the original plan until such period has expired. [104]	Preexisting conditions cannot be excluded or coverage limited if: 1) The condition was not diagnosed or treated within 3 months prior to the date of coverage; 2) The exclusion or limitation extends over more than 6 months after the date of coverage; 3) The exclusion or limitation applies to an individual who, as of the date of birth was covered under the plan; or 4) The exclusion or limitation relates to pregnancy. [1011] Group health plans are required to waive any waiting period applicable to preexisting conditions when the individual was covered for the condition under any other health plan.	Effective on January 1, 1998, preexisting conditions cannot be excluded, if on the date of application for coverage, the individual has been covered by one of the following programs for a period of at least one year prior to the application date: 1) Another federally qualified health insurance plan; 2) An employer-sponsored group health insurance plan in effect before the effective date of this Act; 3) An individual health insurance plan; 4) Medicaid or Medicare; 5) Chapter 55 of title 10, US code; 6) Veterans health care program under chapter 17 of title 38, US code; 7) Federal Employees Health Benefits program under chapter 89 of title 5, US code; or 8) Indian Health Care	Guarantees portability with limitations on preexisting conditions which are conditions which have been diagnosed or treated during the 3 month period ending on the day before coverage under a plan is to begin. Any limitation or exclusion of preexisting conditions may not exceed 6 months and cannot apply to pregnancy. A limitation or exclusion cannot apply to an individual who, as of the date of birth, was covered under the plan. Any period of exclusion must be reduced by one month for each month in a period of continuous coverage. [1112]

WHAT PROVISIONS RELATE TO PORTABILITY?					
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			Continuous coverage does not apply when there is a break in continuous coverage of more than 60 days, or 6 months in the case of a terminated employee. [1012]	Improvement Act. [114] In the case of applicants who have not been continuously insured during the prior year, preexisting conditions can be excluded for up to a year or for the number of months without insurance, whichever is less. [114] Health insurance plans must provide for guaranteed issue and standard rates to all applicants. [114]	

Discussion of Enrollment and Application Issues

When developing legislation, it is often difficult to determine which details need to be included in statutory language rather than being left to regulation. In the case of health reform, if it is the intent of policy makers that the enrollment process be simple and accessible, statutory language will assure that the attention of administrators is directed to that objective. The absence of such language will leave decisions regarding enrollment and application procedures in the hands of public or private sector administrators and it reasonable to expect that doing so will result in excessive paperwork and lack of outreach.

General statutory language can clarify enrollment intent in the following areas: 1) information dissemination; 2) application format and instructions; 3) verification requirements; 4) enrollment sites; and, 5) outreach to provide assistance to persons in rural areas and persons with limited resources, low educational levels and disabling conditions. A strong commitment to enrolling all eligible individuals and families means that attention and resources must be devoted toward that end. A broad unclear mandate to "enroll eligible persons" is empty without specific direction to assure that there are no barriers to enrollment. Additionally, attention must be given to assuring that individuals and families who want to apply for financial assistance receive the help needed to complete the application.

In addition to designing an accessible enrollment system for new programs or insurance mechanisms created by health reform, it is necessary to examine enrollment procedures for existing programs which are expected to provide coverage for all persons eligible under the eligibility criteria. Several of the bills included in this analysis assume that families eligible for Aid to Families with Dependent Children (AFDC) and individuals or couples eligible for Supplemental Security Income (SSI) will be provided Medicaid coverage under those programs. As discussed below, the validity of that assumption is questionable.

Enrollment and application issues are discussed below and recommendations are presented.

Enrollment Forms and Sites

Making enrollment forms widely available helps make the enrollment process more accessible to the general population as well as to disadvantaged individuals and families. Three bills (Administration, McDermott/Wellstone and Thomas/Chafee) contain language specifically directing that enrollment forms be widely available. The locations mentioned include designated public agencies, schools, post offices, outreach sites, employers, banks and provider sites. Cooper/Breaux specifically mentions that applications should be made available at low-income housing projects and homeless shelters. Two bills (Michel/Lott and Stearns/Nickles) contain no provision for making enrollment forms widely available.

The Administration bill specifically directs that "point of service" enrollment take place at provider sites and requires that "essential community provider" sites serve as enrollment sites for children with special needs.

Applications and Required Verification

In the complicated area of low income assistance, the bills generally delegate authority for application design and verification requirements. Determining how accessible or complex the low income assistance process will be is not possible in the absence of specific provisions. The absence of specific language also means that administrators are left to make the final decisions regarding the design of the eligibility process for low income assistance programs.

All of the bills except for the McDermott/Wellstone bill have low income assistance programs or Medicaid. There are five areas where it appears that administrators charged with designing and implementing low income application procedures could require verification. The five areas are income (earned or unearned), citizenship, family size, proof of dependency and relationship.

The Administration bill contains policy directives aimed at assuring that unnecessary application barriers are to be avoided in the low income application process. The Administration bill is the only bill which contains specific language allowing self declaration of estimated annual income during the application process, but it does not specifically allow self declaration for two items which are generally included in the calculation of income—family relationship and family size. It does specify that regional alliances assist individuals in filing applications for premium discounts and cost sharing reductions. The Administration bill delegates authority for application and verification requirements to the Secretary.

In general, both Cooper/Breaux and Thomas/Chafee include language indicating the need for application assistance for low income families. However, specific mention is made that verification can be required and there is no balancing language directing that verification not be excessive. Cooper/Breaux delegates authority to the Health Care Standards Commission to provide for verification "on a sample basis or other basis." Thomas/Chafee specifically grants authority to the Secretary to determine requirements for documentation.

Bills sponsored by the Administration, Michel/Lott, Stearns/Nickles and Thomas/Chafee utilize Medicaid in the coverage of low income persons. No mention is made in these bills regarding simplification of the eligibility process for Medicaid.

Research into Medicaid eligibility barriers under current low income programs indicates that requiring verification for income, citizenship, family size, dependency and relationship may be problematic for enrollment in programs created under national health reform.[1] It has been shown that wage and income verification presents the most difficulty for applicants, followed by verification of personal/family characteristics such as birth certificates, social security numbers, citizenship and proof of relationship.

In interviews with applicants who were denied for not returning verification documents, they indicated a need for more assistance from eligibility workers, particularly when the verification must be obtained from employers, estranged husbands or other third parties who may or may not care whether the applicant obtains benefits. Denied applicants also cited the need for more time to obtain verification documents before a decision is made to deny assistance.[2]

Allowing self declaration is an obvious way to reduce verification requirements. Giving the application worker discretion to decide when self declaration is not sufficient will significantly reduce the paperwork requirements which may otherwise be routinely required as part of the application process.

While accountability is an important goal, experience indicates the need for balance between accountability and accessibility. Minimizing areas in which verification documents are required and providing enrollment outreach programs will substantially reduce instances where individuals and families are eligible, but have difficulty in complying with paperwork requirements.

Application Assistance for Special Groups

Outreach to assist individuals and families, the elderly, the disabled, persons who live in rural areas and others who may need special assistance to file applications for assistance includes the following:

- Wide dissemination of information on benefits and how to apply
- Wide availability of application forms
- Assistance in filing applications, including assistance with verification
- Allowing filing by person, mail and toll free telephone
- Special services to assure enrollment may include transportation, dependent care, home visits and interpreting

Several of the bills contain language to see that outreach is conducted in order to improve access to *health services* for disadvantaged persons, but only the Administration bill and the Cooper/Breaux bill contain specific language addressing the need for outreach for *enrollment* purposes.

The Administration bill contains language directing each regional alliance to assist individuals in filing applications for assistance and income reconciliation statements. The Cooper/Breaux bill specifically requires outreach to enroll eligible individuals, including those who are low income or who reside in medically underserved areas.

The Administration and Cooper/Breaux bills contain provisions which allow applications to be filed by mail which will be helpful to persons who live in rural areas, the elderly and the disabled. The extent to which mail enrollment can be utilized, however, will depend on the simplicity of the enrollment and application forms and the requirements for verification.

None of the bills calls for special initiatives to assist the unemployed to enroll for health coverage and only one bill (Cooper/Breaux) directs attention to the need to assist homeless individuals and families.

For a discussion of the Americans with Disabilities Act as it relates to enrollment issues under health reform proposals, see Appendix A.

Portability Requirements

The Administration bill is the only one which bans enrollment waiting periods on the basis of preexisting conditions. The McDermott/Wellstone bill imposes an enrollment waiting period based on residency, but an individual can continue to receive benefits under his original plan for the duration of the waiting period. The other bills allow waiting periods based on preexisting conditions.

AFDC and SSI

Under two bills (McDermott/Wellstone and Cooper/Breaux), Medicaid is repealed so there is no relationship to AFDC and SSI. Under the remaining four bills, the AFDC and SSI programs are the major conduits to health coverage through Medicaid. Two bills (Stearns/Nickles and Michel/Lott) create new Medicaid groups unrelated to AFDC and SSI.

Research has documented the existence of substantial procedural eligibility barriers under the AFDC program. These barriers affect Medicaid eligibility since families determined eligible for AFDC are automatically eligible for Medicaid. In FFY 1991, 27% of all families applying for AFDC were denied and of those denials, 60% were for procedural reasons unrelated to income or resource criteria. (See Appendix B)

A few studies provide insight into the reasons for AFDC/Medicaid procedural denials. Obtaining wage and income statements has been the most often cited verification problem area followed by personal/family characteristics, such as birth certificates, social security numbers, citizenship and proof of relationship.[3] Outreach programs to provide assistance to individuals and families in collecting verification documents have been shown to significantly increase approval rates.[4]

In regard to SSI, the most serious enrollment barrier is that current federal law allows states to require separate Medicaid enrollment procedures for poor elderly and disabled persons who have been approved for SSI. (See Appendix C) In 31 states and the District of Columbia, referred to as automatic SSI states, individuals and couples determined eligible for SSI are automatically eligible for Medicaid. In the other 19 states, referred to as nonautomatic states, individuals and couples who are approved for SSI must go to a separate location to repeat the eligibility process in order to apply for Medicaid benefits.

The length of Medicaid applications for SSI recipients in the nonautomatic states ranged from two to 43 pages. Only three of the 19 states (Idaho, Kansas and

Nevada) were able to provide data on Medicaid denials of SSI eligible individuals and couples. The table below shows the percentage of SSI eligibles denied Medicaid benefits in these states and demonstrates the extent to which Medicaid is not guaranteed for SSI eligible persons in the nonautomatic states.

Table 1
Medicaid Denial Rates In SSI Criteria States, April 1990

	Medicaid Denial Rate	
State	Aged	Blind & Disabled
Idaho	61%	50%
Kansas	0%	11%
Nevada	21%	57%

Source: Sarah Shuptrine and Associates, Access to Medicaid Impeded in 19 States for Aged and Disabled Supplemental Security Income Recipients, 1990, p 26.

The above information on AFDC and SSI demonstrates that the assumption that all persons eligible for AFDC and SSI are covered by Medicaid is inaccurate. It is true that once health reform is enacted, individuals and families denied eligibility under AFDC and SSI will have another avenue to gain health coverage. However, the coverage available outside AFDC and SSI will be less comprehensive. In particular, for elderly and disabled persons, there will be a separate eligibility procedure for long term care, if it is available at all.

Recommendations

This analysis of eligibility and enrollment issues identifies areas where more attention is needed to assure that access to health coverage is not impeded by the enrollment or application process. Developing strategies to be responsive to various population groups is essential to the design of an effective enrollment or application process. Policy direction to design and implement measures to assure coverage of eligible individuals and families should be embodied in statute as general eligibility principles.

For compulsory programs, the need for aggressive outreach and enrollment initiatives will be essential in the beginning stages and should eventually reach a maintenance mode. For voluntary programs, the need for aggressive outreach and enrollment initiatives will be essential in the beginning and must be continuous to assure enrollment of eligible individuals and families. For both compulsory and voluntary programs, outreach to assure that low income individuals and families are enrolled will be needed on a continuous basis.

It is recommended that the following approach be considered as a conceptual framework for the establishment of enrollment and application policies to ensure that universal access to health coverage becomes a reality:

General Enrollment

- Culturally sensitive information should be widely distributed to inform individuals and families of the alternatives for health coverage and the process for enrollment.
- Enrollment forms should be easy to read and simple to complete.
- Enrollment forms should be available at convenient locations such as schools, government agencies, post offices, banks, grocery stores, shopping centers, provider sites, outreach sites, meal sites and through employers.
- Enrollment should be allowed by person, mail and toll free telephone.
- Self declaration statements should be allowed to the maximum extent feasible.
- Enrollment assistance should be available on request for elderly, disabled, low income families, persons residing in rural areas and others who need help to enroll.
- Enrollment should be as automatic as possible, e.g., enrollment at birth, immigration and at the time of reaching the age of eligibility as an individual.

Applications for Low Income Assistance

- Aggressive, community based and culturally sensitive outreach should be conducted to inform individuals and families of the process and requirements for filing an application for financial assistance or for Medicaid.
- Applications with easy to read instructions for filing should be widely available.
- Applications and general assistance in filing should be available at designated local, state and federal agencies, outreach sites, designated provider sites, homeless shelters and other locations as appropriate.
- Applications should be allowed to be filed by person, mail and toll free telephone.
- Verification requirements should be held to a minimum and self declaration should be allowed to the maximum extent feasible.
- Hands-on assistance in filing applications should be made available to individuals and families who are likely to experience difficulty in completing all requirements for the filing of an application for financial assistance or Medicaid. Special attention should be given to individuals with disabilities which impair their ability to file by mail or telephone. Home visits should be made when necessary to assure enrollment of severely disadvantaged persons.

AFDC and SSI

- SSI elderly and disabled recipients should be automatically eligible for Medicaid in all states.
- Verification requirements should be reduced.
- Outreach should be initiated to provide assistance to individuals and families who want to apply for AFDC and SSI benefits.

End Notes

[1]Sarah C. Shuptrine and Vicki C. Grant, Assessment of Medicaid Eligibility Process in Chatham County, Georgia (Savannah, GA: Memorial Medical Center, June 1991); and Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, Improving Access to Medicaid for Pregnant Women and Children (Atlanta: Grady Memorial Hospital and the Robert Wood Johnson Foundation, February 1993).

[2]Improving Access to Medicaid for Pregnant Women and Children, 31.

[3]Assessment of Medicaid Eligibility Process in Chatham County, Georgia, pp 55-60; and Improving Access to Medicaid for Pregnant Women and Children, pp 23-24.

[4]Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, Addressing the Need for Outreach to Pregnant Women and Children in Georgia, for the Georgia Department of Medical Assistance (Columbia, SC: Sarah Shuptrine and Associates, March 1994).

APPENDIX A

IMPLICATIONS OF THE AMERICANS WITH DISABILITIES ACT FOR HEALTH CARE REFORM PROPOSALS

Bazelon Center for Mental Health Law

The Americans with Disabilities Act requires all public entities to evaluate their current services, policies and practices to determine whether they meet the legal requirements of non-discrimination against individuals with disabilities.

The public entity must reasonably modify the practices and policies to avoid discriminating against people with disabilities. For example, an enrollment process that is extremely lengthy and complex may discriminate against individuals with mental disabilities who may be unable to complete the process successfully. As a result, these individuals would be effectively denied access to a health plan to which they may otherwise be eligible. In this case, the health plan has an obligation to make reasonable modifications to its enrollment process to ensure that otherwise eligible individuals are not denied benefits. Modifications to the enrollment process might include simplifying the enrollment procedure, providing applicants who have mental disabilities with individualized assistance to complete the process or securing necessary information from other sources with the applicant's consent.

A public entity is not required to provide individuals with disabilities with personal or individually prescribed devices such as wheelchairs, prescription eyeglasses or hearing aids. However, public entities must maintain, in working order, equipment and features of facilities that are required to provide ready access to individuals with disabilities. For example, a health plan that provides individualized assistance for the enrollment process must keep its elevator in working order to be accessible to people who use wheelchairs.

The ADA prohibits the use of criteria that "tend to" screen out individuals with a disability. The concept makes it discriminatory to impose policies or criteria that indirectly prevent or limit the ability of some individuals to participate. For example, a health plan may require proof of a permanent residence to establish eligibility. Accepting only a driver's license to establish residency would violate the ADA because individuals with severe vision impairment, developmental disabilities and epilepsy cannot apply for drivers licenses. Since the health plan could use an alternative means to establish residency, they must do so to avoid violating the ADA.

While the legislation does not require private entities to perform the same evaluation, they cannot discriminate against people with disabilities when providing services.

APPENDIX B

TABLE 2
AFDC APPLICATIONS DENIED BY REASON
BY STATE AND U.S., FFY 1991

Area	% Of Applications Denied	No. Of Cases Denied	No. Of Individuals Denied	Percentage Of Cases Denied By Reason			
				Excess Income	Excess Resources	Failure To Comply	Other
UNITED STATES	26.9%	1,111,161	3,137,033	20.4%	4.4%	59.7%	15.5%
ALABAMA	26.8%	7,547	21,307	22.6%	1.8%	67.7%	7.9%
ALASKA	33.4%	5,332	15,053	41.2%	19.1%	8.5%	31.2%
ARIZONA	36.2%	27,466	77,542	23.2%	6.9%	49.3%	20.6%
ARKANSAS	38.4%	17,039	48,105	26.8%	1.9%	60.4%	10.9%
CALIFORNIA	25.2%	157,632	445,027	13.2%	5.0%	59.2%	22.6%
COLORADO	42.6%	26,333	74,343	9.8%	3.5%	83.7%	3.0%
CONNECTICUT	31.7%	11,811	33,345	14.7%	4.1%	56.2%	25.0%
DELAWARE	25.8%	2,339	6,603	39.3%	6.2%	41.1%	13.3%
DC	32.6%	4,526	12,778	24.4%	13.1%	36.9%	25.6%
FLORIDA	35.5%	83,489	235,706	9.11%	1.1%	85.4%	4.5%
GEORGIA	38.8%	56,545	159,638	18.8%	1.4%	68.9%	10.9%
GUAM	28.7%	256	723	10.5%	6.3%	70.7%	12.5%
HAWAII	23.8%	2,941	8,303	35.0%	19.1%	32.5%	13.4%
IDAHO	29.1%	4,723	13,334	39.9%	5.5%	37.2%	17.4%
ILLINOIS	23.7%	33,811	95,455	5.6%	0.5%	88.5%	5.5%
INDIANA	27.8%	18,857	53,237	24.1%	2.3%	66.4%	7.2%
IOWA	26.7%	13,583	38,348	32.3%	3.8%	46.6%	17.3%
KANSAS	15.9%	5,000	14,116	60.2%	4.6%	29.9%	5.4%
KENTUCKY	25.3%	17,350	48,983	18.9%	4.8%	61.2%	15.1%
LOUISIANA	24.7%	21,922	61,890	28.2%	6.1%	47.0%	18.8%
MAINE	27.7%	5,647	15,943	36.8%	7.7%	35.6%	20.0%
MARYLAND	29.0%	19,231	54,293	24.4%	3.6%	58.6%	13.5%
MASSACHUSETTS	19.1%	12,088	34,127	13.3%	6.8%	68.8%	11.2%
MICHIGAN	29.7%	64,910	183,254	28.6%	5.9%	54.8%	10.6%
MINNESOTA	11.5%	6,584	18,588	29.1%	10.3%	54.7%	6.0%
MISSISSIPPI	31.1%	14,249	40,228	29.1%	4.4%	40.3%	26.2%
MISSOURI	22.9%	13,732	38,768	54.5%	6.2%	32.1%	7.1%
MONTANA	3.4%	404	1,141	27.7%	10.4%	39.1%	22.8%
NEBRASKA	7.2%	766	2,163	53.4%	7.8%	2.6%	36.2%
NEVADA	44.5%	12,577	35,507	16.0%	0.9%	76.3%	6.8%
NEW HAMPSHIRE	40.2%	5,955	16,812	28.9%	6.8%	31.4%	32.8%
NEW JERSEY	12.0%	12,683	35,807	20.0%	29.0%	41.0%	10.0%
NEW MEXICO	34.5%	11,720	33,088	29.1%	9.7%	38.1%	23.1%
NEW YORK	4.8%	14,405	40,668	27.9%	5.2%	64.8%	2.0%
NORTH CAROLINA	16.8%	20,321	57,370	32.9%	6.3%	24.1%	36.7%
NORTH DAKOTA	21.3%	1,386	3,913	38.1%	15.8%	30.5%	15.6%
OHIO	26.3%	23,422	66,125	32.6%	2.6%	53.3%	11.5%
OKLAHOMA	25.9%	13,934	39,339	30.9%	2.6%	44.2%	22.2%
OREGON	13.8%	4,002	11,298	18.0%	11.1%	57.5%	13.3%
PENNSYLVANIA	20.2%	30,064	84,877	26.2%	3.5%	67.9%	2.5%
PUERTO RICO	22.3%	5,953	16,807	0.0%	17.6%	69.0%	13.4%
RHODE ISLAND	24.4%	4,466	12,608	28.2%	6.6%	57.6%	7.6%
SOUTH CAROLINA	30.6%	19,272	54,409	19.9%	4.3%	67.8%	8.1%
SOUTH DAKOTA	10.6%	1,332	3,761	25.2%	6.1%	20.0%	48.8%
TENNESSEE	22.3%	16,930	47,797	43.8%	3.3%	36.9%	16.0%
TEXAS	45.9%	156,445	441,676	12.6%	2.3%	69.2%	15.9%
UTAH	26.7%	6,626	18,707	32.4%	4.6%	41.9%	21.1%
VERMONT	32.9%	5,082	14,348	31.2%	7.3%	26.8%	38.1%
VIRGIN ISLANDS	15.6%	107	302	11.2%	6.5%	55.1%	27.1%
VIRGINIA	30.4%	20,298	57,305	22.9%	2.1%	58.9%	16.0%
WASHINGTON	30.4%	26,223	74,033	20.2%	2.9%	71.8%	5.1%
WEST VIRGINIA	17.1%	5,943	16,778	24.7%	7.2%	61.9%	6.2%
WISCONSIN	37.0%	33,447	94,428	27.4%	6.1%	7.9%	58.6%
WYOMING	28.4%	2,455	6,931	29.0%	10.9%	56.0%	4.0%

Source: Calculations by Sarah Shuptrine and Associates of data from "Quarterly Public Assistance Statistics," FFY 1991, Office of Family Assistance, Family Support Administration, US Dept. of Health and Human Services.

Notes: 1) The number of individuals was estimated based on an average number of persons per case of 2.82.
2) "Other" reasons for denial are "no eligible child," "child not deprived of support or care," "alien," "nonresident," and "not specified."

APPENDIX C

TABLE 3
MEDICAID ELIGIBILITY CRITERIA AND ADMINISTRATION OF ELIGIBILITY DETERMINATIONS FOR SSI RECIPIENTS, APRIL 1994

AUTOMATIC "1634"[1]	NONAUTOMATIC SSI CRITERIA[2]	NONAUTOMATIC "209(b)"[3]
32	7	12
Alabama	Alaska	Connecticut
Arizona	Idaho	Hawaii
Arkansas	Kansas	Illinois
California	Nebraska	Indiana
Colorado	Nevada	Minnesota
Delaware	Oregon	Missouri
DC	Utah	New Hampshire
Florida		North Carolina
Georgia		North Dakota
Iowa		Ohio
Kentucky		Oklahoma
Louisiana		Virginia
Maine		
Maryland		
Massachusetts		
Michigan		
Mississippi		
Montana		
New Jersey		
New Mexico		
New York		
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee		
Texas		
Vermont		
Washington		
West Virginia		
Wisconsin		
Wyoming		

Source: Updated by Sarah Shuptrine and Associates from Characteristics of State Assistance Programs for SSI Recipients January 1990, SSA, SSA Pub. No. 17-002.

Notes: 1) Medicaid eligibility is based on SSI criteria and eligibility is determined by the Social Security Administration. These "1634" states require a single application for SSI and Medicaid. 2) Medicaid eligibility is based on SSI criteria and eligibility is determined by the State. Separate applications are required for SSI and Medicaid. 3) Medicaid eligibility is based on state rules that may be more restrictive than SSI criteria and eligibility is determined by the state. These "209(b)" states require separate applications for SSI and Medicaid.