FOCUS on Health Reform

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Explaining Health Reform: Uses of Express Lane Strategies to Promote Participation in Coverage

Executive Summary

Under the Affordable Care Act (ACA), beginning in 2014, millions of uninsured adults and children will gain eligibility for and are expected to enroll in Medicaid and coverage through new health insurance Exchanges. Many of these individuals participate in other need-based public programs for which they have already provided income and other information needed to establish eligibility. The ACA calls for states to leverage existing data sources as much as possible to develop simple and streamlined processes for establishing, verifying, and updating eligibility for Medicaid, CHIP, and subsidies for Exchange coverage. To do this, states will be required to create linkages between the health subsidy programs and public programs such as Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF), and with databases held by federal agencies like the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service.[1] States can already use eligibility findings from other programs to enroll children in Medicaid and CHIP under the "Express Lane Eligibility" authority in federal statute.

Approaching 2014, states can make optimal use of existing databases to enroll and retain individuals in health coverage by applying "express lane" principles, which refer to the automated use by one agency or program of data gathered and/or findings made by another. Such data-sharing could significantly ease states' implementation of the coverage expansion under health reform, create the most consumer-friendly user experience possible for individuals and families, and optimize the investment of public dollars in modernized, efficient enrollment systems that support ACA's vision. In particular, express lane principles could be used to:

- automatically transfer the 700,000 children in CHIP who are between 100% and 133% of the federal poverty level (FPL) into Medicaid, as ACA directs;
- streamline enrollment for the parents of children already enrolled in Medicaid and CHIP and for uninsured children and adults who participate in SNAP and/or other public programs, at ACA's launch in 2014;
- pre-enroll individuals who are currently in limited coverage, many of whom will become eligible for comprehensive coverage under ACA or could be referred to other programs;
- identify and conduct outreach to hard-to-reach individuals who are enrolled in other public programs; and
- routinely renew coverage and facilitate transitions between programs.

Achieving this progress requires building express lane principles into policy and systems design from the beginning. Numerous federal efforts undertaken since ACA's enactment push in this direction, including federal guidance for Exchange and Medicaid IT systems that emphasizes coordination and a first-class customer experience, and enhanced federal funding for the design and development of Medicaid eligibility and enrollment systems that meet standards related to the same kinds of goals. This brief explains express lane principles and related statutory authority, and outlines how states planning for the implementation of ACA can capitalize on the opportunities they present.

What is Express Lane?

Broadly speaking, "express lane" refers to the use of data held by other government agencies to identify individuals who may be eligible for Medicaid, CHIP, or subsidies for health coverage through insurance Exchanges, evaluate their eligibility, and enroll them or renew their coverage, as appropriate. More narrowly, Express Lane Eligibility (ELE) refers to an optional authority provided to states in section 203 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) that permits state Medicaid and CHIP agencies to rely on findings from an Express Lane agency or agencies, designated by the state, to conduct simplified eligibility determinations and facilitate enrollment of children in Medicaid and CHIP.

With statutory ELE, a Medicaid or CHIP agency can rely on findings (e.g., income, residency, etc.) from Express Lane agencies in assessing a child's Medicaid or CHIP eligibility, even if the Express Lane agencies' methodologies differ from the ones used by Medicaid and/or CHIP.[2] In addition, a state can *initiate* an eligibility determination for children using the findings from other public programs, provided the Medicaid or CHIP agency obtains consent before actually enrolling the children in coverage.[3] The statutory ELE authority is available only for purposes of determining Medicaid and CHIP eligibility for children. The Centers for Medicare and Medicaid Services (CMS) is considering granting demonstration waivers, at state request, to permit the use of ELE for parents of children enrolled in Medicaid and CHIP.

How do ACA and Express Lane relate?

Health reform preserves and endorses broader express lane principles as well as statutory ELE. ACA reinforces express lane principles by requiring states to employ cross-program, data-driven eligibility and enrollment that minimizes burdens on individuals and families, to the "maximum extent practicable."[4] Also, it identifies the use of ELE (i.e., the borrowing of and reliance on findings and data from other programs) as a specific exception, or alternative, to the required use of "modified adjusted gross income" (MAGI) to determine income eligibility for health subsidy programs.[5]

Because, as noted earlier, ELE applies only to children, a state would need CMS approval before it could use statutory ELE to process eligibility for subsidized health coverage for adults. However, ACA provides an opening for applying an express lane exception to MAGI, beyond children. Specifically, included among those for whom an exception to using MAGI applies are "[i]ndividuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance."[6]

If the ELE methodology is extended to adults, it will be important that the ELE protections laid out in CHIPRA also be applied. Specifically, those protections prohibit the use of borrowed findings to deny eligibility or renewal; limit other uses of data shared for this purpose; require the state to obtain affirmative consent to enroll an individual who is determined eligible automatically; and require that individuals be notified that they may be eligible for more advantageous or less costly coverage if they provide more complete information.[7]

How can states use Express Lane in an ACA environment?

Using either express lane principles or the statutory ELE methodology, states implementing ACA can capitalize on electronic data-sharing capabilities to accomplish large-scale enrollment of newly eligible individuals and facilitate renewal on an ongoing basis. States can do this by adopting some or all of the following express lane-supported strategies:

Automatically transition CHIP children to Medicaid. ACA requires states to shift children between 100% and 133% FPL who are enrolled in CHIP to Medicaid by 2014. (States can elect to shift additional CHIP children into Medicaid as well, at any time.) Twenty-one states will be affected by this requirement and a 2010 Urban Institute analysis estimated that, in 2007, approximately 700,000 children with income below 133% FPL were enrolled in CHIP.[8]

To implement the shift of CHIP children to Medicaid, states could use CHIPRA's statutory automatic enrollment option, relying on the CHIP agency's income and other eligibility findings as the basis for the Medicaid eligibility determination. Given states' use of joint Medicaid/CHIP applications, it is likely that most CHIP families have already provided affirmative consent to enroll their children in Medicaid, as required by law to complete automatic enrollment. If not, there is time before 2014 to modify CHIP forms to inform families about the upcoming change and obtain their consent for this possible transfer of enrollment.

This approach would allow for a simple, one-time roll-over of affected CHIP children into Medicaid, in much the same manner that Louisiana enrolled over 10,000 children in Medicaid based on SNAP data and findings, with one flip of a switch.[9] States would still need to provide supports to families to help children retain trusted providers when possible, and to ensure that families know how to access care in the new program.

Leverage data for initial high-volume enrollment at the launch of health reform. Under ACA, about 32 million uninsured nonelderly individuals are expected to become newly eligible for coverage.[10] All of these individuals will have to have their eligibility determined. Many of the adults who will gain eligibility for Medicaid or subsidized Exchange coverage are parents of children who are enrolled in Medicaid or CHIP. For most of them, eligibility information already held by the Medicaid and/or CHIP system will be adequate to determine eligibility. In addition, 12% of uninsured adults and children are enrolled in SNAP.[11] These individuals have already provided demographic information, social security number, proof of legal immigration status or citizenship, proof of net income under 100% FPL (and gross income under 130% FPL), and other eligibility data – all of the eligibility data needed to make a Medicaid determination under ACA. SNAP's requirements for frequent recertification and extensive eligibility data collection make it a dependable source of current information about low-income families, of great value for purposes of a Medicaid eligibility determination.

Leveraging data already gathered and evaluated for child enrollment in Medicaid or CHIP to process eligibility for parents, and using SNAP and/or other government program databases, states could implement a large-scale, one-time enrollment initiative when ACA first takes effect. They could identify newly eligible individuals through their enrollment in other programs,[12] process them using data provided to and findings made by those programs, and permit them to either opt into the subsidized coverage program that is indicated or request a more complete

determination (and provide more information) when doing so might increase their benefits or lower their costs.

Pre-enroll people transitioning from limited coverage to Medicaid, CHIP, or Exchange coverage under ACA. Currently, states offer a patchwork of limited health coverage programs, such as family planning services or breast and cervical cancer treatment. Under ACA, most individuals in these programs will be eligible for comprehensive coverage. States can use express lane principles to help transition eligible individuals enrolled in limited benefits programs into comprehensive coverage under Medicaid, CHIP, or the Exchange by notifying enrollees about upcoming program changes, obtaining their consent to share their eligibility information with the Medicaid/CHIP/Exchange authority, and running an eligibility determination in the months leading up to 2014. Those who qualify for comprehensive coverage could be "pre-enrolled," with the final enrollment steps, such as choosing among plans, to occur when ACA is fully launched in 2014. Those who do not qualify for comprehensive benefits could be retained in their current limited coverage if the programs are continued, or be referred to other programs. Such a pre-enrollment process would help states handle the heavy volume expected when new coverage options become available on January 1, 2014.

Identify and enroll hard-to-reach individuals. Of the roughly 7 million children who are uninsured today, nearly two-thirds are eligible for Medicaid or CHIP but not enrolled.[13] To the extent that these low-income children and other hard-to-reach populations participate in other public programs, limited enrollment data from those programs could be shared to help target outreach efforts. If the administrative burden of enrolling in health coverage can be reduced through the use of available data, these individuals may be more likely to participate. This strategy has been used successfully in a school-based initiative in the Chicago public schools that builds upon a family's relationship with a school and utilizes data held by the school to facilitate the Medicaid/CHIP outreach and enrollment process.[14]

Ease the process for individuals who do not benefit from ACA's simplified income rules. ACA simplifies the eligibility determination process by creating a uniform income standard that can be satisfied through data-matching against federal sources.[15] Despite this positive policy development, not all applicants will benefit from this simplification. For example, federal income tax data may not be available electronically for those below the tax-filing threshold. Or, the tax data may no longer be relevant in the case of individuals whose circumstances have changed. For these individuals and their families, there may be other usable, current income data already held and verified by other public programs or databases, such as the National Directory of New Hires. Where possible, such data linkages could be forged and incorporated into the eligibility process.

Deploy routine, data-driven renewal and transition processes. A number of states routinely calculate and renew Medicaid eligibility through electronic verification of eligibility information captured by another need-based program (usually SNAP and TANF), reducing paperwork burdens on applicants and enrollees.[16] Over half the states verify citizenship for purposes of Medicaid and CHIP eligibility through an electronic data-match with the Social Security Administration. Under ACA, too, available information could be used to renew health coverage on a rolling basis as renewal for other public benefits programs is conducted, and/or to transfer beneficiaries seamlessly between subsidy programs without burdening them. For example, each time a family recertifies SNAP eligibility, updated income and other eligibility data (and, with

federal approval, related eligibility findings) could be poured into the Medicaid eligibility system, triggering an automatic renewal of Medicaid eligibility. Similarly, an individual's application for unemployment insurance, which indicates changed circumstances that may result in a coverage transition, could trigger an eligibility review and provide most of the eligibility data for that review.

Alabama has deployed this automated renewal process using statutory ELE, with the Medicaid agency borrowing income findings and other information from TANF and SNAP. In the first nine months of operation, eligibility for 28,927 children was renewed in this manner.[17] Alabama is already working with CMS to obtain the necessary approval to implement automated renewal for the whole family (parents included) as part of its planned ELE roll-out.

Facilitate transitions across state lines. Today's families, particularly low-income families, are highly mobile. Fully 21.5% of uninsured children change addresses each year.[18] Looking at just two states as an example, in a recent year, California experienced 500,691 people leaving the state and 388,244 moving into the state, and New York had 339,191 people leave the state and 240,394 move in.[19] With the greater uniformity of eligibility guidelines provided by ACA, Medicaid and Exchange eligibility processes will become better aligned across states. This alignment creates a new opportunity to facilitate transitions as families move from one state to another, promoting seamless, continuous coverage. Federal databases will support this process, allowing states to retrieve and verify the same information about an individual's income (i.e., MAGI), immigration status, and other eligibility criteria. Using express lane principles, one state could use data from, and/or, with federal approval, adopt the eligibility determination of another state. Wisconsin uses such a procedure to grant migrant workers eligibility for medical assistance when they and their dependents have proof of enrollment in medical assistance in another state.[20]

What federal policies and funding opportunities support use of Express Lane principles?

Numerous federal efforts taken since ACA's enactment promote the development of policies, procedures, and systems that support interoperability – the bi-directional exchange of information between agency systems – directly in line with express lane principles. These include:

- funding guidelines that promote data-sharing;
- calls for greater collaboration, efficiency, and effectiveness;
- new standards and protocols governing enrollment processes; and
- growing emphasis on creating a first-class consumer experience.

All federal guidelines issued as a part of ACA implementation emphasize collaboration across agencies to achieve coordinated and data-driven enrollment processes. Primary among these documents is *the CMS Guidance for Exchange and Medicaid Information Technology (IT) Systems 2.0*, which establishes an expectation for collaborative IT development that ensures a first-class consumer experience.[21] Systems developed or enhanced as part of Exchange development are expected to: "Ensure seamless coordination between the Exchange, Medicaid, and CHIP, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services."[22]

CMS recently issued rules providing a 90% federal matching rate for state expenditures attributable to the development or enhancement of Medicaid eligibility and enrollment systems that meet the rules' standards and conditions, as well as a 75% matching rate for maintenance and operations of such systems.[23] The rules establish standards and conditions that maximize cross-agency systems' interoperability in order to improve efficiency and drive better enrollment and retention. The rules also emphasize the need for a consumer-focused approach to systems change, using available data to assist the consumer.

The consumer focus and emphasis on leveraging available data to promote coverage is also supported by the eligibility and enrollment standards and protocols developed for ACA.[24] The standards specifically task the federal government with developing a tool set that allows for the seamless integration of all health and human services programs.[25] Also, in a manner that supports the ACA eligibility and enrollment process, the federal government is actively developing the National Information Exchange Model (NIEM) guidelines, to support consistent, efficient, and transparent exchange of data between federal programs.[26]

Conclusion

Americans' health and welfare is advanced when it is simple for individuals and families to enroll in the programs or services they need. The technological developments of the past decade make such simplification possible in unprecedented ways, and ACA provides states with the policy guidance and financial incentives to build systems that capitalize on information technology, delivering a first-class user experience. States can use express lane principles in designing these systems, paving the way for Americans to participate in health coverage as ACA envisions, and improving government efficiency and effectiveness in the process.

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ENDNOTES

[1] The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, *Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act* (Oct. 2010) (http://www.kff.org/healthreform/8108.cfm).

[2] 42 U.S.C. 1396a(e)(13)(A)(i) and (ii). Importantly, even where the other program uses a different budget unit, disregard, deeming, or other methodology to make the finding, the finding is still available to borrow for purposes of a Medicaid/CHIP determination, without recalculation under Medicaid/CHIP rules.

[3] In order for data to be available for this purpose, the family must generally have consented (or, not object) to share that data with the health agencies at some point, often on the other program's application form, and the involved program agencies must have entered into an interagency agreement. In addition, before enrolling a child identified as eligible through this process, the agency must obtain affirmative consent to enroll from the child's parent or guardian.

[4] ACA, §1413(c)(3)(A)(ii).

[5] ACA, §2002. Use of the MAGI standard is itself a form of ELE, as it calls upon the Medicaid or CHIP agency or insurance exchange to rely upon the IRS' finding of income.

[6] ACA, § 2002(a) (adding a new 43 U.S.C. 1396a(e)(14)(D)(i)(I); Stan Dorn, Urban Institute, *Implementing National Health Reform: A Five-Part Strategy for Reaching the Eligible Uninsured* (Robert Wood Johnson Foundation, May 2011), footnote 65. It is important to note that this provision distinguishes such an individual from one who receives supplemental security income (SSI) or is in foster care. Thus, just as eligibility for SSI and foster care establishes eligibility for medical assistance, the ACA anticipates eligibility for additional public programs as forming the basis for income eligibility.

[7] The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, *Putting Children on the Express Lane to Health Insurance: Why Express Lane Eligibility Makes Sense for States and Low-Income Families* (Oct. 2009) (http://www.kff.org/medicaid/upload/8006.pdf).

[8] Urban Institute, *Potential Impacts of Alternative Health Care Reform Proposals for Children with Medicaid and CHIP Coverage* (Jan. 2010) 6 (http://www.urban.org/publications/411993.html); Kaiser Family Foundation, "Income Eligibility Limits for Children's Regular Medicaid and Children's CHIP-funded Medicaid Expansions as a Percent of Federal Poverty Level (FPL), January 2011," *statehealthfacts.org* (http://www.statehealthfacts.org/comparereport.jsp?rep=76&cat=4).

[9] Kaiser Commission on Medicaid and the Uninsured, *Optimizing Medicaid Enrollment: Spotlight on Technology - Louisiana's Express Lane Eligibility* (August 2010) (http://www.kff.org/medicaid/8088.cfm).

[10] Congressional Budget Office, letter to the Honorable Nancy Pelosi providing a complete analysis of the reconciliation proposal (March 20, 2010) (http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf).

[11] Figure for adults: Kaiser Commission on Medicaid and the Uninsured, *Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years* (July 2010) 4 (http://www.kff.org/uninsured/upload/8083.pdf); figure for Children (2008): Urban Institute, *Uninsured Children: Who Are They and Where Do They Live?* (August 2010) Exhibit 22 (http://www.rwjf.org/files/research/67668.pdf).

[12] To make the most of this opportunity, states may need to examine and revise their current application forms for the relevant other public programs to provide an opportunity for individuals to consent to information sharing for this purpose.

[13] Urban Institute, "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs*, Sept. 2010 (http://content.healthaffairs.org/content/early/2010/09/03/hlthaff.2010.0747.abstract).

[14] Kaiser Commission on Medicaid and the Uninsured, *Optimizing Medicaid Enrollment: Spotlight on Technology – Using Schools and Data Matching to Enroll Kids in Medicaid and CHIP* (Dec. 2010) (http://www.kff.org/medicaid/upload/8123.pdf).

[15] The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, *Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges* (August 2010) (http://www.kff.org/healthreform/8090.cfm).

[16] Kaiser Commission on Medicaid and the Uninsured, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011* (January 2011) (http://www.kff.org/medicaid/8130.cfm).
[17] Families USA, *Express Lane Eligibility: Early State Experiences and Lessons for Health Reform* (January 2011) (http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf).
[18] http://www.rwjf.org/files/research/67668.pdf, Exhibit 21.
[19] Migration figures, using IRS data for 2007/2008, as calculated by the Tax Foundation, "State to State Migration Data" accessed April 3, 2011 (http://interactive.taxfoundation.org/migration/).
[20] Wisconsin Statutes, s. 49.47(4)(av).
[21] Centers for Medicare & Medicaid Services, *Guidance for Exchange and Medicaid Information Technology (IT) Systems*, Version 2.0 (May 2011) (http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf).
[22] Ibid., 12.
[23] Federal Register, April 19, 2011, pp. 21950-21975 (http://federalregister.gov/a/2011-9340). Development funding is available until December 31, 2015 and enhanced funding for maintenance and operations is only available to systems that meet the conditions as of that date.
[24] Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, HIT Policy & Standards Committee Enrollment Workgroup, "Recommendations" (September 3, 2010) adopted by the Secretary (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__regulations_and_guidance/1496).
[25] Ibid., Rec. 2.1 and Rec. 3.2.
[26] Ibid., Rec. 1.1.

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