CREATIVE SOLUTIONS

Express Lane Eligibility

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Although great progress has been made in providing health coverage to low-income children, 9.2 million children remain uninsured. About 6.8 million of these children are eligible for public health insurance coverage.[1] (See the article by Holahan, Dubay, and Kenney in this journal issue.) Many of these uninsured children are enrolled in other public programs for low-income families that have eligibility requirements similar to those for public health insurance programs (Medicaid and the State Children's Health Insurance Program, or SCHIP).[2] Most low-income, uninsured children (63%, or 4.3 million) are concentrated in families that receive benefits through food stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[3] The school lunch program alone reaches 3.7 million uninsured children, representing more than one-half of all low-income, uninsured children in the United States.[4] Therefore, targeting outreach to and simplifying health insurance enrollment for uninsured children enrolled in other public programs is both logical and efficient.

Programs like food stamps, WIC, and school lunch provide an obvious opportunity to link low-income children with health coverage. States could use eligibility information that families have provided to these programs as a basis for enrolling children in public health insurance coverage, but most states have no such system in place. Instead, families usually must visit multiple public agencies and submit duplicative information to each.

This article describes some states' creative strategies to increase children's enrollment in health insurance by connecting Medicaid and SCHIP with other public programs for low-income children and families. These strategies, referred to as "express lane eligibility" (ELE),[5] have the potential to significantly increase the number of low-income children with health insurance. The article begins with an overview of how ELE works, then assesses challenges facing ELE, and closes by offering several recommendations for how states can expand their use of ELE strategies.

Overview of ELE

States have used a variety of strategies to tackle the problem of high rates of uninsurance among children who participate in other public benefit programs. These strategies include targeted outreach, streamlined application processes, and automatic enrollment.

Targeted outreach uses other public programs as referral sources for finding, contacting, and providing application assistance to uninsured children who are eligible for Medicaid and SCHIP. This strategy has been used most widely with the school lunch program. The income-eligibility threshold for school lunch is more restrictive than that of most state public health insur-

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ance programs: To qualify for the school lunch program, children must live in families with incomes at or below 185% of the federal poverty level (FPL). Therefore, children eligible for school lunch often prove eligible for Medicaid or SCHIP as well. One example of targeted outreach through the school lunch program was recently implemented in Ohio (see Box 1).

The strategy of streamlining applications goes a step further than targeted outreach by allowing the information a family has already provided to another public program to be used to evaluate a child's eligibility for Medicaid/SCHIP, or as a basis for recertification of eligibility. For example, Vermont has implemented a streamlining effort through WIC, and Los Angeles County has implemented a similar initiative through the food stamp program (see Box 2).

Beyond these two primary forms of ELE, the strategy that has the greatest potential benefit for children is automatic enrollment, which uses a child's enrollment in an income-comparable public program as a basis for qualifying that child as income-eligible for Medicaid or SCHIP. In California, for example, a new law will enable schools to use information from school lunch program applications to enroll children in the state's Medicaid program, a process that combines express lane and presumptive eligibility.[6] (See Box 3.) Also called adjunctive eligibility, automatic enrollment is already in place in other programs. For instance, since 1989, WIC agencies have been able to accept an applicant's documented participation in Medicaid, food stamps, or Temporary Assistance for Needy Families (TANF) as evidence of income eligibility for WIC.[7] Automatic enrollment has not been widely used in Medicaid and SCHIP, largely because it involves reconciling eligibility criteria for different programs and is therefore difficult to implement.[8] Thus, while valuable progress has been made in streamlining enrollment processes, many challenges remain.

Challenges to Implementing ELE Strategies

Although ELE offers the potential to find children and enroll them in health insurance programs, inherent difficulties remain in coordinating enrollment across different programs. ELE will also vary from state to state, depending on the state's eligibility rules for health insurance, policies concerning immigrants, level of integration between Medicaid and SCHIP, technological capacity, and ability to coordinate programs across agencies. This section describes the barriers to creating a more unified system across public programs and suggests strategies for overcoming them.

Box 1

Targeted Outreach: Ohio's School Lunch Program

In 2001–2002, all Ohio public schools were required to include a one-page health insurance addendum along with the school lunch application sent to parents. The addendum asked families interested in obtaining free or low-cost health care to complete and return the form with the school lunch application. Schools then sent these forms to the state, which mailed interested families an application for Healthy Start, Healthy Families, the state's Medicaid and SCHIP program. In Cincinnati, the public schools went further, entering the information from the addendum into a database that was then transferred to an outreach contractor for follow-up and application assistance.

In the program's first year (2001–2002), 47% of families who requested applications received health insurance for their children. Among the rest, 32% were already covered by public health insurance, 11% were denied enrollment, and 7% did not complete the process.

Source: Ohio Department of Job and Family Services and Ohio Family and Children First. ODJFS and OFCF school based outreach. Internal report. 2002.

Box 2

Streamlined Application: Vermont's WIC Program and Los Angeles County's Food Stamp Program

Both the state of Vermont and Los Angeles County have sought to streamline enrollment into public health insurance by using information that families provide when they apply to other programs.

Vermont's WIC Program

Vermont has coordinated its Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and its health program application and enrollment systems. WIC's income-eligibility guidelines (up to 185% of the FPL) are far below those of Vermont's health programs (up to 300% of the FPL).

An applicant to WIC or Medicaid/Dr. Dynasaur (Vermont's Medicaid and SCHIP programs) completes a single application and submits it to either program agency. The agency determines eligibility for its program and forwards the application to the other agency for review. Medicaid/Dr. Dynasaur adopts WIC's income determination, although each case is reviewed to see if income needs to be redetermined for health coverage purposes because of slight differences in the way such incomes are calculated. The health programs must also explore any outstanding issues beyond income, such as citizenship, which the health insurance application addresses, but the WIC processing team does not check. As a result of this process, 97% of Vermont's children on WIC had health insurance at the time of their most recent WIC visit.

Los Angeles County's Food Stamp Program

In Los Angeles County, the Department of Public Social Services (DPSS) recognized that the food stamp program was perhaps the most straightforward way to get started with express lane eligibility. The program has an income threshold comparable to most states' Medicaid programs, imposes strict eligibility rules, maintains current data, and is usually administered by the same agency or the same eligibility workers. DPSS implemented a system to ensure that all children enrolled in the food stamp program were also enrolled in Medi-Cal (California's Medicaid program). Staff conducted a computer search to locate all families with children enrolled in food stamps but not Medi-Cal and sent them a notice of potential eligibility. The notice included a card that the family could sign and return, authorizing the county to access the family's food stamp case file. DPSS then used the information and documentation provided on the food stamp application, and through any periodic reporting, to determine the child's Medi-Cal eligibility. More than 1,000 children were enrolled in Medi-Cal in this manner.

Sources: Vermont Department of Health. Insurance status of WIC participants—all district offices. Internal report. March 2002; Los Angeles County Department of Public Social Services. Medi-Cal outreach to uninsured food stamp families. Internal report. May 9, 2000.

Eligibility Rules

Public benefit programs have different eligibility rules pursuant to federal and/or state law. Where eligibility rules differ across programs, states may have to develop a system for following up with families to obtain additional information or documentation needed for a Medicaid/SCHIP determination. Alternatively, states may amend Medicaid/SCHIP rules to make them expansive enough to accept another program's eligibility determination.

For instance, food stamp programs calculate income eligibility based on household income, while Medicaid and SCHIP base eligibility on family income, which potentially incorporates fewer people and/or fewer incomes. A state that wanted to use a food stamp application to make a Medicaid determination could follow up as needed with an applicant to determine which household members were part of the applicant's family. Taking compatibility one step further, states that impose an assets test for health coverage might consider eliminating it, thus making the WIC or school lunch income determinations more relevant to the health program determination (since those programs impose no assets test).

The Centers for Medicare and Medicaid Services allows state Medicaid agencies to accept other programs' determinations, provided that those programs have rules for determining eligibility (such as the income methodology used to assess income) that are equally or more restrictive than the rules in Medicaid.[9]

States' comfort with automatic eligibility would be greatly enhanced by federal legislation that specifically authorized states to accept an income determination made by other specified public program agencies, irrespective of differences in methodology (if doing so would not adversely impact the error rate). Without federal express lane legislation, automatic eligibility is possible through creative planning, but its design is likely to be more administratively complex and less cost effective.

Immigration Requirements

Differences in program eligibility rules also pose challenges when it comes to serving noncitizen families. Some public programs have less restrictive requirements regarding immigrant status than do Medicaid and

Box 3

Automatic Enrollment: California's School Lunch Program

In October 2001, California passed a law that combines automatic express lane eligibility with a presumptive eligibility process, allowing children to immediately receive Medi-Cal (California's Medicaid program) coverage, based on information from their school lunch applications.[a]

In California, Medi-Cal for children ages one to five extends up to 133% of the FPL, and for older children to 100%, while free school lunch eligibility extends up to 130% of the FPL. Approximately 69% of California's low-income, uninsured children are in families that participate in school lunch.[b]

To implement the new law, schools will modify school lunch applications, requesting parental consent to share the information on the application with Medi-Cal, and gathering some additional information, such as information on family relationships. Children under age six who are eligible for free meals will be considered "express eligible"—automatically determined to have met the income requirements for Medi-Cal. The school or other designated entity will review applications of children age six and above (who may have family incomes above Medi-Cal eligibility levels) to determine family income, based on Medi-Cal's household rules. The school lunch program counts income for all members in the household, while Medi-Cal's rules are more limiting, so almost all children age six and above will be easily certified as income-eligible for Medi-Cal (express eligible).[c]

The school will transfer all applications with parental consent to the county Medi-Cal office. The county will enroll express eligible children into Medi-Cal and send each family a benefits card that enables a child to access services while his or her application undergoes further review. As part of the review process, the county will have to follow up with most families to obtain additional information, particularly immigration status, unless the information is available through existing databases. Children who are not eligible for express enrollment will also be contacted for additional information for a Medi-Cal determination; however, they will not receive benefits while their applications are being reviewed.

A number of school districts were prepared to implement express enrollment in the summer of 2002, but budget shortfalls led the governor to delay implementation until July 2003. School districts and counties are currently planning to launch the program in the 2003 school year.[d]

[a] *An act to amend Sections 49075, 49557, and 49558 of, and to add Section 49557.2 to, the Education Code, and to add Sections 10618.5 and 14005.41 to the Welfare and Institutions Code, relating to human services.* California Statutes and Amendments to the Code, chapter 894. 2001.
[b] Urban Institute. Uninsured children and program participation, California and the U.S., 1997–1999. Unpublished tabulations from the 1997 and 1999 National Survey of America's Families. 2002. "Low-income" refers to those with family incomes at or below 200% of the FPL.
[c] California Health and Human Services Agency and Department of Health Services. Internal documents. 2002.
[d] Interviews with school district staff, including staff at the Los Angeles Unified School District, the San Diego Unified School District, and the Fresno Unified School District, February 2003. Information on the status of implementation can be found at http://www.expresslaneca.info.

SCHIP. For instance, federal law requires Medicaid and SCHIP to establish the citizenship and immigration status of applicants, but it does not require WIC and school lunch to do so.[10]

Working with immigrants regarding eligibility for public programs requires extra sensitivity to their concerns about being viewed as public charges. (See the article by Lessard and Ku in this journal issue.) Therefore, any administrative links between Medicaid/SCHIP and other programs would need to respect the trust established between families and other program agencies. Families would need to consent to share the information they provide to another public program and know that they may be asked for additional information, such as immigration documents, to determine eligibility for health insurance. Similarly, families would need reassurance that their eligibility for the other program would not be affected and that the information would be used only to make a Medicaid/SCHIP determination. States would also need to test forms and procedures with immigrants and monitor uptake of the public programs to ensure minimal falloff in enrollment as a result of ELE.

Integration between SCHIP and Medicaid

The compatibility between public health programs themselves is as important as the compatibility between public health and other public programs. States that opted for separate SCHIP rather than Medicaid expansions must address eligibility and administrative differences between the two health programs as they design an ELE system. Steps include: ensuring that information can easily be transmitted between programs; designing procedures that guarantee that Medicaid-eligible children are enrolled in Medicaid rather than SCHIP; and developing a system to ensure that the state receives enhanced federal matching rates, where appropriate. Because of differences between programs, careful planning and strategy development are key to any successful ELE project.

Technological Capacity

ELE can be most efficient across programs that have compatible computer systems, and data can be transferred between agencies. Computers can be used to add data to health care applications from other program applications, or to determine Medicaid/SCHIP eligibility using data from other program applications. Most states lack the technological infrastructure that allows information to be easily shared and enables automatic eligibility determinations between programs.[11]

Collaboration across Agencies and Programs

Express lane processes involve time and resource investment by non-Medicaid programs that are already operating at full capacity. To succeed, ELE requires that agencies collaborate and locate resources to support needed technological advances and personnel. Medicaid and SCHIP administrative funds can finance much of this work. But beyond funding, success hinges on non-Medicaid program staff understanding that this process is valuable, and on making the process as simple and rewarding as possible for all agencies involved.

For example, while families may know how to access school lunch, they may not have much experience with accessing and using health care systems, a problem that can be exacerbated by cultural differences with regard to health and health insurance. (See the article by Lessard and Ku.) When school lunch and Medicaid agencies work together, however, a family's ties to school lunch can smooth the way to enrolling children in public health coverage and an appropriate medical home.

Next Steps for States

In assessing their opportunities for implementing express lane eligibility, states should consider a number of factors. More effective and efficient public health insurance programs for children are likely if states do the following:

- Review other program guidelines to determine which are best aligned with the state's existing Medicaid and SCHIP guidelines.
- Choose programs operated by agencies that have a good working relationship with the health care

agency(ies) and preferably have or can develop the capacity to share information electronically.

- Determine which programs enroll the largest proportion of uninsured children, thus meriting the effort of ELE. If this information is not available, examine the rate of uninsurance among different age groups, and choose programs that serve the least insured age group (infants, preschoolers, or school-agers).
- Where the state operates SCHIP separately, avoid screening and enrollment problems by targeting ELE to Medicaid-eligible children, if possible.
- Assess whether it is most effective and feasible to implement the program at a county/local level or at a state level.
- Consider using presumptive eligibility when a child is referred to a public health insurance program by another program. This process would allow the child to be presumed eligible for health insurance and receive needed services while the state makes a final eligibility determination (see the article by Klein in this journal issue).

Conclusion

Although significant challenges remain to implementing an express lane strategy, successful ELE strategies offer the opportunity to enroll and retain millions of uninsured children in public health programs, improve administrative efficiencies, and simplify enrollment processes. Longer term, ELE offers a first step toward coordinating valuable public service programs that benefit low-income children, making it easier for children to access a range of services they need to improve their well-being and quality of life.

ENDNOTES

1. Dubay, L., Haley, J., and Kenney, G. *Children's eligibility for Medicaid and SCHIP: A view from 2000.* Washington, DC: Urban Institute, March 2002, series B, no. B-41, p. 3. "Low-income" refers to those with family incomes at or below 200% of the FPL.
2. Kenney, G., and Haley, J. Unpublished data compiled at the Urban Institute. May 2002; Uninsured children and program participation, the U.S., 1999. Unpublished tabulations from the National Survey of America's Families. 1999.
3. Currently, 40 states provide Medicaid or SCHIP to children with family incomes at or above 200% of the FPL. Mann, C. Address to the U.S. Senate Subcommittee on Public Health on "Issues Facing Medicaid and CHIP." Washington, DC. March 12, 2002. The food stamp program covers households with gross incomes up to 130% of the FPL, WIC covers families up to 185% of the FPL, and school lunch covers households with incomes up to 130% of the FPL for free meals and up to 185% of the FPL for reduced-price meals. Horner, D., Morrow, B., and Lazarus, W. *Putting express lane eligibility into practice.* Washington, DC: Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, November 2000. Available online at http://www.expresslane.info.
4. See note 2, Kenney and Haley. These 3.7 million uninsured children represent 23% of the low-income children receiving school lunch, or 58% of low-income, uninsured children. Urban Institute tabulations also found that 1.3 million low-income, uninsured children participate in WIC (15% of WIC children, 21% of low-income, uninsured children), and 370,000 participate in food stamps (6% of food stamp children, 6% of low-income, uninsured children).
5. The term "express lane eligibility" was coined by The Children's Partnership. See note 3, Horner, et al.
6. For further information about presumptive eligibility, see the article by Klein in this journal issue.
7. *Omnibus Budget Reconciliation Act of 1989*, Public Law 101-147, 7 CFR § 246.7(d)(2)(vi). 101st Congress, November 10, 1989.
8. Pursuant to federal law, automatic eligibility for Medicaid without a separate Medicaid application exists for Social Security Income (SSI) recipients in some states. 42 CFR § 435.909. Prior to welfare reform, Aid to Families with Dependent Children (AFDC) enrollment also established automatic Medicaid eligibility. Schneider, A., Fennel, K., and Long, P. *Medicaid eligibility for families and children.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 1998, p. 7.
9. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Continuing the progress: Enrolling and retaining low-income families and children in health coverage.* Washington, DC: DHHS, CMMS. August 2001, p. 11.
10. Health Care Financing Administration. Letter to state health and welfare officials. September 21, 2000.
11. For example, see Cohen Ross, D. *Enrolling children in health coverage: It can start with school lunch.* Washington, DC: Center on Budget and Policy Priorities, January 2001.