Putting Children on the *Express Lane* to Health Insurance

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Why Express Lane Eligibility Makes Sense for States and Low-Income Families

SUMMARY

Authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Express Lane Eligibility (ELE) is a new tool available to states to streamline enrollment and renewal of children in Medicaid and CHIP. A primary goal of this and other outreach and simplification initiatives in CHIPRA is to reach the estimated seven in ten uninsured children who are eligible for Medicaid or CHIP. ELE allows state Medicaid and CHIP agencies to utilize eligibility findings from other public programs, such as Head Start or Food Stamps, and/or tax return data to identify, enroll, and recertify children rather than requiring them to re-analyze and determine eligibility under their own rules. This brief provides an overview of ELE and highlights the potential benefits of implementing an ELE initiative, including:

Increased coverage of and access to care for low-income children. Since large numbers of uninsured children who are eligible for Medicaid or CHIP already participate in other need-based programs, ELE offers the potential to reach and enroll large numbers of uninsured children through those programs. Further, ELE enables states to implement "automatic enrollment" by using information from other programs or tax returns to initiate enrollment. State-initiated enrollment efforts reach larger numbers of children than those that wait for a family to apply for or renew coverage. Research suggests that the increases in coverage that can result from ELE will help improve children's access to care, quality of care, and health outcomes.

Simplified Medicaid and CHIP renewal processes and increased stability of coverage. States can use ELE to simplify Medicaid and CHIP renewal processes by relying on updated information and findings from other programs to process redeterminations. In fact, ELE enables a state to create a Medicaid/CHIP renewal process that does not require any action by the family. Simplifying renewal processes supports continuous coverage for children, which has important implications for their care. Even brief gaps in children's coverage are associated with reduced access to care and increased rates of unmet need and forgone care.

Administrative and program savings. By simplifying enrollment and renewal processes, ELE can reduce administrative burdens and costs for states. Further, ELE has the potential to reduce program costs through improvements in children's access to and quality of care that stem from more continuous coverage.

Greater program coordination and modernized enrollment systems. By allowing Medicaid and CHIP to borrow other programs' findings, ELE makes it easier for states to coordinate enrollment across programs and allows them to get real value from data sharing. Technology can be a key element of these efforts. As such, a state can use an ELE initiative as a platform for developing a modernized, online enrollment system that provides a single point of entry for multiple programs and pulls relevant data from various state databases. Further, ELE can help states coordinate program efforts to provide support services. For example, some public programs are required to help facilitate a child's access to health care and coverage as part of their overall missions and can use ELE to meet these requirements.

In sum, ELE provides a new tool to support states' Medicaid and CHIP enrollment and renewal efforts. Regardless of the outcome of health reform, the systemic improvements made as part of an ELE initiative can help facilitate coverage and access to care for low-income children and increase program coordination and collaboration. Furthermore, ELE initiatives provide value by increasing administrative efficiency while also setting the cornerstone for a modernized enrollment system that can help meet a state's future technology needs.

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Introduction

Express Lane Eligibility (ELE) is a new tool available to states to streamline enrollment and renewal of children in Medicaid and CHIP. ELE allows state Medicaid and CHIP agencies to utilize data and eligibility findings from other public need-based programs, such as Head Start or Food Stamps, and/or tax return data to identify, enroll, and recertify children rather than requiring them to re-analyze and determine eligibility under their own rules. ELE offers a number of potential benefits for both Medicaid and CHIP agencies and low-income families. This brief provides an overview of ELE, presents an example of what ELE can look like in practice, and highlights the potential benefits associated with implementing an ELE initiative.

What is Express Lane Eligibility?

Authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), ELE allows state Medicaid and CHIP agencies to rely on eligibility finding(s) from other need-based program(s) like the National School Lunch Program as well as data from tax returns to make Medicaid and/or CHIP eligibility and renewal determinations, even when the other program's method for making that finding is different from that of Medicaid and CHIP. For example, if a state's subsidized child care agency has determined that a child has a net income of 122 percent of the federal poverty level (FPL), then the Medicaid agency can use that income finding to determine Medicaid eligibility for the child rather than re-evaluating the child's income using its own methods.

Prior to ELE, states could not rely on another program's eligibility finding to determine Medicaid or CHIP eligibility if that program's methodology for determining eligibility differed in any way from that used in Medicaid and CHIP. Unless a state uses ELE, even if it has access to all of the necessary eligibility information in another program file, Medicaid and CHIP will often lack some information required to make its final determination – especially for a complicated eligibility element like income. For instance, the State Nutrition Assistance Program (SNAP) collects most eligibility elements required for Medicaid and CHIP enrollment. However, because the programs' income counting rules are not identical, a Medicaid or CHIP eligibility worker would not be able to rely solely on the SNAP application to make its eligibility determination without the benefit of ELE.

Under CHIPRA, states can choose from a wide range of other programs to serve as "Express Lane agencies."[1] Medicaid and CHIP agencies can borrow any timely eligibility finding except citizenship from an Express Lane agency and have the option of obtaining information on citizenship status through an electronic exchange of data with the Social Security Administration. Further, states can use available data and findings from other programs to initiate enrollment or renewal, called "automatic enrollment," rather than waiting for a family to initiate the process.

Beyond providing authority to implement ELE, CHIPRA also encourages states to use ELE by: clarifying rules about data-sharing (who can share what data with whom); encouraging the use of electronic signatures; defining streamlined screen and enroll procedures to ensure children enroll in the program for which they are eligible – Medicaid or CHIP; and providing financial performance bonuses tied to states' use of ELE and other enrollment streamlining measures.

Further, the ELE provisions contain safeguards to ensure that use of ELE does not place children at any disadvantage and does not place programs at risk of penalties. Specifically, under CHIPRA:

- Children found ineligible for Medicaid or CHIP through ELE must have their eligibility evaluated through standard methods before they can be denied coverage.
- Children enrolled using ELE are not to be included in studies done to comply with Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) requirements, which remain in place as to other enrollees. Instead, CHIPRA sets up a separate set of quality control procedures to apply to ELE, with no penalty attached.

What Might Express Lane Eligibility Look Like in Practice?

ELE can be accomplished in collaboration with numerous public programs. The following example gives an idea of how ELE can be incorporated into the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). However, ELE is not a one-size-fits-all effort. The details of how a state implements ELE will vary depending on the state's Medicaid and CHIP program rules, agency structures, available technology, leadership support, program demographics, and funding options, as well as the state's design choices (such as whether to focus on renewal, whether to grant immediate temporary coverage through presumptive eligibility, or whether to utilize automatic enrollment).

An Example of ELE: Electronically-Supported ELE through WIC

Step 1. A mother and her child (age 0-5) apply for WIC in person (per WIC requirements). Mother completes the full WIC application with a WIC eligibility worker, who enters the information directly into WIC's electronic eligibility system.

Step 2. The WIC application asks the mother whether the child has a source of health care. If she enters "no" and/or enters no Medicaid/CHIP identification number, which is also asked, then an additional screen will pop up to initiate the ELE process.

Step 3. The ELE process is initiated. The WIC caseworker will ask: "Do you want to apply for public health insurance coverage for your child(ren) right now? He or she might be able to get immediate coverage."

Step 4. WIC information automatically populates the Medicaid/CHIP application. If the applicant answers "yes," relevant information and eligibility findings from the WIC application are automatically populated into an electronic Medicaid/CHIP application. Ideally, this would also activate an electronic retrieval of all other relevant information that is held by other state databases -- such as vital statistics, unemployment insurance, and other public programs. Those applicants stating that they were born in the U.S. on their WIC application will have their citizenship status checked through new electronic data matching procedures with the Social Security Administration. Those indicating that they were born outside of the U.S. will submit any necessary immigration information/documents through a follow-up process, unless a process can be devised to do this electronically through available databases.

Step 5. The WIC caseworker electronically submits the health coverage application to the appropriate Medicaid/CHIP agency. In most cases, Medicaid/CHIP will not require further information or documentation as to those eligibility elements that were borrowed or retrieved in Step 4, including the applicant's signature.

Step 6: Applicant receives immediate response. In real time, the applicant will receive a decision about immediate, temporary coverage (through presumptive eligibility), along with a printable document that an eligible applicant can use to obtain health services during this temporary coverage period. If the WIC agency finds through a data check that the child is already enrolled in Medicaid/CHIP, a real time reply will provide the family with information about existing coverage and the new WIC application information will be used to renew that coverage, if necessary.

Step 7: If additional information is needed to complete an eligibility or renewal determination, the Medicaid/CHIP agency staff will conduct a simplified follow-up process.

What are the Key Benefits of Express Lane Eligibility?

ELE has a number of potential benefits for both low-income families and states. Specifically, ELE efforts can help:

Increase coverage of low-income children and improve their access to care. Despite decades of outreach efforts to find and enroll eligible children in Medicaid and CHIP, an estimated 8.1 million children remain uninsured, most of whom are already eligible for Medicaid or CHIP.[2] Express Lane Eligibility offers a tremendous opportunity for states to identify, reach, and enroll these uninsured children by building bridges between Medicaid and CHIP and other public programs in which they may already participate.

Data suggest that connecting Medicaid and CHIP outreach and enrollment efforts with other public programs has the potential to reach large numbers of uninsured but eligible children. For example, the most recent studies by the Urban Institute found that 71% of low-income, uninsured children live in families that participate in one or more of the main nutrition assistance programs: the National School Lunch Program (NSLP), Food Stamps (now called the State Nutrition Assistance Program -- SNAP), and/or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[3] Of those programs, NSLP served the largest proportion of uninsured children, with 59% of low-income, uninsured children participating in that program.[4] Using different data, the Urban Institute estimates that 12.4% of *eligible* but uninsured children live in households receiving food stamps.[5]

In addition to nutrition programs, other public programs and functions can connect Medicaid and CHIP agencies with significant numbers of uninsured children. For instance, nationally, 11% of children enrolled in Head Start are uninsured,[6] 58% of subsidized and public housing residents are uninsured and over 3 million children live in such housing,[7] and 15% of households receiving benefits through the Low Income Home Energy Assistance Program (LIHEAP) have no health insurance for any household members.[8] Further, 89% of eligible but uninsured children live in families that file federal income tax forms.[9]

Moreover, CHIPRA's ELE provisions specifically authorize states to use available data and findings from other programs to conduct "automatic enrollment." State experience has demonstrated that such state-initiated enrollment initiatives reach larger numbers of children than those that wait for a family to apply for or renew coverage, particularly when they utilize "ex parte" procedures that collect as much information as possible from existing data sources before asking the family to supply information.[10] Experience with the Medicare Part D Low-Income Subsidy program also illustrates that automatic enrollment has successful results; the program used data matches with the Social Security Administration to automatically enroll nearly three-quarters of eligible seniors in just six months.[11]

Research suggests that reaching and covering currently uninsured low-income children through ELE efforts will improve their ability to access needed care. Children covered by Medicaid or CHIP are much more likely to have a usual source of care, to have had a doctor visit, and are much less likely to have unmet needs compared with uninsured children.[12] Further, research shows that when previously uninsured children enroll in public coverage they experience improvements in their quality of care and health outcomes.[13]

Promote continuous and stable coverage through simplified Medicaid and CHIP renewal processes. ELE can simplify Medicaid and CHIP renewal processes by utilizing updated information a family provides to another needs-based program and the eligibility calculations of

that program agency to process a redetermination. According to the most recent calculations from the Urban Institute, 57% of children in NSLP, WIC, and/or SNAP are covered by Medicaid or CHIP[14], and, in particular, 84% of children participating in SNAP are also enrolled in Medicaid or CHIP.[15]

Because Medicaid and CHIP renewal involves updating only those eligibility elements that have changed, renewal through ELE can be relatively straightforward and is not likely to require follow-up with the family since most of those changing eligibility elements, such as income and residence, are regularly collected by other public programs. For example, since 2001, Louisiana has automatically collected information from Food Stamp and cash assistance files to complete Medicaid renewals rather than waiting for a family to start the renewal process. As a result of this process, about three-quarters of enrollees are now renewed without completing a Medicaid renewal form and the state has experienced a dramatic decline in denials of renewals for procedural reasons (falling from over 25% to just 1%).[16] In contrast, when Florida ended its administrative renewal process, approximately 120,000 children were dropped from coverage in a 90-day period and the disenrollment rates remained ten times higher than they had been under the administrative renewal process.[17]

Simplifying renewal processes helps support continuous and stable coverage for children, which has important implications for their health care. Even brief gaps in children's coverage are associated with reduced access to care and increased rates of unmet need and forgone care due to cost.[18] Further, increasing the stability of coverage reduces administrative burdens and costs for states associated with churning—i.e., the disenrollment and reenrollment of children during a short period of time.

Reduce burdens on Medicaid and CHIP agencies and families. Families who participate in other public programs that can serve as Express Lane agencies have already provided these programs much – if not all -- of the information that is needed to enroll in or retain Medicaid or CHIP coverage. Further, these other public programs have already invested time in collecting, evaluating, processing, archiving, and verifying the information provided by the family.

By using ELE, Medicaid and CHIP agencies can benefit from the work already completed by other agencies by borrowing the relevant and timely information and eligibility findings rather than re-collecting and re-evaluating the data again. At the same time, families benefit because they are no longer required to submit information and documentation more than once and to visit multiple locations to apply for multiple need-based programs.

Generate administrative and program savings. As noted above, ELE has the potential to reduce administrative burdens associated with enrollment and renewal and significantly reduce rates of churning. Data indicate that administrative burdens related to enrollment and renewal contribute to administrative costs. For instance, Ohio incurred $8.5 million in administrative costs in the first year of its effort to meet new federal rules imposed by the Deficit Reduction Act of 2005 that require states to verify citizenship status, despite the fact that the new rules also led to a decrease in monthly enrollment and renewal.[19] Similarly, churning was estimated to cost California $120 million in a three-year period.[20] And, when Florida ended its administrative renewal process referred to above in 2004, total program administration costs rose 33%.[21]

As such, reducing administrative burdens will likely lead to administrative cost savings, as demonstrated by experiences with other programs. For example, when Oklahoma stopped applying an assets test to determine Medicaid and CHIP eligibility for children, it reported $1.2 million in administrative savings above and beyond the costs associated with increased

enrollment.[22] In addition, an analysis of Louisiana's Medicare Savings Program (which serves low-income Medicare beneficiaries) found that simplifying the renewal process to accomplish renewal using available data (*ex parte*) rather than contacting the client would lead to a potential administrative savings of $1.9 million annually.[23]

Beyond administrative cost savings, ELE also has the potential to reduce program costs through savings from improvements in children's access to and quality of care that stem from increased stability in their coverage. For instance, when California revised its Medicaid renewal policy to require redeterminations every twelve months, rather than every three, the program experienced $17 million in savings in hospitalization costs for conditions like asthma and pneumonia.[24] In contrast, when children experience intermittent coverage and the resulting discontinuous care, families increase their use of more costly emergency room care,[25] are less likely to receive preventive care, and experience negative effects on future health – which has future costs.[26]

Enable greater coordination across programs. With ELE, it is no longer necessary to ensure that another public program has precisely the same income counting rules or residency documentation requirement in order to consider that program's income or residency finding relevant and useful for Medicaid/CHIP enrollment. By allowing Medicaid and CHIP to borrow another program's finding, ELE removes the complications posed by cross-program eligibility coordination when different programs apply different eligibility rules and enrollment procedures. As such, ELE makes it easier for states to coordinate enrollment efforts across programs and allows them to get real value from sharing data across programs. In addition, by harmonizing the underlying program rules, ELE makes it easier for states to build enrollment systems technology that can handle the challenge of cross-program enrollment.

Further, ELE can help states coordinate their efforts to provide support services. Some public programs are required to help facilitate a child's access to health care and health coverage as part of their overall mission. For instance, Head Start's Program Performance Standards state that within 90 days of a child's enrollment, Head Start programs must determine whether families have an ongoing source of continuous, accessible health care and must assist parents in securing a source of such health care, if necessary. [27] Similarly, WIC was established to "serve as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems and to improve the health status of these persons."[28] In service of this mission, current federal regulations require WIC agencies to inform their clients about health insurance options and refer them to application assistance. [29] Participation in an Express Lane effort would satisfy such programmatic expectations, while also facilitating greater coordination with Medicaid and CHIP.

Facilitate the development of modernized, cross-program enrollment systems. ELE efforts can benefit greatly from the use of technology.[30] As such, a state that elects to move forward with ELE can use the design and development of the technology to support ELE as a platform for developing an improved, modernized enrollment system that provides a single point of entry for multiple programs and pulls relevant data from other state databases to inform the eligibility process. In the alternative, such systems improvements for the sake of ELE can be incorporated into technology plans that are already in development and, thus, add value to those efforts.

States are already under the directive of the Medicaid Information Technology Architecture (MITA)[31] to transform state Medicaid information systems (such as billing and eligibility systems) into modernized systems that can communicate across organizational boundaries and

agencies. Systems improvements made in pursuit of ELE can help a state meet these federal expectations established by MITA, and vice versa.

It is important to note that technology that makes the most of available data can result in significant and ongoing administrative savings. For instance, the state of Utah has developed a robust, data-brokering eligibility system with the capacity to draw relevant information from other available databases – a system which could add great value to an ELE effort. While the initial cost of building the system was $2 million, it has resulted in an estimated administrative savings of $2.1 million each year since it was implemented.[32]

Conclusion

ELE provides a new tool to states to utilize data and eligibility findings from other public programs to support Medicaid and CHIP enrollment and renewal efforts. States use of ELE has the potential to benefit both low-income families served by the programs as well as the states themselves. By helping states reach and enroll currently eligible but uninsured children, ELE can increase children's coverage rates and improve their access to care. Further, ELE can promote stable and continuous coverage for low-income children over time, preventing access problems associated with disruptions in coverage. ELE also can reduce burdens for families and Medicaid and CHIP agencies, contribute to program savings, enable greater coordination across programs, and facilitate improvements in state enrollment systems.

Regardless of the outcome of health reform, the systemic improvements made as part of an ELE initiative will help facilitate coverage and access to care for low-income children and increase program coordination and collaboration. Furthermore, ELE initiatives provide great value by increasing administrative efficiency while also setting the cornerstone for a modernized enrollment system that can help meet a state's future technology needs.

This brief was prepared by Beth Morrow of The Children's Partnership in partnership with Samantha Artiga of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes

[1] CHIPRA gives states discretion to choose an Express Lane agency, but specifically identifies the public agencies that determine eligibility for: TANF, WIC, food stamps, state Medicaid and CHIP programs, child support services, Head Start, subsidized child care, school breakfast and lunch programs, homeless assistance, housing assistance, and Native American housing assistance, among other programs.
[2] Kaiser Commission on Medicaid and the Uninsured, *Health Coverage of Children: The Role of Medicaid and CHIP* (Kaiser Family Foundation, October 2009) and Lisa Dubay, Allison Cook, and Bowen Garrett, Urban Institute, *How Will Uninsured Children Be Affected by Health Reform?* (Kaiser Family Foundation, August 2009) Table 1, using data from the 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS).
[3] Stan Dorn and Genevieve Kenney, Urban Institute, *Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (The Commonwealth Fund, June 2006) 9, using data from the 2002 National Survey of America's Families.
[4] Ibid.
[5] Stan Dorn, Urban Institute, *Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP* (Robert Wood Johnson Foundation, April 2009) 12, March 2006 CPS data.
[6] Katherine Hart and Rachel Schumacher, Center for Law and Social Policy, "Moving Forward: Head Start Children, Families, and Programs in 2003", *CLASP Policy Brief No. 5* (June 2004) 3.
[7] National Center for Health in Public Housing http://www.healthandpublichousing.org/aboutresidents.html (accessed August 2009), and Larry McReynolds, Testimony for House Committee on Financial Services, Subcommittee on Housing and Community Opportunity Hearing (July 20, 2009).
[8] APPRISE, *2008 National Energy Assistance Survey: Final Report* (National Energy Assistance Directors' Association, Dec. 2008) p. 62, Table IV-51C.
[9] op. cit. (5) 10.
[10] The Children's Partnership & Kaiser Commission on Medicaid and the Uninsured, *Express Lane Eligibility Efforts: Lessons Learned from Early State Cross-Program Enrollment Initiatives* (Kaiser Family Foundation, August 2009).
[11] op.cit. (5), Appendix A.
[12] Caryn Marks, Cathy Hoffman, and Julia Paradise, Kaiser Commission on Medicaid and the Uninsured, *The Impact of Medicaid and SCHIP on Low-Income Children's Health* (Kaiser Family Foundation, Feb. 2009).
[13] Ibid.
[14] op.cit (3) 10.
[15] Ibid.
[16] Andrea Cohen, et.al., Manatt Health Solutions, *Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York* (United Hospital Fund, 2008) 5.
[17] Ibid. 4.
[18] op. cit. (12).
[19] Laura Summer, *Getting and Keeping Coverage: States' Experience with Citizenship Documentation Rules* (Georgetown University Health Policy Institute, January 2009) viii.
[20] Gerry Fairbrother, *How Much Does Churning in Medi-Cal Cost?* (The California Endowment, April 2005) 7.
[21] op. cit (16).
[22] Victoria Wachino and Alice Weiss, National Academy for State Health Policy, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Robert Wood Johnson Foundation, Feb. 2009) 18.
[23] Laura Summer, *State Solutions*, "Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana" (Georgetown University Health Policy Institute) 7.
[24] Andrew Bindman, Arpita Chattopadhyay, and Glenna Auerback, *Medical Care*, "Medicaid Re-Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions," 46(10):1049-1054, October 2008.
[25] D. Mancuso, K. Beall, and B. Felver, *Understanding the Children's Medical Caseload Decline: The First in a Series of Two Analyses—A Look at the Administrative Data* (Washington State Department of Social and Health Services Research and Data Analysis Division, Aug. 2005).
[26] Janet Currie, Sandra Decker, and Wanchuan Lin, "Has Public Health Insurance for Older Children Reduced Disparities in Access to Care and Health Outcomes?" *Journal of Health Economics*, 27:6, Dec. 2008, pp. 1407-1652.
[27] 45 CFR 1304.20(a)(1)(i).
[28] 7 CFR 246
[29] 50 CFR 246.7(1) and (2).
[30] Technology can be used to electronically populate a Medicaid/CHIP application with information from ELE programs' applications, to retrieve data from other third party databases to obtain information needed for the Medicaid/CHIP application and to verify eligibility information; to facilitate the use of electronic signatures; to electronically submit applications to Medicaid and CHIP agencies; and to facilitate administration and tracking. See The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, *E Health Snapshot, Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices* (Kaiser Family Foundation, May 2007) and *How Technology Can Help an Express Lane Eligibility Effort* (Santa Monica, CA: July 2009) at www.childrenspartnership.org/ExpressLaneToolKit
[31] See http://www.cms.hhs.gov/MedicaidInfoTechArch for further information.
[32] op.cit.(30) 15.

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