The Children's Partnership

THE HENRY J. KAISER FAMILY FOUNDATION

EXPRESS LANE ELIGIBILITY
Issue Brief

Building an On-Ramp to Children's Health Coverage:
A Report on California's Express Lane Eligibility Program

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FORWARD

We are pleased to share with you the story of Express Lane Eligibility—a policy that reinvents health insurance enrollment for uninsured children so that it is simpler for families and uses taxpayer dollars more effectively. This report sets out the practical steps and lessons gained from our experiences implementing Express Lane Eligibility (ELE) in California.

For several decades, leaders for children have worked hard to ensure access to health care, especially for the almost nine million children who have no insurance coverage. There have been two principal challenges to reaching this goal: 1) finding resources to pay for the coverage; and 2) breaking the procedural log jams that make it difficult for children to get health insurance coverage and keep it.

The first of these challenges was eased dramatically in 1997 with federal enactment of the State Children's Health Insurance Program (SCHIP). SCHIP, with Medicaid, provided states the funding to provide health coverage to over 80 percent of uninsured children. This report tells the story of how a group of leaders in California joined together to meet the second challenge: to make it easier for eligible but unenrolled children to obtain health insurance. The story involves state legislators, state/local governments, philanthropy, schools and teachers, health plans, technology experts, small business, and children's advocates working in a strategic alliance to get the job done.

It also tells the story of how The Children's Partnership goes about creating change for children. Our goals are two: to directly improve the lives of children in measurable ways and to leverage further change by building strategic alliances, re-thinking how to solve seemingly intractable problems, and ultimately, changing the way systems work.

We are pleased to join with The Kaiser Commission on Medicaid and the Uninsured in telling this story and encouraging other states to adopt these streamlined approaches to children's health. Their research and leadership on the importance of health insurance enrollment simplifications has provided a strong foundation for efforts like ELE. We thank them along with The California Endowment and The David and Lucile Packard Foundation for support of our ELE work for children.

– **Wendy Lazarus and Laurie Lipper**
Founders and Co-Presidents, The Children's Partnership

INTRODUCTION

A promising strategy called Express Lane Eligibility (ELE) has been pioneered in California to more efficiently enroll uninsured children into publicly funded health insurance programs. It is a story of successes and challenges, offering important lessons for other states interested in a high-leverage way to increase children's health insurance enrollment.

Almost 85 percent of America's uninsured children are eligible for coverage through Medicaid or the State Children's Health Insurance Program (SCHIP),[1] but they are not receiving it. Express Lane Eligibility uses two common-sense strategies to find and enroll these nearly seven million "eligible but uninsured" children in health insurance coverage:

- It targets large numbers of eligible children where they can be found: in other public benefit programs like school lunch and food stamps. More than 70 percent of low-income uninsured children are already receiving other public assistance benefits of some kind.[2]
- It expedites children's enrollment in health coverage by using information already submitted by parents when they enrolled their children in other benefit programs.

The moment is particularly ripe for sharing information about California's ELE efforts and for encouraging more states to undertake it for two reasons:

1. Many states still have extremely high numbers of uninsured children eligible for Medicaid and SCHIP, making their top order of business to resourcefully find and enroll these children.[3] By linking health insurance enrollment to enrollment for other public programs, Express Lane Eligibility can do both.

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Support provided by The California Endowment and The Kaiser Commission on Medicaid and the Uninsured *September 2004*

2. Serious budget constraints mean states need more efficient and resourceful ways to get children covered. Express Lane Eligibility offers states a way to piggyback onto processes already underway, such as parents' completing a school lunch application.

ABOUT THIS REPORT

This report provides an early look at results from California's Express Lane Eligibility (ELE) initiative (now one year into implementation), which links health insurance enrollment to the school lunch program. It describes how the policy was developed and how it is being implemented in 72 pilot schools in five school districts across California. While a formal evaluation and a comprehensive data analysis will be available after the three-year pilot phase[5], these early insights can help other states begin Express Lane implementation immediately, and are critical for the continuing national debate on how to more efficiently provide health care to the nation's children.

Geared toward policy-makers at the state and local levels, grant-makers, and nonprofit leaders and advocates, this report includes:

- Background on ELE: what it is and how it can enroll large numbers of uninsured children into health insurance programs.
- A Description of Express Lane in California: how it began, the policy decisions involved and how it works on the ground.
- Early Implementation Results: findings from the first year.
- Ten Guideposts on the Way to Express Lane: practical lessons to help guide efforts to develop ELE in other states.

For over six years The Children's Partnership (TCP) has been involved in the development of ELE policy. Nationally, TCP coined the term "Express Lane Eligibility" and, in 2000, with The Kaiser Commission on Medicaid and the Uninsured, released a seminal document on ELE: *Putting Express Lane Eligibility Into Practice: A Briefing Book and Guide for Enrolling Uninsured Children Who Receive Other Public Benefits into Medicaid and CHIP*.[6] In California, The Children's Partnership has played a critical role in the development of ELE, helping to formulate state policy and providing intensive technical assistance to the school districts and counties implementing it. TCP's ELE policy work in California is conducted in partnership with Children Now and the Children's Defense Fund as part of The 100% Campaign.

The lessons and insights presented in this report are the result of TCP's work. They are presented here for a national audience in partnership with The Kaiser Commission on Medicaid and the Uninsured. The Commission has conducted landmark research on health coverage access and simplification issues, including ELE, for low-income families.

Interest in ELE strategies has significantly increased in the last few years, with at least 14 states now implementing an ELE-type program through Medicaid or SCHIP.[4] But there are a number of challenges to more widespread use of ELE. For example, public benefit programs have different income guidelines and eligibility rules, and are often run out of separate agencies. This makes streamlining and coordination between programs difficult. California has been at the forefront of confronting these challenges and in building a workable model—and, is why this story is so important to tell. So although state efforts may differ (based on the make-up of their health programs), California's experience provides an important framework from which to start.

BACKGROUND

Two-thirds of California's uninsured children are eligible for Medi-Cal (the state's Medicaid program) or Healthy Families (the SCHIP program), yet they remain uncovered.[7] In an effort to address this problem, the state took a number of steps to improve the enrollment processes. Along with many states, California created a short, joint mail-in Medi-Cal/Healthy Families application, enacted 12 months of continuous eligibility for the programs, and eliminated the need to collect information on personal family assets.[8] In addition, California implemented an online application and a process that enables children receiving preventive services at a doctor's office to enroll in temporary Medi-Cal coverage.[9]

ELE was viewed as an extension to these efforts. 800,000 uninsured children in California were already certified for and participating in public programs[10]—like school lunch, food stamps, and WIC—whose eligibility requirements were very similar to those for the public health insurance programs.[11] By linking to other, well-used public benefit programs, California would be able to locate and reach out to large numbers of uninsured children. And, ELE would streamline the enrollment process by using (with parents' consent) information they had already provided for admission into other programs. The approach would make the application process easier for parents and potentially eliminate duplicative work for public agencies.

In 2001, ELE was turned into state policy via two bills (AB 59-Senator Cedillo and SB 493-Senator Sher).[12] Subsequent advocacy efforts resulted in obtaining budget authority and funding to implement the new laws, and with the support of two governors of different political parties, Express Lane became operational in California in July 2003 and was implemented in the 2003-04 school year. The new program allowed children to be "express-laned" into health insurance programs from both the free school lunch program and food stamp program. This report focuses on the ELE-school lunch effort (named Express Enrollment), because it involved linking two separately run programs and agencies and, therefore, offers particularly important lessons.[13]

EXPRESS LANE IN CALIFORNIA

The California Departments of Education (CDE) and Health Services (DHS), with significant input from advocates, schools, counties and others, turned the Express Lane Eligibility (ELE) school lunch legislation into an operational program called Express Enrollment. This section describes how the program works, the design choices that went into its make-up and how it began in five school districts in California.

How Express Enrollment Works

Express Enrollment (EE) was built as an optional program for school districts that utilize the National School Lunch Program application.[14] County departments of social services (which determine Medi-Cal eligibility) in all 58 counties are required to participate. The following steps describe how EE works. (Figure 1 provides a flowchart of the process.)

Step 1: A parent applies for Medi-Cal using the school lunch application. Parents within a participating school district apply for Medi-Cal coverage by authorizing the use of their child's school lunch application information for Medi-Cal purposes. A section added to the school lunch application seeks parental consent and asks for additional pieces of information required for Medi-Cal: the relationship of each family member to the child, and the child's income and date of birth.

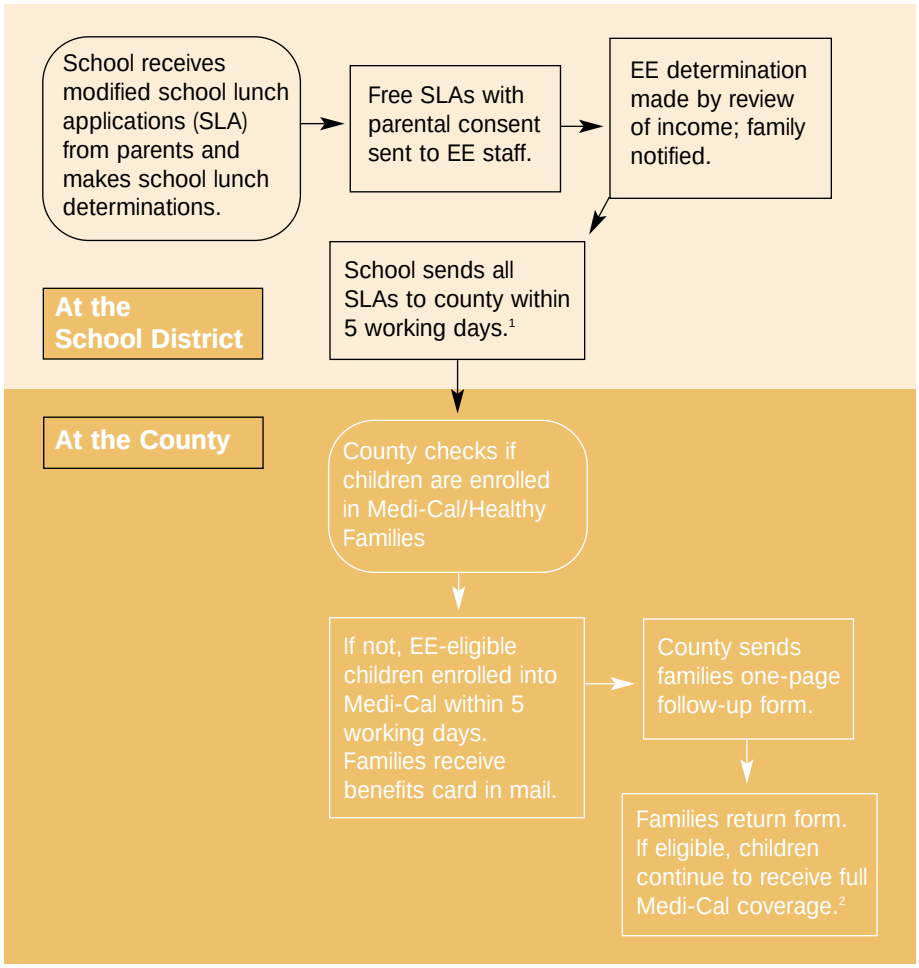
Step 2: The school district reviews the school lunch application. School district EE staff[15] review applications of free-lunch-eligible children that have signed parental consent to determine if the child is income-eligible for Medi-Cal, on the basis of the family's self-declaration of income. Parents are notified of the school district's finding and all applications (whether eligible or not) are sent to the county within five working days.

Step 3: An eligible child receives temporary benefits. Once a county receives the school lunch application from a school district, it checks to see if the child is already on Medi-Cal or Healthy Families.[16] If a child is not already enrolled and was determined by the school district to be income-eligible for Medi-Cal, the county enrolls him or her into Medi-Cal within five working days of receipt of the application. This coverage remains in place until a final Medi-Cal eligibility determination can be made.[17]

Step 4: The county sends an information request to the family. For those not already receiving Medi-Cal, the county collects additional information via a one-page form (also listing Medi-Cal Rights and Responsibilities) that is sent to families.[18] The form seeks the child's social security number and information on the child's immigration status and other health coverage, which Medi-Cal requires and school lunch does not. The county will also send the one-page form to a family with a child that the school district determines is not income-eligible for Medi-Cal. Although the child is not eligible for the temporary Medi-Cal coverage, he or she might still be eligible for full benefits under Medi-Cal, which allows certain deductions to income about which school lunch does not inquire.

Step 5: The county makes a final Medi-Cal eligibility determination. Once the information form is returned, the county determines if the child is eligible to receive, or to

Figure 1. The Express Enrollment (EE) Process



[1] Applications of children not eligible for EE are still transferred to the county. These children do not receive temporary Medi-Cal but are sent the follow-up form to determine if they may still be eligible for Medi-Cal, taking into consideration income deductions allowable under Medi-Cal but not school lunch.

[2] A child not eligible because of income is sent a Medi-Cal/Healthy Families application. Those not eligible because of immigration status receive restricted Medi-Cal benefits. Families with incomes too high for Medi-Cal can also apply for Medi-Cal, full or restricted, with a 'share of cost.'

continue receiving, full Medi-Cal coverage. A child not income-eligible for full Medi-Cal benefits will be sent a joint Medi-Cal/Healthy Families application.[19] A child not eligible for full Medi-Cal benefits because of immigration status only will receive restricted Medi-Cal benefits.[20] In most cases, school districts follow up with these families to connect them to other coverage options.

Building the Express Enrollment Program

Designing the Express Enrollment program was a challenge since the school lunch and Medi-Cal programs operate under different federal and state guidelines:

- School lunch and Medi-Cal have different rules for counting a family's income, which is used to determine eligibility for the programs. School lunch counts income based on the entire household while Medi-Cal only counts income of a family unit, which does not necessarily mean all members of a household.
- Medi-Cal requires documentation of legal immigration status if the applicant is not a U.S. citizen; the school lunch program does not.
- The programs' record keeping and computer systems are different, and staff are not accustomed to working together.

California also had some of its own unique obstacles. States not facing these impediments could have a more straightforward time implementing ELE.[21] In California:

- Medi-Cal income eligibility rules for children differ by age, making children aged 6-19 lower (at 100 percent of the federal poverty level; FPL) than those of free school lunch (at 130 percent of the FPL). This means that some children who are financially eligible for free school lunch might actually be ineligible for Medi-Cal, but eligible for Healthy Families.
- The SCHIP program is run separately from Medi-Cal and is run by a different agency (as compared to the single, seamless Medicaid/SCHIP combined program that exists in some states); and
- The Medicaid enrollment system is not centralized, but is instead operated by 58 individual counties.

(See Figure 2 for a more detailed comparison of eligibility rules across the two programs.)

Although DHS and CDE staff were extremely committed to ensuring the program was successful, they faced a number of challenges, including: the complications described above, a very short (seven-month) implementation timeline (due to a lengthy 2002-03 state budget process), and limited state resources and

Figure 2. Eligibility Rules: Medi-Cal Vs. School Lunch

	MEDI-CAL FOR CHILDREN	NATIONAL SCHOOL LUNCH PROGRAM
Income Standards	Infants: up to 200% FPL Ages 1 – 5: up to 133% FPL Ages 6 – 19: up to 100% FPL Children above these eligibility levels with family income at or below 250% FPL are eligible for Healthy Families.	Free Meals: gross income up to 130% of the FPL Reduced-Price Meals: gross income between 130% and 185% of the FPL
Unit for Determining Income Eligibility	Family: Related persons living in the same home who have financial responsibility for health care for applicant.	Households: Related and unrelated individuals living as one economic unit.
Deductions	$90 per month for each working household; work-related child expenses; court-ordered child support payments.	None.
Documentation	Age, identity, residency, income and deductions (not required under federal law). Immigration status if not a U.S. citizen. Post-eligibility verification conducted.	None at time of application. However, a sample population of enrollees is contacted for verification.
Citizenship	Only citizens and legal immigrants. Social security number of applicant children.	None.
Administrative Bodies	Federal Level: Centers for Medicare and Medicaid Services State Level: Department of Health Services Local Level: 58 counties responsible for administrating Medi-Cal. A single state administrator also processes the Medi-Cal/Healthy Families applications, forwarding Medi-Cal children to counties.	Federal Level: U.S. Department of Agriculture State Level: Department of Education Local Level: Over 1,000 school districts responsible for administrating school lunch.

federal restrictions. Working within these constraints, DHS and CDE made a number of critical policy decisions that have either had a positive impact on the program, or created some impediments to its success. Both the positive and negative policy decisions provide important guidance for future Express Lane efforts. While some of the issues may be unique to California, they, nonetheless, provide a window into the range of challenges that can arise when developing Express Lane.

Successful Design Choices

Following are some choices California made in designing its program that proved to be positive and important ones. Other states should consider establishing similar policies.

Providing Children with Immediate Coverage. To ensure that Express Enrollment provided expedited coverage, California chose to utilize the federal presumptive eligibility (PE) option that allows children to immediately receive health services, based on an income screen, while their health insurance applications are processed.[22] By using PE, California could screen children using the school lunch application and, within 10 working days, place them into Medi-Cal. The child would be able to maintain temporary coverage until a final determination could be made.[23] Providing immediate coverage ensured that children were truly "expressed" into care, an important incentive for families to both enter and complete the EE process.

Allowing Families to Self-Declare Income. In California, families applying for Medi-Cal are required to provide documentation of income. However, federal rules allow a state to accept a family's own declaration of its income without further documentation.[24] Under EE, California modified its documentation requirement such that a self-declared statement of income on a school lunch application would be sufficient. Not only did this decision streamline the process for families, it also ensured that the school lunch program was not burdened with extra documentation requirements.

Adopting a One-Page Form. To make the information-gathering process as easy as possible, DHS limited the information required from a family to that which was required under federal law: the child's social security number, immigration status and other health care coverage. The form also asked if other family members want to apply for Medi-Cal. DHS also developed a new one-page form for families to complete and return. The form included a "Rights and Responsibilities" attachment that a family could keep.

Imposing Time Limits. To create a true "express" program, California established rules that required school districts and counties to act in a timely manner. Under EE, a school district was required to send school lunch applications to the county department of social services within five working days of making an EE determination. And, the county was required to enroll EE-eligible children into temporary Medi-Cal within five working days of receipt of the application. While counties (especially the larger ones) raised concerns about the time limits, participating families appreciated the efficiency of the program.

Protecting the School Lunch Program. Clear steps were taken to ensure that the addition of the EE program did not disrupt the functioning of the school lunch program. For example, careful consideration was given to what could be added to the school lunch application so that parents could continue to apply as they always had. In the end, only four items were added: the child's date of birth and income, relationship of the child to each household member (to indicate whose income would be counted under Medi-Cal rules), and a parental consent section (that required the family to sign under penalty of perjury).[25]

Policy Challenges

Not all of the policy development has been positive. In the course of designing and implementing this new, integrated enrollment system, federal laws and some state decisions created some less-than-optimal policies. The following highlights some of the policy compromises that resulted in program operations in the first year that were not as efficient and effective as they could have been. Some of these California is correcting.

Federal Rules Prevent True Express Lane. The most efficient EE program would have declared a child automatically eligible for Medi-Cal because of his or her eligibility for free school lunch. In fact, the EE legislation attempted to do just that for free-lunch-eligible children under age six (because of the similar income guidelines). However, federal law limits state flexibility in this area and, as a result, a child's income must be calculated under school lunch rules and then again under Medi-Cal rules. California was also not able to bypass the differences between Medi-Cal and the school lunch program's eligibility requirements (primarily related to immigration) and, as a result, has had to implement a two-step information-gathering process. Unfortunately, this has increased the potential for losing families at the second step.

Only Free School Lunch Children, Not Reduced-Price, are Eligible. California chose to limit information-sharing between the school lunch and Medi-Cal programs to those children found eligible for free school lunch (not reduced-price lunch), primarily because the income eligibility thresholds for Medi-Cal are lower than those for reduced-price lunch. This has resulted in confusion among staff and parents, and ultimately in a loss of some potentially eligible families. Ideally, the EE system would simplify the application process for all children.

A Weak Linkage to Healthy Families was Implemented. EE did not create a linkage to Healthy Families because the school lunch income guidelines were so similar to those for Medi-Cal. However, some children processed through EE are ultimately found ineligible due to income for full Medi-Cal benefits. For these children, consent to share information beyond the Medi-Cal program has not been obtained and,

therefore, the state requires counties to send these families a Medi-Cal/Healthy Families application in the mail. This means that these families must start the application process all over again. A superior process would use the school lunch application with Medi-Cal information as the foundation for a Healthy Families application as well. Legislation has been proposed to address this shortcoming.[26]

Multi-Child School Lunch Applications Create a Challenge. Many school districts in California (including two of the EE pilot sites) utilize a multi-child school lunch application: a single application for all children in a household. However, a multi-child application is problematic in EE because Medi-Cal requires information of the relationship between each child and every family member listed on the application. In addition, Medi-Cal must have consent from each child's parent or guardian. (School lunch requires consent from any household member.) For the 2004-05 school year a prototype multi-child school lunch/Medi-Cal application was developed for testing, but it was evident that school districts would need to follow up with families to ensure they provided the correct information and that counties would need to be certain to obtain the proper consents.

Requiring Income from Categorically Eligible Children Confuses Families. Children who receive Temporary Assistance for Needy Families (CalWorks in California), food stamps, or the Food Distribution Program on Indian Reservations (FDPIR) are not required to provide family income information for school lunch.[27] Because of their eligibility for these other programs, they are considered "categorically eligible" for free school lunch. However, in order to determine if a child is eligible for Medi-Cal, the school district and the county must have family income information, and so it is requested within the consent section of the modified school lunch application. This has confused categorically eligible families who had not previously been required to report their income. The great majority of categorically-eligible children are already receiving Medi-Cal (CalWorks children are automatically enrolled in Medi-Cal). But for the others, the state could simply have allowed families to give permission (on the school lunch form) for the county to review the food stamp case file to make a Medi-Cal determination. While the children would not be eligible for temporary Medi-Cal coverage, they would ultimately receive coverage. In the end, however, federal consent may be required to do this.

Processing Applications Only at the Local Level Slows Things Down. Under EE, the school district manually conducts the initial Medi-Cal screen using the applications.[28] In addition, California requires counties to manually process the applications, determine if a child is already on Medi-Cal/Healthy Families, and place those who are eligible into the Medi-Cal system. Both of these tasks are time consuming and resource intensive. A better option would have been to centralize and/or automate these functions.

How Express Enrollment Became Operational

Express Enrollment (EE) began in the 2003-04 school year in 72 schools in five school districts (Alum Rock Union Elementary in Santa Clara County, Fresno Unified, Los Angeles Unified, Redwood City in San Mateo County and San Diego Unified). Although EE required budgetary authority to cover the cost of the Medi-Cal benefits of the children it would bring into the system ($3.5 million in state and federal funds were allocated in the 2003-04 budget year for this purpose), no implementation funds were allocated to school districts. Instead, California developed a public-private partnership through which foundation support would allow the state to

Figure 3. Express Enrollment Pilot Sites, 2003-04

School District	County	Pilot Schools	Student Enrollment, School Lunch Participation
Alum Rock Union Elementary	Santa Clara	District-wide: 23 pre-, elementary and middle schools	13,796 student enrollment; 64% receive free school lunch
Fresno Unified	Fresno	2 elementary schools	1,623 student enrollment; 47% receive free school lunch
Los Angeles Unified	Los Angeles	15 early education centers, 2 elementary, 1 middle and 1 high schools	8,798 student enrollment; 70% receive free school lunch
Redwood City	San Mateo	District-wide: 23 pre-, elementary and middle schools	9,216 student enrollment; 40% receive free school lunch
San Diego Unified	San Diego	4 pre- and 5 elementary schools	2,038 student enrollment; 56% receive free school lunch

Source: Self-reported by school districts, June 2004.

"Our district already has a successful history with health outreach and enrollment efforts. But Express Enrollment helps us find those children that have been harder to reach. We go directly to where these children are and the families find it a fast and convenient way to apply for coverage."

– A nurse in San Diego Unified School District

test and fine-tune EE on a relatively small scale. The pilot focused on five school districts and was only implemented in certain schools in Fresno, Los Angeles and San Diego. (See Figure 3 for more information about the pilot sites.)

The California Endowment was a critical supporter of the EE effort. It provided seed grants of between $250,000 and $750,000 (over two years)[29] to four of the pilot school districts, along with technical assistance, technology support, and an evaluation component. The David and Lucile Packard Foundation, with Consumers Union, provided support for Alum Rock Union Elementary and technical assistance to Redwood City. The school districts were chosen by the foundations based on their stated interests, capacity, and proven history with health outreach and enrollment efforts. The following continues the EE story by describing the pilots' first year of implementation.

EARLY IMPLEMENTATION RESULTS

The first year of Express Enrollment's implementation was successful in many ways. But it also demonstrated the challenges inherent in integrating two public programs. For example, the final enrollment numbers were lower than had been hoped for, due in part to parents' not completing the second enrollment step. This may also be attributable to the fact that more children had health insurance than was originally estimated. In the aggregate, however, the program has had a positive effect—with over 60 percent of children applying for Express Enrollment (EE) who were not already receiving Medi-Cal or Healthy Families receiving temporary Medi-Cal coverage. And, successes beyond enrollment numbers means EE will likely have a longer-term positive impact on children's health and health insurance coverage in the state.

The following provides information on the successes of the first year, along with areas for improvement. Results include both anecdotal information from staff and a look at very preliminary data from the five sites, aggregated across the sites and presented in ranges. The anecdotal results reported here were obtained by The Children's Partnership through day-to-day technical assistance to pilot sites, phone interviews, and site visits. The data were compiled by the USC Division of Community Health and The Children's Partnership.[30] Since the data has not been verified and some sites have not completed their data collection process, the data should be considered preliminary and subject to change. A formal evaluation is being conducted that will provide a more detailed picture of the pilot program and a quantitative analysis of the results. Early data are presented here as a way to understand the potential impact of EE.

Some Important Successes

Children are Getting (and Using) Health Insurance. Roughly half of all free-lunch children in the pilot school districts applied for health coverage under Express Enrollment. Of these, about one-third (roughly 2,000 children) received temporary Medi-Cal coverage, and in one pilot that number was as high as 50 percent. If you subtract the children who already had Medi-Cal or Healthy Families, over 60 percent of children applying received temporary Medi-Cal coverage. The schools that implemented Express Enrollment represent less than one percent of all schools in California, so, by definition, the numbers are small. School staff conducting follow-up with families are reporting that the children who get enrolled are, in fact, using their coverage.

"We are reaching families that we couldn't enroll through traditional outreach efforts and who have never signed up for Medi-Cal before. Through Express Enrollment, families are getting access to services for the first time."

– A health administrator in
Los Angeles Unified School District

The Program is Finding the Hardest-to-Reach Children. Early anecdotal information suggests that some of the children Express Enrollment is finding are the "hardest-to-reach," meaning they were unknown to the system, never having signed-up for coverage before. School districts also found that fewer children than they had originally thought were uninsured–a testament to the schools' previous outreach efforts and to EE's ability to enroll children that cannot be reached through traditional enrollment methods.

Families Like the Coverage. Families are reporting that they are very happy with EE. Comments have ranged from disbelief that it is so easy, to excitement about getting a Medi-Cal card in the mail so quickly.

"We got very positive feedback from the families. They are excited about applying right there, at the school, and not having to go to a government office. And they couldn't believe that they got their benefits card so fast."

– A health outreach manager in Los Angeles Unified School District

Schools and Counties are Working Together, Many for the First Time. The first year of EE created relationships between entities that had rarely worked together, namely school districts and county Medi-Cal offices. These relationships could have a broader impact as the players work to further streamline and improve the way they connect families to health insurance coverage. In addition, school staff (including teachers and food nutrition workers) who knew nothing about children's health insurance programs have become motivated to "get the word out."

The School Lunch Program Appears to Benefit. Ensuring that a link to Medi-Cal did not harm the school lunch program was an important goal of EE. Many other funding streams are based on school lunch participation rates, and the program has established a trust with participating families. In the five pilot school districts, there was no real change in free school lunch participation. Two school districts witnessed an increase in the percent of free school lunch participation (of eight and two percent, respectively) as a proportion of student enrollment from the previous year and one stayed constant. Two school districts showed a slight decrease (of one and two percent, respectively), but this was consistent with overall school district trends. Food service managers in the sites did not equate EE with any decreases and, in fact, believed that any increases were due to EE outreach.

"Express Enrollment has definitely helped our relationship with the county. We now work together to provide some continuity of coverage to families. Because families are still hesitant to get help from a government agency, we help the county by following up with families."

– A nurse in San Diego Unified School District

Areas for Improvement

While the EE pilot has had some important successes, implementation has also revealed areas needing improvement. In some of these areas, positive changes are already in progress.

Many Children are Already on Medi-Cal. When Express Enrollment was launched, it was expected that at least some children already in Medi-Cal and Healthy Families would inadvertently submit applications for EE. This has indeed been the case, and has become a point of concern for counties and school districts allocating already limited resources toward application processing. Across the pilot sites, one-third to two-thirds of free-lunch-eligible children who submitted applications with parental consent were already participating in Medi-Cal or Healthy Families.

This problem is not unique to California, and there has been some analysis of the reasons for it. First, busy parents may not carefully read the application and, even if they do, the school lunch and Medi-Cal sections are hard to distinguish. Second, parents may not realize that their children have Medi-Cal or Healthy Families (they may call it something else). This is especially true where private managed care companies provide the services.

Solutions: For next year, California plans to make the school lunch application easier to understand, and ensure that outreach materials more clearly describe Medi-Cal/Healthy Families. In addition, policy work is underway to allow school districts to identify for counties children already receiving Medi-Cal and Healthy Families.

As mentioned previously, shifting the screening and enrollment responsibility from the school districts and counties to a central administrator or by automating processes through technology interfaces would significantly diminish the resource burden. For example, the state's administrator for Medi-Cal/Healthy Families could conduct the initial screen, check the computer systems to see if the child was already receiving coverage, and then put the child into Medi-Cal, leaving the county to conduct the follow-up. Another option is to create a technological solution where the functions would be automated through an Internet-based program connected to state and/or county computer systems.

For the 2004-05 school year The California Endowment will test a technology system called One-E-App that will allow school districts to collect school lunch data in electronic format and to automate the EE determination process. California should explore expanding upon this model to connect the system to state computers to make the county function more efficient.

"Families find it very easy to sign up for Medi-Cal through the school lunch program…it is easier and simpler than filling out the regular, complicated Medi-Cal application and all the necessary paperwork."

– An EE coordinator in Redwood City School District

Children Drop Out Before Completing the Enrollment Process. In order for children to maintain the temporary Medi-Cal coverage provided by EE, parents must complete and return a one-page follow-up form. The number of families completing the enrollment process varied widely by pilot site, with one school district enrolling in Medi-Cal as many as 80 percent of children not already in Medi-Cal or Healthy Families and one enrolling only 25 percent.[31] Sites with better success rates were those in which the school district or county made concerted efforts to follow up with families and help them complete the enrollment process. However, across the pilots, only about 1,000 children have been enrolled into some type of Medi-Cal coverage.[32]

There are a few reasons why children are likely to drop out before they get continuing coverage. First, most public programs (and even private companies) find that busy families do not always complete forms as requested. In addition, the form may be discouraging immigrant families since it seeks the child's immigration information. More work must to be done to document this hypothesis.

"We received more school lunch applications at one of our pilot schools than ever before… Express Enrollment was the cause."

– A food service manager in Fresno Unified School District

Solutions: For next year, school districts will be strongly encouraged to follow up with families. To assist school districts in this, there is an effort to allow counties, at their option, to share the names and contact information of students who have not returned the follow-up form, so school districts can strategically target their outreach. In the long run, however, more work is needed to adopt a truly one-step eligibility model and it would require federal action. Again, technology can also play a role in this process.

The first year of Express Lane Eligibility in California is a study in what works and does not work, and of the long-term commitment needed by all stakeholders to make a program like this effective. Over the coming year, a handful of new school districts and counties will join the existing pilot sites as EE is optional for any school district in California. Some have applied for foundation support; others have decided to implement the program on their own. Continuing to closely monitor and learn from these efforts will ensure the long-term viability of the program.

TEN GUIDEPOSTS ON THE WAY TO EXPRESS LANE

The early story of Express Enrollment (EE) in California—from creation to design to implementation—offers many important lessons. States launching these programs will have varied experiences (and those with more centralized enrollment systems and one children's health program through Medicaid will have a much easier time). But, in many ways, they will also face similar challenges, including the need to get the policy right from the beginning.

In that spirit, following are ten "guideposts" for any state seeking to navigate the complex highways of Express Lane Eligibility (ELE).

1. State-Level Leadership Ensures Viability.

ELE in California would never have gotten off the ground without the committed leadership of state officials. With the support of State Senators Gilbert Cedillo and Byron Sher and the leadership provided by the administrations of Governors Gray Davis and Arnold Schwarzenegger, the program remained viable even in the face of large state budget deficits. In addition, a dedicated and committed staff at the agencies charged with building the program (Health and Human Services Agency, Education, and Health Services) was critical. ELE's ability to garner this broad support is testament to the common-sense approach it advocates, which is attractive to individuals and groups across the political spectrum. That supporters were able to see (and promote) the ultimate goal as a major shift in the way we provide health insurance to our children, helped sustain the effort in its early years.

2. Public/Private Partnerships Can Make It Happen.

ELE was possible in California, in large part, because of the support of The California Endowment (TCE). Through its commitment to create access for uninsured low-income families to California's public health programs, TCE helped support the policy movement in California on ELE. In addition, TCE invested over $3 million to date in support of ELE implementation, providing seed grants to school districts and investing in technology solutions. The David and Lucile Packard Foundation also gave critical support. Besides funding, both foundations provided technical assistance to the pilot school districts

through The Children's Partnership and Consumers Union.

Foundations, however, cannot sustain an ongoing state program, and are best viewed as "helpers" while the effort is planned and the infrastructure built. While costs will vary by state, more funding will likely be required in the development phase. In California, although grants to the first five EE pilot sites ranged from $250,000 to $750,000 (over two years), the sites needed some of this funding to help the state build the program's infrastructure. Less money will be required for future school sites since that infrastructure is now in place. In addition, since school districts (versus the state) in California were required to conduct EE eligibility screens, the pilot sites required resources for staffing that states with other systems, especially centralized or automated, might not. One very important on-going financing option for states is Medicaid administrative funds. Under the Medicaid Administrative Activity (MAA) program, school districts can receive federal reimbursement for health- and health insurance-related administrative activities.[33] States implementing Express Lane can help school districts secure these funds.

3. Piloting Can Promote Long-Term Effectiveness.

California used a pilot-site model in order to test EE on a limited basis before going to scale. Pilot projects allow for early evaluation and ongoing modifications in response to lessons learned. California is already exploring "fixes" for the second year of implementation based on experiences from the first year. These changes will help make the program more efficient and effective, ensuring sustainability beyond the pilot phase.

4. Institutional Change Will Take Time.

Institutional change is not easy to achieve. This is especially true when the changes sought require government agencies–each with its own system and culture—to work closely with one another. It necessitates people to be willing to do business differently, which is challenging in an environment of limited resources. It took four years to develop and implement EE in California. While other states can use California's experiences to shorten the process, there must always be enough time built in to ensure that all the pieces are in place and that the various stakeholders, particularly school lunch staff, are committed. And, it is important to remember that the actual implementation of ELE is an ongoing process requiring annual "fixes" and improvements.

5. Family Protections Must Be Balanced Against Program Efficiency.

Any Express Lane effort should ensure that the there are no unintended consequences to a program because of a new connection with Medicaid or SCHIP. The school lunch program has long been trusted by parents because of its simple application and the fact that it does not ask for immigration information. California's efforts have proven that school lunch can be linked to Medi-Cal without negative consequences, as long as protections are put in place. These include being careful when making changes to the application and ensuring confidentiality. However, such protections should always be balanced against the ultimate goal of the program: to provide health insurance to children. California's decision to prohibit a county from sharing a child's eligibility information with school districts has, in practice, hampered school districts in their follow-up effort. And following up with families is essential to ensuring that children ultimately receive coverage.

6. "Simple" Should Be the Watchword.

Because developing an ELE system is a complex undertaking, it is important to achieve simplicity wherever possible. ELE already faces the challenges of working within federal rules; there is no reason to add to these challenges by creating unnecessary state complications. California sought this simplicity by allowing families to self-certify income, by creating a new, one-page follow-up form that only asks the few questions required for a Medi-Cal eligibility determination, and by establishing time limits for processing applications. However, California also created confusion among families by limiting eligibility to free school lunch children, by not linking the program to Healthy Families, and by seeking information from categorically eligible children. It is also crucial to ensure that materials for families (especially any changes to an existing application) are easy to read and understand. In California, many families signed the school lunch application even though their children already had Medi-Cal. Some of this confusion may have been because the application was hard to understand.

7. Families Must Be Helped All the Way Through.

Express Lane does not end with the initial outreach to potentially eligible families. Helping families until they are fully enrolled is a crucial component of any Express Lane system. Ongoing outreach is essential to making sure families understand what's available to them and how to access it, and helping them complete the process is vital. Again, Medicaid Administrative Activities funding may be available to support this component of ELE.

8. A Wider Group of Health Leaders Can Be Formed.

The development and passage of ELE in California brought together a wide array of people, from small business to teachers to health plans. This diverse group has subsequently begun to address more fundamental issues related to uninsured children across the state. For example, a group of community and philanthropic leaders in Los Angeles County who came together around the issue of ELE broadened their ranks and have been pushing successfully for health insurance coverage for all uninsured children in the county.[34] Other groups with no previous connection to children's health issues (such as the California Teachers Association) have became formally involved in the cause, partly as a result of their involvement in EE implementation efforts.

9. Technology Can Help Resolve Many Challenges.

At the most fundamental level, ELE is really about getting the computer systems of the different programs to talk to one another. Without this technological connection, eligibility determinations must be done manually, which requires extra time and resources. California is exploring the potential for using technology to streamline the application process for a number of public programs. The California HealthCare Foundation and The California Endowment have created "One-E-App," a Web-based electronic application used to enroll people in a range of publicly funded programs. ELE is being built into the One-E-App system and will be piloted in 2004-05.

10. Federal Action Can Make It Work Better.

A clear lesson from California's experience is that there is only so far a state can go in putting an ELE system in place. In the end, existing federal rules tend to thwart efforts to create a truly efficient process. In California, instead of allowing Medi-Cal to use a school lunch program's income determination, both school lunch and Medi-Cal have to recount a family's income based on their own rules. Efforts are underway in Congress (e.g., through The Children's Express Lane to Health Coverage Act, S. 1083) to make it easier for states to design Express Lane programs that fit their needs.

CONCLUSION

The biggest headline from California's Express Lane Eligibility (ELE) story is that although it takes patience, innovative thinking, leadership and a strong commitment, we can significantly improve the efficiency of our country's public health insurance programs and their ability to reach and provide for those in need. California's experience also demonstrates conclusively that getting state-level policy right from the beginning is critical.

Yet, Express Lane Eligibility also shows us that certain barriers are beyond the ability of any one program or initiative to "fix." As long as federal and state children's health insurance programs use complex and differing income and eligibility rules, any streamlining effort can only go so far. Multiple steps are burdensome for parents and can trip up even the most advanced computer systems.

The Express Lane experience in California underscores the urgent need to rethink the way we provide health insurance to families. Ultimately, the complicated and conflicting rules must be eliminated and replaced with a simple-to-use program for all children. Under this scenario, different funding streams must be combined to create a single-access program that automatically enrolls children into health coverage, bypassing the administrative complications of the current system and focusing resources on care rather than bureaucracy. ELE can be an important building block for such a system, and the lessons learned in California provide a strong foundation from which to begin.

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ENDNOTES

[1] L. Dubay, J. Haley, G. Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000* (The Urban Institute, March 2002).

[2] Calculations by The Urban Institute, 2002, based on 1997 and 1999 National Survey of America's Families.

[3] For information on insurance rates by state, see The Henry J. Kaiser Family Foundation's State Health Facts Online at www.statehealthfacts.kff.org.

[4] Research by The Children's Partnership. For information on other states' efforts with Express Lane Eligibility programs, see www.expresslane.info.

[5] The California Endowment has funded the USC Division of Community Health to conduct a cluster evaluation of its four grantees (Fresno Unified, Los Angeles Unified, Redwood City Unified in San Mateo County and San Diego Unified) over the three-year pilot phase. Alum Rock Union Elementary will be evaluated through its grant from The David and Lucile Packard Foundation.

[6] In December 1999, The Children's Partnership also released *Express Lane Eligibility: How to Enroll Large Groups of Uninsured Children in Medicaid and CHIP*. Other seminal reports on the issue of program integration include: Donna Cohen Ross, *Enrolling Children in Health Coverage: It Can Start with School Lunch* (Center on Budget and Policy Priorities, January 2001) and Sharon Parrott and Stacy Dean, *Aligning Policies and Procedures In Benefit Programs: An Overview of the Opportunities and Challenges Under Current Federal Laws and Regulations* (Center on Budget and Policy Priorities, February 2004).

[7] E.R. Brown, N. Ponce, T. Rice, S.A. Lavarreda. The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey (UCLA Center for Health Policy Research, 2002).

[8] The Kaiser Commission on Medicaid and the Uninsured has various resources available to states on Medicaid and SCHIP eligibility and enrollment simplifications. See *Enrolling Uninsured Low-Income Children in Medicaid and CHIP*; *Reaching Uninsured Children Through Medicaid*; and *Enrolling Children and Families in Health Coverage: The Promise of Doing More* at www.kff.org/medicaid.

[9] For more information on these efforts, see www.100percent-campaign.org and www.healtheapp.org.

[10] Calculations by The Urban Institute, ibid.

[11] Medi-Cal provides coverage to children ages 1 through 5 with incomes up to 133% of the federal poverty level (FPL), ages 6 through 19 to 100% of the FPL. The school lunch program provides meals to school age children with incomes up to 130% of the FPL for free meals and 131% to 185% of the FPL for reduced-price meals. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) serves children ages 0-5 with incomes up to 185% of the FPL. The food stamp program provides benefits to families with net incomes up to 100% of the FPL.

[12] AB 59 was sponsored by the County Welfare Directors Association and Los Angeles Unified School District. SB 493 was sponsored by the 100% Campaign, a collaborative of The Children's Partnership, Children Now and Children's Defense Fund.

[13] The Express Lane food stamp program requires California counties to offer food stamp recipients the opportunity to have information in their food stamp file serve as the basis for a Medi-Cal determination. This process involves a data match between the Medi-Cal and food stamp programs to determine which food stamp recipients are not currently enrolled in Medi-Cal. As county welfare databases are being reconstructed, methods for automating the process are being planned. For more information, visit www.expresslaneca.info.

[14] Under federal rules, schools that show evidence of a high percentage of low-income students can apply for "provisional" status, which allows them to offer free meals through the school lunch program to all children in the school. Families do not have to submit school lunch applications every year for a period of time, depending on the school's status. Since Express Enrollment relies on the school lunch application, provisional schools can only implement Express Enrollment in the year they collect applications. Because of the high-need population within these schools, alternatives are being explored.

[15] Non-food service staff usually conducts EE since school lunch funds can only be used for activities that directly support the school lunch program. However, they are allowed to conduct "incidental" activities related to EE. For example, if a food service staff person calls a family to ask for missing information on the school lunch application, they can also ask the family about missing information related to EE. In addition, schools can use other sources of funds to pay for the time food service staff participates in EE.

[16] A child that is already enrolled in Medi-Cal or Healthy Families is sent a letter informing the parents of such.

[17] The standard processing time for applications in California is 45 days. 22 California Code of Regulations section 50177(a).

[18] MC 368 Notice and Supplemental Form for Express Enrollment Applicants and MC 368(A) Important Information for Medi-Cal Applicants, available at www.expresslane.info.

ENDNOTES

[19] A child determined to have income too high for Medi-Cal, even if the child does not meet immigration guidelines, will also be asked to submit property verification for Share of Cost Medi-Cal, a program in which a family can pay up to a certain level, determined by monthly family income, before Medi-Cal begins to offer assistance.

[20] Restricted Medi-Cal, commonly referred to as emergency Medi-Cal, is available for undocumented persons requiring emergency or pregnancy-related care.

[21] Eighteen states have Medicaid programs with income rules that do not differ by age, over age 1, and meet or exceed 185% of the FPL; 16 states do not have separate SCHIP programs. See www.statehealthfacts.kff.org.

[22] California received federal approval to implement Express Enrollment through a state plan amendment, which sought permission to do presumptive eligibility (PE). The amendment was approved in May of 2003. 42 Code of Federal Regulations (CFR) 435.1101.

[23] The Centers for Medicare and Medicaid Services (CMS), the federal body that administers Medicaid, agreed to classify the modified school lunch application as a Medicaid application if a Medi-Cal perjury statement was included in the consent section. It was significant that CMS did not require the application to ask for the child's social security number in order to be considered a Medicaid application. As such, temporary coverage can extend until a complete eligibility determination is made and does not arbitrarily end at the 45 day presumptive eligibility period. See 42 CFR 435.1101.

[24] Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, August 2001, pp. 2-3.

[25] California Department of Education and the U.S. Department of Agriculture, which oversee the school lunch program, allowed these changes as long as they were marked optional.

[26] In the 2003-04 legislative session, SB 1196 (authored by Senator Cedillo) was introduced to allow school lunch applications and any supplemental forms received in the EE process to be shared, with a parent's consent, with the Healthy Families program or with county- and locally-sponsored health insurance program agencies when an EE applicant is found ineligible for full Medi-Cal benefits.

[27] 7 CFR 245.6(b).

[28] Under federal presumptive eligibility rules, only a "qualified entity" can conduct the screen. States have discretion to decide which entities function as qualified entities, but federal law sets out that Medicaid providers, schools, WIC agencies, Head Start, etc., can be considered. Section 1920A of the Social Security Act, 42 U.S.C. 1396r-1a.

[29] Note: some of the grants also covered activities outside of EE.

[30] The site-based data were compiled by the USC Division of Community Health as part of its evaluation of the Express Lane Eligibility project funded by The California Endowment. These were reported to USC by four of the pilot sites (Fresno, Los Angeles, Redwood City and San Diego) in June 2004. The data reports have not been verified and should be considered preliminary and subject to change. The data from Alum Rock Union Elementary was reported to The Children's Partnership and should be considered preliminary and subject to change.

[31] Los Angeles County currently is reporting that only six percent of children who went through Express Enrollment completed the process. However, the county is still processing applications so this number is not reliable.

[32] The numbers of children who completed the enrollment process and were enrolled in Medi-Cal represent children who returned the follow-up form and were enrolled in full, restricted or share of cost Medi-Cal.

[33] For more information on the Medicaid Administrative Activity (MAA) program, see www.cms.hhs.gov/medicaid/schools/clmguide.asp.

[34] For more information, see www.chigla.org/.

Copies of this report are available at www.expresslane.info or www.kff.org, by sending an e-mail to frontdoor@expresslane.info or by calling (310) 260-1220.

For More Information

All materials and documents mentioned in this report are available at www.expresslane.info. Click on "California Report" and the link "School Lunch" to find information on the pilot school districts and counties implementing Express Enrollment, state guidance and sample forms. The Children's Partnership has also developed a detailed Owner's Manual for school districts implementing Express Enrollment in California that can be obtained by sending an e-mail to frontdoor@expresslane.info or calling (310) 260-1220.

The Kaiser Commission on Medicaid and the Uninsured has published numerous documents on the importance of simplifying the Medicaid and SCHIP application and enrollment process, and providing outreach and follow-up to families. Please visit www.kff.org.

The Children's Partnership

The Children's Partnership (TCP) is a national, nonprofit organization working to ensure that all children—especially those at risk of being left behind—have the resources and the opportunities they need to grow up healthy and lead productive lives. The Children's Partnership focuses particular attention on the goals of securing health coverage for uninsured children and ensuring that the opportunities and benefits of digital technology reach all children and families. With input from its highly respected advisors, The Children's Partnership advances its goals by combining national research with state-based activities that translate analysis into local action. TCP has offices in Santa Monica, CA and Washington, DC.

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The Kaiser Commission on Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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