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CHIPRA Express Lane Eligibility Evaluation

Case Study of Louisiana's Express Lane Eligibility

Final Report

January 12, 2014

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Mathematica Reference Number:
06988.700

Submitted to:
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CONTENTS

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TABLES

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EXECUTIVE SUMMARY

Louisiana was the first state to implement the automatic enrollment option for Express Lane Eligibility (ELE). Beginning in February 2010, the state established financial eligibility for Medicaid based on income determinations made by the Supplemental Nutrition Assistance Program (SNAP). Louisiana has also been using ELE for statewide renewals since November of 2010. The state's implementation of ELE built on its prior efforts to streamline enrollment and renewal, which already placed Louisiana among the nation's leaders. Table 1 summarizes key facts about the state's ELE processes.

Table 1. Key Facts about Louisiana's Express Lane Eligibility Processes

Policy Simplification Adopted?	ELE
Policy in Medicaid, CHIP, or both?	Medicaid
Processes affected?	Enrollment and renewal
If ELE, what eligibility factors are addressed by ELE?	Income, State Residence, Identity, Social Security Number
Implementation Date?	Enrollment: February 2010 Renewal: November 2010
Partner agencies (if applicable)?	SNAP (Department of Children and Family Services)
Is process 'different' from view of the enrollee/applicant?	Yes. No need to file application or renewal forms, unless, at application, SNAP's determination of citizenship or immigration status failed to meet Medicaid requirements.
Faster time to coverage for applicants?	Yes, 23 days faster for initial applications, on average.
Any time savings for the state?	Yes, more than 30 minutes per application and 21 minutes per renewal.
Estimated cost to implement?	Major costs include $393,000 in health agency staff time and programming costs, $22,500 in partner agency programming costs
Estimated ongoing net administrative costs or savings?	Approximately $1 million per year

Note: Facts about time savings, implementation costs, and ongoing net administrative costs and savings are taken from an analysis by Mathematica for the evaluation.

The state has used two basic approaches to ELE enrollment. Under the first approach, Louisiana sent letters to SNAP recipients giving them a chance to "opt out" of data matching with Medicaid. When they did not opt out, and data-matching showed that their children received SNAP but not Medicaid, the families were sent Medicaid cards. They were told that using the cards to obtain fee-for-service care for their children would constitute consent to enrollment. More than 10,000 children were sent cards on February 11, 2010, and more than 20,000 were sent cards during calendar year 2010. The administrative cost of securing these gains was less than the $650,000 the state spent on intensive outreach grants during 2009-2011 that resulted in just 329 children receiving coverage.

Louisiana realized significant administrative savings, since the use of SNAP data eliminated the need for caseworkers from the Department of Health and Hospitals (DHH) to evaluate income. Such savings grew particularly large beginning in November 2010, when ELE was expanded to renew eligibility for Medicaid children based on their receipt of SNAP, regardless of how they originally enrolled into coverage. Currently, ELE automates renewals for more than one in four Medicaid-covered children.

Renewal of the state's original ELE enrollees proved problematic, however. Renewal procedures varied based on whether children had consented to enrollment through card use. However, determining which procedure applied to a particular child required cumbersome, manual intervention by state staff, because the state's fee-for-service claims payment system, which recorded whether a child's Medicaid card had been used, could not communicate with the state's eligibility system.

To permit ELE renewals within a single computer system, the state moved to a new consent approach, beginning in January 2011. Now, families consent both to data matching and enrollment by checking an "opt-in" box on the SNAP application form. Nearly 670 children a month are processed through ELE via this new procedure, which DHH officials view as a high participation level, given the state's very low levels of uninsurance among eligible children. However, shifting from the state's prior "consent through card use" system to requiring a parent to "opt-in" on the SNAP application form reduced monthly ELE enrollment from new

SNAP applicants by 62 percent. At the time of our site visit, DHH officials were interested in working with SNAP officials to make the new system more effective by requiring all SNAP applicants to make a choice of either "opting in" or "opting out."

State officials believe that their experience with ELE will help them transition to the Patient Protection and Affordable Care Act's more data-based eligibility methods. The skills developed in working with the SNAP interface can transfer over to the new eligibility interfaces that will be an important part of Medicaid eligibility determination in the future.

Key lessons learned included the following:

- Automating children's Medicaid enrollment based on SNAP's prior determination of eligibility, without requiring parents to take further action other than to seek care for their children, can provide numerous children with health coverage. Requiring parents to take action, even by doing nothing more than checking an "opt-in box" on SNAP application forms, greatly reduces the number of children who receive Medicaid. In this case, the state's shift to such an "opt-in box" reduced the number of children enrolled through ELE by 62 percent.
- Letting families consent to their children's enrollment through accessing services—that is, through Medicaid card use—can improve children's access to care and provide coverage valued by their families. In 2010, 54 percent of ELE children used their cards to access care, consenting to enrollment in less than 12 months. When the state offered one final chance to consent before termination, an additional 6 percent requested coverage, even though their Medicaid cards had never been used to access care.
- The sustainability of auto-enrollment strategies that base consent on accessing care ultimately depends on information technology (IT) infrastructure. To be done in an automated rather than a labor-intensive way, such strategies require IT systems that integrate information about service use with other eligibility records.
- Automated eligibility determination can replace consumers' provision of documents and caseworker verification, yielding large gains in participation and efficiency, while strengthening program integrity by lessening inherent risks of human error. However, significant up-front investments of staff time are needed to achieve gains in participation, efficiency, and accuracy. In Louisiana, the gains were substantial and ongoing, but initial costs were significant; officials believed that this could be true in other states as well.
- Louisiana officials suggested that other states implementing ELE could consider starting ELE with renewal rather than enrollment. Renewal was easier to implement, in Louisiana's experience, and renewal can yield significant and ongoing administrative savings that could build momentum for further ELE implementation in the potentially more challenging context of enrollment.

- Louisiana's success with ELE was built on a foundation of prior, related work. Other states without a similar history may experience less success with innovations like ELE.

Key Louisiana informants urged federal policymakers to continue the ELE option beyond its current statutory sunset date.

1. INTRODUCTION

The Children's Health Insurance Program (CHIP), a landmark legislative initiative passed in 1997 to help close the health insurance coverage gap for low-income children, was reauthorized with bipartisan support in 2009. Although CHIP had helped to fuel a substantial increase in health insurance coverage among children, Congress remained concerned about the many children—estimated at 4.4 million in 2010—who are eligible for but not enrolled in coverage (Kenney et al. 2012). In the CHIP Reauthorization Act (CHIPRA) of 2009, Congress gave states new tools to address enrollment and retention shortfalls, along with new incentives to do so.

One of these new options is a policy called Express Lane Eligibility (ELE). With ELE, a state's Medicaid and/or CHIP program can rely on another agency's eligibility findings to qualify children for public health coverage, even when programs use different methods to assess income or otherwise determine eligibility. ELE thus gives states another way to try to identify, enroll, and retain children who are eligible for Medicaid or CHIP but who remain uninsured. The concept of using data from existing government databases and other means-tested programs to expedite and simplify enrollment in CHIP and Medicaid has been promoted for more than a decade; before CHIPRA, however, federal law limited state reliance on information from other agencies by requiring such information to be cross-walked into the Medicaid and CHIP eligibility methodologies (Families USA 2010; The Children's Partnership n.d.). To promote adoption of ELE, Congress made it one of eight simplifications states could implement to qualify for performance bonus payments. These were new funds available to states that implemented five of the eight named simplifications and which also increased Medicaid enrollment (CHIPRA Section 104).

Federal and state policymakers are keenly interested in understanding the full implications of ELE as a route to enrolling children, or keeping them enrolled, in public coverage. To that end, Congress mandated an evaluation of ELE in the CHIPRA legislation. In addition to reviewing states that implemented ELE, the evaluation provides an opportunity to study other methods of simplified or streamlined enrollment or renewal (termed "non-ELE strategies") that states have

pursued, and to assess the benefits and potential costs of these methods compared with those of ELE. Taken together, findings from the study will help Congress and the nation better understand and assess the value of ELE and related strategies.

This report summarizes findings from a case study of Louisiana's ELE program. After CHIPRA's passage, Louisiana was the first state to implement ELE using the automatic enrollment option; one other state (New Jersey) had already implemented ELE, but without the automatic enrollment option. In determining children's eligibility at both initial enrollment and renewal through ELE, Louisiana's Medicaid program relies on findings about income and other matters already made by the Supplemental Nutrition Assistance Program (SNAP).

To learn about the state's implementation of ELE, staff from the Urban Institute visited Louisiana in January 2013, interviewing 20 key informants over a three-day period. While on site, the research team also conducted focus groups with four parents of children who had been recently enrolled via ELE. These focus groups took place in two places—Baton Rouge and Hammond. Through these focus groups parents shared their experiences with the new ELE procedures compared to the traditional enrollment systems. This qualitative research built on earlier investigation of Louisiana's ELE policies conducted by researchers from the Urban Institute and Mathematica. In addition, the project team reviewed documents and administrative data provided by state officials and conducted follow-up interviews with officials.

2. STATE CONTEXT: WHY PURSUE ELE?

Pursuing ELE was consistent with Louisiana's long commitment to streamlining enrollment and retention of children's health coverage. These efforts began shortly after the 1998 creation of LaCHIP—the state's Medicaid-expansion CHIP program—when state officials noticed that they were losing as many children at renewal as were signing up for coverage (Adams et al., 2012). The state then became a national leader in streamlining eligibility, enrollment, and renewal processes in Medicaid and CHIP. For instance, the state's innovations around renewal reduced the proportion of procedural terminations to less than 1 percent of children covered by both programs and lowered the percentage of beneficiaries who needed to complete

renewal forms to 10 percent and 16 percent of Medicaid families and CHIP families, respectively (Brooks 2009). Before the enactment of CHIPRA, Medicaid case workers were already using a variety of databases—such as SNAP, an employer wage database, Social Security Administration records, and Health Management Systems Coordination of Benefits data—to verify income, citizenship, identity, and health insurance status. This significantly decreased the need for families to submit documentation when initially applying or renewing Medicaid coverage.

As a result, the Department of Health and Hospitals (DHH), which administers Medicaid and LaCHIP, was already employing the necessary five of eight simplifications CHIPRA required for performance bonuses, without any need to add ELE. Louisiana thus qualified for over $7 million in CHIPRA performance bonuses in FY 2009, 2010, and 2011 for its use of a joint application with Medicaid and CHIP; ex parte renewal; 12-month continuous eligibility; the elimination of assets tests; the elimination of required in-person interviews; as well as increases in Medicaid enrollment that met or exceeded target levels.

The state's policy changes were accompanied by intensive efforts to change the culture of eligibility determination in social services offices. State officials took steps to engage local staff in shaping policy and procedure. In addition to educating the public, the state conducted outreach to local offices, emphasizing the importance of covering all eligible children. This effort conveyed a vision of case workers who would proactively look for information demonstrating eligibility, rather than passively wait for applicants to provide information and then search for flaws in that information to find reasons to deny assistance. Whenever consumers were known to be substantially certain to qualify for Medicaid, procedures were designed so they would be found eligible, despite the lack of complete certainty. Table 2 summarizes key facts about Louisiana's child health coverage policies as of January 2013.

Table 2. Key Facts About Louisiana's Medicaid and CHIP Programs

Medicaid Program Name	Medicaid
Upper income limits for Medicaid	Infants: 133% FPL Age 1-5: 133% FPL Age 6-18: 100% FPL
CHIP Program Name	LaCHIP
Upper income limit for CHIP	250% FPL
12 months Continuous Eligibility?	Yes
Presumptive Eligibility for Children?	No
In-Person Interview Required?	No
Asset Test?	No
Joint Medicaid and CHIP Forms for Application and Renewal?	Yes
Premium Assistance Subsidies?	Yes, Health Insurance Premium Payment Program
Adult Coverage	Parents of dependent children without jobs up to 11% FPL and working parents with dependent children with incomes up to 24% FPL are eligible for Medicaid
Renewal Processes	Renewals are first analyzed in terms of ELE, administrative renewal, and ex parte renewal. Families that are not renewed through these methods are encouraged to renew telephonically. Only if all else fails must beneficiaries complete renewal forms.
Delivery system	Risk-based managed care began in 2012; state also uses primary care case management, and, in some cases, fee-for-service care.

Sources: Site Visit Interviews, Heberlein et al. 2013, Kaiser State Health Facts 2013.

Note: ELE=express lane eligibility; FPL=federal poverty level; PCCM=primary care case management. Administrative renewal involves automated renewal based on characteristics showing a very high likelihood of continued eligibility, with beneficiaries receiving notices indicating an obligation to report changes. With ex parte renewal, caseworkers examine available data and renew coverage if data show reasonable certainty of continued eligibility, without any obligation for beneficiaries to provide information. For more information, see discussion below.

Through these simplifications, Louisiana has been able to greatly reduce uninsurance among children in the state. However, despite a high Medicaid and CHIP penetration rate among eligible children, top DHH leadership, legislators, and other state officials felt it was important to pursue an automated ELE process, for several reasons.

First, officials believed that ELE could help cover the relatively few remaining uninsured children in the state who had proven difficult to reach. Officials believed that the bulk of these

children fell between 50 and 100 percent of the federal poverty level (FPL), an income band well-served by SNAP. By reaching these new enrollees and more efficiently retaining current enrollees, officials recognized that ELE had the potential to achieve state administrative savings and perhaps lower spending overall. Enrolling eligible children at an earlier stage (or retaining them in coverage) could prevent more costly, emergency enrollments, which require expedited administrative procedures and sometimes involve increased health care costs due to deferral of essential care.

More broadly, DHH saw the logic of "piggybacking" Medicaid coverage atop SNAP applications. The agency's leaders sometimes referenced Maslow's well-known "hierarchy of needs," through which people first seek the satisfaction of basic, physiological needs, such as for food, before they address other requirements (Maslow 1954). Expediting enrollment into health coverage based on low-income families' need for food made sense, given this perspective.

The state also saw ELE as an opportunity to reduce Medicaid's administrative costs more broadly. Economic downturn increased the volume of Medicaid applications even as state budget pressures reduced the number of Medicaid analysts, making it imperative to "do more with less." Without ELE, Medicaid analysts could examine the SNAP database to verify children's eligibility at initial eligibility and renewal, but they had to "touch" each SNAP case and analyze its facts to make a Medicaid eligibility determination. Households are defined differently for purposes of SNAP and Medicaid, and income is counted differently. Analysts were required to sort through these differences for each child, even though they rarely affected the eligibility outcome. By contrast, ELE allowed SNAP-recipient children to meet Medicaid's financial eligibility requirements based on data matches between SNAP and Medicaid records, without any need for caseworker involvement. According to key informants, using trusted data from the SNAP agency, the Department of Child and Family Services (DCFS), just "made sense" as a way to target the remaining low-income uninsured children, keep children enrolled, improve the application process, and increase DHH efficiency.

3. PLANNING AND DESIGN: WHAT WAS NEEDED TO DEVELOP THE POLICY?

Before CHIPRA's enactment, Louisiana state officials were tracking federal policy options in various CHIP reauthorization proposals. They learned about ELE and quickly recognized the new option's potential benefits. Exercising unusual foresight, Louisiana policymakers enacted legislation in 2007 directing DHH to pursue ELE whenever it was permitted by federal law; no other state took similar action before CHIPRA's passage. State lawmakers likewise passed legislation in 2007 (LA-R.S:46-56) permitting data sharing between agencies. Soon after CHIPRA passed in 2009, state officials began planning and designing the state's approach to ELE.

The selection of the SNAP program, housed at DCFS, was a natural and easy choice in Louisiana. DHH and DCFS had a long-standing working relationship, with Medicaid's eligibility system physically residing on a mainframe maintained by DCFS. Moreover, DHH officials trusted DCFS eligibility records and income verifications and had been using the database to verify income for several years. Almost 381,000 children in the state received SNAP benefits in 2011—many of whom had income between 50 and 100 percent FPL (Children's Defense Fund, 2012). As discussed above, state officials believed that a large proportion of the remaining Medicaid-eligible but uninsured children in the state fell in this income band, leading state officials to view the SNAP program as a promising partner agency for ELE implementation.

Using ELE's automatic enrollment option seemed like a logical approach to a state that had already incorporated many insights of behavioral economics into its Medicaid and CHIP program design, simplifying and streamlining consumers' enrollment and retention. An intensive effort at culture change emphasized staff seeking to qualify eligible children for coverage, rather than waiting for families to provide requested information and finding reasons to disqualify children if their parents failed to "dot all the i's and cross all the t's," as noted earlier. So long as ELE was implemented in a way that prevented ineligible children from receiving coverage and that precluded duplicative enrollment of children who already received Medicaid, state officials viewed automatic enrollment as a sensible strategy for efficiently providing eligible children with Medicaid.

To facilitate the exchange of data between the two agencies, a Medicaid programmer needed to make various changes to the information technology (IT) interface between DHH and DCFS. Although Medicaid tried to reduce the burden on DCFS by drafting and later mailing out all letters to SNAP families (Dorn et al., 2012), DCFS shouldered several tasks. A programmer and two testers at DCFS added a question to the SNAP application giving families the chance to opt-out of sharing their information and establishing a file transfer system with DHH. At the same time, Medicaid staff spent thousands of hours structuring ELE policies and procedures.

DCFS was supportive of ELE, as agency leadership believed it would help fulfill shared missions with DHH—namely, helping their common low-income clientele and using state taxpayer resources more efficiently. That said, DHH leadership understood that DCFS faced mission-critical priorities that competed for resources with ELE. As a result, some changes needed from DCFS took more time to implement than DHH would have preferred.

Throughout this time, several staff members in Medicaid's Policy section worked with the Centers for Medicare and Medicaid Services (CMS) to gain approval for the State Plan Amendment (SPA) required to implement ELE. Although officials reported that the development of the SPA did not take much time and was straightforward, Louisiana's consent process presented complications. Based on initial guidance from regional CMS officers, state officials believed they could offer families the chance to opt-out of sharing SNAP information with Medicaid, and if families chose not to opt-out, they could be automatically enrolled in Medicaid. However, national CMS officials subsequently disagreed, ruling that an opt-out notice only allowed the state *to initiate data matching* and qualify children for Medicaid. To actually *enroll* children into Medicaid coverage, parents needed to affirmatively consent (Dorn et al., 2012). By the time Louisiana received this information from CMS, letters had already been mailed out to families (as described in more detail in Section 4, below). To comply with national CMS guidance without reneging on the commitments that state officials believed they had made to families, DHH decided to mail the families Medicaid cards along with notices explaining that using such cards to access care would constitute acceptance of enrollment into Medicaid

coverage. CMS agreed to this approach and granted Louisiana formal approval for its SPA and ELE process in January 2010.

4. IMPLEMENTATION: WHAT HAPPENED?

Initial ELE enrollment. Louisiana's ELE process for initial eligibility has evolved greatly over time, as illustrated in Table 3. The first phase began in earnest when, after much planning and preparation, more than 10,000 children were found eligible for Medicaid in December 2009, based on the SNAP programs' findings regarding income, state residence, identity, and Social Security number. This group was limited to children who were receiving SNAP, were not enrolled in Medicaid or CHIP, but had received Medicaid or CHIP in the past. The latter constraint was imposed to prevent automatic enrollment through ELE from leading to duplicative coverage. Minor differences in Medicaid and SNAP case records, such as one program's use of a formal first name and another program's use of an initial, or transposed digits in an address or social security number, could cause a child who already received Medicaid to be enrolled a second time, albeit with slightly different identifying information taken from SNAP case files. To prevent this, the state developed protocols for matching apparently different cases, expanding on algorithms developed for similar purposes by the Social Security Administration. These families had been sent information about ELE and about "consent through card use;" they had also been given a chance to opt-out of data sharing with Medicaid, but fewer than 1 percent chose to do so (Dorn et al., 2012). Children without a previous DHH case were added to the ELE enrollment group at a later date after state-level DHH staff verified through manual analysis that, in fact, they were not receiving Medicaid with slightly different identifying information (Dorn et al., 2012).

Table 3. Timeline of ELE implementation in Louisiana

2007	2008	2009	2010	2011
State legislation passes authorizing ELE implementation .		*February*: CHIPRA signed into law. *November*: DHH proposes state plan amendment (SPA) for ELE. *December*: SNAP program sends "opt-out data sharing" notice, funded by DHH, to families of children receiving SNAP but not Medicaid. *December*: After end of opt-out period, DHH finds 10,573 children eligible for Medicaid based on data from SNAP, after verifying that they are not enrolled in Medicaid.	*January*: CMS formally approves SPA. *January*: "Opt-out" box is added to SNAP application as a new approach through which SNAP parents can opt out of data sharing with Medicaid. *February*: State sends Medicaid cards to 10,573 children found eligible in 12/09, preceded by notices explaining that card use constitutes consent to enrollment. *January through April*: Monthly data matches result in enrolling new ELE children. "Consent to enrollment" requirement met through card use, with opt-out on SNAP form authorizing data sharing. *November*: Initial ELE enrollees who had not used cards were sent closure notices. *November*: Start of statewide ELE renewal for non-ELE enrollees, after manual pilot testing.	*January*: New policy implemented through which families consent to both data sharing and enrollment through "opt-in" box on SNAP application form.

On February 11, 2010, state officials mailed out Medicaid cards to families and activated 10,573 ELE Medicaid cases, with eligibility periods that began in December 2009. Over the course of 2010, approximately 21,000 children received Medicaid cards, according to the state's unduplicated count.

Medicaid analysts in the state, who handle both initial applications and renewals, received three to four ELE trainings during normally scheduled quarterly meetings. Each training lasted less than thirty minutes and was primarily focused on answering staff questions. Afterwards, a "frequently asked questions" document was put on the intranet portal for staff. Although state-level officials believed that ELE was "an evolutionary step" for Medicaid analysts, who had already experienced numerous enrollment and renewal simplifications, some caseworkers were initially hesitant to accept determinations made by a different agency. In particular, they felt "possessive" of the accuracy of the Medicaid system and were concerned about different household definitions used by SNAP. However, by the time of our site visit, analysts reported that they had overcome their initial hesitancy, as they saw ELE aligning with their broader mission of helping to enroll all eligible Louisiana children into Medicaid and CHIP. ELE also fit into the above-described culture of innovation and gained widespread acceptance—particularly since many ELE procedures were highly automated and eliminated the need for caseworker involvement.

In January 2010, DHH streamlined opt-out procedures by making a relatively minor change to the ELE enrollment process. Instead of using letters to notify SNAP families about data match procedures and giving them a chance to opt-out by a certain date, families could avoid data sharing by checking an "opt out" box on the SNAP application form. This change, which saved money on mailing costs, did not affect the need to meet the separate federal requirement to obtain the family's affirmative consent to enrollment before their children received coverage. For families who did not opt-out of data matching, the state continued to use its former method of sending Medicaid cards and explaining to families that use of the card to access care would constitute consent to enrollment.

From January through April 2010, the state conducted periodic monthly data matches with SNAP records, using the same criteria as the initial, 10,000-child enrollment and the same procedures to prevent inadvertent duplicative enrollment. With monthly data flows, the number of cases requiring manual analysis imposed significant demands on state-level DHH staff; such steps prevented duplicative enrollment, as explained earlier. Over time, rules were developed to decrease the number of cases requiring manual analysis while still maintaining program integrity by ensuring that children added to Medicaid were not already enrolled. For instance, the state's data-mining of its eligibility records showed that when a SNAP-recipient family included several children, all of whom appeared to be previously unknown to Medicaid and CHIP, such children could be automatically added to the Medicaid system without risking duplicative enrollment. Despite such rules, which reduced the number of cases requiring manual intervention, the process remained burdensome until daily matches were implemented, when the total volume of work reached more manageable levels.

Focus Group Findings: The Importance of Streamlined Enrollment

Ease of enrollment made a big difference to overwhelmed, low-income parents.

"I was applying for childcare assistance...I hadn't thought about healthcare so much because there was so many other things…I had to find us housing. We have to eat. I need someone to watch him so I can work…but when I was applying for childcare assistance, it was like check this box…so I just checked the box, and I had an insurance card."

"Definitely a no-brainer…[with] so much already on my plate to do and to take care of, and then there's this box, and it's like, oh that's one less thing, one less application packet I have to fill out."

The state's initial approach to ELE enrollment ran into trouble in November 2010, when the time came to redetermine eligibility for the large group of children who had initially enrolled through ELE. The state used different procedures for ELE children, depending on whether they had consented to enrollment through card use or not. Accordingly, DHH staff began the renewal process for such children by querying the state's fee-for-service claims payment database to see whether they had used their cards. This process could not be fully automated, because the state's eligibility system and claims databases could not communicate with one another.

Children who had consented through card use were renewed using the same procedures that applied to other children, which apply the following renewal hierarchy:

1. If possible, eligibility is renewed via the same ELE renewal procedures that apply to all children, as described below.
2. If ELE renewal is not possible, the eligibility system tests to see if the children qualify for what Louisiana terms, "administrative renewal," which is limited to certain categories of children (such as those in households with income that consists entirely of social security payments) whose eligibility rarely changes. If so, the family is automatically sent a notice of renewal that requires a response only if household circumstances have changed.
3. If neither ELE renewal nor administrative renewal is possible, a caseworker tries to renew eligibility on an *ex parte* basis. This involves investigating all available sources of data, including quarterly wage records, child support enforcement data, and the records of other public benefit programs. If such data shows the child continues to qualify, eligibility is renewed without contacting the family except to send a notice explaining that coverage is continuing for another 12 months.
4. Only if none of the above procedures are possible does the caseworker try to contact the family to obtain information needed to determine whether the child continues to qualify.

Focus Group Findings: Privacy and SNAP Check-Boxes

While some parents felt comfortable checking opt-in boxes on SNAP forms to share their information, others were worried that their information might be shared too broadly.

"I just feel like as long as I'm truthful about everything…nothing will happen to me…I really believe they respect our privacy."

"For me, it was odd, because it was one of those things where is it okay for us to share your information with such and such…and when you see that, and you're filling out an application that has your Social Security number on it, your cell phone number…your income information…it's like…what are they going to want?"

By contrast, for children whose families had never consented to enrollment through card use, special procedures applied. DHH queried SNAP records to see if the children were still receiving SNAP benefits. If not, families were sent closure notices but encouraged to apply for Medicaid or CHIP. If they were continuing to receive SNAP, the family was sent another notice, providing a final opportunity to consent by contacting DHH. State officials had to maintain an

extensive, largely manual tracking system to ensure that the correct step was taken for each child, based on the child's prior consent posture.

Overall, the inability of the state's eligibility system and its system for paying fee-for-service claims to communicate with one another made this renewal process administratively cumbersome and ultimately unsustainable, because it required extensive manual involvement. This was the most important factor leading the state to change its method of ELE consent so that consent could be tracked entirely within the state's eligibility system, as described below.

Revised ELE enrollment. Beginning in January 2011, the state changed its approach. The SNAP form was again modified so that, instead of "opting out" of data-sharing, SNAP applicants needed to "opt in" to both data-sharing and enrollment. Such an opt-in was then conveyed through data matches from SNAP into DHH's eligibility system.

This revised method is still in operation. If a family opts into ELE and subsequent data-matching shows that a child receiving SNAP does not receive Medicaid, that child is enrolled into Medicaid without any additional effort from either the family or DHH. At renewal, DHH staff is not required to obtain any information from the state's fee-for-service database. Instead, renewal proceeds with all ELE children as with any other children.

ELE renewals. After success with implementing ELE for enrollment, Louisiana implemented a completely automated renewal process that uses data matching to continue Medicaid eligibility based on children's receipt of SNAP, regardless of their initial method of enrollment. This differs from the prior process of using SNAP records for ex parte renewal, which required Medicaid analysts to actually open a case, go into the SNAP database, and

Focus Group Findings: Express Lane Renewals

Parents reported being surprised by the automatic renewal and positively compared the ELE renewal process to standard applications for public benefits.

"I fully anticipated to receive something requesting information again, like that was my expectation of it, you know. They're going to send me something"

"I didn't have to do anything. I just got letters for both of them…that said that they still qualify. I never got any paperwork…but I did get some paperwork saying that they still qualified until 2014."

"I've been through both processes where after her first year I just… reapplied online for her…when her year was up with him…she just continued and got a letter in the mail that she still qualified"

"This is a great moment. It's like I didn't have to do anything. You know, with working, now being a full-time student, a single mother too, again it was another one of those things where it's like, okay. I didn't have another [requirement to meet], some weight lifted off."

assess the impact of the differences between the two programs' household definitions and income-counting rules on the child's Medicaid eligibility. That work rarely resulted in finding a SNAP-recipient child ineligible for Medicaid.

By contrast, redeterminations facilitated by ELE never have to be touched by a Medicaid analyst. Instead, the system automatically matches Medicaid children to active SNAP cases to make a renewal determination. Even though SNAP and Medicaid use different methods of measuring household income, once SNAP has found a particular child to have net income below 100 percent of the federal poverty level, Medicaid uses that finding to renew eligibility, notwithstanding the technical differences between the two programs' eligibility methods—precisely as intended by the federal ELE statute, which allows a state Medicaid program to "rely on a finding" from SNAP, "notwithstanding … any differences in budget unit, disregard, deeming, or other methodology" (Social Security Act Section 1902(e)(13)(A)(i)).

After testing these procedures manually with small groups of children to ensure accuracy, the state implemented ELE for renewals statewide in November 2010. Not all SNAP-recipient children are renewed using ELE, however. ELE renewal is limited to certified households in which all Medicaid beneficiaries are children who receive SNAP. If a certified household also contains other Medicaid recipients—either adults or a child who does not receive SNAP—ELE does not apply. The state made this exclusion because the certified household members who are not SNAP-recipient children must have their eligibility redetermined using other methods, so applying ELE to expedite eligibility determination for the family's SNAP-recipient children would yield no administrative savings for the state.

Focus Group Findings: Outreach

Before their children received coverage, most (but not all) parents had heard about Medicaid through TV commercials, or previous experience with state programs.

"I heard it on television"

"I was on the LaCHIP."

"I've been with Medicaid all my life."

"I actually hadn't heard anything about the program prior to enrolling."

Outreach. At each stage of its development, ELE enrollment and renewal was an internal process at DHH. The state did not engage in a concerted effort to engage community groups in discussion about its implementation of ELE.

However, the state continued its broader initiatives to find uninsured, eligible children and sign them up for coverage. As ELE was being implemented in 2010, the state was carrying out such a hands-on, community-based outreach effort using CHIPRA grant funding, with resources and results described below.

5. OUTCOMES: WHAT ARE THE OBSERVED OUTCOMES?

Initial ELE enrollment. State officials believe the initial implementation of ELE allowed them to have a major impact reaching the remaining pockets of eligible but uninsured children. As noted in earlier research, the ELE children who enrolled in 2010 differed, in important ways, from other Medicaid children, suggesting that some children were reached who may not otherwise have been covered (Dorn et al. 2012). For example:

- 12.3 percent of ELE children used their Medicaid coverage to supplement employer-sponsored insurance, compared to 4.7 percent of Medicaid children as a whole;
- For ELE children, dental care and hospital care accounted for 21.4 percent and 19.7 percent of all Medicaid spending, respectively, compared to 8.5 percent and 34.2 percent for non-ELE children; and
- 74 percent of ELE children were age 7 or older, compared to 57 percent of other Medicaid children; and Louisiana children in this older age group were 22 percent more likely to be uninsured than were younger children.

According to a state survey, the percentage of Medicaid-eligible children who lacked coverage fell from 5.3 percent in 2009 to 2.9 percent in 2011—the period that overlapped with ELE implementation (Goidel et al. 2012). At that time, state officials did not implement any other policies that sought to increase participation among eligible children, and the percentage of uninsured increased for all other groups of low-income state residents (Dorn 2012). As a result, state officials believed that ELE was responsible for these gains in children's enrollment. Such gains were confirmed by the observations of community outreach groups, described below.

Key informants also noted the much greater efficiency of ELE's data-based approach, compared to the state's use of community groups to reach the uninsured. Over the three-year period from 2009-2011, the state spent $650,000 in CHIPRA grants for intensive outreach and enrollment, which resulted in 329 children receiving coverage. By contrast, the initial implementation of ELE in 2010 cost less than this amount, as indicated earlier, but resulted in more than 20,000 children receiving coverage from February through December 2010, according to state records.

The use of this data matching approach also allowed the determination of eligibility with less effort on the part of caseworkers.[1] The agency experienced major cutbacks to administrative staff in recent years, due to major state budget reductions, even as caseloads continued to rise. Because of ELE, along with other measures to automate eligibility determinations, the agency was able to cope with those changes without overstressing remaining staff, creating waits for consumers, or reducing the quality of eligibility determinations. In some circumstances, ELE achieved a particularly high level of efficiency by allowing enrollment and renewal without any involvement whatsoever by state or local staff.

In analyzing the extent to which ELE enrollees retained coverage, it is important to focus on the bifurcated process that applied to children who used the state's original "consent-through-card-use" process. Among children who had consented, 92 percent were renewed using ELE; of the remaining 8 percent, state officials did not know how many were renewed using other methods and how many lost coverage. Put differently, no more than 8 percent of those who *had* consented via card use were terminated. By contrast, 88 percent of those who had *not* consented through card use did not respond to the state's final offer and so were terminated (Dorn et al. 2012).

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[1] Prior research agreed that Louisiana's use of ELE resulted in administrative savings but disagreed on its amount (cf. Dorn et al. 2012; Hoag et al. 2012). Through this site visit we were able to ascertain that the totals produced by Dorn, et al. (2012), relied on the state's estimates of *average* administrative costs to process applications, rather than the *incremental* cost of processing each additional application. Using the latter measure yields a more accurate estimate of Louisiana's administrative savings, as explained in this project's preliminary report to Congress (Hoag et al. 2012).

Although there was a nearly 50 percent overall disenrollment rate among the initial group of ELE children, it makes more sense to analyze retention separately for two distinct groups: the children who consented, almost all of whom renewed; and those whose parents did not respond when they were initially sent Medicaid cards, most of whom also failed to respond later. The latter group never truly enrolled and so typically did not renew their coverage.

In 2010, 54 percent of ELE children used their cards to access care, consenting to enrollment in less than 12 months. Not only did most ELE children who were enrolled under the state's original approach use care, some families valued coverage even though their children did not use services. Our focus group participants included parents who reported that obtaining coverage for their children gave them peace of mind, even without accessing services; these parents knew that if their children experienced health problems, care was readily available. Consistent with those reports, when final termination notices were sent to the original group of ELE enrollees, an additional 6 percent, who had not used services, consented to their children's Medicaid coverage by asking to have their children renewed (Dorn et al. 2012).

ELE renewals. For more than one in four of Louisiana's Medicaid-enrolled children, ELE allows fully automated renewal, without any caseworker involvement, which provides the state with considerable, ongoing administrative savings. Between enrollment and renewal, net state savings equal approximately $1 million per year (Mathematica analysis of administrative savings as part of the federal evaluation of ELE, 2013). Key informants further noted that, by reducing procedural terminations, the state improved its ability to monitor and improve quality of care, since most quality measures presume ongoing, annual enrollment periods. In addition, procedural terminations can make it difficult to re-enroll a child; state officials observed that one factor inhibiting such re-enrollment seems to be parental guilt about having allowed coverage to lapse, which can cause parents to avoid Medicaid entirely. Reducing such terminations can thus make a particularly significant contribution to coverage gains.

Revised ELE enrollment. The state's new approach to ELE enrollment relies on families checking the "opt-in" box on SNAP application forms, as explained earlier. Research in many different contexts suggests that using an opt-in, rather than an opt-out process, can reduce participation levels (Johnson and Goldstein 2004; Sunstein and Thaler 2003). Nevertheless, in this particular context, state officials were pleased at the general level of ELE enrollment using the opt-in system, which averaged 667 children a month from July through December 2012. This level of enrollment seemed particularly high given that SNAP caseworkers reportedly received little instruction in the use of the current ELE form. Our informants suggested that SNAP caseworkers, frequently overwhelmed by other priorities, are unlikely to devote any significant attention to the ELE check-box. Although the ELE "opt-in" question is prominently placed on the second page of the written SNAP application, bolded, and written in clear language, many of those features do not come through when the SNAP application is completed electronically. DHH leadership viewed this ongoing ELE enrollment as a significant accomplishment, given that the vast majority of eligible children already receive Medicaid.

Focus Group Findings: Access

Most of the parents were very satisfied with the care their children received, including dental and specialty care. However, one parent felt that her child would receive better care with private insurance. Another parent didn't actually use her coverage to obtain services but greatly appreciated the security that a Medicaid card provided.

"My kid's pediatrician was still under the list, so we're still there.

"[My doctor] specifically deals with the adolescent group. And she has been wonderful."

"My oldest son goes to Distinctive Smiles…one of the premier dentists here in Baton Rouge. So I was pleased to know that they accepted Medicaid…sometimes when you receive government insurance, the quality of care is kind of diminished…but I haven't experienced that."

"I feel like Medicaid…they just try to appease [you]…they just try to get you out of there, like you're a rush, rush on Medicaid. Whereas [private] insurance, I think they're going to do their best they can do because…you get more money with insurance."

"You've already lost your job, you go from making this type of money a year to making nothing. And so to know that at least there is a program out there that [you] don't feel like you've lost everything in the world. So for me, I'm just extremely grateful and that the program exists for my children, even though it doesn't exist for me. Just that I'm able to just kind of shelter them from all of the foolery of the world. ***Just the option of knowing if they did get ill and they do get sick, that I can take them to the doctor and I'm not going to have to worry about where am I going to get this money from to pay for the $80 visit plus whatever****."*

On the other hand, during the four months from January through April 2010 when monthly data matches with the SNAP program were taking place based on new SNAP applications

containing the "opt-out" box, an average of at least 1,770 children a month received ELE.[2] The state's switch to the SNAP "opt-in" box thus reduced the number of children enrolling via ELE, based on new monthly SNAP applications, by 62 percent.

Only 25 percent of children checking the "opt-in" box wound up enrolling in Medicaid via ELE. The rest were typically already enrolled in Medicaid, according to our informants, reinforcing the importance of Louisiana's steps to prevent automatic enrollment from causing duplicative coverage.

Program integrity. Outside the context of ELE, Louisiana's overall record on eligibility-related program integrity is extraordinary. The state's most recent federal payment error review, for example, found an eligibility error rate of 0.3 percent—less than one-tenth the national average (CMS 2012b). In the state's entire federal payment error review sample, auditors found only one eligibility error.

State officials believe that ELE made an important further contribution to preventing mistaken decisions because automation reduced the opportunity for manual errors. Although county-level Medicaid caseworkers were originally anxious about trusting a different agency's findings and concerned about different definitions of household, as noted earlier, state-level officials understood the high quality of SNAP's eligibility records. SNAP cases are reviewed at least once every six months, and precise income measurement is the focus of intense program effort, since SNAP benefit amounts vary directly based on income.

Views from outside state government. Community-based outreach groups quickly noticed an impact of the state's initial implementation of ELE. Before ELE, outreach specialists would typically begin community events by asking the parents of uninsured children to raise their hands. Inevitably, some would do so. Following initial ELE implementation, parents no longer

[2] This is the average number of ELE-enrolled children whose cases were due for renewal in December 2010 through March 2011, which means that their start dates were in January 2010 through April 2010. Additional children whose ELE coverage began in January through April 2010 may have lost such coverage before the end of their 12 month eligibility periods, so the actual number of ELE enrollees could be higher than the average presented in the text.

indicated that their children were uninsured at such events. Outreach specialists saw this as a dramatic change signaling ELE's impact in reaching uninsured, previously unenrolled children.

6. LOOKING FORWARD: FUTURE PROSPECTS FOR USING ELE

Refining the new approach to ELE enrollment. State policymakers believed that their new approach to ELE enrollment—using "opt-in" check-boxes on SNAP application forms—represented a significant improvement over prior efforts. While they saw the current level of ELE enrollment as a significant accomplishment in light of very high penetration levels of Medicaid into the ranks of eligible children, they acknowledged that some parents of uninsured children could inadvertently fail to check the box, leaving their children without coverage. To reduce the number of such occurrences, DHH officials indicated interest in the possibility of SNAP requiring applicants to check either an opt-in box or an opt-out box. Under this approach, failure to make this choice would prevent a SNAP application from being accepted. A parent who does not opt-in would then be making an explicit choice, rather than failing to act because of behavioral factors. We were not able to explore this idea with SNAP staff during our visit and so cannot present any kind of assessment of its advantages and disadvantages or its permissibility under the federal SNAP statute; rather, we simply note that the idea emerged during our visit as a topic for further exploration.

Moving towards Affordable Care Act implementation. Louisiana residents will be served by a Federally-Facilitated Marketplace (FFM) for 2014, and the state has not expanded Medicaid eligibility as permitted by the Affordable Care Act.

Regardless of whether Louisiana expands Medicaid, the Affordable Care Act makes changes to Medicaid eligibility rules. In particular, Section 1413 requires Medicaid to determine eligibility based on matches with reliable sources of data, whenever possible. CMS has operationalized this statute by requiring states to verify attestations of eligibility through data matches, without seeking documentation from applications, whenever available data are reasonably compatible with applicant attestations; by requiring states to connect with sources of useful data; by requiring data interfaces between Medicaid and health insurance

marketplaces, including those that are federally facilitated; and by directing states to renew eligibility administratively whenever reliable data demonstrate eligibility (CMS 2012a).

State officials in Louisiana believe that implementing ELE will greatly help their transition to the Affordable Care Act's new, data-driven method of eligibility determination. ELE has provided valuable experience working with an external interface to obtain data and using it to determine eligibility. For example, the matching criteria that DHH staff developed could prove helpful in identifying records in external databases that correspond to particular Medicaid applicants or beneficiaries, including those operated by the FFM that will serve Louisiana residents.

The Affordable Care Act makes clear that ELE can continue to operate under the new rules that will apply beginning in 2014. As a general rule, Medicaid and CHIP eligibility must be based on modified adjusted gross income (MAGI), except for people with disabilities and the elderly. However, the MAGI requirement does not apply to children who qualify based on ELE (Social Security Act Section 1902(e)(14)(D)(ii)). As a result, state officials did not anticipate ending their use of ELE in 2014.

State recommendations for federal policymakers. Federal policymakers should continue giving states the option to implement ELE, according to virtually all key informants interviewed. They believed that ELE's gains in children's coverage and savings in federal and state administrative costs amply justify its ongoing availability as a state option. Some key informants went farther, recommending broader federal efforts at multi-program coordination and integration. SNAP and Medicaid are not the only programs that serve an overlapping population.

7. LESSONS LEARNED

Louisiana's experience with Express Lane strategies offers the following insights:

Automating children's Medicaid enrollment based on SNAP's prior determination of eligibility, without requiring parents to take further action other than to seek care for their children, can cover numerous children. Requiring parents to take action, even by doing nothing

more than checking an "opt-in box" on SNAP application forms, can greatly reduce the number of children who received coverage. In this case, the shift to such an opt-in check-box reduced the number of children receiving coverage through ELE by 62 percent.

Letting families consent to their children's enrollment through accessing services—that is, through Medicaid card use—can improve children's access to care and provide coverage valued by their families. In less than 12 months during 2010, 60 percent of ELE children either used their cards to obtain care or were enrolled at their parents' request, even though the children had not used services.

The viability of auto-enrollment strategies that base consent on accessing care ultimately depends on information technology (IT) infrastructure. Louisiana was unable to continue using its "consent through card use" approach because the state's fee-for-service IT system could not communicate with its eligibility system. However, in other states with more integrated systems, such an auto-enrollment strategy could be viable and thus merit consideration.

A robust and streamlined ELE system can cover large numbers of children and achieve administrative efficiencies while strengthening program integrity by lessening the inherent risk of human error. However, creating a system that operates with both efficiency and integrity can require major up-front investments. Staff time and creativity was required, not just to develop IT infrastructure, but also to work through detailed policy and operations issues. With an automated enrollment system, for example, it proved important to develop systems to prevent the inadvertent duplicative enrollment of children who were already receiving coverage. However, the substantial pay-off exceeded the cost of the necessary work, and the benefits will be experienced as long the program continues. Medicaid Director Ruth Kennedy explained, "Simplification isn't simple." But in this case, she concluded, "The juice was worth the squeeze."

Other states could consider beginning with ELE renewals, rather than ELE applications. State officials made this suggestion, in view of the greater administrative complexity of ELE applications, compared to ELE renewals. Renewals of Medicaid children involve cases already

known to the system, which reduces the challenge of screening out duplicative enrollment. Also, significant, early short-term administrative savings from renewal can build momentum for further ELE implementation in the potentially more difficult context of initial applications.

Louisiana's success with ELE was built on a foundation of prior, related work, including the creation of electronic case records, ex parte renewals, business process reengineering, and efforts focused at changing agency culture. Other states that have not built similar foundations may experience less success with innovations like ELE.

CONCLUSION

With ELE, Louisiana provides an impressive model, implementing strategies that increased participation rates among eligible children, reduced administrative costs, and improved the accuracy of eligibility determination. Key elements of Louisiana's approach may be replicable in other states as they move forward with implementing the Affordable Care Act.

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