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Expanding Medicaid to Low-Income Individuals: Action Must Be Taken to Ensure Eligibility Results in Enrollment

*William VanMeter**

I. INTRODUCTION

Uninsured adults are more likely to forgo needed medical treatment than adults with private insurance coverage.[1] However, Medicaid insurance increases the chance that a low-income person will have access to health care.[2] In an effort to improve low-income adults ability to access health care, the Patient Protection and Affordable Care Act (PPACA) expands Medicaid eligibility to all people at or below 133 percent of the Federal Poverty Line (FPL).[3] While eligibility for insurance is the first step to improving access to health care for low-income individuals, obstacles may still prevent them from receiving care. Even after eligibility is extended, the newly eligible must enroll to obtain Medicaid insurance.[4]

This article examines the difficulty low-income individuals face when obtaining Medicaid insurance under new PPACA policies. Part II of this article briefly describes general Medicaid enrollment procedures. Next, Part III examines several of the problems associated with Medicaid enrollment. Part IV discusses solutions to Medicaid enrollment

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2012. Mr. VanMeter is a staff member of *Annals of Health Law*.

1. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 10 (Dec. 2010), http://www.kff.org/uninsured/upload/7451-06.pdf [hereinafter UNINSURED KEY FACTS].

2. *See id*. at 10 (stating that "The uninsured are far more likely than those with insurance to report problems getting needed medical care.").

3. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-146, § 2001, 124 Stat. 271, 271-73 (2010).

4. ELIZABETH CUSICK & KEN NIBALI, NAT'L ACAD. OF SOC. INS. STUDY PANEL ON MEDICARE/MEDICAID DUEL ELIGIBLES, CURRENT PROCESSES FOR ENROLLING MEDICARE/MEDICAID DUAL ELIGIBLES IN MEDICARE SAVINGS PROGRAMS AND EFFORTS TO INCREASE ENROLLMENT 5 (2005),

problems and specific state initiatives aimed at increasing Medicaid enrollment. Finally, this article concludes by analyzing the merits of the identified solutions.

II. APPLYING FOR MEDICAID

Individuals must apply to enroll in Medicaid; however, enrollment procedures vary, sometimes drastically, from state-to-state.[5] Generally, the procedure consists of completing a multi-page application and providing documentation of income, assets, and residency.[6] Many states also require in-person application at either a welfare or social security office.[7] For instance, in Illinois, applicants must visit the Department of Human Services (DHS) office.[8] Applicants with health problems that are unable to visit the office may request to have an application mailed to them.[9] These applicants must complete and return the application, and then are subject to a phone interview by a DHS staff member.[10] Additionally, some states even call for periodic verification of eligibility after initial enrollment.[11]

III. PROBLEMS WITH ENROLLMENT

For Medicaid expansion under the PPACA to be successful, newly eligible, low-income individuals must enroll in Medicaid.[12] Yet, eligibility for Medicaid does not necessarily translate into enrollment, as evidenced by the millions of individuals currently eligible for Medicaid that remain uninsured.[13] As recently as 2009, seventy percent of children eligible for Medicaid or Children's Health Insurance Program (CHIP) were uninsured.[14] Historically, eligible children do not remain uninsured because of their

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www.nasi.org/usr_doc/Current_Process.doc.

5. *Id.* at 5.

6. *Id.*; Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion – The Soft Underbelly of Health Care Reform*, 363 NEW ENG. J. MED. 2085, 2085 (Nov. 25, 2010).

7. CUSICK & NIBALI, *supra* note 4, at 5

8. *How to Apply for Medicaid*, ILL. DEP'T OF HEALTHCARE AND FAMILY SERVICES, http://www.hfs.illinois.gov/medical/apply.html (last visited May 5, 2011).

9. *Id.*

10. *Id.*

11. CUSICK & NIBALI, *supra* note 4, at 5 (verification of eligibility requires the enrollee to go through a similar process as the initial application and may require an additional visit to a government office.)

12. *See* Sommers & Epstein, *supra* note 6, at 2087 (commenting on enrollment being the key to successful health insurance expansion).

13. *Id.* at 2085.

14. AM. ACAD. OF PEDIATRICS, ACCESS: MEDICAID, CHIP, AND STATE MEDICAL HOME EFFORTS 1 (2011),

parents' failure to apply for Medicaid enrollment, but instead due to other administrative issues.[15]

Enrollment problems also extend to adults that are already eligible for coverage.[16] The average participation in Medicaid from 2007 to 2009 for eligible adults without any other health insurance alternative was 61.7 percent and enrollment among states varied from 44 percent to 88 percent.[17] Medicaid expansion may exacerbate enrollment problems, as states with the largest number of newly eligible adults under the PPACA are historically the worst at initial enrollment and maintaining enrollment for eligible adults.[18]

An eligible individual's failure to enroll in Medicaid often stems from perceived barriers to enrollment.[19] Barriers include difficulty completing the Medicaid application and lack of access to transportation, when in-person registration is required.[20] Parents of eligible children that started but failed to complete the enrollment processes reportedly withdrew because of the "difficulty of getting all the required papers (72%), overall hassle of the enrollment process (66%), and belief that the process was complicated and confusing (62%)."[21] In order for low-income individuals to benefit from Medicaid expansion, the enrollment process must be simplified and the perceived barriers to enrollment must be overcome.[22]

A 2005 survey on perceived enrollment barriers[23] found that forty percent of respondents interviewed at both urban and rural community health centers thought that

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http://www.aap.org/advocacy/access_slr.pdf.

15. MICHAEL PERRY ET AL., KAISER FAMILY FOUND., MEDICAID AND CHILDREN: OVERCOMING BARRIERS TO ENROLLMENT: FINDINGS FROM A NATIONAL SURVEY 8 (Jan. 2000), http://www.kff.org/medicaid/upload/Medicaid-and-Children-Overcoming-Barriers-to-Enrollment-Report.pdf [hereinafter OVERCOMING BARRIERS] (finding that twenty-one person of parents tried but could not complete the application process, twenty-one percent were denied coverage, and fifteen percent tried to enroll multiple times and had problems completing the process and gaining approval).

16. *See* Sommers & Epstein, *supra* note 6, at 2085 (discussing the Medicaid participation rates for eligible adults).

17. *Id.*

18. *Id.* (finding that the states that will have the most newly eligible adults are historically the worst at enrolling and keeping eligible adults enrolled in Medicaid, but not significantly worse).

19. Jennifer Stuber & Elizabeth Bradley, *Barriers to Medicaid Enrollment: Who is at Risk?*, 95 AM. J. PUB. HEALTH 292, 292 (2005).

20. *Id.*

21. OVERCOMING BARRIERS, *supra* note 15, at 9 (finding that seventy-two percent of parents had difficult getting the required documents, sixty-six percent found the process to be a hassle, and sixty-two percent thought the process was complicated and confusing).

22. *See* Stuber & Bradley, *supra* note 19, at 296 (finding that increased paperwork may make it more difficult to enroll in public insurance programs resulting in reduced enrollment).

23. *See id.* at 292-98 (identifying factors associated with perceived Medicaid enrollment barriers).

the Medicaid application was too long and complicated.[24] The respondents specifically identified several other enrollment barriers, specifically: difficulties accessing a translator, finding transportation to apply, and finding the documents required to apply.[25]

A prime example of a seemingly simple application requirement that negatively impacted enrollment is proof of United States citizenship.[26] After implementing the new requirement of presenting proof of citizenship, Medicaid enrollment declined.[27] Although the goal of demanding proof of citizenship was to prevent non-citizens from enrolling in Medicaid is laudable, U.S. citizens are often those burdened by the adverse affects.[28]

The citizenship requirement is evidence that enrollment procedures must be tailored towards simplification in order for the newly eligible to fully benefit from expanded Medicaid eligibility.[29] In fact, those newly eligible for Medicaid via the PPACA are primarily working-age adults without prior Medicaid experience.[30] Thus, because of the lack of experience with Medicaid enrollment procedures, enrollment procedures must be user friendly to help facilitate completion and ensure enrollment.[31]

A trend exists here for those already eligible and those that will be newly eligible from healthcare reform – enrollment is too difficult and actually prevents effective utilization of the services Medicaid is meant to provide. Despite a lack of effective utilization, or services where providers would receive payment, reduced Medicaid enrollment does not

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24. *Id.* at 294.

25. *Id.* (reporting that forty-one percent of respondents said it was difficult to find assistance from a translator, thirty-four percent agreed or strongly agreed they had difficulty finding transportation, and thirty percent agreed or strongly agreed that it was difficult to obtain the required documents).

26. Donna Cohen Ross, *New Medicaid Citizenship Documentation Requirement Is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up*, CTR. ON BUDGET AND POLICY PRIORITIES, 1 (rev. 2007).

27. *Id.* at 1, 4-7 (discussing the negative impact citizen require had on state Medicaid enrollment including: Wisconsin denying two-third of applications for lacking identify verification and 19.9 percent for not providing citizenship documents, Iowa experiencing a decline in Medicaid for three consecutive months for the first time in five years, Louisiana experiencing a net loss of nearly 15,000 children from its Medicaid program, and New Hampshire receiving half as many applications with all necessary documents).

28. *Id.* at 1, 4 (pointing to Wisconsin denying two-thirds of applications for failure to verify identity opposed to 19.9 percent for failure to provide citizenship documents as evidence that most people denied Medicaid were citizens).

29. *See* JULIA PARADISE, KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND. & MICHAEL PERRY, LAKE RESEARCH PARTNERS, OPTIMIZING MEDICAID ENROLLMENT: PERSPECTIVES ON STRENGTHENING MEDICAID'S REACH UNDER HEALTH CARE REFORM, 1 (Apr. 2010) (commenting on the need for easy enrollment processes to ensure Medicaid covers eligible individuals).

30. *Id.*

31. *See generally id.* at 1 (stating that individuals newly eligible for Medicaid do not have experience in

limit uninsured visits to emergency departments.[32] This burdens hospitals providing essential services and is not something we can accept, given available resources.[33]

IV. POSSIBLE SOLUTIONS TO ENROLLMENT PROBLEMS

Improving the enrollment rate among Medicaid eligible individuals will require the simplification of eligibility requirements so that applicants can easily ascertain their status before engaging in the enrollment process.[34] Additionally, the enrollment and renewal processes must pursue more streamlined avenues.[35] While these strategies will take time, introducing the public to Medicaid expansion in ways that encourage participation can operate as a quick approach to increasing enrollment.[36]

Methods to increase awareness, encourage participation, and simplify enrollment include: new outreach programs, use of automation and technology, diverse modes for enrollment, and partnering with community organizations.[37] Outreach programs may include using the media for public awareness.[38] At a most basic level, a change in organizational culture at state Medicaid agencies must occur in order for its expansion to be successful.[39] States originally took the roll of "gatekeepers" to reduce Medicaid fraud;[40] however, the hardship created by stringent enrollment procedures is in stark conflict with the goals of expanded coverage.[41] State Medicaid organizations must shift from their role as "gatekeepers," aimed at keeping non-eligible applicants out, to pro-coverage agents for eligible participants.[42]

Several states have already implemented programs to ease enrollment procedures and increase overall enrollment in Medicaid.[43] Specifically, Wisconsin has developed

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the program and commenting on the need for easy enrollment procedures).

32. *See Communities Matter*, COVER THE UNINSURED, http://covertheuninsured.org/content/communities-matter (last visited May 8, 2011) (commenting on the over crowding of emergency departments in both urban and rural areas).

33. Reed Abelson, *Uninsured Put a Strain on Hospitals*, N.Y. TIMES, Dec. 9, 2008, at B0.

34. *See* Sommers & Epstein, *supra* note 6, at 2086.

35. PARADISE & PERRY, *supra* note 29, at 1.

36. *Id.* at 1.

37. PARADISE & PERRY, *supra* note 29, at 1.

38. Sommers & Epstein, *supra* note 6, at 2086.

39. *Id.* at 7-8.

40. *Id.* at 7-8.

41. *Id.* at 7.

42. *Id.* at 7-8.

43. *See generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND.,

ACCESS, a web-based tool that assists in public benefits enrollment.[44] Oklahoma implemented a feature into SoonerCare that automatically enrolls newborn babies.[45] Additionally, Louisiana has utilized a strategy called Express Lane Eligibility (ELE) to simply enrollment.[46] ELE, as discussed below, is an effort to increase enrollment by individuals eligible for public benefits by allowing programs or agencies to use information that was previously provided to another agency. These programs offer viable solutions to improve enrollment of Medicaid-eligible participants.

Wisconsin's ACCESS is a web-based tool that allows residents to determine if they are eligible for benefits, apply for benefits, check benefits status, renew benefits, or report changes to eligibility for public benefits, including Medicaid.[47] Wisconsin provides numerous locations for assistance with and use of ACCESS, as it is aware that many low-income residents that receive benefits do not have Internet access.[48] These locations include: public libraries, county and tribunal agencies, health centers, and food pantries.[49] Additionally, ACCESS is written at a forth grade level to ensure that residents can understand and work through the application, and is available in both English and Spanish.[50] Furthermore, specialists are trained to help people that need assistance with the application process.[51]

Oklahoma implemented a feature into SoonerCare[52] that automatically enrolls

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OPTIMIZING MEDICAID ENROLLMENT: SPOTLIGHT ON TECHNOLOGY: WISCONSIN'S ACCESS INTERNET PORTAL, 1 (2010) [hereinafter WISCONSIN ACCESS]; *see generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., OPTIMIZING MEDICAID ENROLLMENT: SPOTLIGHT ON TECHNOLOGY: LOUISIANA'S EXPRESS LANE ELIGIBILTY, 1 (2010) [hereinafter LOUISIANA EXPRESS LANE]; *see generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., OPTIMIZING MEDICAID ENROLLMENT: SPOTLIGHT ON TECHNOLOGY: OKLAHOMA'S AUTOMATIC NEWBORN ENROLLMENT SYSTEM, 1 (2010) [hereinafter OKLAHOMA AUTOMATIC ENROLLMENT].

44. WISCONSIN ACCESS, *supra* note 43, at 1.

45. OKLAHOMA AUTOMATIC ENROLLMENT, *supra* note 43, at 1 (SoonerCare is Oklahoma's Medicaid program).

46. *See* NAT'L COUNCIL ON AGING, EXPRESS LANE ELIGIBILITY: NEW STRATEGIES FOR INCREASING ENROLLMENT 2-4 (June 2009), http://www.centerforbenefits.org/NCBOE_ELE_Issue_Brief_FINAL.pdf [hereinafter ELE ENROLLMENT] (Defining ELE and discussing methods to ensure ELE is successful. ELE is used to describe the processes of identifying a person in one public program that may be eligible for benefits in another public program, information sharing among public benefit programs, and auto-enrolling a person in a public benefit program when he is found eligible for another program.).

47. WISCONSIN ACCESS, *supra* note 43, at 1.

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *See* OKLAHOMA AUTOMATIC ENROLLMENT, *supra* note 43, at 1 (SoonerCare is Oklahoma's Medicaid program).

newborns if the baby's mother was enrolled in Medicaid at the time of birth.[53] This feature increased enrollment efficiency in the Medicaid program as SoonerCare now covers over sixty percent of births.[54] The previous system for enrollment was a paper-based system that was both time-consuming and error prone.[55] In addition to increasing enrollment efficiency, the automatic enrollment system also ensures that eligibility rules are applied consistently.[56]

Louisiana has developed an ELE program to determine eligibility, enroll, and verify eligibility for Medicaid.[57] ELE generally refers to identification of eligible people, information sharing between programs, and auto-enrollment of a person based on enrollment in another benefit program.[58] For an ELE program to be successful, the benefit programs should have similar eligibility rules.[59] Existing eligibility rules should be aligned to make eligibility determination as uniform as possible.[60] In Louisiana's case, sharing information among agencies made the enrollment process more efficient.[61] The agency does not have to reassess eligibility and look at factors that were already examined by another state agency to determine eligibility for other public benefits.[62] However, consent of the individual is required for agencies to share information and to permit automatic enrollment in Medicaid, if the person is eligible.[63] In its first month, Louisiana enrolled 10,000 children in Medicaid, despite reducing the Medicaid workforce by twelve percent in the pervious two years.[64]

The efforts in Wisconsin, Oklahoma, and Louisiana confirm the need to simplify Medicaid enrollment procedures to ensure that eligibility results in enrollment. These programs aim to improve enrollment by eliminating or reducing barriers to enrollment.

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53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.* at 2.
57. LOUISIANA EXPRESS LANE, *supra* note 43, at 1 (Louisiana's ELE program uses data elements from the state's Supplemental Nutrition Assistance Program (SNAP) to automatically enroll children in the states Medicaid program when their parents qualify for SNAP benefits).
58. *Id.*
59. *Id.* at 2-3.
60. *See Id.* at 3 (discussing states that have already modified eligibility rules).
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.* at 2.

V. ANALYSIS OF EFFORTS TO IMPROVE MEDICAID ENROLLMENT

The three main barriers to enrollment discussed above include complicated. applications, lack of transportation, and difficulty obtaining documents. These have been addressed in different ways by Wisconsin, Louisiana, and Oklahoma.[65]

Two ways that Wisconsin addressed the problem of the complicated applications was by providing access to assistance and limiting the language used in the application to a fourth grade reading level.[66] In using a web-based system it is important for people to have access to assistance; many low-income people do not have access to or experience using the internet. Since implementing the ACCESS program, over eighty percent of childless adults enrolled in state insurance programs have used ACCESS.[67]

Louisiana took note and moved a step further by proactively enrolling eligible-but-not-enrolled children.[68] However, Louisiana's system is still problematic as the person must authorize information sharing and be enrolled in another public program to be enrolled.[69] SoonerCare, in Oklahoma, has a similar problem in that enrollment only applies to newborn children when the mother is enrolled in Medicaid[70] The automatic enrollment feature, however, is a good base to build on and shows the development of a pro-enrollment mind-set.[71]

All of the programs discussed address the problem of transportation. Wisconsin established numerous locations that residents can visit to receive help with the application.[72] Automatic enrollment systems, like Louisiana and Oklahoma's, essentially eliminate the need for transportation to enroll; however, transportation may be needed to apply for the benefits that Medicaid eligibility is based.

The state programs do not specifically address the problem with obtaining documents.

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65. *See infra* Part IV.
66. WISCONSIN ACCESS, *supra* note 43, at 1.
67. *Id.* at 3.
68. LOUISIANA EXPRESS LANE, *supra* note 43, at 1.
69. *Id.* (stating that family consent is required for agencies to share date). The problem with consent is that, as described *infa* Part II, seemingly simple requirements can have a negative impact on the ability for a qualified individual to enroll in Medicaid.
70. OKLAHOMA AUTOMATIC ENROLLMENT, *supra* note 43, at 1.
71. *See generally Id.* at 1-3 (describing how auto-enrollment in SoonerCare works and explaining that the program was needed to fix the time consuming error prone enrollment procedures that prevented or delayed eligible childrens' enrollment).
72. WISCONSIN ACCESS, *supra* note 43, at 1.

Because the criterion for eligibility under the PPACA, which is income below 133 percent of the FPL,[73] is simplified, the requirements to prove eligibility should be reduced. The expansion of Medicaid to the newly eligible "establishes an expectation that everyone should be insured;"[74] however, as evidenced by the impact of proof of citizenship, simple requirements can have a negative impact on enrollment of eligible individuals.[75]

Even if the state programs address barriers to enrollment, the programs must actually result in higher enrollment to be successful. In Wisconsin, the percent of applicants that use the ACCESS system who are determined to be eligible for state health insurance is lower than other methods of applying.[76] The reason for the discrepancy is unclear; ACCESS applicants may be less likely to be actually eligible or the procedure of ACCESS may impede eligibility recognition.[77] ACCESS is utilized more in metropolitan areas and by applicants above 150 percent of the FPL.[78] The newly eligible will be below 133 percent of the FLP;[79] therefore, Wisconsin must consider whether additional procedures will be necessary to ensure that the newly eligible will enroll in Medicaid.

In addition, states that have implemented ELE initiatives have also experienced some setbacks.[80] While ELE makes enrollment easier for the benefit recipient, caseworkers used to a complex determination system may not easily adopt to the pro-enrollment

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73. PPACA § 2001, 124 Stat. at 271-73.

74. PARADISE & PERRY, *supra* note 29, at 1.

75. LAURA SUMMER, GEORGETOWN UNIV. HEALTH POLICY INST., GETTING AND KEEPING COVERAGE: STATES' EXPERIENCE WITH CITIZENSHIP DOCUMENTATION RULES 2 (Jan. 2009) (finding that enrollment in all seven states analyzed declined in the six month period following the implementation of the proof of citizenship requirement).

76. ROBERT WOOD JOHNSON FOUND., THE TARGET EFFICIENCY OF ONLINE MEDICAID/CHIP ENROLLMENT: AN EVALUATION OF WISCONSIN'S ACCESS INTERNET PORTAL 4 (Feb. 2011), http://www.rwjf.org/files/research/71923.pdf [hereinafter EVALUATION OF ACCESS] (finding that walk-in, mail-in, and phone applicants are more likely to be found eligible for health insurance).

77. *Id.*

78. *Id.* at 3 (finding that eighty percent of applications submitted by applicants above 150 percent of the FLP were submitted through ACCESS and fifty-six percent of applications submitted by applicants below 150 percent of the FLP and applicants in metropolitan areas used ACCESS sixth-five percent of the time opposed to sixty-percent for applicants from rural areas).

79. PPACA § 2001, 124 Stat. at 271-73.

80. *See* KAISER FAMILY FOUND. & CHILDREN'S PARTNERSHIP, EXPRESS LANE ELIGIBILITY EFFORTS: LESSONS LEARNED FROM EARLY STATE CROSS-PROGRAM ENROLLMENT INITIATIVES 1-8 (Aug. 2009), http://www.kff.org/medicaid/upload/7956.pdf (discussing the ELE programs in Alabama, Iowa, Louisiana, and New Jersey and identifying initial problems the states encountered) [hereinafter LESSONS LEARNED]; *see* JENNIFER SULLIVAN & LAURA PARISI, FAMILIES USA, EXPRESS LANE ELIGIBILITY: EARLY STATE EXPERIENCES AND LESSONS FOR HEALTH REFORM 3-14 (Jan. 2011), http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf (identifying lessons learned by states that have ELE programs).

environment.[81] Problems may also arise when agency information is mismatched; for example, last names may not be spelled the same.[82] Enrollment can also be stymied if the enrollment process, despite sharing of information between agencies, has multiple steps.[83] Enrollment significantly drops-off if the application process involves more than one form or visit to an agency.[84]

States are moving in the right direction to ensure that individuals newly eligible for Medicaid actually enroll. However, to achieve the goal of health insurance and access to healthcare for all low-income people, a default or retroactive system is needed for Medicaid enrollment. While the PPACA addresses access to health care by providing for the expansion of Community Health Centers (CHCs),[85] health centers that provide care regardless of a person's ability to pay,[86] uninsured are still more likely than those with insurance to have a regular access to health care.[87]

Currently, individuals must apply to be enrolled. Even ELE programs that automatically enroll eligible people have problems.[88] If an eligible person does not apply, and then receives medical treatment, the health provider bears the cost when the person is unable to pay. Hospitals and private organizations offer Medicaid application assistance to help low-income, uninsured individuals apply for Medicaid,[89] but for the true objective of Medicaid expansion to be realized, Medicaid enrollment procedures must be simplified and a default payment system for medical providers that provide treatment to Medicaid eligible individuals must be in place.

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81. SULLIVAN & PARISI, *supra* note 80, at 5 (discussing Alabama's problem with caseworkers used to a complex determination system).

82. *Id.* at 8 (discussing Louisiana's problem with mismatched enrollees, specifically, problems because the agencies use different identification numbers for beneficiaries and discrepancies in applications, such as different name spellings).

83. LESSONS LEARNED, *supra* note 80, at 4.

84. *Id.*

85. PPACA § 10503, 124 Stat. at 886.

86. Eli Y. Adashi, M.D. et al, *Health Care Reform and Primary Care – The Growing Importance of Community Health Centers*, 362 NEW ENG. J. MED. 2047, 2047 (2010).

87. UNINSURED KEY FACTS, *supra* note **Error! Bookmark not defined.**, at 10 (stating that "half of uninsured adults do not have a regular place to go when they are sick or need medical advice").

88. *See infra* Part V.

89. Examples of organization that offer Medicaid application assistance are the Health Justice Project at Loyola University of Chicago School of Law and Northwestern University Medical Center.

VI. CONCLUSION

Extending Medicaid to low-income individuals at or below 133 percent of the FPL is a step in the right direction to ensuring that low-income people have access to adequate health care.[90] Additional steps need to be taken to establish a default enrollment system for low-income individuals that do not actively apply for Medicaid. While granting eligibility is necessary for enrollment to take place, eligibility alone is not sufficient to ensure that the newly eligible will enroll and, therefore, receive benefits. By improving enrollment rates, states will be able to realize some of the intended benefits associated with Medicaid, including reducing the burden on hospital emergency departments. This could come with a cost to state budgets, an issue addressed by several states in 2011. Nevertheless, as long as eligibility requirements remain the same, states should strive to enroll those individuals.

90. PPACA § 2001, 124 Stat. at 271-73.