ACAP Association for Community Affiliated Plans

11/16/2007

FACT SHEET:

SURVEY RESULTS:
The Impact of Citizenship Documentation on Safety Net Health Plans

Introduction

The Deficit Reduction Act of 2005 DRA included new citizenship and identity documentation requirements for all Medicaid applicants claiming to be citizens of the United States. These requirements, which went into effect July 1, 2006, were ostensibly intended to restrict ineligible noncitizens from participating in Medicaid, but were widely expected to have a broader negative impact on many Medicaid enrollees, state programs, and the safety net providers and health plans that serve these individuals.

Since that time, the effect of the rule has been documented. Several reports provide evidence that new enrollment in Medicaid programs has decreased and state administrative costs have increased. George Washington University, in partnership with the National Association of Community Health Centers, published a report asserting that "documentation requirements have caused a nationwide disruption in coverage for health center patients, with more than 90 percent of all health centers reporting enrollment difficulties for patients of all ages, including newborn children." Very recently, the Center on Budget and Policy Priorities published a study showing that following implementation of the rule, Medicaid enrollment declined by a larger percentage among African American and Caucasian children than among Latino children, and that citizen children have been removed from Medicaid rolls because of difficulty gathering the required documentation.

The Association of Community Affiliated Plans (ACAP) undertook a survey of its own members – 34 nonprofit, community-based safety net health plans serving primarily Medicaid enrollees – to assess the effect of the new rule on health plans serving Medicaid. The survey included questions on state policies and practices, impact on enrollment and reenrollment, and expenditure of resources by health plans. (The survey also asked general questions related to health plans' experiences with redetermination.) Twenty-eight health plans representing 16 states[1] responded to the survey; each question received between twenty-four and twenty-six responses. These states are home to 47 percent of all Medicaid managed care enrollees and 48 percent of all Medicaid enrollees in the United States.

Twelve months after the citizenship and identify documentation rule went into effect, health plans provide a varied view on the overall impact. Most of the respondents operate in states

[1] AZ, CA, CO, CT, IN, MD, MA, MI, NJ, NY, OH, OR, RI, SC, VA and WA.

that have followed federal rules and implemented the requirements. Nearly 50 percent of plans responding have experienced decreases in new enrollment and increases in disenrollment at redetermination. Some have committed additional resources to training and hiring staff. Others appear not to have experienced substantial reductions in enrollment or increases in administrative expenses, although this may be due to the hard work of the plans themselves, who have conducted outreach and application assistance activities on behalf of applications and enrollees affected by the rule.

The aggregated responses to the survey questions are summarized below.

State Practices

- Of the 25 respondents, 18 plans representing 15 states (Arizona, Colorado, Connecticut, Indiana, Maryland, Massachusetts, Michigan, New Jersey, New York, Ohio, Oregon, Rhode Island, South Carolina, Virginia and Washington) confirmed that their states had implemented the DRA's citizenship and identity documentation requirements. These states are home to 36 percent of all Medicaid managed care enrollees and 34 percent of all Medicaid enrollees in the U.S[2].

- Four plans representing two states (California and Rhode Island) responded that their states have not yet implemented the rules. (Several states have delayed implementation of the rules, and others have avoided an impact on enrollees by employing various protective policies.)

- When asked whether states electronically match for citizenship and identity using birth records, motor vehicle registries and other government data bases, respondents representing four states (Arizona, Massachusetts, Maryland and Washington) said their states do. However, another block of responding plans said their states, including Michigan, New Jersey, New York, Ohio, Rhode Island and South Carolina, do not utilize electronic data matches. Plans from California and Connecticut also said that although their states do not use electronic matching now, they plan to do so eventually.

- The states of several respondent plans have already made strides in documenting the citizenship and identity of Medicaid enrollees. Although a majority of respondents (15) stated they were not aware what progress their states have made, three plans, all in Massachusetts, said their state has completed the documentation process for 71 to 80 percent of all enrollees, and another, from Maryland, said its state had done so for 61 to 70 percent of all enrollees.

Impact on Health Plan Enrollment and Reenrollment

The survey queried respondents about the impact of the rule on enrollment and reenrollment.

[2] Medicaid enrollment data and Medicaid managed care enrollment data from Centers for Medicare and Medicaid Services as of December 31, 2006. Available: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcpr06.pdf.

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- New member enrollment has decreased among just under 50 percent (9 plans) of those respondents whose states have implemented citizenship and identity documentation and that were able to answer the question. These nine plans represent Colorado, Connecticut, Maryland, Massachusetts, Michigan, New York, Ohio, Oregon and Rhode Island. Eight plans (42 percent) – from Colorado, Connecticut, Maryland, Massachusetts, Michigan, New York, Ohio, Oregon and Rhode Island – have not experienced a decrease in new enrollment. Two plans expressed that they experienced an increase in enrollment, although one of these, in New York State, suggests that the increase is due to other factors, including a new contract cycle and plan growth to cover a larger geographic area.

- Individuals already enrolled in Medicaid are required to undergo periodic eligibility redetermination, typically every six or twelve months, depending on state policy. The new rule asserts that currently-enrolled individuals must document their citizenship and identity upon redetermination. Eight (47 percent) of the 17 plans whose states have implemented citizenship and identity documentation and that were able to answer the question said that reenrollment has decreased. These plans represent Colorado, Maryland, Massachusetts, New York, South Carolina and Virginia. No plans surveyed have seen reenrollment increase, but 53 percent of respondents (9 plans) have experienced no change in reenrollment numbers. These plans are in Arizona, Connecticut, Massachusetts, New Jersey, New York and Washington.

- Plans were also asked whether their states track disenrollment to learn specifically whether citizenship documentation is the cause for failure to reenroll. Most plans were unable to respond to the question because they were not certain of the answer or their states had not yet implemented the rule. Of the 8 plans that did answer, half (4) said their states (Arizona, Connecticut, Massachusetts, and South Carolina) do track this information, and half (in Maryland, Massachusetts, Michigan, New York and Ohio) said they do not.[3]

New Burden on Health Plan Resources

- Respondent health plans were queried about resource outlays resulting from the citizenship and identity documentation requirements. With some exceptions, most plans have not yet expended significant new resources related to the rule, although some have made staffing changes and have changed mailings and materials to explain the rule. Costs were related to staff time for keeping updated on the new requirements, hiring outside firms to inform and help enrollees, and hiring new staff to review applications.

    - The majority of plans have not hired new staff to meet the new requirements, although two plans have done so, and a third has contracted with a community agency and legal aid firm to provide training to other key community organizations on the requirements and to deal with difficult cases.

[3] Plan responses provide contradictory information about state practices.

- Half of the plans (11) able to respond to the question and whose states have implemented the rule said they have conducted special trainings of existing or new staff, while 10 have not. One plan has developed an ad hoc committee that meets to determine how to best educate both members and providers on the rule, plus disseminate information from the state on the rule to staff.

Conclusion

One year after implementation of the citizenship and identify documentation provision, the impact – from the health plan perspective – on states, enrollees and health plans is real, but varied. Some health plans appear not to have experienced substantial reductions in enrollment or increases in administrative expenses. Additional information collected in the survey shows, however, that others have mitigated the impact of the rule by conducting outreach to enrollees at redetermination and providing assistance specifically related to citizenship documentation upon member enrollment. That any plan has experienced a decrease in enrollment suggests that it is likely that individuals eligible for Medicaid are leaving the program unnecessarily.

Recently introduced Senate legislation to reauthorization the State Children's Health Insurance Program (SCHIP) includes a provision to moderate this requirement in Medicaid by allowing states greater flexibility to accept social security numbers as proof of citizenship and identity. However, the provision also applies citizenship documentation standards to SCHIP, potentially expanding the impact of the rule. ACAP will continue to monitor the effects of the rule on Medicaid and, if the provision passes, on SCHIP. ACAP's wishes to see fewer obstacles to enrollment and eligibility for health care coverage for low-income and vulnerable individuals, and therefore generally holds that a greater effort to reverse the rule is needed.