Connecticut Health
FOUNDATION

Policy Brief

No Wrong Door: Improving Health Equity and the Health Coverage Consumer Experience in Connecticut

August 2013

KEY FINDINGS

- **Over the course of a year, "No Wrong Door" (NWD) would prevent 36,000 Connecticut residents from losing health insurance coverage for at least part of the year.**
- **Fully implemented, the Affordable Care Act with NWD would reduce the percentage of uninsured adults for Blacks (from 15.9 percent to 7.7 percent), Hispanics (from 21.0 percent to 10.3 percent), and Asian Americans (from 12.6 percent to 6.4 percent), thereby contributing to health equity.**
- **NWD would improve the consumer experience at the time of coverage enrollment and renewal.**
- **NWD could yield administrative efficiencies for the state.**

OVERVIEW

"No Wrong Door" (NWD): A system that allows consumers to apply for health insurance through different agencies, and then seamlessly routes them to the program for which they qualify. Full implementation is critical in order for the Affordable Care Act (ACA) to accomplish its goals.

Even without NWD, the ACA would increase the number of state residents with health insurance. However, adding NWD would increase that enrollment figure by 13 percent, with the greatest advantage accruing to children and people of color. With full implementation of NWD, over the course of a year, 36,000 people who would otherwise experience periods without coverage will instead be continuously insured.

Connecticut's leaders have committed to full implementation of NWD by the end of 2015. If this commitment is fulfilled, significant gains will result for both state government and residents. However, monitoring implementation efforts is critical as the state "opens the health insurance door" to tens of thousands of consumers.

THE AFFORDABLE CARE ACT REQUIRES A BETTER APPROACH: "NO WRONG DOOR"

Once Medicaid (administered by DSS, the Department of Social Services) eligibility rules change and new subsidy programs in Access Health CT (AHCT), the state's health insurance marketplace, become available in 2014, there is an increased risk that consumers who qualify for assistance from either DSS or AHCT could be forced to move from program to program or agency to agency in seeking coverage. Some could fall through the cracks and become uninsured. Such gaps are a common feature of coverage efforts with multiple programs serving different populations.[1] These problems could undermine efforts to enroll many of the approximately 338,000 people in Connecticut currently lacking health insurance (Figure 1).

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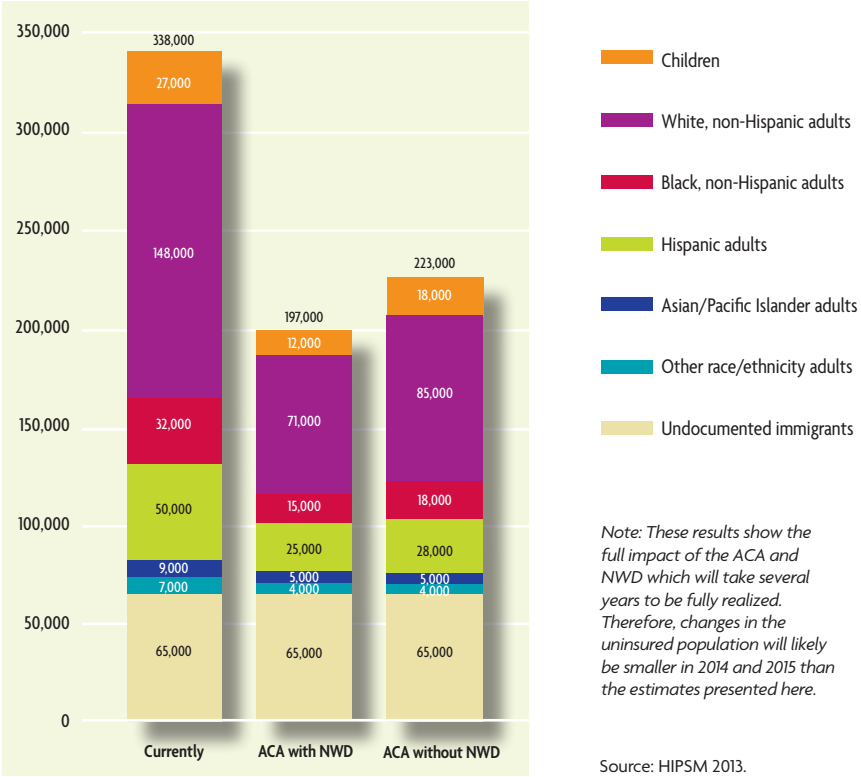
METHODS SUMMARY

The impact of NWD under the ACA was analyzed using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). The analysis began with a large, representative sample of Connecticut residents from the U.S. Census Bureau's American Community Survey. Coverage options for each surveyed individual and family – e.g. Medicaid, CHIP, AHCT (with or without subsidies), and employer offers of coverage – were identified. Decisions each individual and family would most likely make are predicted using equations based on health economics literature and other observations. These equations take into account factors such as affordability (both premiums and out-of-pocket health care costs), family disposable income, individual health needs, and the tax implications of each choice, including the effects of the ACA's individual mandate.[2] The simulations show what would happen to Connecticut residents without the ACA; under the ACA without NWD; and under the ACA with NWD. **Please visit http://bit.ly/nowrongdoor for detailed methods and estimates.**

Figure 1. The Uninsured in Connecticut, by Racial/Ethnic Group[3]



Note: These results show the full impact of the ACA and NWD which will take several years to be fully realized. Therefore, changes in the uninsured population will likely be smaller in 2014 and 2015 than the estimates presented here.

Source: HIPSM 2013.

Through the Affordable Care Act, the country is now committed to a streamlined process for eligible consumers to get help applying for, paying for, and staying enrolled in health insurance coverage. The consumer-friendly system design of "No Wrong Door" accomplishes several goals:

- **Less frustration and lost paperwork:** One simplified form can be used to apply for all state insurance affordability programs. Regardless of how the application is filed – by mail, phone, online, or in-person – or with what agency, all agencies work together to ensure that each consumer is routed to the correct program.
- **Easier renewal process:** When coverage must be renewed, agencies assess eligibility and route each beneficiary to the proper program. Information from the consumer is required only when absolutely essential to redetermining eligibility.
- **Greater numbers of insured:** With fewer consumers giving up in frustration or seeking assistance through the "wrong" agency, and an easier renewal process, more people will become – and stay – insured.
- **Greater administrative efficiencies and reduced costs:** Once one agency has determined facts relevant to eligibility (e.g. income, citizenship, immigration status), other agencies are not forced to waste resources making that same determination. And when fewer consumers are terminated for procedural reasons, fewer cycle back to re-apply for coverage, forcing state officials to redetermine eligibility. Also, the use of automated eligibility determination could reduce costs for health and human services programs, meaning fewer taxpayer dollars spent on administration and more going to help families in need, even within capped programs.

Monitoring implementation efforts is critical as the state "opens the health insurance door" to tens of thousands of consumers.

WHAT WILL NO WRONG DOOR LOOK LIKE IN CONNECTICUT?

Connecticut has a goal of fully implementing NWD by the end of 2015, though at the time of writing, many details were still being worked out at state and federal levels. As envisioned by state officials, the AHCT and DSS websites will eventually be consolidated into a single portal. Regardless of where consumers initiate applications – online, by phone, in-person, or by mail – they will be able to:

- **learn** if they are eligible for Medicaid or the Children's Health Insurance Program (CHIP) (sometimes referred to as "HUSKY" programs);
- **learn** whether they qualify for subsidies to buy health insurance from AHCT;
- **shop** for health plans;
- **enroll** in whatever form of coverage is available to them, whether private insurance, Medicaid or CHIP;[4] and
- **learn** if they are eligible for other programs administered by DSS, such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF).[5]

NO WRONG DOOR INCREASES THE NUMBER OF INSURED

In addition to simplifying interactions with DSS and AHCT, fully implementing the NWD approach would increase the number of Connecticut residents with health insurance. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), the number of people who would be covered under the ACA with and without full implementation of NWD was simulated.

Estimates show that full implementation of NWD would yield the following results:

- At any point in time, about 20,000 more adults would have insurance coverage than under the ACA without NWD: 16,000 through Medicaid, and 4,000 through plans sold through AHCT. This represents a 30.2 percent increase in the number of adults who would gain coverage under Medicaid, compared to ACA implementation without NWD, and an 11.4 percent increase in the number of adults gaining coverage through AHCT (Figure 2).
- At any point in time, about 6,000 additional children would have insurance coverage, primarily through Medicaid and CHIP. This number represents just over 50 percent of children who are currently uninsured and legally resident in the state. Without NWD, the share gaining coverage under the ACA drops to just over 30 percent (Figure 3).
- Some people are uninsured only part of a year due to "churning" – when changing circumstances affect eligibility. As a result, the number of people uninsured for some part of the year is higher than the uninsured number at any given time. Over a year, NWD would prevent an estimated 36,000 people from losing health coverage for at least part of the year.

Figure 2. ACA Coverage of Currently Uninsured Adults

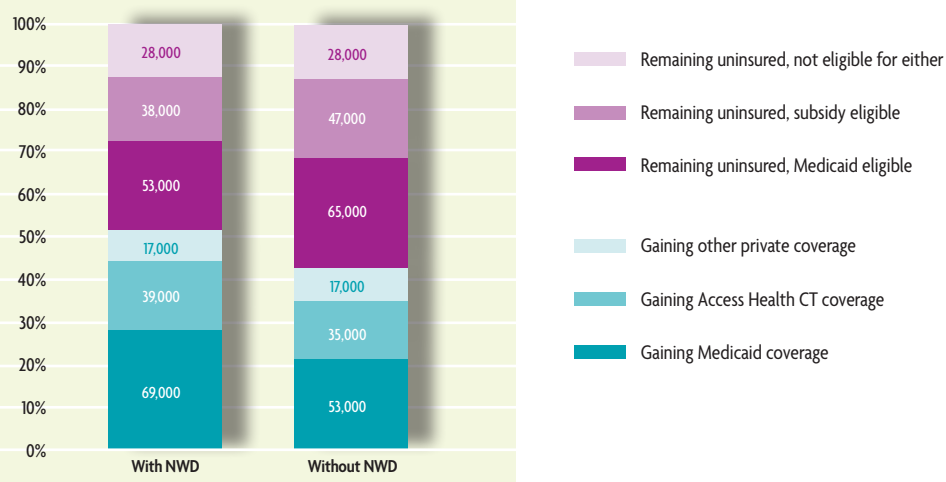
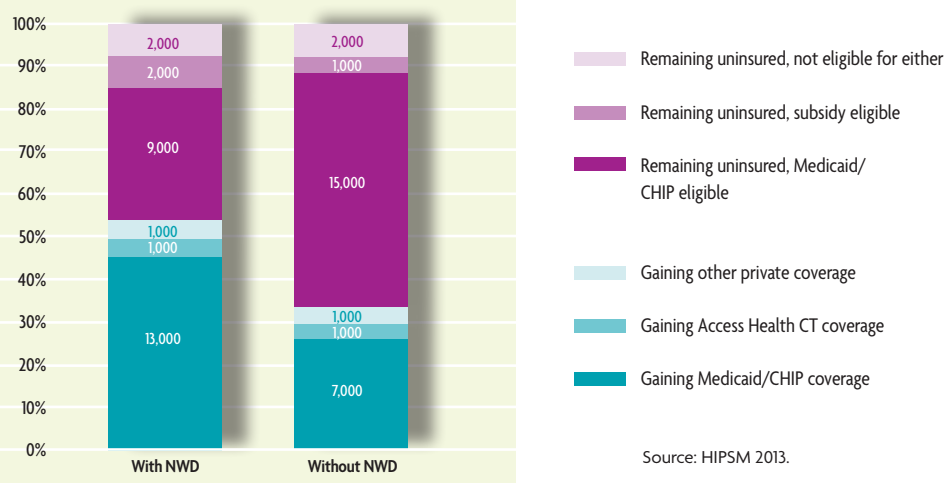


Figure 3. ACA Coverage of Currently Uninsured Children



Source: HIPSM 2013.

Figures are limited to U.S. citizens and lawfully present immigrants.

NWD EXPANDS HEALTH EQUITY FOR PEOPLE OF COLOR

Making the process simple and accessible will help equalize rates of new enrollment for almost all racial and ethnic groups (Table 1). Trying to navigate several different application processes for separate programs with different requirements can be particularly burdensome to those who already experience disparities in health coverage – particularly when different family members are eligible for different types of coverage (e.g. if children qualify for CHIP and their parents qualify for subsidized AHCT coverage).

What about undocumented immigrants? Of the 338,000 people in Connecticut currently without insurance, an estimated 65,000 are undocumented immigrants.[6] Undocumented immigrants are not eligible for either Medicaid or enrollment in AHCT, are not affected by NWD, and are thus separated from the rest of the uninsured estimates. Lawfully present immigrants are included in the estimates.

Table 1. Uninsured Rates of Connecticut Residents, by Racial/Ethnic Group

	Pre-ACA	Post-ACA with NWD		Post-ACA without NWD	
	uninsured rate	uninsured rate	% change	uninsured rate	% change
Adults	11.6%	5.6%	-51.2%	6.6%	-42.9%
• White, non-Hispanic	9.4%	4.5%	-51.8%	5.4%	-42.8%
• Black, non-Hispanic	15.9%	7.7%	-51.8%	9.1%	-43.1%
• Hispanic	21.0%	10.3%	-50.7%	11.9%	-43.3%
• Asian/Pacific Islander	12.6%	6.4%	-49.1%	7.0%	-44.1%
• Other race/ethnicity	19.5%	11.4%	-41.4%	11.3%	-42.3%
Children*	3.3%	1.5%	-54.7%	2.2%	-33.7%

Source: HIPSM 2013

Note: Results are limited to U.S. citizens and lawfully present immigrants.

** Connecticut has covered a much higher percentage of children than adults. As a result, sample sizes for children who are expected to remain uninsured are too small for a detailed analysis by race/ethnicity.*

REACHING PEOPLE WHO WILL REMAIN UNINSURED

Experience shows that most consumers eligible for insurance affordability programs under the ACA will participate, particularly if NWD is fully implemented. Additional enrollment efforts could potentially reach the small population that would otherwise not enroll.

Language and cultural barriers potentially affect a large percentage of non-participants: Of 120,000 legally resident adults who are expected to remain uninsured even with NWD, more than 30 percent do not speak English at home (see Appendix B: Detailed Estimates Table B.1 **online**). Navigators and community assisters can help participants of different linguistic and cultural backgrounds. Specific information about Connecticut's Navigator and Assister Program was not available at this writing and its effect was not modeled. Adequately funded, linguistically and culturally competent community education and hands-on assistance are vital for disadvantaged groups to receive the full benefits of the ACA.[7]

CONNECTICUT'S TRANSITION TO NWD BY DECEMBER 2015

The analysis shows the potential impact of NWD for Connecticut residents. Among other implications, the number of uninsured will be directly affected by where the state falls on the continuum between full and no implementation of NWD.

During the two years needed for transition to full implementation of NWD (2013-2015), implementation will be hampered by the limited capacity of DSS's legacy computer system – used for Medicaid and CHIP eligibility – to interact with external databases.

One important question is: *During the transition, how will the state distribute the burden of compensating for limitations in the state's information technology (IT) system? To what extent will the state shoulder the burden (e.g., by hiring staff for manual information processing)? How much will consumers shoulder the burden (e.g., through waiting for coverage decisions or being required to furnish the same information multiple times to different agencies)?*

In addition, many other questions must be answered to ensure that the NWD approach is implemented as envisioned in the federal legislation. **These questions can help develop an agenda for the state and advocates to monitor how implementation is affecting low- and moderate-income consumers and, when problems emerge, to generate effective solutions.**

KEY POLICY QUESTIONS INCLUDE

When someone who qualifies for Medicaid or CHIP based on ACA's new income rules ("MAGI")[8] applies for coverage through AHCT:

- Will AHCT determine eligibility or merely assess eligibility and then transfer the applicant's file to DSS for the final determination?
- If AHCT determines eligibility, what further steps (if any) will be needed for the consumer's coverage to be fully activated at DSS? How will the consumer receive health coverage in the interim? What else will happen to the consumer?
- If AHCT assesses rather than determines eligibility, other questions arise.
    - If AHCT finds a consumer is likely to qualify for Medicaid, how will the applicant's case file be transferred electronically to DSS for determination, as required by federal Medicaid? How will the state overcome the barriers posed by DSS's legacy system?
    - If AHCT has verified eligibility using measures permitted by federal law, under what circumstances (if any) will DSS require additional verification before granting eligibility?
    - Under what circumstances (if any) will DSS require or allow caseworkers to use their discretion before confirming eligibility?
    - How much time will pass between the initial submission of the application to AHCT and DSS's final eligibility determination? How will the consumer receive health coverage in the interim? What else will happen to the consumer?

When someone who qualifies for Medicaid through categories not subject to MAGI rules – for example, aged, blind, and disabled coverage – applies through AHCT:

- How will such consumers be identified and informed of their right to seek Medicaid eligibility determinations on a non-MAGI basis? Will those procedures be automated?
- Will these consumers receive subsidized AHCT coverage while they complete the Medicaid eligibility determination process on non-MAGI grounds? That process can be lengthy, particularly if it involves a disability determination.

When people who qualify for subsidies to help pay for plans that are sold through ACHCT apply for coverage through DSS:

- How, after DSS has determined that the consumer is ineligible for Medicaid and CHIP because he or she exceeds income limits, will the case file and relevant verification be transferred to AHCT, given the limitations of DSS's IT system?
- Will consumers be denied AHCT subsidies unless they give AHCT some of the same information they already provided to DSS?
- What delays (if any) will result from the "handoff" from DSS to AHCT? How will the consumer receive health coverage in the interim? What else will happen to the consumer?

For each of the above issues, there are additional questions:

- How will DSS and AHCT prevent eligible consumers from losing coverage at renewal?
- Will the path the consumer takes vary based on whether they apply online, by phone, in-person, or by mail?
- What happens when coverage is denied?

CONCLUSION

Connecticut's leaders have articulated an exciting, consumer-friendly vision of NWD implementation. Fully implemented, NWD could mean the difference between continuous coverage and periods of uninsurance for 36,000 Connecticut residents, and would contribute to health equity for people of color. But careful monitoring of many operational details will be needed over the next two years to see whether and how policymakers overcome significant obstacles and put this inspiring vision into practice.

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ENDNOTES

1. Studies documenting this include Ketsche, Patricia, E. Kathleen Adams, Angela Snyder, Mei Zhou, Karen Minyard, and Rebecca Kellenberg. Dec. 2007. "Discontinuity of Coverage for Medicaid and S-CHIP Children at a Transitional Birthday." *Health Services Research*. 42(6 Pt 2):2410-23; Sommers, Benjamin D. 2005. "The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP." *Health Affairs* 24 (6): 1611–8; and Kronebusch, Karl, and Brian Elbel. May/June 2004. "Simplifying Children's Medicaid And SCHIP." *Health Affair*s 23(3):233-246.

2. The Urban Institute's Health Microsimulation Capabilities. Washington, DC; The Urban Institute; 2012. http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf

3. All numbers in Figure 1 are rounded to the nearest thousand; this rounding hides the difference in coverage for the two smallest racial and ethnic groups.

4. Kristin Dowty, Connecticut DSS. May 1, 2013. "Access Health CT and HUSKY Programs," http://www.ctvoices.org/sites/default/files/files/CCKF/CCKF%20Mtg%20Handouts%20May%202013/AccessHealthCTHUSKY050113KD.pdf

5. Eligibility for all DSS programs will be integrated into NWD (Dowty 2013).

6. Estimated using American Community Survey data. See Appendix A: Methods, available online, for details.

7. For an example of the remarkable effectiveness of such strategies, see G.Flores et al. "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." Pediatrics. 116.6. (December 2005).

8. Modified Adjusted Gross Income rules apply to children, parents, pregnant women, and low-income adults. Most eligibility categories exempt from MAGI involve people who are over age 65, blind or disabled.

This policy brief presents analysis from the Urban Institute Health Policy Simulation Model (HIPSM) commissioned by the Connecticut Health Foundation.

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