MATHEMATICA
Policy Research

CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings

Final Report

December 2013

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Mathematica Reference Number:
06988.920

Submitted to:
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EXECUTIVE SUMMARY

The Children's Health Insurance Program (CHIP), a landmark initiative to help close the health insurance coverage gap for low-income children, celebrated its 16th anniversary in August 2013. Together with Medicaid, CHIP has helped fuel a decline in the number of uninsured children, from 11.4 million (15.1 percent of children) in 1997 when CHIP was enacted to 6.6 million (8.9 percent of children) in 2012 (U.S. Census Bureau 2013). In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP and funded it through September 30, 2013. Funding for CHIP was further extended through September 30, 2015 by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act).

Concerned about the many children eligible for but not enrolled in public coverage—estimated at 4.4 million children as of 2010 (Kenney et al. 2012)—Congress provided states with new tools and new funds through CHIPRA to address shortfalls in enrollment as well as in access to, and quality of, care (Hoag et al. 2012). One of these is a new policy option under CHIPRA section 203 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, despite their different methods of assessing income or otherwise determining eligibility. ELE thus gives states another way to identify and enroll children who are eligible for Medicaid or CHIP but who remain uninsured, and to retain children in coverage for which they are eligible. CHIPRA also gave states an incentive to implement ELE by making it one of the eight policies states could adopt to qualify for performance bonus payments (temporary bonuses permitted through CHIPRA section 104).

The CHIPRA legislation authorized a comprehensive, independent evaluation of ELE, calling for a report to Congress not later than September 30, 2012 (CHIPRA Section 203). To comply with this mandate, in September 2011, a contract was awarded to Mathematica Policy Research and its subcontractors, the Urban Institute and Health Management Associates, to conduct the evaluation, which is being overseen by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The evaluation's interim Congressional report, summarizing findings from the evaluation's first year, was submitted to Congress in 2012 (Hoag et al. 2012).

This document is the project's final report to Congress. It has six aims:

1. To describe 13 ELE processes implemented in eight states.
2. To estimate the impact of ELE adoption on total enrollment.
3. To examine enrollment and renewal trends associated with ELE implementation and resulting administrative costs and/or savings.
4. To describe the volume, type, and timing of service use for ELE children compared to children who enroll through traditional processes.
5. To report key cross-state lessons learned from ELE implementation and operations.
6. To review other enrollment and renewal simplifications adopted in three states and compare them to ELE.

Findings presented in this report draw on three main studies conducted as part of the comprehensive, Congressionally-mandated evaluation of ELE. The first is an analysis of ELE's

impact on enrollment, which draws on state-reported Medicaid and CHIP enrollment data from the Statistical Enrollment Data System (SEDS). The second is a descriptive study of enrollment, administrative costs and savings, and utilization among those enrolled and/or renewed through ELE, as well as a companion study of enrollment and administrative costs and savings in the states implementing other simplifications. Finally, the third is a case study of each of the eight ELE states and three states that implemented other simplifications; case study methods included document review, site visits and focus groups with parents of children enrolled or renewed through ELE or the other simplifications studied.

What Problem is ELE Trying to Solve?

The two major public insurance programs for children—Medicaid and CHIP—together insure about one-third of all children nationwide and over half of low-income children (Kaiser Commission on Medicaid and the Uninsured 2012). Nevertheless, the potential of these programs to expand coverage remains only partly fulfilled, as roughly two out of every three uninsured children in the United States—an estimated 4.4 million children as of 2010—are eligible for one of these programs but not covered by them (Kenney et al. 2012).

Many of these eligible-but-uninsured children have been covered by CHIP or Medicaid in the past and often experienced program "churn," enrolling back into one of these programs after a gap in coverage. For example, a 2010 study finds that just over a quarter of all eligible-but-uninsured children had Medicaid or CHIP coverage within the past year but lost that coverage (Sommers 2010). Estimates from a 2007 multistate study found that half of eligible children leaving public coverage return in two or three months (Fairbrother et al 2007). Other research indicates that most children who do not quickly churn back into public coverage are uninsured for an extended period (Trenholm, Mabli and Wilson 2009). Only a small fraction of these children obtain private insurance.

Together, this research suggests that Medicaid and CHIP programs confront two challenges in insuring children who are eligible for coverage: the first is enrolling those uninsured children who are eligible for coverage; the second is keeping those children who remain eligible for CHIP or Medicaid in coverage. Although prior research on ELE's effects on coverage is limited, what research is available suggests that the policy holds considerable promise. For example, using ELE to qualify children for health coverage based on their participation in the Supplemental Nutrition Assistance Program (SNAP), Kenney et al. (2010) estimate that ELE could reach 15.4 percent of eligible, uninsured children. Using ELE to qualify children for health coverage based on state income tax records could reach even more children: an estimated 89 percent of uninsured children who qualify for Medicaid or CHIP live in families who file Federal income tax returns (Dorn 2009). Moreover, by relying on determinations that other programs have already made, ELE may reduce staff time spent on eligibility determinations, thereby producing administrative efficiencies that could ultimately yield net administrative savings for states.

How Does ELE Work?

Section 203 of CHIPRA authorizes ELE and permits states to rely on findings of other public agencies to determine whether a child satisfies one or more requirements for Medicaid or CHIP eligibility. In doing so, states can disregard technical differences in how these programs define the household members whose earnings are considered in determining eligibility, as well as other methodological differences in assessing whether children meet applicable requirements.

ELE can be used to meet any eligibility criterion except U.S. citizenship, which must be verified using Medicaid rules.

Under the statute, states can choose to partner with any of 11 specific types of public agencies; with federal approval, states also can select an agency not specified in the law that fits the definition of an Express Lane agency; and if they choose, states can obtain and use information directly from state income tax records or returns (CHIPRA section 203; Center for Medicaid and State Operations 2010). With ELE, not only can the Express Lane agency vary, but so can ELE features. For example, states can apply ELE to CHIP and/or Medicaid, with a focus on enrollment, renewal, or both. In addition, in pursuing ELE, states can choose to include or exclude an "automatic enrollment" option, possible when states have all the information they need from the Express Lane agency findings to make an eligibility determination or renew coverage, without the need for an application for coverage.

CHIPRA included several provisions to protect children determined eligible through ELE. For example, Express Lane partner agencies must notify families that their information will be shared with the Medicaid or CHIP agencies for the sole purpose of determining Medicaid or CHIP eligibility, and families must be able to opt out of sharing this information (CHIPRA section 203). States must obtain the family's consent to enroll the child in Medicaid or CHIP through ELE, and the family must be informed about the available services, how to access them, if there is cost sharing, how to maintain the coverage, and with any other information that families need to enroll their children. In addition, for children subject to premiums or cost sharing (which are common in CHIP programs), the state must provide notice to the family that the child might qualify for lower premiums or cost sharing if the child were evaluated for eligibility using "regular" procedures (Center for Medicaid and State Operations 2010). ELE cannot be used to deny coverage; CHIPRA requires states to initiate a standard eligibility determination for Medicaid and CHIP for any child found ineligible through the use of ELE.

What Did the Evaluation Find?

As summarized in Table ES.1, findings from the Congressionally-mandated evaluation of ELE support the promise of the ELE policy for increasing enrollment of eligible children and yielding administrative savings compared with standard processes. However, as detailed further below, the extent of these gains appears to depend on how states specifically implement the policy.

Table ES.1. Key Findings from the ELE Evaluation

1. ELE adoption can increase enrollment.
2. States have adopted ELE differently and those differences can affect its potential benefits.
3. Automatic ELE processes serve the most individuals, yield the greatest administrative savings, and eliminate procedural barriers to coverage.
4. Simplified procedure and simplified application ELE processes, which rely on families initiating or returning an application for coverage, produce little to no administrative savings and show more modest descriptive evidence of increasing enrollment.
5. Given the size of renewal caseloads compared to new enrollment caseloads and the recurring nature of renewal, using ELE for renewals holds great promise for administrative savings and keeping kids covered.
6. ELE enrollees use health care services, though fewer than those who enroll through standard routes.
7. Like ELE, all three of the other simplifications studied can help simplify the enrollment or renewal process for families, but they differ in their reach and impact.

Finding 1: ELE adoption can increase enrollment.

After we control for multiple economic and state policy changes over the period, our formal impact analysis finds significant evidence that ELE increased children's enrollment in Medicaid by about 6 percent on average among the ELE states in the study. This estimate is robust to several robustness tests; however, its certainty should not be overstated given the complex factors that can drive enrollment across states. For example, the estimate could be overstated due to other beneficial policy or procedural changes taking place in states that cannot be fully accounted for. Our descriptive analyses and case studies find that in all states, ELE contributed to enrolling or retaining children in Medicaid and CHIP, although the magnitude varied greatly depending on the type of ELE process used. It also finds that children who enroll through ELE were no more likely to experience churn after disenrollment than were other children.

Finding 2: States have adopted ELE differently and those differences can affect its potential benefits.

As of August 1, 2013, CMS had approved state plan amendments for ELE in 13 states and the U.S. Virgin Islands. Eight of these states were able to participate in this evaluation, and this study of ELE focuses on 13 ELE processes implemented in these eight states: Alabama, Iowa, Louisiana, Maryland, Massachusetts, New Jersey, Oregon, and South Carolina. The 13 ELE processes fall into three types:

1. **Automatic processing.** Used in Alabama, Louisiana, Massachusetts, and South Carolina, this ELE process enables states to use eligibility findings from Express Lane partner agencies to automatically enroll or renew children in Medicaid or CHIP who are also receiving SNAP or TANF benefits, without any additional action by the family (beyond enrolling in SNAP or TANF). In the states using ELE for initial enrollment (which requires consent), South Carolina obtains consent from families through use of Medicaid services or enrollment in a managed care plan; Louisiana initially used a similar approach but later switched to obtain consent on the SNAP application.

2. **Simplified procedure.** This ELE process includes Alabama's manual ELE process (in which Medicaid eligibility workers manually check SNAP or TANF databases for income determination rather than using standard Medicaid financial methodologies) and the ELE process used by Iowa's Separate CHIP program, in which children found ineligible for Medicaid because of income but found income-eligible for CHIP are electronically referred to the Separate CHIP program. Since these ELE processes use standard applications submitted by families, consent to coverage is obtained through standard means.

3. **Simplified application.** Used by Iowa Medicaid, Maryland, New Jersey, and Oregon, this ELE process uses findings from Express Lane partner agencies to identify children who are likely to be eligible for Medicaid or CHIP and sends them a shortened application that must be processed manually. Because of ELE, these forms can be simplified, and when families complete them, they sign a consent statement permitting Medicaid and/or CHIP agencies to base eligibility factors on findings from

the Express Lane partner agencies, rather than obtaining additional information from applicants.

In addition to the type of ELE process, the choice of the Express Lane partner agency, and how partner data are used, can differ and affect the efficacy of ELE. Some agencies that would seem to be ideal for ELE, because they have data on likely eligible children, have proven to be quite challenging partners. For example, many states have attempted to partner with the National School Lunch Program (NSLP), but these ELE partnerships have been difficult to implement because NSLP data are decentralized, maintained at either the individual school or school district, and are not always in a standard format or easily accessed. Likewise, the state tax agency seemed a natural partner for identifying children who are income eligible, and two of the states in the study changed their tax returns to obtain information about uninsured children. However, data sharing with tax agencies is challenging. In addition, states using the tax agency as a partner have relied on simplified application ELE processes, resulting in few enrollments.

ELE processes that partner with SNAP (sometimes in combination with TANF) or create a CHIP-Medicaid partnership (as in Iowa) show the most promising enrollment results to date. However, partnering with SNAP alone is not enough to guarantee that a large number of children will be processed through ELE. Rather, states' methods of using SNAP data make the difference. ELE partnerships with SNAP in Alabama, Louisiana, and South Carolina have resulted in many ELE enrollments, but Iowa Medicaid and Oregon have not enrolled many children through the process. The difference is the process: Louisiana and South Carolina enroll children into coverage automatically based on SNAP income findings, whereas Alabama uses ELE to process applications already received. In contrast, Iowa Medicaid and Oregon use SNAP data to identify income-eligible children, but families must still complete and return an application form (albeit a simplified form) to be enrolled. This difference in the process for using SNAP data has a greater effect on the levels of child enrollments than the fact that SNAP is the partner.

Finding 3: Automatic ELE processes serve the most individuals, yield the greatest administrative savings, and eliminate procedural barriers to coverage.

All of the ELE processes studied serve as a means of enrolling or renewing children in coverage, but the descriptive analysis found that its importance for coverage and cost varies (Table ES.2). Compared to the other ELE processes studied, automatic processing serves the most individuals. For example, through its new automatic renewal ELE process, Alabama expects to renew 300,000 individuals per year, accounting for more than 40 percent of all Medicaid renewals, based on its first four months of operation. The automatic ELE renewal process in South Carolina renews coverage for nearly 125,000 children a year and has accounted for nearly half of all Medicaid and Medicaid-expansion CHIP renewals in the two years it has been in place. In Louisiana, nearly 10,000 children are enrolled through ELE each year. Louisiana's automatic renewal process renews coverage for more than 170,000 children per year, representing about 20 percent of all Medicaid and Medicaid-expansion CHIP renewals in the state. Based on its first six months of experience, we expect Massachusetts to renew roughly 72,000 children and 46,500 adults annually through its automatic ELE renewal process—about one third of the child and adult renewals under 150 percent of the federal poverty level in the state's MassHealth program.

Table ES.2. Annual Number of Children and Adults Newly Enrolled or Renewed in Medicaid and/or CHIP Through ELE and Net Annual Administrative Costs and Savings Associated with ELE, by State and Type of ELE Process

State (Express Lane Partners)	Annual New ELE Enrollments (Percent of Annual New Enrollments)	Annual ELE Renewals (Percent of Annual Renewals)	Annual Administrative Savings (Costs) Estimate from Implementing ELE
Automatic ELE Processes			
Alabama (SNAP, TANF) (Automated)	NA	300,000 (44 percent)	$1,100,000
South Carolina (SNAP, TANF)	110,440 (Unknown)[a]	124,361 (48 percent)	$1,600,000
Louisiana (SNAP, TANF)	9,652 (10 percent)	171,869 (20 percent)	$979,000
Massachusetts (SNAP, TANF)	NA	118,545 (38 percent)	$192,000
Simplified Procedure ELE			
Alabama (SNAP, TANF) (Manual)	41,117 (28 percent)	109,078 (16 percent)	$68,000
Iowa Separate CHIP (Medicaid)	12,557 (53 percent)	NA	NA
Simplified Application ELE Processes			
Oregon (SNAP)	2,212 (Unknown)[a]	NA	($12,000)
New Jersey (NSLP)	1,400 (Less than 1 percent)	NA	($96,000)
New Jersey (Tax)	1,289 (Less than 1 percent)	NA	($74,000)
Iowa Medicaid (SNAP)	1,149 (2 percent)	NA	($2,000)
Maryland (Income)	113 (Less than 1 percent)	NA	NA
Maryland (Residence)	--	NA	($96,000)

Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

[a] The denominator total new enrollments is not available for this state, thus the percentage cannot be calculated.

Note: Massachusetts renews both children and adults through ELE (adults are renewed through an approved Section 1115 waiver). Alabama's automatic ELE renewal process includes women eligible for family planning services coverage (also approved through a Section 1115 waiver). The annual renewal figures shown for Massachusetts, South Carolina, and Alabama's automatic ELE process are projected estimates based on the early experiences from each state (ranging from 4 months of experience in Alabama's automatic ELE process to 10 months in South Carolina). Data were not available to include Oregon's NSLP ELE process in this table.

-- = Not available; CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NA= Not Applicable; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

Automatic processing ELE succeeds in large part because of up-front investments that permit the state's information systems, rather than eligibility workers and other state staff, to do the work of determining initial or ongoing eligibility. The recurring administrative costs for automatic ELE processes also are minimal. As a result, automatic processing ELE has led to substantial administrative savings—an average of $1 million per year in recurring net gains in the four states using automatic ELE processes, compared to what the states would have spent to enroll and renew the same number of people via standard enrollment and renewal methods (Table ES.2).

Finding 4: Simplified procedure and simplified application ELE processes, which rely on families initiating or returning an application for coverage, produce little to no administrative savings and show more modest descriptive evidence of increasing enrollment.

Although some observers may equate ELE with automation, ELE does not have to be automated to find and enroll or renew children eligible for coverage. Although the most efficient ELE processes use automation, they also required the largest up-front investments. Non-automated ELE processes, including simplified procedure and simplified application ELE processes, can also work for states.

With simplified procedure ELE, states are able to expedite eligibility determinations for families that have already applied; because it affects so many applications, it saves money for the state and presumably results in a better experience for the family because applications are processed more quickly. For example, Alabama's simplified procedure ELE process is used to enroll more than 41,000 and to renew 110,000 individuals per year, saving the state about $68,000 annually. It also shortens families' wait for coverage by 19 days, from up to 25 days under standard processes to less than 6 days using this ELE process. However, in contrast to automatic processing, this type of ELE does not identify new, eligible applicants or remove the family's application burden.

Despite the limitations of the simplified application ELE method in terms of enrollment, states using ELE to mail out simplified applications to children identified as eligible for coverage may find this approach as cost effective as traditional outreach methods. Moreover, it offers advantages over traditional outreach because ELE allows states to use the findings of the Express Lane partner agency to establish eligibility for returned applications. However, simplified application ELE processes are either cost neutral or incur a net cost of nearly $100,000 per year.

With simplified application ELE processes, states do identify eligible-but-uninsured children, drawing on existing information to reduce the amount of information needed from the family (sending families a shortened application form). In turn, the process has significant potential both to enroll children who might not otherwise obtain CHIP or Medicaid coverage and to produce administrative cost savings in much the same way as simplified procedure ELE. However, this process has to date relied on a mail-based outreach approach to reach families, which has not resulted in much enrollment—less than one percent of each state's Medicaid and/or CHIP enrollment—compared to other types of ELE. Across the five ELE processes using the simplified application ELE approach, between 5 and 13 percent of families completed and returned the simplified applications. Perhaps not surprisingly, therefore, we find the least descriptive evidence of meaningful administrative savings or enrollment gains from this process:

enrollments have ranged from 113 children per year in Maryland to about 1,400 children per year through New Jersey's NSLP ELE partnership (see Table ES.2).

Despite their relatively modest numbers, the simplified application ELE approaches show promise in reaching certain key target populations. For example, the evaluation found that children enrolling through ELE were more likely to be teens. Given that teenagers are traditionally the most likely among all children to be uninsured, this finding suggests that even ELE processes that reach a small proportion of the target population may be useful for reaching and enrolling older children. We also found that simplified application ELE processes, which focus on identifying children who have not applied for coverage, were more likely to reach children who did not have recent spells of public coverage. These findings suggest that simplified application ELE processes hold promise for identifying and enrolling children disconnected from coverage.

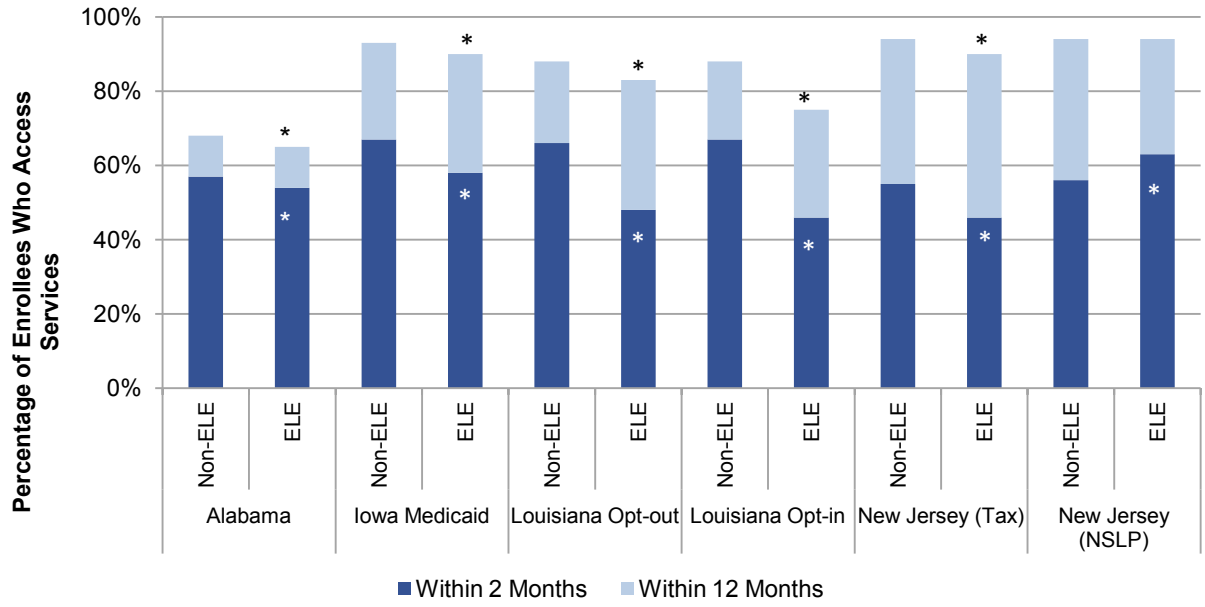
Finding 5: Given the size of renewal caseloads compared to new enrollment caseloads and the recurring nature of renewal, using ELE for renewals holds great promise for administrative savings and keeping kids covered.

Approximately 170,000 and 120,000 children each year in Louisiana and South Carolina, respectively, nearly 80,000 children and adults in the first six months of Massachusetts' ELE process, and more than 90,000 children and adults in the first four months of Alabama's automatic ELE process have had their coverage renewed via ELE. These sizable numbers demonstrate the potential of implementing ELE for renewal as a means to generate administrative savings and efficiencies, particularly in contrast to using ELE for applications. Although this result is not surprising, given the relative size of a state's renewal caseload compared to the applications received, ELE for renewal has not been as widely adopted as has ELE used for processing applications.

Finding 6: ELE enrollees use health care services, though fewer than those who enroll through standard routes.

Our analysis of utilization data in four states finds that most ELE enrollees accessed a variety of health care services through their coverage (Figure ES.1) and rarely used only wraparound services such as vision care. This finding was consistent across states and across the three types of ELE employed (automatic processing, simplified procedure, and simplified application).

Figure ES.1. Most ELE Enrollees Access Services in First Year



Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

Note: Regression-adjusted estimates.

* Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).

ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

The evaluation also found that ELE enrollees are somewhat less likely to use services, and those who do use services do so less intensively compared to similar enrollees who did not enter through ELE. The lower service use among ELE enrollees may have several explanations, which we cannot disentangle through this analysis. Our results are consistent with the theory that even though their families may be seeking other social support services, children who are eligible for but not enrolled in public insurance programs may simply be healthier than their enrolled peers and have lower health care needs. Some have raised the concern that ELE enrollees—especially those enrolled through automated, passive processes—may not access services because they are unaware they are covered or, if they know they are covered, may be unfamiliar with the ways they should begin seeking services. The fact that most ELE enrollees use a variety of services, and the consistency of our results across states that use diverse ELE mechanisms, mitigate these concerns. These findings also suggest that states adopting ELE may find the children who enroll through the process are less expensive to cover than are their typical beneficiaries.

Finding 7: Like ELE, all of the other simplifications studied help simplify the enrollment or renewal process for families, but they differ in their reach and in the magnitude of effects.

Three other simplifications were studied: presumptive eligibility in Michigan; phone renewals in New York; and online enrollment in Oklahoma (Table ES.3). All of the other simplifications studied simplify the enrollment or renewal processes for families, improving the consumer experience. Moreover, the two focused on enrollment (presumptive eligibility and

online enrollment) also expedite coverage. These other simplifications we studied still require families to spend time either to apply for or renew their coverage, so they are less streamlined compared to automatic ELE processes. However, the time spent by families to enroll or renew is similar to that of families in the states that adopted simplified application and simplified procedure ELE processes.

Enrollment and renewal results from the other simplifications vary. Oklahoma's online system processes far more enrollments and renewals than any of the ELE processes studied, but that was as the state intended: online enrollment was meant to be a simplification for nearly all Medicaid and CHIP beneficiaries in Oklahoma (about 72 percent of enrollees qualify to use the system, and they are required to use it for enrollment or renewal). Michigan's presumptive eligibility process is more similar to simplified application ELE processes in that it provides a pathway to enrollment for populations that may not be reached through traditional means. Michigan's presumptive eligibility leads to more annual enrollments compared to states that adopted simplified application ELE, but fewer annual enrollments compared to states that adopted either simplified procedure or automatic processing ELE. In New York, half of renewals in counties where phone renewal is an option are processed through the phone center (but because New York City is excluded from phone center renewals, renewals processed through the phone center represent a small proportion of all renewals). By comparison, states using ELE for renewal are processing between 16 and 48 percent of their statewide monthly renewals through the ELE process.

Table ES.3. Annual Enrollments, Renewals, and Net Administrative Savings or Costs from Other Simplifications

State	Simplification Implemented	Annual New Enrollments	Annual Renewals	Net Annual Administrative Savings (Costs) Estimate from Implementing Process
Michigan	Presumptive eligibility in Medicaid for children and pregnant women	28,992	NA	($10,000)
New York	Phone renewals	NA	89,736	NA
Oklahoma	Online enrollment and renewal system	142,572	400,584	$1,500,000

Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Cost data was not available for New York's phone renewal process. Data were not available to present these enrollments and renewals as a proportion of all enrollments/renewals in each state. The number of enrollments shown for Michigan is the number of referrals from the presumptive eligibility process to Medicaid; not all of these referrals result in enrollment, although officials believe most referrals result in enrollment.

NA = Not applicable.

New administrative savings or costs from these processes likewise vary. For example, Oklahoma's online enrollment and renewal system saves the state about $1.5 million per year, on par with automated ELE processes; Michigan's presumptive eligibility process incurs small administrative costs, similar to some of the simplified application ELE processes.

Conclusions

Findings from the Congressionally-mandated ELE evaluation show quite clearly that there is no one way to implement ELE and that how a state decides to implement ELE can profoundly affect its potential benefits. These findings reflect an inherent value of ELE: the policy is adaptable and states that have used it did so in ways that suited their circumstances, whether that meant phasing it in over time or using it as a new outreach mechanism.

Nevertheless, for states wishing to maximize coverage through ELE in the most efficient manner, the evaluation findings suggest adopting these ELE best practices:

Evaluation Findings Suggest Four ELE Best Practices to Maximize Coverage:

1. Adopt automated ELE processes.
2. Use ELE for renewal.
3. Choose Express Lane partners with centralized, linkable data.
4. Consider ELE processes that remove administrative barriers for families.

The most efficient ELE processes are automated. Although these types of ELE processes cost the most to implement, the efficiencies gained means they can be used to process large numbers of individuals. In turn, they yield the greatest administrative savings. Using automated ELE processes for renewal show the most promise for maximizing coverage, as states already adopting these processes are capturing one-fifth to one-half of their renewal caseloads through ELE. Moreover, most automated renewal processes remove all administrative barriers for families; removal of administrative barriers has been demonstrated to maximize coverage and reduce churn. Partner selection matters as well, and programs such as NSLP and state tax agencies can be challenging partners. To date, states have had more success working with SNAP, although states also should consider other agencies with centralized, linkable data.

Evaluation findings also suggest further policy implications for states considering implementing ELE. They include:

Data-based verification processes can work well for states and consumers. ELE and the online enrollment system studied in Oklahoma are both forerunners to the types of data matching required under Affordable Care Act provisions that will enroll newly eligible individuals into either Medicaid or Marketplace plans beginning in 2014. These experiences demonstrate how data matching may improve the accuracy of eligibility determinations and can remove barriers for families. The efficiencies gained by using data-based eligibility methods are substantial, resulting in labor savings and, in turn, administrative savings for states. For consumers, these methods expedite coverage and reduce paperwork burdens for families; parents who participated in focus groups reported that they appreciated both of these benefits.

ELE may be less costly to implement among states that have already invested in new eligibility and management information systems. One of the biggest drivers of administrative ELE implementation costs is the investment in technology upgrades needed to make ELE work. For example, Iowa Medicaid invested about $84,000 in programming costs, whereas in South Carolina, information technology appears to have cost between $400,000 and $500,000 at

implementation (officials could not provide an exact number). Both states were using legacy Medicaid management information systems (MMISs), which made programming more cumbersome than it would have been for newer systems. Findings from other states were mixed. For example, Louisiana spent more than $100,000 on programming, but officials there think the higher costs were because the ELE process they were implementing was highly automated rather than because of the age of their MMIS (which was also a legacy system). In Oklahoma, which invested $15 million in its new MMIS, officials observed that programming changes are far less costly in the new system, primarily because they can be implemented quickly and easily and therefore do not use substantial staff time. Given federal incentives available under the Affordable Care Act to invest in modernizing eligibility systems, many states are in the process of upgrading their systems, which may bring down the costs of programming the changes needed to implement ELE.

Continuing ELE as a policy option will benefit states that have enacted an ELE process and will potentially expand its use, ideally drawing on lessons learned. Continuing ELE as a policy option will ensure that states already enacting the policy do not need to return to standard processing methods. Although administrative savings and costs have varied, in states using automatic ELE processes, the administrative savings generated from ELE have been substantial: on average, these states are saving $1,000,000 per year. Because ELE saves so much time in these states, remaining eligibility staff have been able to process standard applications and renewals more quickly, typically saving 20 to 30 minutes per application or renewal. In South Carolina, officials reported that they plan to redirect staff resources previously required for application processing toward future program improvements for more rapidly connecting children with appropriate services, such as well-child visits. In Louisiana, state staff reported that ELE enabled them to stay on top of workloads despite staffing reductions caused by state budget cuts. In all of the states except Maryland, ELE has expedited coverage, which benefits consumers.

I. THE FEDERAL EVALUATION OF EXPRESS LANE ELIGIBILITY

The Children's Health Insurance Program (CHIP), a landmark initiative to help close the health insurance coverage gap for low-income children, celebrated its 16th anniversary in August 2013. Together with Medicaid, CHIP has helped fuel a decline in the number of uninsured children, from 11.4 million (15.1 percent of children) in 1997 when CHIP was enacted to 6.6 million (8.9 percent of children) in 2012 (U.S. Census Bureau 2013).

Initially authorized with bipartisan support through the Balanced Budget Act of 1997, CHIP was set to expire in 2007 unless reauthorized by Congress. Congress gave CHIP a temporary reprieve in December 2007: the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the program and funded it through March 2009 (Kaiser Commission on Medicaid and the Uninsured 2009). In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP and funded it through September 30, 2013. Funding for CHIP was further extended through September 30, 2015 by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act).

Concerned about the many children eligible for but not enrolled in public coverage—estimated at 4.4 million children as of 2010 (Kenney et al. 2012)—Congress provided states with new tools and new funds through CHIPRA to address shortfalls in enrollment as well as in access to, and quality of, care (Hoag et al. 2012). One of these is a new policy option under CHIPRA section 203 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, despite their different methods of assessing income or otherwise determining eligibility. ELE thus gives states another way to identify and enroll children who are eligible for Medicaid or CHIP but who remain uninsured, and to retain children in coverage for which they are eligible. 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 Medicaid and CHIP eligibility methodologies to be applied to data from other agencies (Families USA 2010; Children's Partnership 2012).

CHIPRA slated the ELE policy option to end September 30, 2013, unless extended or modified. Through the Taxpayer Relief Act of 2012, Congress extended ELE through September 2014 (P.L. 112-240). Despite the possible end to ELE as a policy option, CHIPRA also gave states an incentive to adopt ELE by making it one of the eight policies states could adopt to qualify for performance bonus payments (CHIPRA Section 104).[1]

[1] Section 104 of CHIPRA specifies that the performance bonus money is intended to offset the additional costs resulting from enrollment and retention efforts. To qualify for CHIPRA performance bonuses, states must increase Medicaid enrollment beyond a specified target and implement at least five of eight administrative policies considered best practices for simplifying enrollment and renewal. These funds are temporary.

A. Purpose of this Report

The CHIPRA legislation authorized a comprehensive, independent evaluation of ELE, calling for a report to Congress not later than September 30, 2012 (CHIPRA Section 203). To comply with this mandate, in September 2011, a contract was awarded to Mathematica Policy Research and its subcontractors, the Urban Institute and Health Management Associates, to conduct the evaluation, which is being overseen by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The evaluation's interim Congressional report, summarizing findings from the evaluation's first year, was submitted to Congress in 2012 (Hoag et al. 2012).

This document is the project's final report to Congress. It has six aims:

1. To describe 13 ELE processes implemented in eight states.
2. To estimate the impact of ELE adoption on total enrollment.
3. To examine enrollment and renewal trends associated with ELE implementation and resulting administrative costs and/or savings.
4. To describe the volume, type, and timing of service use for ELE children compared to children who enroll through traditional processes.
5. To report key cross-state lessons learned from ELE implementation and operations.
6. To review other enrollment and renewal simplifications adopted in three states and compare them to ELE.

Section 203(b)(1)(A) of CHIPRA also specifies that the ELE evaluation obtain a statistically valid sample of the children who were enrolled in Medicaid or CHIP through ELE and determine the percentage of children who were erroneously enrolled. This report does not address that requirement because the Centers for Medicare & Medicaid Services (CMS) has not finalized the methodology that states would use to report error rates. CMS plans to issue guidance on that methodology, and the Department will report to Congress on the finalized methodology and the related findings in a separate document.

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. This evaluation provides an important opportunity to document ELE implementation and understand the implications of adopting the policy. The study also permits us to explore three other strategies that states have pursued to simplify enrollment and renewal processes and to assess the benefits and potential administrative costs of these methods compared with those of ELE. Taken together, findings from the study will help Congress and the nation better understand ELE and assess its value.

B. What is Express Lane Eligibility?

ELE permits states to rely on the findings of other public agencies to determine whether a child satisfies one or more requirements for Medicaid or CHIP eligibility. In doing so, states can disregard technical differences in how these programs define the household members whose earnings are considered in determining eligibility, as well as disregard other methodological

differences in assessing whether children meet applicable requirements. The criteria for Medicaid and CHIP eligibility include income, age, residency, and immigration status or U.S. citizenship; ELE can be used to meet any of these except U.S. citizenship, which must be verified based on Medicaid rules.[2] ELE is authorized only for children's eligibility determinations, although states can obtain permission from CMS to use ELE for adults through waivers to the Medicaid or CHIP state plans.

In adopting ELE, states can choose to partner with any of 11 named public agencies, can obtain federal approval to select an agency not specified in the law that fits the definition of an Express Lane partner agency, and can also obtain and use information directly from state income tax records or returns. Based on guidance from CMS, the definition of an Express Lane partner includes an agency determining eligibility for assistance through any of the following programs:

- Temporary Assistance for Needy Families (TANF);
- Child support enforcement;
- Medicaid;
- CHIP;
- Supplemental Nutrition Assistance Program (SNAP);
- The National School Lunch Program (NSLP);
- The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);
- The United States Housing Act of 1937;
- Head Start;
- Child care provided under the Child Care and Development Block Grant Act of 1990; or
- The Native American Housing Assistance and Self-Determination Act of 1996 (Center for Medicaid and State Operations 2010).

With federal approval, states may select any other state government agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the state or a public agency subject to an interagency agreement limiting the disclosure and use of information shared for determining Medicaid or CHIP eligibility. This public agency may be an agency administered by an Indian tribe recognized by the state or federal government that determines eligibility for any of the programs listed. Express Lane partner agencies cannot be private, for-profit organizations, even if they are contracted to determine eligibility for a partner

[2] CHIPRA extended the citizenship verification requirements already used in Medicaid to CHIP, effective January 1, 2010. CHIPRA also permits a new option for states to meet this requirement through a data-matching process with the Social Security Administration (CHIPRA Section 211).

program, or agencies that only determine eligibility for programs funded under the Title XX Social Services Block Grant.[3]

States have discretion to choose the features of their ELE program(s) as well as the Express Lane partner agency. For example, states can apply ELE to Medicaid and/or CHIP, with a focus on enrollment, renewal, or both. In addition, in pursuing ELE, states can choose to include or exclude an "automatic enrollment" option that avoids the need for an application. This is possible when states have all the information they need from the Express Lane partner agency findings to determine eligibility or to renew coverage. States also can choose more than one Express Lane partner agency.

CHIP has "screen and enroll" requirements, which dictate that children do not qualify for CHIP unless they have been screened for Medicaid and found ineligible. To satisfy these requirements, states adopting ELE can either use traditional approaches or apply one of two new methods. In the first method, states can set a screening threshold 30 percentage points (or more) above the highest Medicaid eligibility threshold. Children with a family income at or below the threshold, as found by the Express Lane agency, are considered to have met the Medicaid eligibility income test for the purpose of complying with the Title XXI screen and enroll requirements and must be enrolled in Medicaid. For children with family incomes above this threshold, states must assess whether these children are income-eligible for CHIP based on the Express Lane partner agency findings, but they need not be screened for Medicaid eligibility (Center for Medicaid and State Operations 2010). Using the second new method, states can temporarily enroll children in CHIP if the child appears CHIP eligible using the Express Lane partner agency findings; however, during the temporary enrollment period, states must conduct a full eligibility determination to establish either Medicaid or CHIP eligibility.[4] Even for children ultimately found Medicaid eligible, states can claim Title XXI matching funds for the temporary CHIP enrollment period. This is an advantage for states because the federal government matching rate is higher in CHIP than in Medicaid.

Federal rules offer several protections for children determined eligible through ELE. For example, Express Lane agencies must notify families that their information will be shared with Medicaid or CHIP agencies solely to determine Medicaid or CHIP eligibility, and families must be able to opt out of sharing this information. States must obtain the family's consent to enroll the child, and the family must be informed about the available services, how to access them, if there is cost sharing, how to maintain the coverage, and with any other information that families need to enroll their children.[5] In addition, whether or not a state implements the automatic enrollment option, for children subject to premiums or cost sharing (both of which are common

[3] Title XX block grants include programs to prevent child abuse, increase the availability of child care, and provide community-based care for the elderly and disabled (P.L. 97-35).

[4] States must use simplified procedures to minimize the family burden for this full eligibility determination. For example, the state cannot require the family to submit or verify information already provided by the Express Lane partner agency or available to the state from another source, unless the state believes that information to be false (Center for Medicaid and State Operations 2010).

[5] CMS permits a wide range of consent methods for states using automatic enrollment, including oral, written, electronic signature, signature on an Express Lane partner agency application, or other means that CMS approves (Center for Medicaid and State Operations 2010).

in CHIP programs), the state must provide notice to the family that the child might qualify for lower premiums or cost sharing if the child were evaluated for eligibility using "regular" procedures (Center for Medicaid and State Operations 2010). ELE cannot be used to deny coverage; CHIPRA requires states to initiate a standard eligibility determination for Medicaid and CHIP for any child found ineligible through the use of ELE.

As with other options, CMS approval is required to implement ELE. States submit a state plan amendment (SPA) to CMS specifying the state's ELE plans. The SPA must provide detail on how the ELE option will operate, which Express Lane partner agency (or agencies) were selected, how the screen and enroll requirements will be satisfied, and how the Express Lane partner agency's rules differ from Medicaid or CHIP rules with regard to income eligibility determination. ELE SPAs are required for Medicaid, CHIP, or both, depending on the health program(s) to which ELE applies.

C. Potential Benefits of ELE

The two major public insurance programs for children—Medicaid and CHIP—together insure about one-third of all children nationwide and over half of low-income children (Kaiser Commission on Medicaid and the Uninsured 2012). Nevertheless, the potential of these programs to expand coverage remains only partly fulfilled, as roughly two out of every three uninsured children in the United States—an estimated 4.4 million children as of 2010—are eligible for one of these programs but not covered by them (Kenney et al. 2012).

Many of these eligible-but-uninsured children have been covered by CHIP or Medicaid in the past and often experienced program "churn," enrolling back into one of these programs after a gap in coverage. For example, a 2010 study finds that just over a quarter of all eligible-but-uninsured children had Medicaid or CHIP coverage within the past year but lost that coverage (Sommers 2010). Estimates from a 2007 multistate study found that half of eligible children leaving public coverage return in two or three months (Fairbrother et al 2007). Other research indicates that most children who do not quickly churn back into public coverage are uninsured for an extended period (Trenholm, Mabli and Wilson 2009). Only a small fraction of these children obtain private insurance.

Thus, this research suggests that Medicaid and CHIP programs confront two challenges in insuring children who are eligible for coverage: the first is enrolling those uninsured children who are eligible for coverage; the second is keeping those children who remain eligible for CHIP or Medicaid in coverage. Although prior research on ELE's possible coverage effects is limited, the available evidence supports the potential of the policy to produce meaningful gains, along with potential administrative efficiencies. Here, we review the potential benefits of ELE in more detail.

1. Potential Coverage Gains

Coverage gains through ELE could be achieved in several ways:

- **ELE can simplify the enrollment or renewal experience for uninsured children eligible for Medicaid or CHIP.** Using information from another benefit program to enroll or renew a child in Medicaid or CHIP simplifies the enrollment or renewal experience for families. It may produce gains in coverage because families who might

otherwise not apply for (or renew) coverage for their eligible children, or might not complete this process successfully, are able to do so. Prior research has estimated that using ELE to qualify children for health coverage based on their participation in SNAP could reach 15.4 percent of eligible, uninsured children (Kenney et al. 2010). Using ELE to qualify children for health coverage based on state income tax records could reach even more children: an estimated 89 percent of uninsured children who qualify for Medicaid or CHIP live in families who file federal income tax returns (Dorn et al. 2009).

- **ELE could be used for targeted outreach.** Outreach—the process of finding and then enrolling eligible children in coverage—is a constant challenge for Medicaid and CHIP programs. Among children, the average participation rate in these programs in 2010 was about 86 percent, leaving states to try to find and enroll the 4.4 million children eligible for, but not enrolled in, these programs (Kenney et al. 2012). This challenge has been exacerbated in recent years by state budget crises, which have led many states to cut outreach funding. Moreover, even using proven outreach methods, public coverage programs can struggle to maximize coverage if clients find application or renewal processes overwhelming. Through targeting uninsured children eligible for other public benefit programs, ELE processes can serve as a new method of outreach, leading to coverage gains.
- **ELE could smooth transitions between Medicaid and CHIP.** CHIPRA permits both Medicaid and CHIP to be ELE partner programs. As a result, ELE could also ease transitions between the two programs at renewal, eliminating the churning sometimes triggered when family income changes.

2. Potential Administrative Savings Resulting from Administrative Efficiencies

ELE may also produce administrative efficiencies that ultimately yield net administrative savings for states:

- **ELE may reduce staff time spent on eligibility determinations.** By relying on determinations that other programs have already made, Medicaid and CHIP can reduce the administrative costs of enrollment or renewal. Although states will need to expend funds to create the infrastructure and make policy decisions regarding ELE's implementation, the end result may be an operationally more efficient system that can reduce ongoing administrative costs. To determine the impact of ELE on administrative efficiency, we must compare and assess start-up costs to ongoing administrative savings resulting from ELE implementation.
- **ELE may reduce churning, thereby saving staff time spent reprocessing cases and reducing families' burden of reapplying.** Churning—when children disenroll and then soon reenroll in one of these programs, experiencing breaks in coverage—is a nontrivial problem among children eligible for public coverage: in 2008, a quarter of all uninsured children had been enrolled in Medicaid or CHIP the year before (Sommers 2010). In addition to extending continuous coverage for children in these programs, reducing churn could also yield administrative saving by eliminating the administrative costs of reprocessing eligibility for children already on their programs. These costs can be significant: studies of administrative changes in Washington state showed that shortening eligibility periods from 12 to 6 months increased

administrative costs by $5 million and reduced enrollment by more than 30,000 children (Ku et al. 2009; Wachino and Weiss 2009).

3. Shorter Wait Times

Administrative efficiency in processing applications or renewals may shorten wait times for consumers:

- **ELE may expedite coverage, leading to a better consumer experience.** Although simplified processes can lead to administrative savings for states, they may also benefit families by speeding the time to coverage. If coverage eligibility factors such as income, residency, and age can be verified from the Express Lane partner agency's data, the application or renewal may be processed faster than standard paperwork processes. This efficiency reduces days without coverage for the eligible child and improves the consumer experience for the family, which does not have to resubmit information already provided to other benefit programs.

D. Other Approaches to Expanding Coverage and Simplifying Enrollment and Renewal

ELE is one of many simplifications states can adopt to try to expand coverage while simplifying the enrollment and/or renewal process in Medicaid and CHIP. The evaluation design called for a study of other simplifications besides ELE. The assessment of other simplifications has two main purposes: first, to understand how other simplifications compare to ELE in terms of administrative costs or enrollment effects; and second, to disseminate information on the experiences of states that implemented simplifications that could be applied to the enrollment of adults who are newly eligible for Medicaid in 2014, when the Affordable Care Act's coverage expansions take effect.

The evaluation team studied three other simplifications:

1. A presumptive eligibility process, which permits states to give temporary Medicaid coverage to those who appear eligible.
2. A phone renewal process, which allows families to call rather than submit paper documentation for their child's Medicaid renewal.
3. An online enrollment and renewal system for Medicaid and CHIP that makes real-time eligibility decisions, permitting families to know immediately whether they or their children have coverage.

We chose to study these three simplifications because they offer potential benefit to states under the Affordable Care Act (in fact, beginning in 2014, online and telephone enrollment and renewal are required under the Affordable Care Act; and all states must allow for presumptive eligibility if a hospital within the state wants to use it). This assessment was informed by a review of the research literature on Medicaid and CHIP simplifications and by recommendations from the evaluation's technical advisory group. Like ELE, these approaches could increase the enrollment of children into Medicaid and/or CHIP by simplifying the process of applying for or renewing coverage among those who are eligible for Medicaid or CHIP. Moreover, the

approaches could produce administrative savings to states by reducing the time needed to process applications or renewals and/or by reducing unnecessary program churn.

E. Overview of the ELE Evaluation

In September 2011, Mathematica Policy Research and its subcontractors, the Urban Institute and Health Management Associates, were awarded the contract to conduct the congressionally mandated evaluation of ELE. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is overseeing this contract.

1. Evaluation Goals

CHIPRA Section 203 specifies that "...a comprehensive, independent evaluation of the [ELE] option…" should be conducted, to include the following:[6]

1. An assessment of whether enrolling children in such plans through reliance on a finding made by an Express Lane agency improves the ability of a state to identify and enroll low-income, uninsured children who are eligible but not enrolled (CHIPRA Sec. 203 (b)(1)(B));
2. An evaluation of the administrative costs or savings related to identifying and enrolling children through ELE, and the extent to which such costs differ from the costs that the state otherwise would have incurred to identify and enroll low-income, uninsured children who are eligible but not enrolled (CHIPRA Sec. 203(b)(1)(C));
3. Any recommendations for legislative or administrative changes that would improve the effectiveness of enrolling children in such plans through reliance on such findings (CHIPRA Sec. 203 (b)(1)(D)).

Table I.1 summarizes the major research activities and reporting used to inform each of these three evaluation components. Major research activities include an impact analysis, using data from the CHIP Statistical Enrollment Data System (SEDS); a descriptive study of program enrollment, administrative costs, and utilization; and case studies.

Table I.2 reviews the scope of the three main study methods and the planned timing of each component. The first study component, the analysis of SEDS data, uses state-reported data to assess ELE's impact on enrollment. The second study component aims to understand from a descriptive perspective ELE's effects on enrollment, administrative costs, and utilization, as well as to study effects on enrollment and administrative costs in states that have implemented other simplifications. In the evaluation's first year, we conducted the impact analysis as well as a descriptive analysis of enrollment in four of the six states that had implemented ELE as of

[6] As noted above in Section 1. A., CHIPRA section 203(b) also specifies that a determination of the percentage of children erroneously enrolled in Medicaid or CHIP based on Express Lane agency findings should be included in the evaluation of ELE and the results of the evaluation reported to Congress. This report does not contain that evaluation because CMS has not finalized the methodology that states would use to report error rates. CMS plans to issue guidance on that methodology, and the Department will report to Congress on the finalized methodology and the related findings in a separate document.

December 2010 (limited to those states that could identify beneficiaries who had enrolled or renewed through ELE), and a descriptive analysis of administrative costs in each of the six states. We assessed these components again in the study's second year, extending the descriptive study of enrollment and administrative costs to all case study states, including two additional ELE states as well as three states that adopted other simplifications. We also studied utilization differences in a four of the ELE states and conducted site visits as part of the case studies.

Table I.1. Mandated Evaluation Components and Corresponding Research Activities and Reporting

	Research Activities			Reporting		
Evaluation Components Mandated by Congress	Impact Analysis	Descriptive Analyses of Enrollment, Administrative Costs, and Utilization	Case Studies	Interim Report to Congress (2012)	Final Report to Congress (2013)	Standalone Reports
1. An assessment of whether ELE improves a state's ability to identify and enroll eligible but unenrolled children	X	X	X	X	X	X
2. An evaluation of the administrative costs or savings related to identifying and enrolling children through ELE methods, compared to the administrative costs of identifying and enrolling eligible but unenrolled children through the state's regular methods		X	X	X	X	X
3.Recommendations for legislative or administrative changes that would improve ELE's effectiveness as a method for enrolling or retaining children in Medicaid or CHIP	X	X	X			X

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility.

Table I.2. Key Methods Used in the Evaluation of ELE, Their Purpose, and Timing

		Timing	
Research Activity	Scope	Year 1	Year 2
Impact Analysis	• Assess ELE's effect on enrollment using data from SEDS	X	X
Descriptive Analyses of Enrollment, Administrative Costs, and Utilization	• Understand descriptive trends in new enrollment and retention in ELE/other simplification states • Assess whether utilization differs between ELE enrollees and those who enroll through traditional enrollment approaches in four states where individual-level data with an indicator for ELE enrollment pathway are available • Understand administrative costs or savings from ELE/other simplifications	X	X
Case Studies	• Describe ELE implementation, evaluate its benefits, assess best practices in ELE states and in states that have adopted other simplification approaches (key informant interviews)		X

Research Activity	Scope	Timing	
		Year 1	Year 2
	• Hear and report on family experiences about ELE and other simplification approaches (focus groups)		

ELE = Express Lane Eligibility; SEDS = Statistical Enrollment Data System.

Case studies for the evaluation, including site visits and focus groups with parents, were conducted in 11 states: 8 states that had implemented ELE as of fall 2012, and 3 states that were selected for their use of other enrollment or renewal simplifications. These other simplification case studies were used to document, assess, and compare ELE with other approaches that streamline eligibility or renewal for Medicaid and CHIP.

2. Research Questions Addressed by This Report and Data Sources Used to Answer Them

This final Report to Congress details findings from the three key components of the evaluation: (1) the analysis of the impact of ELE on enrollment in Medicaid and CHIP programs; (2) case studies and a descriptive analysis of enrollment and administrative costs in eight states that adopted ELE and three states that adopted other simplifications; and (3) a study of utilization patterns in four states that adopted ELE. Table I.3 describes the key research questions each of these components addresses.

Table I.3. Key Research Questions Addressed in This Report

Research Activity	Key Research Questions Addressed Through Evaluation Activities
Impact Analysis	• Does the implementation of ELE have a positive effect on Medicaid/CHIP enrollment? If so, how large are the enrollment gains? • Are enrollment effects similar across different types of ELE programs? • To what extent are enrollment effects robust within the subset of states that implemented ELE? • If there are positive enrollment impacts, do they appear to be sustained over time?
Descriptive Analyses of Enrollment, Administrative Costs, and Utilization	• How many children are enrolled through ELE or another simplification—both upon initial implementation and on an ongoing basis? • Do children who enter Medicaid and CHIP through ELE or another simplification stay enrolled as long as children who enroll through standard pathways? • Within a state, how do the demographic characteristics of enrollees who enter through ELE or another simplification compare with those of children who enroll through standard pathways? • Have enrollees who enter through simplified approaches to enrollment ever been Medicaid or CHIP beneficiaries in the past? • How does the volume and type of service use among ELE children compare with that of children who enroll through traditional processes? • How does the timing of service use compare across enrollees entering through ELE versus through traditional routes? • What are the up-front investment costs associated with implementing ELE or other simplifications? • What are the marginal administrative savings or costs to the state from processing an application or renewal using ELE or another simplification rather than the traditional mechanism?
Case Studies	• How has ELE or the other simplification been implemented? • How does ELE/other simplification work in practice? How is it different from the standard enrollment or renewal process for Medicaid and/or CHIP beneficiaries in the state?

Research Activity	Key Research Questions Addressed Through Evaluation Activities
	• How does ELE/other simplification benefit the state? For example, are there time savings to processing a new enrollment or renewal? • Does ELE/other simplification benefit enrollees? For example, is there less paperwork or faster time to receipt of coverage for beneficiaries? • What do key stakeholders view as the advantages or disadvantages to these processes? • How are ELE programs similar and different across states? • What are the key lessons learned about ELE and other simplifications?

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility.

The evaluation drew on data collected through both primary and secondary sources. We did a multivariate analysis of the impact of ELE on enrollment, using data from SEDS, a reporting system maintained by CMS since 2000 that collects new and total Medicaid and CHIP enrollment data from states on a quarterly basis, as well as from other secondary sources, including data from the Bureau of Labor Statistics, U.S. Census Bureau, and Kaiser Family Foundation. For the descriptive analysis of new enrollment and retention, we either obtained populated aggregate table shells from state staff or we obtained access to individual-level data on which to base the analyses. Researchers also interviewed staff in eight states that adopted ELE and three states that adopted other simplifications to support the descriptive analysis of enrollment and retention, to collect information on their ELE programs and processes, and to assess the administrative costs of ELE implementation. Claims and encounter data to enable us to study utilization patterns were obtained directly from four of the participating ELE states. Finally, we used published and unpublished literature on CHIP, CHIPRA, and ELE to supplement the main data sources and to provide motivation and context for the findings in each chapter. Sources include State Plan Amendments (SPAs), ELE and standard application forms, and state budget and performance reports. In each chapter of the report, we elaborate further on these data source(s) as relevant, and we describe our methods for analyzing them in order to produce study findings.

3. Evaluation States

Table I.4 summarizes the states that were able to participate in the evaluation, highlighting the components in which each state participated. Subsequent chapters provide details on why a given state was included or excluded from an evaluation component. For example, only four states are included in the utilization study because we limited it to ELE processes that were operational for more than one year at the time of data collection, to reduce analytic problems with seasonal utilization patterns.

Table I.4. Evaluation States and Methods

State	Impact Analysis	Descriptive Studies			Case Studies
		Enrollment	Administrative Costs	Utilization	
ELE States					
1. Alabama		X	X	X	X
2. Iowa	X	X	X	X	X
3. Louisiana	X	X	X	X	X
4. Maryland	X		X		X
5. Massachusetts	X	X	X		X
6. New Jersey	X	X	X	X	X
7. Oregon	X		X		X
8. South Carolina	X	X	X		X
Other Simplification States					
9. Michigan		X	X		X
10. New York		X			X
11. Oklahoma		X	X		X

F. Road Map for the Report

Chapter II describes the designs of the ELE processes included in the evaluation, presenting a comparative review of how the ELE processes adopted are similar and discussing each state's ELE approaches (some states have adopted more than one ELE process). Chapter III presents findings from the analysis of SEDS data on ELE's impact on enrollment. Chapters IV through VI present the results from the three respective descriptive analyses of ELE—on enrollment and retention (Chapter IV), administrative costs (Chapter V), and service utilization (Chapter VI). Chapter VII summarizes findings from the ELE case studies. Chapter VIII presents findings from the analyses of other simplifications implemented in three states. Finally, Chapter IX summarizes and synthesizes findings from the evaluation and discusses the implications of these findings for national and state policy.

II. KEY DESIGN FEATURES OF ELE IN EVALUATION STATES

Key Findings:

- For the thirteen ELE processes we studied, Medicaid and CHIP agencies were most likely to obtain data from the Supplemental Nutrition Assistance Program.
- Eleven of the thirteen ELE processes are used for initial enrollments, while five are used for renewals. ELE is usually designed to make enrollment or renewal less burdensome for both state staff and applicants, through efficient use of available data, and in some cases, automation.
- Different types of ELE are "automatic processing," "simplified procedure" and "simplified application." Automatic processing ELE is used in four states and has enrolled and renewed more people in Medicaid and CHIP than the other types.

A. Background and Motivation

As of August 1, 2013, CMS had approved state plan amendments for ELE in 13 states and the U.S. Virgin Islands. Eight of these states—Alabama, Iowa, Louisiana, Maryland, Massachusetts, New Jersey, Oregon, and South Carolina—were able to participate in this evaluation.[7] Through detailed discussions with state and local government staff, child and family advocates, legislators, and families, we evaluated ELE in eight of these states. We sought to understand (1) the key features of ELE in each state, (2) why those features were chosen, (3) how ELE was implemented, and (4) the challenges states faced and how they addressed those challenges.

In this chapter, we first compare the ELE processes adopted by the eight states in the evaluation and then provide detail on the specific designs of the 13 ELE processes adopted in these eight states.

B. Data Collection and Analysis Methods

This chapter draws on three primary data sources:

1. **Document review.** First, to prepare for and to supplement information from the telephone and site visit interviews (below), we reviewed publicly available documents, including state plan amendments, ELE and standard application forms, state budget and performance reports, and state-level evaluations of ELE where available. We later compared notes from staff interviews with program descriptions available through these secondary documents and resolved any apparent conflicts concerning implementation dates, current operational status, or any other inconsistencies identified.

[7] Five other states with approved ELE processes, including those in Colorado, Georgia, New York, Pennsylvania, and Utah, either declined to participate or began ELE too late to be included in the study.

2. **Phone interviews.** Initial telephone interviews with staff in six states that adopted ELE as of December 2010 (Alabama, Iowa, Louisiana, Maryland, New Jersey, and Oregon) were conducted between January and March 2012 using a semi-structured discussion guide to understand each ELE process. (The guide can be found in Appendix A.) Follow-up interviews were conducted between November 2012 and July 2013 to understand any changes to ELE processes in the original six states since the first set of interviews. In two states new to the evaluation in the second year—Massachusetts and South Carolina—we conducted initial interviews in this latter time period. For all interviews, findings and follow-up questions were submitted to state staff for review and clarification.

3. **Site visits.** To support our ELE case studies, we conducted three- to four-day site visits in all eight ELE states in the evaluation between December 2012 and June 2013. As part of this work, we held face-to-face interviews with CHIP and Medicaid program staff, Express Lane partner agency staff, enrollment processing contractors, child and family advocates, legislators, and local social services staff, among other stakeholders, using semi-structured protocols. We also conducted focus groups with parents whose children had been enrolled or renewed through ELE (the focus group protocol is also found in Appendix A). Each site visit informed a corresponding case study report, which we sent to state staff for review and verification.[8]

C. Comparison of Key ELE Features in Eight States

States implemented ELE with a small number of Express Lane partner programs. Five of the eight states implemented ELE with information from more than one partner program (Table II.1). The most common partner is the Supplemental Nutrition Assistance Program (SNAP), which is used in six of the eight states; two of these states also use information from Temporary Assistance to Needy Families (TANF). Two states use state tax agency information, and two states have enrolled children in partnership with the National School Lunch Program (NSLP).

Table II.1. Express Lane Partner Programs

State (Program(s) for which ELE is Used)	SNAP	TANF	NSLP	State Income Tax Returns	Medicaid
Alabama (Medicaid)	X	X			
Iowa (Medicaid)	X				
Iowa (Separate CHIP)					X
Louisiana (Medicaid)	X				
Maryland (Medicaid)				X	
Massachusetts (Medicaid/ CHIP)	X				
New Jersey (Medicaid/ CHIP)			X	X	
Oregon (Medicaid/ CHIP)	X		X		
South Carolina (Medicaid)	X	X			

Source: Evaluation team interviews with state staff between January 2012 and July 2013.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance to Needy Families.

[8] Case study reports are cited in the references and are publicly available on the Mathematica website (http://www.mathematica-mpr.com).

Three states in the evaluation have only one ELE process, and five states have two. These processes are distinguished by the use of a different partner, as is the case in New Jersey (which has one ELE process with NSLP and one with the state tax agency), or by a partnership being used in a different way, as is the case in Maryland (which partners with the tax agency to establish state residency under one process, and both residency and income under its second process). In all, there are 13 ELE processes used in these eight states (Table II.2).[9] Of these, seven ELE processes are used for initial enrollments only, two are used for renewals only, and three are used for both initial enrollments and renewals. Iowa Separate CHIP's ELE process is used both for initial enrollments and transfers from Medicaid to CHIP: when someone applies to Medicaid but is found income eligible for CHIP, or when a Medicaid enrollee is found no longer eligible for Medicaid at renewal, ELE is used to transfer these applications or renewals to CHIP).

Table II.2. Summary of ELE Processes, by State

State (Program(s) for Which ELE is Used)	Process Type	All Eligibility Criteria (Aside from Citizenship) Established via ELE Partner Programs?[a]	Express Lane Partner Programs	Used for Initial Enrollments	Used for Renewals	Used for Transfers from Medicaid to CHIP
1. Alabama (Medicaid)	Simplified procedure	No: income only	SNAP, TANF	X	X	
2. Alabama (Medicaid)	Automatic processing	Yes	SNAP, TANF		X	
3. Iowa (Medicaid)	Simplified application	No: all except insurance status	SNAP	X		
4. Iowa (Separate CHIP)	Simplified procedure	No: all except insurance status	Medicaid	X		X
5. Louisiana (Medicaid)	Automatic processing	Yes	SNAP	X	X	
6. Maryland (Medicaid)	Simplified application	No: state residence only	State income tax	X		
7. Maryland (Medicaid)	Simplified application	No: income and state residence only	State income tax	X		
8. Massachusetts (Medicaid/ CHIP)	Automatic processing	Yes	SNAP		X	
9. New Jersey (Medicaid/ CHIP)	Simplified application	No: income only	State income tax	X		
10. New Jersey (Medicaid/ CHIP)	Simplified application	No: income only	NSLP	X		
11. Oregon (Medicaid/ CHIP)	Simplified application	No: all except insurance status	SNAP	X		
12. Oregon (Medicaid/ CHIP)	Simplified application	No: income only	NSLP	X		
13. South Carolina (Medicaid)	Automatic processing	Yes	SNAP, TANF	X	X	

Source: Evaluation team interviews with state staff between January 2012 and July 2013.

[a] Eligibility criteria that must be established for enrollment or renewal vary by state; for enrollment, they typically include identity, income, household size, Social Security number, and state residence, whereas for renewals they usually include income and household size. In no case does information from an Express Lane partner program establish citizenship because this is not permitted by federal rules.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

[9] As will be described later, Oregon has since discontinued its second ELE partnership with NSLP.

The 13 ELE processes fall into three types:

1. **Automatic processing.** Used in Alabama, Louisiana, Massachusetts, and South Carolina, this ELE process enables states to use eligibility findings from Express Lane partner agencies to automatically enroll or renew children in Medicaid or CHIP who are also receiving SNAP or TANF benefits, without any additional action by the family (beyond enrolling in SNAP or TANF). In the states using ELE for initial enrollment (which requires consent), South Carolina obtains consent from families through use of Medicaid services or enrollment in a managed care plan; Louisiana initially used a similar approach but later switched to obtain consent on the SNAP application.
2. **Simplified procedure.** This ELE process includes Alabama's manual ELE process (in which Medicaid eligibility workers manually check SNAP or TANF databases for income determination rather than using standard Medicaid financial methodologies) and the ELE process used by Iowa's Separate CHIP program, in which children found ineligible for Medicaid because of income but found income-eligible for CHIP are electronically referred to the Separate CHIP program. Since these ELE processes use standard applications submitted by families, consent to coverage is obtained through standard means.
3. **Simplified application.** Used by Iowa Medicaid, Maryland, New Jersey, and Oregon, this ELE process functions as a form of outreach by using findings from Express Lane partner agencies to identify children who are likely to be eligible for Medicaid or CHIP and sending them a shortened application that must be processed manually. Because of ELE, these forms can be simplified, and when families complete them, they sign a consent statement permitting Medicaid and/or CHIP agencies to base eligibility factors on findings from the Express Lane partner agencies, rather than obtaining additional information from applicants.

Organized by these three types of processes, Table II.3 shows the dates that processes were approved and implemented and the number of enrollments or renewals completed in each process. The more recently introduced ELE processes tend to be automated processes, whereas earlier processes typically are not automated, although there are exceptions.

Table II.3. Key Dates, Enrollments, and Renewals, by ELE Process

State (Program(s) for Which ELE is Used)	All Eligibility Criteria (Aside from Citizenship) Established via ELE Partner Programs?[a]	Express Lane Partner Programs	Enrollments			Renewals		
			State Plan Amendment Approval Date for Enrollments	Implemented for Enrollments	Enrollments (From Implementation Through November 2012 Except Where Noted)	State Plan Amendment Approval Date for Renewals	Implemented for Renewals	Renewals (From Implementation Through November 2012 Except Where Noted)
Automatic Processing								
Alabama (Medicaid)	Yes	SNAP, TANF	–	–	–	November 2009	February 2013	92,673 (through May 2013)
Louisiana (Medicaid)	Yes	SNAP	January 2010	February 2010	27,347	January 2010	November 2010	329,415 (since January 2011)
Massachusetts (Medicaid/CHIP)	Yes	SNAP	–	–	–	August 2012[b]	September 2012	79,487 (through March 2013)[c]
South Carolina (Medicaid)	Yes	SNAP, TANF	December 2012	September 2012	Approximately 92,000 (through June 2013)	June 2011	July 2011	276,622 (through June 2013)
Simplified Procedure								
Alabama (Medicaid)	No: income only	SNAP, TANF	June 2010	April 2010	109,645	November 2009	October 2009	327,233
Iowa (Separate CHIP)	No: all except citizenship and insurance status	Medicaid	June 2011	July 2004	41,858 (since August 2009)[d]	–	–	–
Simplified Application								
Iowa (Medicaid)	No: all except citizenship and insurance status	SNAP	June 2010	June 2010	2,872	–	–	–
Maryland (Medicaid)	No: state residence only	State income tax	September 2010	September 2008	Unknown	–	–	–
Maryland (Medicaid)	No: income and state residence only	State income tax	September 2010	December 2012	113 (through February 2013)	–	–	–
New Jersey (Medicaid/CHIP)	No: income only	State income tax	June 2009	May 2009	4, 619	–	–	–
New Jersey (Medicaid/CHIP)	No: income only	NSLP	October 2011	September 2010	3,150	–	–	–
Oregon (Medicaid/ CHIP)	No: all except citizenship and insurance status	SNAP	October 2010	September 2010	6,636 (through January 2013)	–	–	–
Oregon (Medicaid/CHIP)	No: income only	NSLP	October 2010	March 2012 (pilot)	186 (through January 2013)	–	–	–

Source: Enrollment and/or renewal counts for Alabama's automatic ELE process, South Carolina's ELE process, Maryland's income-establishment process, and Oregon's processes, and the renewal count for Louisiana, were reported to Mathematica. Other counts are based on Mathematica's analysis of state administrative data. Dates are from state plan amendments and evaluation team interviews with state staff.

Table II.3 (*Continued*)

[a] Eligibility criteria that must be established for enrollment or renewal vary by state; for enrollment, they typically include identity, income, household size, Social Security number, and state residence, whereas for renewals they usually include income and household size. In no case does information from an Express Lane partner program establish citizenship because this is not permitted by federal rules.

[b] This is the date the Medicaid State Plan Amendment was approved. The CHIP State Plan Amendment for Massachusetts was not approved until November 2012.

[c] This number includes just under 1,000 people enrolled in September 2012, when the state piloted the program prior to full implementation in October 2012. The number does not include a very small number of children renewed through ELE in the state's Separate CHIP. Over 99% of the 79,487 renewals in Massachusetts were for adults in Medicaid, or children in Medicaid or the state's Medicaid-expansion CHIP. The remainder were children in MassHealth Limited or adults in MassHealth Limited, Commonwealth Care, or Health Safety Net (all of which are other subsidized health programs for low-income individuals in Massachusetts).

[d] Iowa's Separate CHIP ELE process does not include renewals. However, children whose eligibility is redetermined by Medicaid, resulting in an ineligibility finding, may be ELE-referred to CHIP, with income eligibility for CHIP based on Medicaid's income findings. This constitutes an ELE transfer rather than a renewal. These transfers are included in the enrollment count.

- = not applicable; CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

Despite the variation in process design, almost all ELE processes aim to reduce the hands-on time that eligibility staff spend processing applications and the time it takes for applicants to become enrolled (Table II.4). Most ELE processes also simplify the application experience for enrollees and improve outreach—either by sending targeted mailings to families with potentially eligible children or by automatically enrolling individuals in Medicaid or CHIP who have enrolled in Express Lane partner agency programs.

Table II.4. Aims of ELE Processes

State (Program(s) for Which ELE is Used)	All Eligibility Criteria (Aside from Citizenship) Established via ELE Partner Programs?[a]	Express Lane Partner Programs	Reduce Eligibility Staff Time	Reduce Time to Coverage[b]	Improve Outreach	Simplify Enrollment Experience	Simplify Renewal Experience	Smooth Medicaid-CHIP Transitions
Automatic Processing								
Alabama (Medicaid)	Yes	SNAP, TANF	X				X	
Louisiana (Medicaid)	Yes	SNAP	X	X	X	X	X	
Massachusetts (Medicaid/CHIP)	Yes	SNAP	X				X	
South Carolina (Medicaid)	Yes	SNAP, TANF	X	X	X	X	X	
Simplified Procedure								
Alabama (Medicaid)[c]	No: income only	SNAP, TANF	X	X		[c]	[c]	
Iowa (Separate CHIP)	No: all except insurance status	Medicaid	X	X		X		X
Simplified Application								
Iowa (Medicaid)	No: all except insurance status	SNAP	X	X	X	X		
Maryland (Medicaid)	No: state residence only	State income tax			X	X		
Maryland (Medicaid)	No: income and state residence only	State income tax	X	X	X	X		
New Jersey (Medicaid/CHIP)	No: income only	State income tax	X	X	X	X		
New Jersey (Medicaid/CHIP)	No: income only	NSLP	X	X	X	X		
Oregon (Medicaid/CHIP)	No: all except insurance status	SNAP	X	X	X	X		
Oregon (Medicaid/CHIP)	No: income only	NSLP	X	X	X	X		

Source: Evaluation team interviews with state staff between January 2012 and July 2013.

[a] Eligibility criteria that must be established for enrollment or renewal vary by state; for enrollment, they typically include identity, income, household size, Social Security number, and state residence, whereas for renewals they usually include income and household size. In no case does information from an Express Lane partner program establish citizenship, because this is not permitted by federal rules.

[b] For most simplified application processes, ELE reduces time to coverage by cutting the time between a Medicaid or CHIP application being received and an individual being enrolled. For automatic processes in Louisiana and Alabama, ELE reduces time to coverage from the point of view that enrollees are enrolled in Medicaid within a few days of SNAP or TANF application receipt, compared to a larger number of days between Medicaid application receipt and enrollment in Medicaid under the standard process.

[c] Since April 2010, self-declaration of income has been accepted for most ELE and non-ELE children in Alabama, if income cannot be verified through databases accessible to state eligibility staff. ELE therefore simplifies the application and renewal process only for a small minority of children: those for whom verification is required, and for whom verification is not possible via other databases. For these children, SNAP and TANF databases provide additional verification sources that staff can use in place of asking parents to submit paper documentation.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

Table II.5 summarizes the documentation requirements of the various ELE processes. As noted earlier, there is no need for a beneficiary to submit any additional forms after applying to the Express Lane partner agency in states using automatic ELE processes. In the seven simplified application processes, applicants submit an application form (or confirmation letter) that is shorter than what is required under the standard application process (for example because information about income is not required). Ten ELE processes require no additional paper documentation to be submitted by most beneficiaries, and the other three ELE processes require submission of less documentation than the standard application or renewal process requires.

Table II.5. Forms and Documentation that Applicants Entering Through ELE Are Required to Submit

State (Program)	All Eligibility Criteria (Aside from Citizenship) Established via ELE Partner Programs?[a]	Express Lane Partner Programs	Standard Application/ Renewal Form	Shortened Application/ Renewal Form	No Application/ Renewal Form	Reduced Documentation Submitted Exclusively for Medicaid/ CHIP	No Documentation Submitted Exclusively for Medicaid/ CHIP
Automatic Processing							
Alabama[b] (Medicaid)	Yes	SNAP, TANF			X		X[b]
Louisiana (Medicaid)	Yes	SNAP			X		X
Massachusetts (Medicaid/ CHIP)[c]	Yes	SNAP			X[c]		X
South Carolina (Medicaid)	Yes	SNAP, TANF			X		X
Simplified Procedure							
Alabama[b] (Medicaid)	No: income only	SNAP, TANF	X				X[b]
Iowa (Separate CHIP)	No: all except insurance status	Medicaid			X	X	
Simplified Application							
Iowa (Medicaid)	No: all except insurance status	SNAP		X			X
Maryland[b] (Medicaid)	No: state residence only	State income tax		X			X[b]
Maryland[b] (Medicaid)	No: income and state residence only	State income tax		X			X[b]
New Jersey (Medicaid/CHIP)	No: income only	State income tax		X			X
New Jersey (Medicaid/CHIP)	No: income only	NSLP		X			X
Oregon (Medicaid/ CHIP)	No: all except insurance status	SNAP		X		X	
Oregon (Medicaid/ CHIP)	No: income only	NSLP		X		X	

Source: Evaluation team interviews with state staff between January 2012 and July 2013.

[a] Eligibility criteria that must be established for enrollment or renewal vary by state; for enrollment, they typically include identity, income, household size, Social Security number, and state residence, whereas for renewals they usually include income and household size. In no case does information from an Express Lane partner program establish citizenship because this is not permitted by federal rules.

[b] These states require no documentation for most applicants in the traditional application process, so ELE does not reduce the documentation burden.

[c] Massachusetts currently sends a blank renewal form to families renewed through ELE to permit them to report relevant changes, if any. As of January 2014, the state will no longer be sending this form; those renewed will be sent a letter informing them they have been renewed, and letting them know they can go online, call, mail or fax changes to MassHealth if they need to do so.

ELE = Express Lane Eligibility; CHIP = Children's Health Insurance Program; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

D. Descriptions of ELE Processes Adopted in Eight States

In this section, organized by state, we elaborate on each of the 13 ELE processes currently in use in the eight study states.

1. Alabama

a. Alabama's Manual ELE Process

Alabama's manual ELE process has been used primarily to streamline Medicaid administrative processing for both renewals (beginning in October 2009) and initial enrollments (beginning in April 2010). Alabama Medicaid Agency's Express Lane partner agency is the Department of Human Resources, which provides information for ELE processing from SNAP and TANF. For most families, the ELE process does not appear different from the standard process: families must still initiate an application for coverage or respond to a renewal notice as they would under the standard process, and most families must also submit the same forms and information as they would without ELE in place. Eligibility workers manually check SNAP and TANF databases to establish income after it has been declared on Medicaid application and renewal forms, but when they are able to verify income declarations in SNAP or TANF, they do not check other databases, which saves staff time.[10] Alabama's manual ELE process had been used to enroll more than 100,000 children and to renew more than 300,000 enrollees as of December 2012.

b. Alabama's Automated ELE Process

In February 2013, Alabama's Medicaid agency introduced an automated renewal process. Under this process, cases of Medicaid enrollees who also are enrolled in SNAP or TANF are automatically reviewed before the standard renewal process is initiated. If SNAP or TANF databases at the Department of Human Resources show that an individual is income eligible for Medicaid, that person is automatically renewed, and sent a letter confirming the renewal. The individual does not need to take any other action (such as submitting a renewal form or any documentation). This automated renewal process does not require any staff involvement, saving staff time compared to the standard renewal process. Although Alabama's automated ELE process is much more efficient than its manual ELE process, both processes continue to be used because the manual ELE process can be used for beneficiaries not captured by the automated ELE process.[11] However, since Alabama's automatic process will renew some children who

[10] Alabama's manual ELE process simplifies the application and renewal experience only for children with self-employed parents whose income cannot be verified via other databases but can be verified via SNAP or TANF databases. (Since April 2010, when Alabama's manual ELE process was implemented for initial applications, self-declaration of income has been accepted for most ELE and non-ELE children, if income cannot be verified through databases accessible to state eligibility staff. This is not the case for children of self-employed parents, for whom income verification is required.)

[11] For example, if individuals enroll in SNAP or TANF after their Medicaid renewal process has been initiated, they cannot be automatically renewed but can be renewed via Alabama's manual ELE process. Alternatively, if a household's eligibility is reviewed by the automatic ELE process, but some members of the household are not in SNAP or TANF, then the household will not be automatically renewed. However, SNAP or TANF individuals in the household can still be renewed using the manual ELE process.

would have previously been renewed through Alabama's simplified procedure, partly replacing the simplified procedure, the annual renewal and savings estimates presented later in this report for Alabama's two ELE processes are not cumulative.

Alabama's automated ELE process is used to renew both children and women receiving family planning services. (Although CHIPRA authorized ELE for children, Alabama negotiated with CMS to use ELE for these adults via a Section 1115 waiver.) Thus, a large majority of Medicaid enrollees who are enrolled in SNAP or TANF can be renewed via ELE; more than 90,000 people were renewed in the first four months following implementation of Alabama's automated ELE process.

2. Iowa

a. Iowa Medicaid's ELE Process

Iowa Medicaid's ELE process was introduced in June 2010. Using an automated data-matching procedure, families enrolling in SNAP are screened for Medicaid eligibility by the Department of Human Services, which administers both programs. A shortened, six-page Medicaid application form—with no questions about income and resources—is automatically mailed to families of children on SNAP who are not publicly insured. Typically, parents are required only to sign and return the form, signifying that they would like to have their child enrolled in Medicaid. However, the application includes a series of questions about whether children have other sources of insurance coverage, if the parent would like help from the state in obtaining child support from an absent parent, and (in some cases) if children in the household are citizens or legal residents. Upon receipt of a completed application form, state eligibility workers enter the family's information and finalize Medicaid enrollment.

To try to make clear to parents the link between SNAP enrollment and contact from Medicaid, matches are conducted and the short Medicaid application forms are sent daily, thus preventing a lengthy gap between completing the SNAP application and receiving the follow-up form for health coverage. From June 2010 through November 2012, 2,872 children were enrolled via ELE.

b. Iowa Separate CHIP's ELE Process

Iowa's ELE partnership between Medicaid and its Separate CHIP program—*hawk-i*—was initially implemented in July 2004 to address problems that occurred when applications were referred from Medicaid to CHIP.[12] Prior to July 2004, case files for children who were found income ineligible for Medicaid but likely income eligible for CHIP either at initial application or at Medicaid redetermination were manually transferred to the Separate CHIP program. CHIP staff then independently conducted another eligibility assessment using their own income calculation rules. This led to inefficiencies because paper applications were passed between different staff; in some cases, children were found ineligible for Medicaid on the basis of income levels being too high and then ineligible for CHIP on the basis of having Medicaid-level income.

[12] Under new Affordable Care Act rules, including 42 CFR 435.1200, states must assess eligibility for CHIP when someone leaves Medicaid and vice versa, in an effort to improve coordination among insurance affordability programs.

Iowa developed a referral process through which children who are assessed for Medicaid eligibility (either at initial application or at redetermination) and found ineligible because of income are electronically referred to CHIP. CHIP staff then accept the Medicaid income finding, verify insurance status (usually without applicant involvement), and enroll the children in CHIP.[13] This enhanced coordination between the two agencies helps ensure that children eligible for public coverage do not "fall through the cracks" and remain or become uninsured.

CMS approved this referral process as an ELE process as of July 2010. Although several other states with a Separate CHIP and Medicaid program have also adopted automatic systems or procedures to coordinate eligibility decisions, Iowa is the only state in this evaluation with a process approved as ELE that has a primary goal of coordinating eligibility between two public health insurance programs. From August 2009 through November 2012, more than 40,000 children have been enrolled through Iowa Separate CHIP's ELE process.[14]

3. Louisiana

Louisiana's Department of Health and Hospitals, which administers Medicaid, chose the Department of Children and Family Services, which administers SNAP, as its Express Lane partner agency. The ELE program was initially implemented for new Medicaid enrollments. Officials first conducted a one-time data match between the two programs in December 2009 to identify families receiving SNAP but not Medicaid. SNAP families whose children were not enrolled in Medicaid received a letter informing them of their children's Medicaid eligibility and explaining how they could opt out of enrollment. Children identified from the initial data match who did not opt out were automatically enrolled in Medicaid in February 2010, using income, state residence, identity, and Social Security findings from SNAP. Because ELE requires a family's consent to automatically enroll a child, families were mailed a Medicaid card and a letter informing them that use of the card would constitute consent to the child's enrollment in Medicaid. At the point of renewal, children who had never used the card and did not take advantage of a final opportunity to consent to enrollment were disenrolled (Dorn et al. 2013).

Since initial implementation, ELE in Louisiana has seen some important adjustments. First, in November 2010, ELE began to be used for renewals, using the same automatic matching process to establish income eligibility based on SNAP receipt at redetermination. In January 2011, the SNAP application form was changed to include a check box that required families to opt in before the state could match SNAP and Medicaid data and enroll a child into coverage (that is, to affirmatively consent before enrollment rather than consenting through the use of services). Relative to the prior opt-out procedure, this simplified the administrative process because state officials did not need to monitor card usage to confirm consent to enrollment (which was challenging because the enrollment and claims systems were not linked). Among children who opt in, those found eligible for and not already in Medicaid are automatically

[13] CHIP staff check to see whether records indicate that a child has private health insurance. If the records indicate he or she has insurance, applicants must provide evidence to the contrary.

[14] For this study, we requested enrollment data from states for the period beginning one year prior to the ELE program effective date. Because CMS recognizes the effective date as July 1, 2010, we requested and present data on enrollments since June 2009.

enrolled. Data matches and enrollments are now processed daily, and Medicaid staff are not involved unless the Medicaid and SNAP information shows a mismatch.

Because ELE is fully automated, Louisiana's process does not require beneficiaries to submit an application form or any documentation specifically for Medicaid. As of November 2012, more than 27,000 enrollments and 320,000 renewals had been processed via Louisiana's ELE process.

4. Maryland

a. Maryland's Residence-Establishment ELE Process

Since 2008, the Maryland Department of Health and Mental Hygiene (DHMH), which administers the Medicaid program, has partnered with the Office of the Comptroller, the state taxation agency, to conduct outreach to tax filers whose children are potentially eligible for Medicaid. CMS recognized Maryland's process as ELE effective April 2010.

Maryland's state income tax form includes a box for families to check to indicate whether their dependents have health insurance. The comptroller's office sends a streamlined Medicaid application form—with fewer reference pages and no questions on immigration status—to families with incomes below 300 percent of the federal poverty level (FPL), as shown on their tax returns, who indicate they have uninsured dependents. Returning the comptroller's streamlined application is accepted as evidence of state residency. For standard applications, residency is self-declared and confirmed by consulting a state database; otherwise, application processing for ELE and standard routes is currently the same. Four annual mailings were sent out during the first five years this process was in place, with the annual number of mailed ELE application forms ranging between 137,000 and 447,000. These forms yielded an unknown number of enrollments because Maryland has not tracked enrollments through this process.[15]

b. Maryland's Income-Establishment ELE Process

Building on its residence-establishment ELE process, Maryland developed an ELE process that establishes both residence and income. First implemented at the end of 2012, Maryland's income-establishment ELE process also uses the Office of the Comptroller as DHMH's partner agency. Thanks to legislation which enabled data sharing between the comptroller and DHMH, the comptroller can share data with the permission of the tax filer. This enables DHMH to identify families who appear income eligible and not already enrolled in Medicaid, who have uninsured dependents, and who have given permission on their tax returns for the comptroller to share data. The comptroller then prints letters with income and household size information filled in from tax returns and mails these to families who qualify. Families are told that they do not need to fill in these sections of the application as long as the information is accurate. Applicants fill out the remainder of the streamlined ELE application form. All processing of the application forms for Maryland's income-establishment ELE process is done by the contractor that normally processes Medicaid applications for the City of Baltimore rather than by the Department of

[15] The number of mailings has declined over time, as the state revised the tax form question to try to better target uninsured children. The initial question asked only whether dependents had "health care." This was later refined to ask whether the dependents "have health insurance now."

Social Services or by local health departments around the state, as is the case for most non-ELE applications.

Although the tax return checkbox has only been in use for a short time, most tax filers have not checked it to allow the Comptroller to share data with DHMH. Thus, only 4,000 income-establishment ELE letters were mailed out in the first batch at the end of 2012, compared to the 137,000 letters mailed to tax filers with uninsured dependents under Maryland's residence-establishment ELE process for the same tax year. These 4,000 letters resulted in 113 enrollments by the end of February 2013.

5. Massachusetts

Massachusetts implemented an ELE process exclusively for renewals in September 2012. The Medicaid and CHIP agency, MassHealth, uses SNAP data from the Department of Transitional Assistance to establish income eligibility. Massachusetts is the only state in the evaluation aside from Alabama where ELE is used for adults. (Massachusetts obtained a Section 1115 waiver to use ELE for parents in households where children were eligible for ELE renewal, in order to maintain the state's household-level redetermination process.)

When families are due for renewal in MassHealth (the name of Massachusetts's Medicaid and CHIP program), MassHealth's automated eligibility system checks to see if the family includes at least one child under age 19 receiving MassHealth benefits, and had an income level at or below 150 percent FPL when income information was last submitted to MassHealth. If every member of the family is currently receiving SNAP, the eligibility system checks whether SNAP income is reported as being at or below 180 percent FPL. If so, the family is automatically renewed and is sent a letter telling them that they have been renewed based on SNAP information. The family is given the opportunity to provide updated income information if they believe MassHealth data could be out of date. Nearly 80,000 people had their coverage renewed via ELE through March 2013.

6. New Jersey

a. New Jersey's Tax ELE Process

Since May 2009, the New Jersey Department of Human Services (DHS), which administers Medicaid and CHIP, has partnered with the state's Division of Taxation to implement its tax ELE process. Since 2010, the state income tax form has included a box that families can check to indicate whether dependents under age 19 have health insurance. For families who indicate uninsured dependents, the Division of Taxation provides only the family's contact information to DHS, and DHS then matches the information with Medicaid and CHIP records (to avoid sending applications for children already covered), creating a targeted mailing list for outreach. DHS sends these targeted families an abbreviated public health insurance application form that does not require parents to submit income or employment status information. If the form is returned, the Division of Taxation then provides DHS information obtained from the tax return, including income and Social Security number. This information is used to process the ELE application so that families are not required to provide documentation of income when filing the Medicaid application. As of November 2012, 4,619 children had been enrolled in CHIP or Medicaid via New Jersey's tax ELE process.

b. New Jersey's National School Lunch Program ELE process

New Jersey launched a full-scale ELE process with NSLP in October 2011, after a series of pilots that allowed the state to test and develop its NSLP approach. Under this ELE process, school districts provide New Jersey DHS with a list of uninsured children, with an indicator for those children who receive free or reduced-price school lunches. Families of children with such an indicator are sent ELE application packets. Families returning an ELE application form who are identified as receiving free or reduced-price school lunches are temporarily enrolled in Medicaid or CHIP, respectively, without the need to provide income documentation. After enrollment, the state checks income against records from the Division of Taxation or the state wages database.

In New Jersey (as in most states), NSLP data are only available at the individual-level from school districts themselves. Because the state has no way to mandate participation, each school district can choose whether or not to participate in ELE. However, state staff report that participation exceeded 75 percent of school districts by April 2013 and is on an upward trend. Although DHS staff must spend considerable time processing the data that schools submit, the state is looking to refine its model further and considers its ELE process to be sustainable. More than 3,100 children had been enrolled via New Jersey's NSLP ELE process by the end of 2012.

7. Oregon

a. Oregon's Supplemental Nutrition Assistance Program ELE Process

Each month since September 2010, the Oregon Health Authority (OHA), which administers the Medicaid and CHIP programs, has screened children enrolled in SNAP against its database of publicly insured children. Families of SNAP children who lack public insurance are sent a shortened application form with no questions about income. Parents can return the form by mail or can call the OHA to have their children's public health insurance eligibility assessed. Once parents either return the form by mail or call OHA, income, household size, Social Security number, and state residency information reported to SNAP is used to establish eligibility and enroll children in Medicaid or CHIP. Occasionally, eligibility staff must obtain additional information, such as proof of medical insurance expiration or cancellation if a child is found to have private health insurance but appears to be otherwise CHIP eligible. As of January 2013, 6,636 enrollments had been processed through Oregon's SNAP ELE process.

b. Oregon's National School Lunch Program ELE process

Oregon's NSLP ELE process was piloted in four of the state's 200 school districts. Data collection to identify potentially eligible children began in September 2010. Under this process, parents checked a box on the NSLP application form indicating that their child did not have health insurance and expressing interest in free or reduced-price health coverage. School districts provided the OHA with a list of uninsured children whose parents checked this box, which the OHA then matched against its records of publicly insured children. Families of children receiving NSLP who were uninsured and indicated an interest in health coverage for their children were sent short ELE application forms. Families returning an ELE application form were enrolled in Medicaid or CHIP.

Oregon's NSLP ELE process never expanded beyond the four pilot school districts, largely because of data challenges. One district struggled to record the additional data from NSLP

application forms efficiently and found data extraction difficult. Additionally, OHA did not use the data in a timely way, so there was a substantial lag between families indicating an interest in health care coverage and receiving an ELE application form. OHA discontinued its NSLP ELE process after enrolling 186 children during 2012, the only year that mailings based on NSLP data were sent to families.

8. South Carolina

South Carolina implemented ELE for renewals in July 2011. Prior to initiating the standard renewal process, the Medicaid eligibility system automatically checks to see whether children are currently enrolled in SNAP or TANF. Those currently enrolled in either program are automatically renewed, and their families are sent a notice to that effect. If they are not currently enrolled in SNAP or TANF, the standard renewal process is initiated. SNAP and TANF eligibility is verified by South Carolina's Department of Social Services every two months, so income eligibility is assumed to be current for the purpose of ELE.

ELE was implemented for initial enrollments in September 2012. The Department of Health and Human Services automatically enrolls any child in Medicaid who applies for and is found to be eligible for SNAP or TANF. SNAP and TANF applicants are not asked to confirm whether they want to be enrolled in Medicaid; rather, as was the case for Louisiana's original opt-out process, families' subsequent use of a Medicaid card is taken to mean they are content to be enrolled in Medicaid, and families can contact the state if they wish to opt out of Medicaid coverage.[16] Use of the card also triggers mandatory managed care enrollment, with a plan chosen by default if the family fails to make a health choice by a specified date. This consent process is temporary; CMS requires the state to develop a new consent process by 2014.

As of June 2013, approximately 92,000 enrollments and more than 276,000 renewals had been processed via South Carolina's ELE process.

E. Discussion

The eight states in the evaluation have implemented 13 ELE processes. These processes vary in their use of Express Lane partner programs and whether they are used for applications, renewals, or transfers. Four processes enroll or renew SNAP or TANF beneficiaries without the need for them to submit a separate Medicaid or CHIP application or renewal form. These processes are fully automated, and a fifth is partly automated, yielding possible administrative savings in staff time and resources dedicated to eligibility processing. Another seven processes use mailings to potential applicants, who must complete and return a simplified application form or letter in order to be enrolled. These outreach-focused processes could introduce potential administrative costs arising from the mailings but might yield a significant number of new applicants, including eligible children who may otherwise be hard to reach. In the next several chapters, we explore these potential benefits and costs of ELE processes, drawing on both a formal impact analysis, focused on ELE's impact on enrollment, and an extensive descriptive analysis, examining the enrollment, administrative costs, and utilization patterns associated with ELE.

[16] See Edwards and Kellenberg (2013) for more detail on the state's consent procedures.

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III. ASSESSING ELE'S IMPACT ON ENROLLMENT: AN UPDATED ANALYSIS OF THE STATISTICAL ENROLLMENT DATA SYSTEM

Key Findings:

- We find significant evidence that adoption of ELE has increased Medicaid enrollment based on an analysis of 9 or 10 states implementing an ELE policy for children since 2007. Across several alternative model specifications, the estimated impacts of ELE were consistently positive, with most of them statistically significant at the 5 percent level. The estimated impacts had a central tendency of about 6.3 percent.
- We find less evidence that ELE increased combined Medicaid/CHIP enrollment; across several specifications, estimated impacts were again consistently positive but usually not statistically significant. The estimated impacts had a central tendency of about 4.5 percent.
- These findings reflect the estimated impact of ELE on average, across the nine states that have adopted the policy and been included in the study. However, because ELE has been implemented differently in each state, its impact across states can be expected to vary.

A. Background and Motivation

ELE has the potential to efficiently increase enrollment in Medicaid and CHIP by allowing state Medicaid and CHIP agencies to use data already acquired by other agencies to determine program eligibility. In contrast to other enrollment and retention policies that have common structural features across states (for example, presumptive eligibility, continuous eligibility, and elimination of asset requirements), ELE processes have additional features that vary across states. For example, ELE can apply to initial eligibility determination or redetermination; to Medicaid alone, CHIP alone, or both programs; and to any Medicaid or CHIP eligibility factor other than citizenship. Also, ELE processes can include or dispense with the need to submit a separate application for health coverage and can utilize different levels of technology and automation.

In the 2012 report to Congress, referred to from here on as the Year 1 analysis, we used 2007 to 2011 Medicaid and CHIP quarterly enrollment data available through the Statistical Enrollment Data System (SEDS) to assess changes in Medicaid and CHIP enrollment in states after ELE implementation, using changes occurring over the same period in other states as a counterfactual. This impact analysis relied on multivariate models to account for possible confounding policy, demographic, and economic changes and time-invariant differences between ELE and non-ELE comparison states that might be driving Medicaid/CHIP enrollment changes and might otherwise be incorrectly attributed to ELE adoption or mask the effects of ELE. To our knowledge, this is the first analysis that quantified the impact of ELE policies adopted by

eight states (Alabama, Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, and South Carolina) under CHIPRA.[17]

The purpose of the analysis discussed in this chapter is to assess a more substantial period of ELE performance, providing more detail on the effects of ELE. This chapter updates the original multivariate analysis by adding six additional quarters of data, through the second fiscal quarter of 2013, and incorporating the early ELE experience of two states—New York and Massachusetts—that implemented ELE after the Year 1 analysis was conducted. However, this analysis provides an incomplete picture of the overall impact of ELE because we were not able to include one of the original ELE states (Alabama) because of data limitations.

Consistent with the Year 1 report, the multivariate analysis presented in this chapter accounts for changes in economic conditions and Medicaid and CHIP policies outside of ELE that might otherwise bias estimates of the ELE effect. A recession that began in 2007 dominated the earlier period of analysis, when unemployment rose, real personal income fell, and more people lived in families without a full-time worker. Economic conditions between 2009 and 2013 stabilized but remained depressed relative to conditions before the recession. The loss of coverage during economic downturns, such as during the most recent recession, is linked to declines in employment and thus the loss of employer-sponsored coverage. Not surprisingly, prior research has found strong links between the unemployment rate and the overall loss of coverage (Cawley and Simon 2003; Cawley et al. 2011; Holahan and Garrett 2009). However, Medicaid and CHIP enrollment increases offset some losses in private coverage. In fact, the uninsured rate among children has declined slightly in recent years because of increased enrollment in Medicaid and CHIP (Blavin et al. 2012; Holahan and Chen 2011).

Consistent with the Year 1 report, the Year 2 analysis controls for Medicaid/CHIP eligibility changes, joint application for Medicaid and CHIP, presumptive eligibility, administrative verification of income, elimination of in-person interviews, elimination of asset test requirements, and continuous eligibility. From 2007 to early 2013, several states expanded Medicaid/CHIP eligibility to children from families with higher income and introduced changes to their enrollment and renewal processes designed to reduce the number of children eligible for Medicaid and CHIP who were still uninsured (Heberlein et al. 2013). Prior research findings conclude that these enrollment and renewal simplifications can promote enrollment and continuous coverage (Wachino and Weiss 2009). Without controlling for changes in these policies, Medicaid/CHIP enrollment increases during the period of analysis might be incorrectly attributed to ELE.[18]

[17] Prior studies have used descriptive or qualitative methods to examine the experiences of a single state (for example, Louisiana in Dorn et al. 2012) or the experiences of early adopting ELE states (for example, reviews of ELE policies in Alabama, Iowa, Louisiana, and New Jersey in Families USA 2011).

[18] Appendix A of the detailed impact analysis report to the ASPE on this issue describes the aggregate changes to these Medicaid/CHIP policies among ELE and non-ELE states (Blavin et al. 2012). For example, 5 ELE states increased Medicaid/CHIP thresholds for children between 2007 and 2011, while 13 non-ELE states increased thresholds. Similarly, eight states, including three ELE states, added continuous eligibility—where any enrolled child maintains coverage for 12 months from the time of enrollment—to their Medicaid or CHIP programs during the analysis period.

This chapter uses data from 2007 to 2013 to examine the following questions:

1. Does the implementation of ELE have a positive effect on combined Medicaid/CHIP or Medicaid-only enrollment?[19] If so, how large are the enrollment gains?
2. Are enrollment effects similar across different types of ELE programs or features?
3. To what extent are enrollment effects robust within the subset of states that implemented ELE?
4. If there are positive enrollment impacts, do they appear to be sustained over time?

Findings detailed later in this report offer evidence that ELE implementation increased Medicaid enrollment. Similar to the Year 1 findings, the estimated impacts of ELE on Medicaid enrollment were consistently positive and statistically significant, with a central tendency of about 6.3 percent. We also find some evidence that ELE increased combined Medicaid/CHIP enrollment; across a series of models, estimated impacts were again consistently positive, though statistically insignificant in most cases, with a central tendency of about 4.5 percent. Estimates are robust to the design and specification of the impact model; however, our estimates could be biased because of confounding policy changes that are not fully captured in the models.

The next sections describe the data, methodological approach, and results. The concluding section summarizes the key findings, discusses the policy implications, and describes the limitations of this analysis.

B. Data

The Year 1 analysis estimated the impacts of ELE among the eight states that had received CMS approval of ELE state plan amendments as of January 2012: Alabama, Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, and South Carolina.[20] For this update, we add six additional quarters of data to assess a more substantial period of ELE performance in most states. We also include two new states—New York and Massachusetts—as ELE states. New York's ELE program, approved by CMS in September 2012, allows the state's Medicaid office to use income information from CHIP to enroll children in Medicaid, effective with CHIP renewals on or after May 1, 2012 (Hensley-Quinn et al. 2012). Medicaid and CHIP in Massachusetts also implemented ELE through SNAP for children in October 2012.

It is important to note that we exclude Alabama from the Year 2 analysis because the state had not submitted its 2012–2013 enrollment data to the SEDS as of September 2013. Unless otherwise noted, all estimates in this report exclude Alabama from the sample.

[19] We also estimate a model restricted to Separate CHIP programs only, but this model is limited by a smaller sample size and much smaller numbers of enrollees in each state.

[20] The Year 1 report to Congress includes a complete description of these eight programs (Hoag et al. 2012). Table IV.1 of that report also summarizes the programs and the implementation date assumptions used for the empirical analysis.

1. SEDS Data

SEDS is a web-based system maintained by CMS since 2000 that collects new and total Medicaid and CHIP enrollment data from states on a quarterly basis. States must submit quarterly enrollment data within 30 days after the end of the fiscal quarter and aggregate annual data within 30 days after the end of the fourth quarter (Q4).[21]

This report uses Q1 2007 to Q2 2013 fiscal quarterly SEDS data on total enrollment (the unduplicated number of children ever enrolled during the quarter), incorporating updated data that states submitted to the SEDS between March 2012 (corresponding to the data download for the Year 1 analysis) and May 2013. Throughout the analysis, we define Medicaid enrollment to include both traditional Medicaid and Title XXI Medicaid expansion CHIP programs. We define total Medicaid/CHIP enrollment to include enrollment in traditional Medicaid, Medicaid expansion CHIP, and Separate CHIP programs. Quarterly data before 2007 are excluded because of reporting errors and high item nonresponse rates.

Some quality issues are evident in the total enrollment data, including missing observations and likely reporting errors. We addressed quality issues in the quarterly data by imputing missing values and repairing reporting errors on a case-by-case basis. Our imputation strategy, which uses interpolation in most instances, is consistent with procedures that Mathematica developed while working with the annual SEDS data (Ellwood et al. 2003).[22] Data points were also cross-validated using the Medicaid Statistical Information System and monthly Medicaid/CHIP enrollment data reports from the Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission on Medicaid and the Uninsured 2011a, 2011b). We made imputations on fewer than 5 percent of state-quarter observations in the final analysis file.

Two non-ELE states, Maine and Montana, are excluded from this analysis because of concerns about data reliability. Maine implemented a new Medicaid Management Information System (MMIS) in 2011 and identified problems in its enrollment data caused by reporting errors. Similarly, we found substantial variation in the Montana data from 2007 to 2013, although patterns in the 2009 to 2011 data could be partially explained by Medicaid/CHIP expansions and changes in economic conditions, according to the CMS Regional Office.[23] We also conducted several statistical tests (for example, difference in fit, a diagnostic meant to show how influential a point is in a statistical regression) and determined that Montana was an outlier state, which indicated that it might not serve as an accurate counterfactual to ELE states. Although Montana had some influence on the regression model in the multivariate analysis, we found that our main results did not substantially change by its inclusion or exclusion. However, given the outlier tests and uncertainty over the validity of the state's data, we excluded Montana from the descriptive and multivariate analyses.

[21] Federal fiscal year quarters are as follows: first quarter, October 1 through December 31; second quarter, January 1 through March 31; third quarter, April 1 through June 30; and fourth quarter, July 1 to September 30.

[22] For instance, if data from a particular quarter were missing or inconsistent, we averaged data from the previous and subsequent quarters. If states had more than one quarter of missing data, we allocated the difference between the last- and the next-reported quarter evenly over the missing quarters. Edited cases were cross-validated with other data sources when possible.

[23] Email correspondence with Jeffery Silverman, CMS contact person for SEDS, on March 30, 2012.

2. Additional Data Sources

The multivariate analysis accounts for many variables, such as changes in economic conditions and in various non-ELE enrollment policies that might otherwise bias the estimates of ELE's effects. To construct these variables, we draw on a number of data sources:

- Quarterly state unemployment rate data from the Bureau of Labor Statistics[24]
- Child state population estimates from the U.S. Census Bureau[25]
- Annual state Medicaid and CHIP eligibility rules for parents and children from the Urban Institute's Medicaid eligibility simulation model and the Kaiser Family Foundation
- Implementation dates of various state policies that influence the ease of new enrollment into Medicaid or CHIP, from publications from the Kaiser Commission on Medicaid and the Uninsured and the Georgetown Center for Children and Families (Cohen-Ross et al. 2007, 2008, 2009; Cohen-Ross and Marks 2009; Heberlein et al. 2011, 2012, 2013). When we could not find the exact implementation date for a given policy, we assumed implementation during the second quarter of the federal fiscal year. We selected the following Medicaid and CHIP policy covariates: joint application for Medicaid and CHIP, presumptive eligibility, administrative verification of income, no in-person interview, elimination of an asset test in CHIP, and continuous eligibility.[26] We did not include the elimination of an asset test in Medicaid because no state in our sample made changes to this policy during the period of analysis.
- Finally, we use the 2011 Current Population Survey to create simulated adult and child eligibility variables, consistent with the method developed by Cutler and Gruber (1996). This method applies each state's eligibility thresholds to a standardized national sample of parents and children, as opposed to a particular state's own population, removing time-variant factors and differences in the income distribution across states. The derived eligibility variables capture the generosity of each state's eligibility criteria, and are not confounded by varying conditions across or within states over time.

C. Methods

This analysis focuses on updating the multivariate analysis that was presented in the Year 1 analysis. The multivariate analysis uses regression-based modeling to control for confounding

[24] Bureau of Labor Statistics, U.S. Department of Labor. "Local Area Unemployment Statistics." Available at [http://www.bls.gov/lau/]. Accessed September 1, 2013.

[25] U.S. Census Bureau, Population Division. "2000-2011 State Characteristics Population Estimates File." Available at [http://www.census.gov/popest/]. Accessed September 1, 2013.

[26] We selected these variables based on data quality, the ability to characterize the policy change in a quantitative analysis, the number of program changes observed during the period of analysis to ensure sufficient degrees of freedom, and prior evidence on the policy's potential impact on Medicaid/CHIP enrollment (for example, policies documented in Wachino and Weiss 2009).

changes over the same period to establish a counterfactual—that is, what the trend in Medicaid and CHIP enrollment would have been in ELE states in the absence of the policy. Drawing on this estimate, the multivariate analysis provides a causal estimate of the impact of ELE and Medicaid/CHIP enrollment, offering arguably the best evidence to date on how and whether ELE expands coverage to children who would otherwise be uninsured.[27]

1. Multivariate Analysis: The Main Model

Using 2007 to 2013 quarterly SEDS data, we estimate separate regression models for total Medicaid/CHIP enrollment and for Medicaid enrollment only, where the dependent variable is the log transformation of children's enrollment in each state and quarter. We estimate two-way fixed effect difference-in-difference equations with balanced panels as our main models for this analysis, where the eight ELE states constitute the treatment group (with the intervention occurring at different points in time) and matched non-ELE states with similar pre-2009 enrollment trends make up the comparison group. The main estimation equations are the following:

$$(1)\quad Log(McaidCHIP)_{i,t} = \propto +\beta_1 ELE_{i,t} + \beta_2 OTHERPOLICY_{i,t} + \beta_3 COVARIATES_{i,t} + \gamma_i + \delta_t + \epsilon_{i,t}$$

$$(2)\quad Log(Medicaid)_{i,t} = \propto +\beta_1 ELE_{i,t} + \beta_2 OTHERPOLICY_{i,t} + \beta_3 COVARIATES_{i,t} + \gamma_i + \delta_t + \epsilon_{i,t}$$

where $\propto$ is the intercept term, *i* is an index for state, *t* is an index for unique quarter, γ_i is a set of state dummy variables (state fixed effects), δ_t is a set of quarter-specific dummy variables (quarter fixed effects), and $\epsilon_{i,t}$ is a random error term. The dependent variable, $Log(McaidCHIP)_{i,t}$, is the log of the number of children ever enrolled in Medicaid or CHIP in state *i* during quarter *t,* and $Log(Medicaid)_{i,t}$ corresponds to the log of the number of children ever enrolled in Medicaid. We log transform enrollment so that the dependent variable has a normal distribution; otherwise, the distribution of the untransformed variable is heavily skewed. We report robust standard errors clustered at the state level to correct for possible heteroskedasticity and autocorrelation (White 1980; Bertrand et al. 2004).

The key independent variable of interest is $ELE_{i,t}$, which is set to one when the observation is an ELE state and the quarter either contains the month when ELE was implemented or is after ELE implementation.[28] This variable measures the effects of ELE on Medicaid/CHIP or on Medicaid-only enrollment, depending on the model. With a log-transformed dependent variable, the estimated ELE coefficient reflects the percentage change in total enrollment associated with ELE implementation. We anticipate that ELE will have a positive impact on Medicaid/CHIP enrollment—that is, β_1 is greater than zero.

[27] However, given the nature of the data, we are unable to determine actual coverage status before enrollment in Medicaid/CHIP. For instance, some of the estimated enrollment gains through ELE could be attributable to children who were previously uninsured or had private health insurance.

[28] The implementation date is based on when the state had an ELE process for Medicaid approved by CMS. We also estimate a model restricted to Separate CHIP programs only, but this model is limited by a smaller sample size and much smaller numbers of enrollees in each state.

Compared with descriptive comparisons of change over time, findings from this model offer far more rigorous evidence of the effects of ELE because they control for many sources of potential confounding factors. The state fixed effects γ_i help control time-invariant differences across states that could be correlated with the ELE variable, such as inherent differences between ELE and non-ELE states, for example, or potential differences in reporting accuracy of the SEDS data. The quarter fixed effects δ_t control for factors common to all states that vary from quarter to quarter.

By including indicators for other state policy changes and time-varying covariates, we control for other factors that change over time, which could also contribute to differences in aggregate Medicaid and CHIP enrollment numbers. $OTHERPOLICY$ is a series of state policy variables and $COVARIATES$ is a series of other state-level controls that vary over time and that could influence Medicaid/CHIP enrollment. In the combined Medicaid/CHIP model—Equation (1)—$OTHERPOLICY$ includes the simulated Medicaid/CHIP eligibility threshold for children;[29] the simulated Medicaid eligibility threshold for parents; and, dummy indicators for the presence of Separate CHIP, joint applications for Medicaid and CHIP, presumptive eligibility for Medicaid, administrative verification of income for Medicaid, no in-person interview for Medicaid, continuous eligibility for Medicaid, presumptive eligibility for CHIP, administrative verification of income for CHIP, no in-person interview for CHIP, elimination of asset test for CHIP, and continuous eligibility for CHIP. In the Medicaid-only model—Equation (2)—we use the simulated child Medicaid eligibility threshold and do not include the CHIP-specific policy dummy variables. In the main specification, $COVARIATES$ includes the state quarter-specific unemployment rate and year-state child population estimates that are log transformed.

a. Choosing Comparison States

Difference-in-difference models provide consistent estimates of the treatment effect only if, in the absence of the policy intervention, the time path in the outcome is the same for both the treatment and comparison states (Meyer 1995). For example, if Medicaid enrollment is trending upward (downward) at a faster rate within the comparison group relative to the ELE states in the pre-ELE period, the difference-in-difference model will understate (overstate) the benefits of ELE implementation. Given the widespread variation in Medicaid/CHIP participation, enrollment, and policies across states, we anticipate that some non-ELE states will have similar trends in enrollment compared with ELE states, whereas others will have dissimilar trends.

Using a method similar to that employed by Lien and Evans (2005), we chose comparison states that had pre-ELE trends in Medicaid and Medicaid/CHIP enrollment similar to the ELE states. Because the first ELE program was implemented in 2009, we focus on trends in the 2007 and 2008 quarters before adoption of ELE. To select the comparison states, we estimate models similar to Equations (1) and (2) that include a time trend interacted with an ELE state indicator. We include one non-ELE state at a time and test if the average trend among ELE states differs from the trend for that non-ELE state. If we reject the hypothesis at the 5 percent level that the

[29] The simulated CHIP eligibility threshold is used for states with Separate CHIP programs, and the simulated child Medicaid eligibility threshold is used for all other states. In sensitivity models in which we focus on Separate CHIP only, $COVARIATES$ includes the CHIP eligibility threshold and CHIP-specific administrative simplification dummy variables.

coefficient associated with the interaction term equals zero, we exclude the non-ELE state from the sample, thus increasing the likelihood of choosing comparison states that possess a trend in Medicaid or Medicaid/CHIP enrollment similar to that of the average treatment state before ELE implementation.

The final Medicaid model includes 31 comparison states and the final Medicaid/CHIP model includes 23 comparison states.[30] In the Medicaid model, we exclude Arizona, Colorado, Illinois, Nevada, New Mexico, Virginia, Washington, and Wyoming from the comparison group. In the combined Medicaid/CHIP model, we exclude Arizona, California, Connecticut, Florida, Illinois, Indiana, Kentucky, Missouri, Nevada, New Mexico, North Dakota, Ohio, Tennessee, Texas, Virginia, and Washington. We exclude Maine and Montana from both models.

b. Sensitivity Tests

Consistent with the Year 1 analysis, we conduct a series of robustness checks to explore the consistency of the ELE parameter estimates. To the extent that these estimates display consistency, they strengthen the evidence provided by the original model specification and thereby the conclusions that can be drawn from the analysis. These robustness checks include reestimating the main model with the following variants:

- Alternative specifications of the control variables to determine the source of the ELE effect:
  - To start, we remove the policy variables, unemployment rate, and child population from the main model specification (that is, this model includes only state and quarter fixed effects). This simple unadjusted difference-in-difference model removes all time-varying covariates and approximates the average ELE treatment effect from the descriptive data, relative to the chosen set of comparison states (alternative 1).
  - We then add the policy variables to the simple model (all at once and each individually) to determine if their inclusion alters the magnitude and significance of the ELE variable (alternative 2).
  - We also add the unemployment rate and child population variables to the simple model to determine if their inclusion alters the magnitude and significance of the coefficient on the ELE variable (alternative 3).
  - We replace all of the administrative simplification dummy variables with a count of the number of enrollment and renewal simplifications that the state had in place in that quarter, ranging from 0 to 5 in the Medicaid model and 0 to 10 in the Medicaid/CHIP model (alternative 4).
- Alternative specifications with respect to how the comparison group is defined, excluding non-ELE states in a systematic manner to determine if specific control states drive the main results. These tests are important because the non-ELE states

[30] For the Year 1 analysis, Massachusetts and New York were included in the comparison state group. As such, the final Medicaid model included 33 comparison states and the final Medicaid/CHIP model included 25 comparison states.

control for what the baseline trend in Medicaid/CHIP enrollment would have been in the absence of ELE.

- We include all 39 non-ELE states as the comparison group in the Medicaid/CHIP and Medicaid models (alternative 5).
- We exclude non-ELE states that are statistical outliers and might not serve as ideal comparison states. For this exercise, we remove eight non-ELE states from the Medicaid/CHIP model and nine non-ELE states from the Medicaid-only model that had observations with studentized residuals greater than 2.5 and less than –2.5 in the main model specification (alternative 6).
- Similarly, we reestimate the simple unadjusted Medicaid/CHIP and Medicaid-only difference-in-difference models, including one non-ELE state at a time, to determine which comparison states have the strongest influence on the ELE coefficient magnitude. We then rank the states based on the estimated ELE coefficient when they are included in the model and reestimate the main model, excluding the comparison states that resulted in the five highest and the five lowest ELE effects, respectively (alternative 7). We also estimate a variant that excludes comparison states with the 10 highest and 10 lowest ELE effects (alternative 8).

D. Characterizing ELE Effects

Any attempt to characterize the effects of ELE must be seen in the context of a policy that can vary widely in both its implementation and target population. This underscores the importance of assessing the effects of ELE within individual states as a way to best understand the ELE models that might be most effective. In order to do so, we reestimate the main model, excluding one ELE state at a time to determine if the overall effect is primarily driven by the ELE experience in a single state or if the ELE effect seems to vary across states. Taking advantage of the longer post-implementation period, this analysis also assesses whether ELE works instantaneously or gradually by estimating a model that interacts the main ELE variable with a "number of quarters since ELE adoption" variable (set to zero for pre-ELE implementation and for non-ELE states).

We also estimate several models where we assess the effects of ELE for groups of states based on the type of ELE process. We create different ELE policy variables—"ELE through SNAP," "ELE through tax returns," "ELE with simplified applications," and "ELE with automatic processing"—to explore whether there appeared to be a differential effect based on the type of ELE program implemented. These analyses are intrinsically exploratory given the many dimensions on which ELE programs can and do vary across states and given the variable size of the post-ELE experience across states adopting the different models.

E. Results

1. Year 1 Multivariate Findings

To recap, findings from the Year 1 ELE impact analysis showed statistically significant evidence of a positive effect of ELE on enrollment. Using multivariate difference-in-difference models with quarterly SEDS data from fiscal year 2007 to 2011 (including Alabama), we found that, on average, ELE implementation increased Medicaid enrollment by 5.6 percent (statistically

significant at the 5 percent level) and combined Medicaid/CHIP enrollment by 4.2 percent (statistically significant at the 10 percent level), holding constant all other observed policy and economic changes during the period. Across a series of model specifications, estimated impacts of ELE on Medicaid enrollment were consistently positive, ranging between 4.0 and 7.3 percent, with most estimates statistically significant at the 5 percent level. We also found evidence that ELE increased combined Medicaid/CHIP enrollment; estimated impacts in these models were consistently positive, though less often statistically significant, with a central tendency of 4.2 percent.

2. Year 2: Main Multivariate Findings

Findings from the Year 2 main multivariate difference-in-difference models show statistically significant evidence of a positive effect of ELE on Medicaid enrollment (Table III.1). On average, the main model—which excludes Alabama and includes New York and Massachusetts as ELE states (in addition to Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, and South Carolina)—indicates that ELE implementation increased Medicaid enrollment by 5.8 percent (statistically significant at the 5 percent level), holding constant all other observed policy and economic changes. We also find a positive ELE effect (3.4 percent) in the combined Medicaid/CHIP model, although this effect is not statistically significant at conventional levels (*p*-value=.176).

Table III.1. Results for Main Multivariate Regression Models (Year 2 Analysis); 2007-2013 Quarterly SEDS Data

	Dependent Variable (Log Transformed)	
	Total Medicaid/CHIP Enrollment	Medicaid Enrollment Only
Express Lane Eligibility	0.0337	0.0582**
	(0.024)	(0.028)
Unemployment Rate	0.00650	0.00694
	(0.006)	(0.005)
Log(Child Population)	0.831***	0.982***
	(0.288)	(0.292)
Separate CHIP	-0.00506	-0.0327
	(0.035)	(0.029)
Simulated Eligibility Threshold for Children	0.00111	-0.0000574
	(0.001)	(0.001)
Simulated Eligibility Threshold for Parents	-0.00146	-0.00400
	(0.003)	(0.003)
Joint Application	-0.00647	-0.0181
	(0.031)	(0.033)
Presumptive Eligibility-Medicaid	0.0814*	0.0345
	(0.047)	(0.023)
Admin. Verification of Income-Medicaid	0.0142	0.0798***
	(0.050)	(0.020)
No In-Person Interviews-Medicaid	0.0177	0.0189
	(0.063)	(0.044)
Continuous Eligibility-Medicaid	0.0501	0.0351
	(0.058)	(0.029)
Presumptive Eligibility-CHIP	-0.0378	N/A
	(0.048)	
Admin. Verification of Income-CHIP	0.0225	N/A
	(0.047)	

Table III.1 (*Continued*)

	Dependent Variable (Log Transformed)	
	Total Medicaid/CHIP Enrollment	Medicaid Enrollment Only
No In-Person Interviews-CHIP	-0.00745	N/A
	(0.067)	
No Asset Test-CHIP	0.0365	N/A
	(0.059)	
Continuous Eligibility-CHIP	0.0208	N/A
	(0.056)	
Constant	1.586	-0.695
	(4.380)	(4.479)
R-sqr	0.99	0.99
Sample Size	832	1040

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: (1) Robust standard errors clustered at the state level are in parentheses. (2) * p < .10, ** p < .05, and *** p < .01 for two-tailed tests. (3) All models include state and quarter fixed effects (coefficients not shown). (4) Total enrollment includes children who were ever enrolled in Medicaid or CHIP during the fiscal quarter. Medicaid enrollment only includes children who were ever enrolled in Title XIX or Title XXI Medicaid during the fiscal quarter. (5) ELE states include Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, South Carolina, New York, and Massachusetts. The Year 2 models exclude Alabama from the sample. (6) In the Medicaid model, we exclude Arizona, Colorado, Illinois, Nevada, New Mexico, Virginia, Washington, and Wyoming from the comparison group. In the combined Medicaid/CHIP model, we exclude Arizona, California, Connecticut, Florida, Illinois, Indiana, Kentucky, Missouri, Nevada, New Mexico, North Dakota, Ohio, Tennessee, Texas, Virginia, and Washington. Maine and Montana are excluded from both models.

CHIP = Child Health Insurance Program; ELE = Express Lane Eligibility; SEDS = Statistical Enrollment Data System.

The results from the Year 1 and Year 2 main multivariate models are very consistent. When we exclude Alabama from the 2007–2011 Year 1 main models, we find that the estimated ELE effect is 6.1 percent (statistically significant at the 5 percent level) in the Medicaid enrollment model and 5.0 percent (statistically significant at the 10 percent level) in the combined Medicaid/CHIP model, holding all other observed policy and economic changes constant (results not shown). The difference in the ELE effect on combined Medicaid/CHIP enrollment across analyses is consistent with the Year 1 results, where we found ELE estimates that were less imprecise and less often statistically significant relative to the Medicaid model.

3. Year 2: Characterizing ELE Effects

The results in Table III.2 suggest that ELE implementation had a sustained impact on Medicaid enrollment over the period of analysis. We explore this by including a continuous variable that measures the number of quarters since ELE was implemented in the state, along with an interaction term with the ELE dummy variable. In contrast to the Year 1 analysis, which was limited by a relatively short post-ELE implementation period, we find that the interaction term is consistently positive and statistically significant in the Medicaid enrollment model (1 percent level) and the Medicaid/CHIP model (5 percent level). We also find that this effect holds when excluding one ELE state at a time. Altogether, this suggests that the ELE effect on enrollment could be stronger the longer states have had ELE in place.

Table III.2. Estimated ELE Effects for Regressions that Model the ELE Effect Over Time (Year 2 Analysis); 2007-2013 Quarterly SEDS Data

	Dependent Variable (Log Transformed)	
	Total Medicaid/ CHIP Enrollment	Medicaid Enrollment Only
Main Regression Model	0.0337	0.0582**
	(0.024)	(0.028)
Number of Quarters Since ELE Implementation		
ELE	0.00632	0.0263
	(0.022)	(0.023)
ELE*Number of quarters since ELE implementation	0.00582**	0.00605***

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: (1) Robust standard errors clustered at the state level are in parentheses. (2) * p < .10, ** p < .05, and *** p < .01 for two-tailed tests. (3) All models include state and quarter fixed effects (coefficients not shown). All other right-hand side variables are the same as those in the Table III.1 main results. (4) Total enrollment includes children who were ever enrolled in Medicaid or CHIP during the fiscal quarter. Medicaid enrollment only includes children who were ever enrolled in Title XIX or Title XXI Medicaid during the fiscal quarter. (5) ELE states include Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, South Carolina, New York, and Massachusetts. The Year 2 models exclude Alabama from the sample. (6) In the Medicaid model, we exclude Arizona, Colorado, Illinois, Nevada, New Mexico, Virginia, Washington, and Wyoming from the comparison group. In the combined Medicaid/CHIP model, we exclude Arizona, California, Connecticut, Florida, Illinois, Indiana, Kentucky, Missouri, Nevada, New Mexico, North Dakota, Ohio, Tennessee, Texas, Virginia, and Washington. Maine and Montana are excluded from both models.

CHIP = Child Health Insurance Program; ELE = Express Lane Eligibility; SEDS = Statistical Enrollment Data System.

The results in Table III.3 suggest that the ELE effect on Medicaid/CHIP and Medicaid enrollment varies across states. When we reestimate each of the main models excluding one ELE state at a time, we find that the coefficient on the ELE variable is smaller in magnitude (compared with the main effect) and statistically insignificant at conventional levels when Iowa and Oregon are excluded, suggesting that the ELE effect might have been stronger in these states. We also find that removing Maryland and New Jersey from the Medicaid model yields a slightly smaller and less precise ELE effect relative to the main model. Consistent with the main model, the ELE effect is statistically insignificant in the Medicaid/CHIP model when each ELE state is removed one at a time (except for Georgia).

Table III.3. Estimated ELE Effect for Models on Different Subsets of ELE States (Year 2 Analysis); 2007-2013 Quarterly SEDS Data

	Dependent Variable (Log Transformed)	
	Total Medicaid/CHIP Enrollment	Medicaid Enrollment Only
Year 2 Main Regression Model (2007-2013 Excluding Alabama)	0.0337	0.0582**
	(0.024)	(0.028)
Year 2 Main Regression Model Excluding Individual States		
Georgia	0.0527**	0.0690**
	(0.022)	(0.030)
Iowa	0.0196	0.0530
	(0.025)	(0.033)
Louisiana	0.0446	0.0737**
	(0.027)	(0.028)
Maryland	0.0286	0.0549*
	(0.025)	(0.028)
New Jersey	0.0288	0.0526*
	(0.025)	(0.028)
Oregon	0.0321	0.0288
	(0.026)	(0.020)
South Carolina	0.0374	0.0669**
	(0.029)	(0.030)
New York	0.0288	0.0619**
	(0.027)	(0.029)
Massachusetts	0.0361	0.0605**
	(0.026)	(0.029)

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: (1) Robust standard errors clustered at the state level are in parentheses. (2) * p < .10, ** p < .05, and *** p < .01 for two-tailed tests (3) All models include state and quarter fixed effects (coefficients not shown). All other right-hand side variables are the same as those in the Table III.1 main results. (4) Total enrollment includes children who were ever enrolled in Medicaid or CHIP during the fiscal quarter. Medicaid enrollment only includes children who were ever enrolled in Title XIX or Title XXI Medicaid during the fiscal quarter. (5) ELE states include Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, South Carolina, New York, and Massachusetts. The Year 2 models exclude Alabama from the sample. (6) In the Medicaid model, we exclude Arizona, Colorado, Illinois, Nevada, New Mexico, Virginia, Washington, and Wyoming from the comparison group. In the combined Medicaid/CHIP model, we exclude Arizona, California, Connecticut, Florida, Illinois, Indiana, Kentucky, Missouri, Nevada, New Mexico, North Dakota, Ohio, Tennessee, Texas, Virginia, and Washington. Maine and Montana are excluded from both models.

CHIP = Child Health Insurance Program; ELE = Express Lane Eligibility; SEDS = Statistical Enrollment Data System.

Consistent with the Year 1 results, we also find that grouping states by type of ELE program yields inconsistent results across model specifications (results not shown). While it would have been desirable to estimate the relative impact of various approaches to ELE, the small number of states in our sample, the significant unique features of each state's ELE process, and limitations of available data make it challenging to obtain meaningful results. In future years, as additional states implement ELE and more enrollment data become available, multivariate analyses like this study may yield valuable insights about the relative effectiveness of different types of ELE processes.

a. Sensitivity Analyses

Across a series of alternative models that address different potential sources of specification error and bias (Table III.4), we consistently find a positive estimated ELE effect, supporting the findings from the main model. In all of the alternative models in Table III.2, the ELE coefficient remains positive with a central tendency that is close to what we find in the main model. The magnitude associated with the ELE variable in the total Medicaid/CHIP alternative models ranges from 3.4 (the lowest estimated coefficient is in the main model specification) to 4.8 percent and in the Medicaid-only alternative models ranges from 4.5 to 7.6 percent. In all other models for which the results are not shown (for example, additional models described in the Year 1 report), we find that the ELE effect is also close to what we find in the main model.

Table III.4. Estimated ELE Effects for Alternative Models (Year 3 Analysis); 2007-2013 Quarterly SEDS Data

	Dependent Variable (Log Transformed)	
	Total Medicaid/ CHIP Enrollment	Medicaid Enrollment Only
Year 2 Main Regression Model (2007-2013 Excluding Alabama)	0.0337 (0.024)	0.0582** (0.028)
Alternative Specification of Control Variables		
(1) State and quarter fixed effects only (unadjusted model)	0.0394 (0.036)	0.0495 (0.030)
(2) Unadjusted model + policy variables	0.0366 (0.022)	0.0615** (0.028)
(3) Unadjusted model + unemployment rate and child population	0.0392 (0.036)	0.0477 (0.031)
(4) Policy index instead of dummy variables	0.0399 (0.033)	0.0492* (0.028)
Alternative Specification of Comparison States		
(5) Including all 39 non-ELE states as comparison states	0.0309 (0.024)	0.0445 (0.029)
(6) Excluding outlier comparison states	0.0483** (0.022)	0.0755*** (0.026)
(7) Excluding top 5 and bottom 5 comparison states in terms of ELE effect	0.0454** (0.022)	0.0653** (0.027)
(8) Excluding top 10 and bottom 10 comparison states in terms of ELE effect	0.0415**	0.0647**

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: (1) Robust standard errors clustered at the state level are in parentheses. (2) * p < .10, ** p < .05, and *** p < .01 for two-tailed tests (3) All models include state and quarter fixed effects (coefficients not shown). All other right-hand side variables are the same as those in the Table III.1 main results. (4) Total enrollment includes children who were ever enrolled in Medicaid or CHIP during the fiscal quarter. Medicaid enrollment only includes children who were ever enrolled in Title XIX or Title XXI Medicaid during the fiscal quarter. (5) ELE states include Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, South Carolina, New York, and Massachusetts. The Year 2 models exclude Alabama from the sample. (6) In the Medicaid model, we exclude Arizona, Colorado, Illinois, Nevada, New Mexico, Virginia, Washington, and Wyoming from the comparison group. In the combined Medicaid/CHIP model, we exclude Arizona, California, Connecticut, Florida, Illinois, Indiana, Kentucky, Missouri, Nevada, New Mexico, North Dakota, Ohio, Tennessee, Texas, Virginia, and Washington. Maine and Montana are excluded from both models.

CHIP = Child Health Insurance Program; ELE = Express Lane Eligibility; SEDS = Statistical Enrollment Data System.

Although remaining consistently positive, the statistical significance of the estimated ELE effect varies across the model specifications. The estimated ELE coefficient in the basic unadjusted difference-in-difference model (alternative 1) is still similar in magnitude to the main

fully adjusted model result but is not statistically significant at a conventional level (*p*-value = 0.11 in the Medicaid model and 0.28 in the Medicaid/CHIP model). Alternatives 2 and 4 show that controlling for differential policy changes among ELE states and the comparison group strengthens the precision of the estimated effect, but that the inclusion or exclusion of the policy variables does not drive the magnitude and direction of the ELE variable in the main model.

We also find that the ELE effect is slightly smaller in magnitude and statistically insignificant (*p*-value =0.13 in the Medicaid model and 0.20 in the Medicaid/CHIP model) when we use all 39 non-ELE states as the comparison group, as opposed to using states with similar pre-ELE enrollment trends (alternative 5). However, the estimates of the ELE effect from this model are likely to be biased downward because they include comparison states with quarterly enrollment levels trending upward relative to ELE states' trends during the pre-implementation period. We also find that the ELE effect in the Medicaid/CHIP and Medicaid models is statistically significant in all of the remaining comparison group sensitivity models and larger in magnitude relative to the main model specification (alternatives 6 through 8).

b. Findings on Other Variables

According to the results in the Year 2 main models, the log transformation of the child population has a positive and statistically significant effect on enrollment, as expected (Table III.1). These results imply that a 1 percent increase in a state's total child population would yield a 0.83 percent increase in quarterly Medicaid/CHIP enrollment and a 0.98 percent increase in Medicaid enrollment on average, holding all else constant. The coefficient on the unemployment variable is 0.007 in the Medicaid/CHIP and Medicaid-only model but is statistically insignificant. These findings are nearly identical to those in the Year 1 analysis.

The remaining variables control for observed changes in Medicaid/CHIP policy during the period of analysis. Consistent with the Year 1 results, we find that administrative verification of income increases Medicaid enrollment by approximately 8 percent (statistically significant at the 1 percent level), holding all else constant. We also find that presumptive eligibility in Medicaid increases combined Medicaid/CHIP enrollment by approximately 8.1 percent (statistically significant at the 10 percent level), holding all else constant. None of the other policy variables are statistically significant at conventional levels in the main model, but the estimated non-ELE policy effects vary in magnitude and statistical significance depending on the model specification. However, this analysis cannot conclude whether some of these policies had a positive or negative effect on enrollment during the period of analysis because we did not subject the other policy variables to similar robustness analyses and there were very few changes in some of these policies over the analysis period. In contrast, we are more confident in the ELE policy variable, given the certainty over the ELE implementation dates and the robustness of the estimated ELE effect based on the extensive range of sensitivity models that we estimated. A more rigorous analysis would be necessary to determine if the estimated effects of the other policy variables are sensitive to alternative model specifications.

F. Discussion

This update of the Year 1 multivariate analysis adds six additional quarters of data through the second fiscal quarter of 2013 and adds New York and Massachusetts to the sample of ELE states. However, despite this additional data, this update is limited by the exclusion of Alabama from the sample, one of the first states to implement ELE. Based on our analysis of 9 of the

10 states that implemented ELE for children during the 2007 to 2013 period, we find strong evidence that ELE implementation increased Medicaid enrollment. Similar to the Year 1 findings, the estimated impacts of ELE were consistently positive, ranging between 4.5 to 7.6 percent, with most estimates statistically significant at the 5 percent level. Overall, these estimates had a central tendency of about 6.3 percent. We also find some evidence that ELE increased combined Medicaid/CHIP enrollment; across a series of models, estimated impacts were again consistently positive, though statistically insignificant in most cases, with a central tendency of about 4.5 percent.

Our updated findings suggest that ELE might have an extended effect over time rather than a one-time increase. By using additional quarterly data to obtain the longest possible window of post-ELE data over the analysis period, we are able to provide more confident estimates on the effects of ELE over time. Even though most ELE policies were implemented quickly, unlike other eligibility and enrollment simplification strategies that might diffuse slowly, our results in Table III.4 suggest that the positive effect of ELE on enrollment had not phased out over time, at least during the post-ELE window we were able to observe.

The less robust evidence of an effect of ELE on combined Medicaid/CHIP enrollment is not surprising given how modestly ELE has been implemented for CHIP. Indeed, at the time of this analysis, only five states implemented ELE for CHIP; one (Iowa) had an ELE-like policy in effect before the period of analysis and another (Massachusetts) is limited by a short post-ELE implementation period of two quarters. Also discussed in the Year 1 analysis, we would also expect the effects from Oregon's and Georgia's ELE programs to be heavily weighted toward Medicaid because each state's Express Lane agency—WIC and SNAP, respectively—has income eligibility levels that encompass the Medicaid threshold but are below the CHIP threshold. In other words, these findings do not mean that ELE policies cannot affect CHIP enrollment but rather that the existing ELE programs are targeted more toward Medicaid than to CHIP enrollment.

Although our results suggest that ELE can have a positive effect on Medicaid enrollment, it is uncertain how this finding might be true for a particular state or state program. We find some evidence that ELE had an above average effect on enrollment in Iowa and Oregon, where ELE primarily functioned through SNAP, and in Maryland and New Jersey, where ELE functioned to accompany use of the tax system as an outreach tool. However, differences across states were not found to be statistically significant and the experience for any individual state could vary widely because of differences in policy design, implementation, or its target population.

As we have indicated, unobservable factors might bias our estimated ELE effects, especially as the post-implementation period becomes longer. Specifically, unless accounted for in our models, any factors correlated with the timing of ELE adoption that also affect enrollment might bias our estimates of ELE effects. Some states might have upgraded their information technology systems or implemented targeted outreach programs, subsequently increasing enrollment, at the same time they carried out ELE. For example, in New Jersey, ELE was the centerpiece of a broader initiative to increase coverage of uninsured children eligible for Medicaid/CHIP and to ensure retention of enrollees in these programs (State of New Jersey 2009). The initiative included broader changes to information technology, staffing, public awareness and media outreach, and application simplification. In addition, at the same time as ELE, Oregon pursued several streamlining initiatives to improve the enrollment experience for families, including providing 12 months of continuous eligibility for children (which we control for in this analysis),

reducing income verification requirements, aligning SNAP and public health insurance renewal dates, allowing a verbal signature during telephone application and renewal, and creating an online application (Colby and Frost 2013). Should such unobservable factors increase enrollment in ELE states, it would introduce upward bias in our ELE estimates. Alternatively, should non-ELE states also be pursuing such unmeasured initiatives, or should ELE states be taking steps that reduce enrollment, it could bias our impact estimates toward zero; an example of the latter would be Louisiana's 20 percent reduction in social service eligibility staff available to provide application assistance, which coincided with ELE implementation (Dorn et al. 2012). Despite our attempts to control for potentially confounding policy changes, it is impossible to draw definitive conclusions about the precise magnitude of ELE impacts on enrollment, given the heterogeneous nature of ELE programs and the limited information we have about enrollment changes following ELE implementation in many states that adopted ELE. Although this analysis is certainly suggestive that ELE policies have positive enrollment effects, caution is warranted in interpreting these estimates as causal.

Since CHIPRA's passage, Congress subsequently extended ELE until October 1, 2014 (P.L. 112-240). It is therefore important to continue to track the impacts of ELE on child enrollment in current and future ELE states and to assess whether the effects are sustained over time. Our results have implications for the implementation of the Affordable Care Act. They show that states can apply ELE-like principles (such as streamlined applications, elimination of duplicative paper documentation, and sharing of data across agencies) to enroll and retain individuals in Medicaid/CHIP or subsidized Marketplace coverage. ELE could also have beneficial effects beyond enrollment gains; in Chapter V, we review whether ELE produces administrative efficiencies that in turn save administrative funds.

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IV. ELE ENROLLMENT AND RETENTION: FINDINGS FROM THE ADMINISTRATIVE DATA ANALYSIS

Key Findings:

- The number of new enrollees reached through ELE varied by the type of ELE process adopted; programs using ELE as form of administrative simplification (Alabama, Iowa Separate CHIP) enroll a sizable proportion of child enrollees. Among programs using ELE to target eligible non-applicants, only Louisiana—which has used an automatic enrollment ELE process that requires no additional beneficiary action—appears to have added a meaningful number of children to public coverage; simplified application ELE processes that have used targeted mailings realized few enrollments.
- States are using ELE to simplify the redetermination process for a sizable number of individuals and a significant proportion of their renewal caseload.
- ELE appears to be finding hard-to-reach children; children enrolling via ELE were older and less likely than non-ELE children to have experienced a recent spell of coverage, particularly in states using ELE to target eligible non-applicants.
- We find that ELE enrollees in Iowa's Separate CHIP, Louisiana, and New Jersey are less likely than non-ELE enrollees to remain enrolled beyond their likely first redetermination date. It may be that, for some ELE processes, children enrolled through ELE are more difficult to retain in the system at renewal when compared to non-ELE enrollees in their state.

A. Background and Motivation

The primary goal of ELE is to increase enrollment in public insurance among eligible children. In principle, using ELE for simplifying enrollment and renewal has three potential effects: (1) attracting new families into Medicaid and CHIP; (2) more efficiently enrolling families that would have been enrolled through traditional pathways, expediting coverage for families while reducing the administrative burden on caseworkers; and (3) keeping beneficiaries who might otherwise not renew or might not successfully complete the renewal process enrolled in coverage for which they are eligible. In this chapter, we use aggregate and individual-level enrollment data to provide insight into the potential effects of ELE.

Findings from the analysis address five key research questions:

1. How many beneficiaries are **enrolled** or **renewed** through ELE?
2. How do the demographic characteristics of beneficiaries who are **enrolled** or **renewed** through ELE compare to those of beneficiaries who complete the traditional enrollment or renewal process?
3. Have beneficiaries who **enroll** through ELE previously been Medicaid or CHIP beneficiaries? How recently?
4. How long do beneficiaries who **enroll** through ELE remain enrolled relative to those who enroll or renew through traditional processes?

5. Has the implementation of ELE **renewal** processes increased the likelihood that beneficiaries successfully complete the renewal process?

By addressing these questions, this analysis complements and expands on the findings presented in the prior chapter from the SEDS-based analysis of ELE impacts on enrollment, providing a critical consistency check of those findings in the process. The analysis further assesses the extent that ELE reaches targeted demographic groups and whether ELE enrollees remain enrolled—both of which are critical policy issues in examining the potential value of the policy for enrolling and retaining children in coverage.

B. Data Collection and Analysis Methods

The study includes data provided by six states with ELE programs approved by CMS as of December 2012: Alabama, Iowa, Louisiana, New Jersey, Massachusetts, and South Carolina.[31] To support the analyses for this report, we collected data in two ways. First, in four ELE states—Alabama, Iowa, Louisiana, and New Jersey—we collected individual-level enrollment data obtained either directly from states or, in the case of Louisiana, through a separate Mathematica project.[32] For Massachusetts and South Carolina, we asked state officials to populate data tables with monthly counts of ELE and traditional renewals, disaggregated by selected demographic characteristics. In each case, we requested renewal data for the period one year before implementation through at least December 2012. A detailed description of data collection methods can be found in Appendix B.

1. Assessing ELE for New Enrollment

Using data collected from the participating states, we were able to examine six processes in four states that use ELE for enrollment: Alabama, Iowa, Louisiana, and New Jersey. This analysis focused on ELE's reach in facilitating *new enrollment*. We defined a new enrollee as a child who is enrolled in the specified program (Medicaid or CHIP) during at least two consecutive months. In addition, when comparing ELE and non-ELE enrollees, we limited new enrollees to those without coverage in either program during the previous two months, meaning that they have not newly enrolled as result of a program transfer or recent reenrollment (churn). We adopt this limitation because ELE seeks in all study states to enroll eligible-but-uninsured children, and we want to draw comparisons with the equivalent group of non-ELE children.[33] To further ensure the validity of comparisons between ELE and non-ELE groups, in Medicaid programs we also restrict the sample to children who qualify primarily on the basis of income rather than on bases such as disability or foster care status.

[31] Maryland and Oregon, two other ELE states, were invited to participate but could not respond to our request; Oregon lacked sufficient staff resources to provide data needed for the evaluation, and Maryland's data system lacks a marker for ELE-facilitated enrollments.

[32] To capture transfers out of Alabama's Medicaid program, we also obtained Alabama's Separate CHIP enrollment data through the Maximizing Enrollment project and combined it with Medicaid data received directly from the state.

[33] The exception is Iowa Separate CHIP. Because the purpose of this ELE process is to smooth transitions across the two programs, we included redeterminations in our counts of new enrollments. In analyses comparing ELE to non-ELE, we limited the Iowa Separate CHIP sample to new enrollments.

Our approach was largely descriptive, drawing inferences from an examination of unadjusted enrollment and retention trends, counts, and proportions. In addition, for the ELE processes for which we have individual-level data, we conducted descriptive regression analyses to compare retention outcomes for ELE versus non-ELE new enrollees within a state after controlling for differences in observable characteristics across the groups.[34] Despite being regression-based, this analysis is exploratory and not causal, allowing us to identify any differences in retention between children enrolling through the two mechanisms that are not explained simply by sociodemographics.

Estimation of these differences followed the general regression model in Equation (IV.1), below, which we estimate state by state for the period since ELE was adopted in the state. The model specifies the retention outcome for person p as a linear function of the enrollment pathway (*ELE*), a vector (X) of demographic characteristics, and a fixed effect for the initial enrollment month. *ELE* is defined as a dummy variable that equals one if the beneficiary enrolled through the ELE pathway or zero if they enrolled through the standard application routes.

$$\text{(IV.1)} \quad \text{Retention Outcome}_p = \beta_0 + \beta_1 ELE + \gamma' X_p + \delta_t \text{Enrollment Month}_p + \varepsilon_p$$

In each state, the coefficient β_1 estimates the difference in retention patterns between ELE and non-ELE participants after controlling for observable personal characteristics.

2. Assessing ELE for Renewals

We examined four ELE processes for simplifying renewals in their respective states: Alabama, Louisiana, Massachusetts, and South Carolina. The approach to assessing the reach of ELE renewal processes also is largely descriptive. We obtained counts of renewals directly from the states or, in the case of Alabama, estimated the number of ELE renewals by using the individual-level administrative data.[35] We were only able to compare the characteristics of individuals renewing via ELE to those renewing via standard processes in Massachusetts and South Carolina, which provided aggregate information for the two groups.

We explored further the relationship between the adoption of the ELE renewal policy and program retention in Alabama and Louisiana, the two states that have authorized ELE for renewal for which we have individual data. Even though the available data did not include specific information on renewals, we knew the length of a child's continuous spell of coverage after his or her initial month of enrollment. To test whether the adoption of ELE coincided with an increase in the likelihood of successfully completing a first redetermination, we used a multivariate regression framework to estimate the likelihood of remaining enrolled for 12 and 15 months for all new enrollees—ELE and non-ELE—over the period of the data in these two states.

[34] Specifically, we estimated multivariate regression models for (1) continuous coverage at specific time points (6, 11, 12, 13, 15, 18 months) and (2) churning after disenrollment. See Appendix B for variable specifications.

[35] See Appendix B for a detailed description of our methods.

The model for examining retention differences within each of these states followed closely the one used above for ELE states adopting processed focused on new enrollment. The main distinction in Equation (IV.2) is that the retention difference associated with ELE here was estimated by the change in retention over time before and after the policy's adoption, as opposed to the difference between those enrolled or not enrolled through ELE since the policy began; the sample therefore consisted of new enrollees over the entire period of the data.

$$\text{(IV.2)} \quad \text{Retention Outcome}_p = \beta_0 + \beta_1 \textit{POST-ELE} + \gamma' X_p + \delta_t \text{Enrollment Month}_p + \varepsilon_p$$

Specifically, our estimate of the difference in retention came from the coefficient β_1 on the *POST-ELE* covariate, which indicates whether the child's expected first redetermination date occurred in the period after the state adopted ELE for renewal.[36] For example, given Alabama's October 2010 implementation date for use of ELE for renewals, children who started a spell of coverage on or after October 2009 would have been eligible for renewal via ELE; however, those who enrolled before October 2009 would have come up for renewal before ELE implementation.[37]

Given the use of binary outcome measures, we used logistic regression models for Equations (IV.1) and (IV.2), clustering standard errors at the person level.[38] To facilitate interpretation, we reported results from all regressions as average adjusted probabilities or average marginal effect and the significance of the differences in group means between ELE and non-ELE participants.

C. Findings

1. New Enrollment

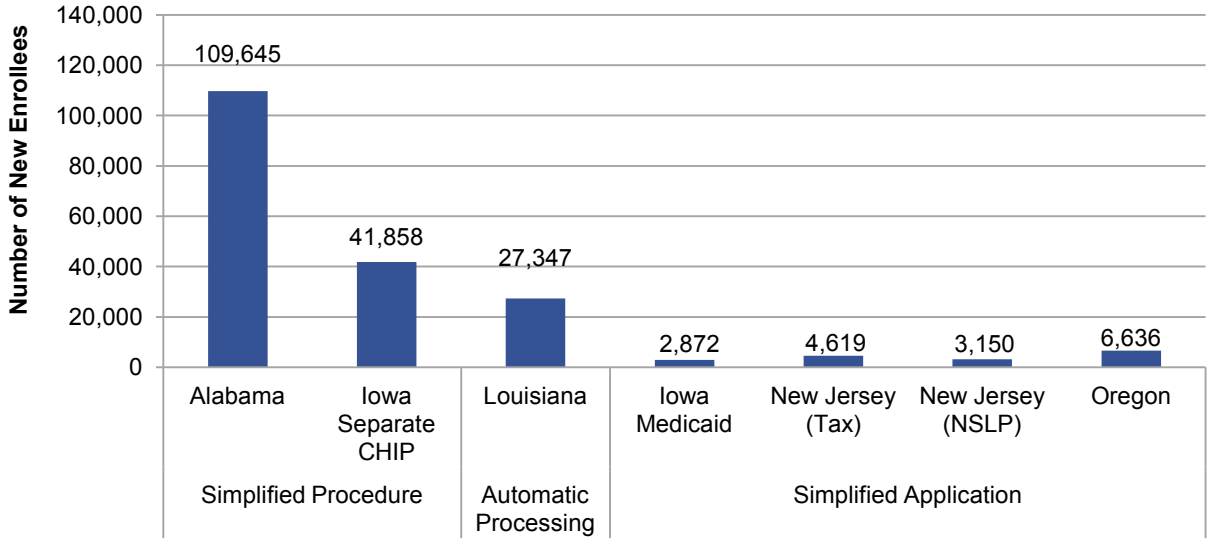
The number of children enrolled through the ELE pathway depended substantially on the design of the policy. As shown in Figure IV.1, those ELE programs designed to simplify procedures used to process applications already received (Alabama and Iowa Separate CHIP) enrolled the most individuals, whereas the state using automatic ELE processes for enrolling uninsured eligibles (Louisiana) generated a sizable number of new enrollments. States using ELE to send simplified applications to reach uninsured eligibles (Iowa Medicaid, New Jersey tax and NSLP, and Oregon) enrolled a modest number of children.

[36] Both Alabama and Louisiana have 12-month redetermination periods for their public health insurance programs.

[37] We similarly looked at the likelihood of disenrollment/churn at redetermination.

[38] Regressions using linear probability models yielded similar results.

Figure IV.1. Number of New Enrollments Processed via Express Lane Eligibility



Source: Mathematica analysis of state-reported data, 2013.

Note: The time frame varies by ELE process; counts are total counts since implementation of the processes through November 2012, except for Iowa Separate CHIP, where the start date of the data is August 2009, and Oregon, where we have data from implementation through Jan 2013.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

Using ELE to Facilitate Enrollment of Applicants Enrolled Large Numbers (Alabama, Iowa Separate CHIP)

Over the study period, ELE became an integral method for enrollment and eligibility determination in Alabama Medicaid and Iowa's Separate CHIP. Since implementation of the ELE process in Alabama, approximately one third of children newly enrolled in Medicaid were enrolled using the state's manual ELE process to establish income eligibility. In Iowa Separate CHIP, where ELE smoothes transitions for individuals leaving Medicaid and enrolling in CHIP, more than half of all new Separate CHIP enrollments were automatically enrolled by using Medicaid's income eligibility findings.

In April 2010, Alabama Medicaid began using SNAP and TANF databases to establish income on initial applications and, through November 2012, used ELE to process 109,645 new Medicaid enrollments, of which 94 percent were processed using SNAP data to establish income, 1 percent using TANF data, and 5 percent using both SNAP and TANF data (Table IV.1, column 1). Alabama's use of ELE to facilitate enrollments has been growing in terms of both monthly counts and as a proportion of all new enrollments. In the last six months of our data, Alabama used ELE to process almost 38 percent of all new enrollments in Medicaid.

Table IV.1. Counts of Children Enrolled Through ELE

	Simplified Procedure		Automatic Processing	Simplified Application			
Time Period Since ELE Implemented	Alabama	Iowa Separate CHIP	Louisiana	Iowa Medicaid	New Jersey (Tax)	New Jersey (NSLP)	Oregon
	109,645	41,858	27,347	2,872	4,619	3,150	6,636
0 to 6 months	14,059	4,255	16,987	612	2,981	282	--
7 to 12 months	17,697	5,491	926	554	889	114	--
13 to 18 months	19,991	6,676	2	573	121	1,698	--
19 to 24 months	20,064	6,426	3,846	602	176	649	--
25 to 30 months	27,626	7,240	3,355	531	213	407	--
31 to 36 months	10,208	6,755	2,231	--	128	--	--
37 to 42 months	--	5,015	--	--	102	--	--
43 to 48 months	--	--	--	--	9	--	--
Monthly average	3,426	1,046	804	96	107	117	--
Yearly average	41,117	12,557	9,652	1,149	1,289	1,400	--

Source: Mathematica analysis of state-reported data.

Note: Counts are total counts since implementation of the process through November 2012, except for Iowa Separate CHIP, where the start date of the data is August 2009, and Oregon, where we have data through January 2013.

Data are not available at monthly level for Oregon. Because of the timing of the implementation of ELE in the states, the months available for inclusion in the last period reported vary by state as follows: six months for Iowa Medicaid; one month for New Jersey (tax); three months for New Jersey (NSLP); four months for Louisiana; two months for Alabama; and, four months for Iowa Separate CHIP.

-- = Data not available; CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

Between August 2009 and November 2012, Iowa's program of referring Medicaid applications and redeterminations with CHIP-level income to Separate CHIP for automatic enrollment facilitated 41,858 new enrollments in the state's Separate CHIP program. The semiannual numbers in Table IV.1, column 2, describe a mature program, with approximately 1,000 new enrollments per month being facilitated by the ELE process over the time period. The majority of these new enrollments included transfers of children previously enrolled in Medicaid (approximately three quarters), with new application referrals accounting for the remainder.

Automatic ELE Enrollment Processes Showed More Promise for Reaching Nonapplicants (Louisiana)

In Table IV.1, column 3, we show the semiannual trend in new enrollments for Louisiana's ELE program, which automatically enrolls eligible children based on the state SNAP agency's determination. The table illustrates the potential of an auto-enrollment process to provide a one-time spike in enrollment (during the first six months) when ELE processes are applied to an existing caseload and, perhaps, a meaningful flow of individuals enrolling in public insurance each month.

The initial data match with SNAP, coupled with a data match opt-out policy,[39] extended coverage to a substantial number of children in Louisiana: ELE was used to newly enroll approximately 17,000 children in Medicaid between February 2010 and July 2010; 28 percent of all new enrollments during this six-month period entered via ELE. The initial influx of new enrollees coincided with an apparent increase in total enrollment. Total enrollment in Medicaid and the state's Medicaid-expansion CHIP increased from 646,977 in January 2010, the month before the first ELE enrollments, to 669,435 in July 2012—a 3.5 percent increase (data not shown).

In January 2011, Louisiana changed its consent approach, modifying it so that SNAP applicants needed to opt in to ELE by agreeing simultaneously to data sharing and enrollment in Medicaid. The first ELE enrollments after implementation of the new process are reflected in administrative data starting August 2011. In the subsequent 16 months, ELE auto-enrolled approximately 600 children per month, or 8 percent of all children newly enrolled in Medicaid over the period. These figures suggest some continued new enrollment gains with the ELE automatic process.

Mailing-based ELE Enrollment Processes Showed Limited Success (Iowa Medicaid, New Jersey, Oregon)

In Iowa Medicaid, New Jersey, and Oregon—states that use Express Lane partner agencies' findings to target application mailings—we found a relatively small number of ELE-linked new enrollments. Unlike the ELE processes studied in Alabama and Iowa Separate CHIP that simplify the enrollment process for families who have already made the decision to apply for coverage, the aim of ELE processes in Iowa Medicaid, New Jersey, and Oregon is to target and enroll potentially eligible children. However, the processes in these states are paper based; families must respond to the mailing by submitting a shortened application form, after which Express Lane partner agency findings are used to establish certain eligibility criteria.

ELE-generated new enrollments from Iowa Medicaid's partnership with the state SNAP agency were steady but extremely modest since ELE's June 2010 implementation. Over the 30 months for which we had data on new enrollments, Iowa's ELE process accounted for the enrollment of approximately 100 individuals per month (Table IV.1, column 4). ELE applications represented less than 2 percent of all new Medicaid enrollments during the study period.

Overall, New Jersey's two ELE processes were responsible for approximately 1 percent of all new enrollments processed by the state over the period May 2009 through November 2012. New Jersey's partnership with the state Division of Taxation began in May 2009 and in the first 12 months newly enrolled 3,870 children in Medicaid and CHIP by using the shortened application mailed to approximately 300,121 households (Table IV.1, column 5). Between May 2009 and April 2010, approximately 2 percent of all new CHIP and Medicaid enrollments were

[39] Under this policy, families identified in the initial data match were mailed a letter describing the ELE process and allowing them a means to opt out. Families that did not opt out were mailed Medicaid cards and enrolled in coverage.

ELE applications. However, in the subsequent two plus years, New Jersey's tax ELE process facilitated far fewer enrollments—749 total.

New Jersey also administers a similar but separate ELE process with the NSLP. In the first 12 months, when only 9 districts participated in a pilot test of the process, the NSLP-ELE partnership enrolled fewer than 400 children (Table IV.1, column 6). In the second year, when many school districts participated, the NSLP ELE partnership enrolled 2,347 children, or 1 percent of all new enrollments during the period, accounting for an almost fivefold increase over the first year.[40] In the first three months of the third year, 407 children enrolled via this process.

2. Characteristics of Children Enrolling Through ELE

Children enrolling through ELE were more likely to be teens. For every state, teenagers (13 to 18 years old) accounted for a larger share of ELE enrollees than for non-ELE enrollees (Table IV.2). The difference was greatest for ELE programs in Iowa Medicaid, Louisiana, and New Jersey (for both tax- and NSLP-based ELE processes) but was most noticeable in New Jersey, where approximately 42 percent of ELE enrollees are teens, compared to 20 percent of non-ELE enrollees. These findings are notable given that insurance coverage for low-income children has historically differed by age group, with older children being more likely to be uninsured, partly due to differences in income eligibility rules for public insurance. These eligibility gaps narrowed as CHIP programs were implemented in the late 1990's, however, age differences in Medicaid/CHIP coverage for low-income children continues to persist, with estimated 2010 Medicaid/CHIP coverage rates of 67 percent for low-income children ages 0 to 5, 61 percent for ages 6 to 12, and 52 percent for ages 13 to 18 (Hoag et al. 2011). Given this, the finding suggests that ELE may be a useful means of reaching and enrolling hard-to-reach older children, though, as discussed, of these four processes only Louisiana's ELE process enrolled a sizable number of children to date.

Data limitations made other demographic characteristics aside from age difficult to examine. For Iowa, the only state with available income data, we found that children enrolling in Medicaid through ELE had lower family incomes: 23 percent of ELE enrollees came from a family earning less than 50 percent of the federal poverty level, compared to 13 percent of non-ELE enrollees. And for Alabama and Louisiana, the two states for which we had complete data on race and ethnicity, ELE enrollees were more likely than were non-ELE enrollees to have been identified as black or African American. The differences were fairly large, at 11 and 17 percentage points, respectively.

Finally, in Louisiana, the only state for which we had information on private insurance coverage, we found that ELE enrollees were more likely to have private insurance coverage than were non-ELE enrollees (Table IV.2). The finding suggests that Louisiana's automatic ELE enrolls more families in Medicaid than do standard processes, so families gain wraparound coverage of dental care and other services not provided by their private insurance coverage.

[40] In the second and subsequent years of the NSLP-ELE process, the program was implemented statewide but school district participation was voluntary.

Table IV.2. Selected Demographic Characteristics of New Enrollees, ELE versus non-ELE

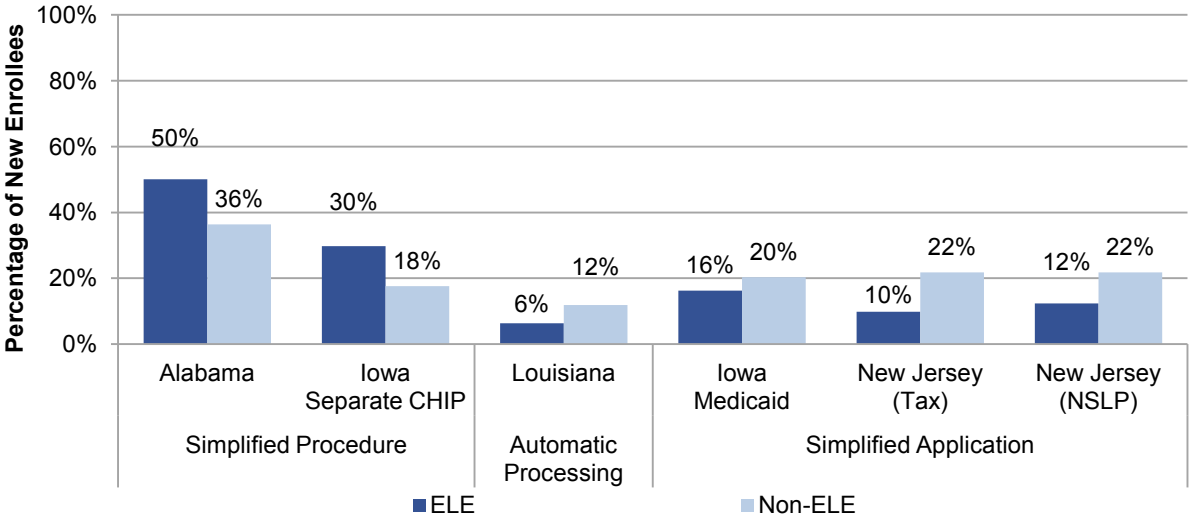
	Simplified Procedure				Automatic Processing		Simplified Application					
	Alabama		Iowa Separate CHIP		Louisiana		Iowa Medicaid		New Jersey (Tax)		New Jersey NSLP	
	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE
Age												
0 to 1	5	38	0	0	3	8	3	36	4	33	1	33
1 to 5	38	27	35	32	23	32	25	25	24	22	12	22
6 to 12	37	22	36	41	39	34	40	24	37	24	45	24
13 to 18	21	14	29	26	36	26	31	16	36	20	42	20
Income (% FPL)												
< 50	--	--	--	--	--	--	23	13	--	--	--	--
50 to 99.9	--	--	--	--	--	--	66	71	--	--	--	--
≥ 100	--	--	--	--	--	--	11	16	--	--	--	--
Race/Ethnicity												
Black	56	39	--	--	50	39	--	--	--	--	--	--
Hispanic	4	10	--	--	3	8	--	--	--	--	--	--
White	37	48	--	--	46	46	--	--	--	--	--	--
Other/Unknown	2	3	--	--	1	7	--	--	--	--	--	--
Private Insurance Coverage	--	--	--	--	21	13	--	--	--	--	--	--

Source: Mathematica analysis of state-reported data.

-- = Data not available; CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; FPL = federal poverty level; NSLP = National School Lunch Program.

ELE processes that targeted nonapplicants were more likely to reach children without recent spells of public coverage. Figure IV.2 shows the proportion of new enrollees who were at least one year old with public coverage in the six months before enrollment. The measure provides a sense of whether ELE processes are more or less likely to capture individuals churning back to public coverage after a short gap (two to five months) without public insurance. We found in Alabama and in Iowa's Separate CHIP program that ELE enrollees were between 12 and 14 percentage points more likely than were non-ELE enrollees to have had a recent spell of public coverage prior to enrollment. Again, the ELE processes in these two states are applied to applications already received; families of children in the two programs still need to apply for coverage as they would if ELE were not in place, regardless of the type of income determinations used to establish Medicaid eligibility. Accordingly, we did not expect to find children in the ELE group to be more disconnected from public coverage than non-ELE children because their parents had already taken the step of applying for coverage.

Figure IV.2. Public Coverage Six Months Prior to New Enrollment, ELE versus Non-ELE



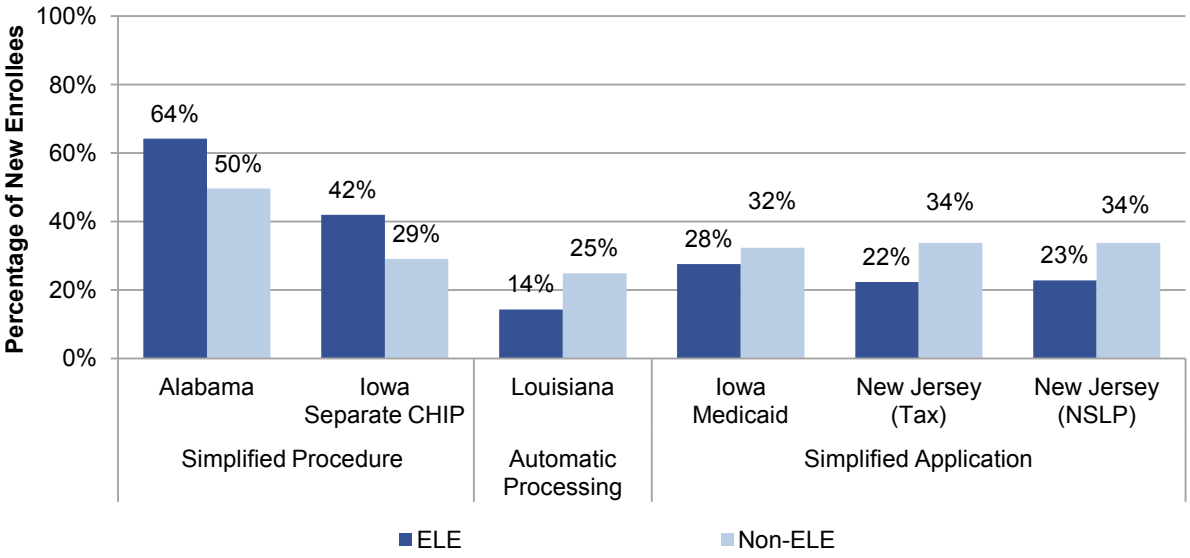
Source: Mathematica analysis of state-reported data.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

However, we found in Iowa Medicaid and the two New Jersey programs, all of which adopted a simplified application-based ELE process, between only 10 and 16 percent of new ELE enrollees were returning to public coverage after a short gap without coverage, a rate of 4 to 12 percentage points less than non-ELE new enrollees in these programs. Similarly in Louisiana, which uses an automatic ELE enrollment process to reach nonapplicants and auto-enroll them, only 6 percent of ELE enrollees returned to public coverage, whereas twice as many non-ELE enrollees in these programs returned after a short gap in coverage.

We found a similar pattern when examining public coverage in the year prior to enrollment (Figure IV.3). In Alabama and Iowa Separate CHIP, ELE enrollees were between 13 and 14 percentage points more likely to have been previously enrolled in public programs, but in Iowa Medicaid and New Jersey, ELE enrollees were generally less likely than non-ELE enrollees to have been previously enrolled. The differences were relatively large in New Jersey—between 11 and 12 percentage points. Similarly, in Louisiana, ELE enrollees were 11 percentage points less likely to have been previously enrolled in public programs in the prior year. These differences provide additional evidence that the ELE processes used in New Jersey and Louisiana are reaching a different group of families than are traditional enrollment mechanisms.

Figure IV.3. Public Coverage Twelve Months Prior to New Enrollment, ELE versus Non-ELE



Source: Mathematica analysis of state-reported data.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

Retention of enrollees served by ELE showed no consistent pattern across states. After controlling for observed differences between ELE and non-ELE enrollees, we found no consistent pattern in retention between the two groups; retention of ELE new enrollees exceeded that of non-ELE new enrollees in Alabama and Iowa Medicaid, but retention was lower through at least the first renewal period in Iowa's Separate CHIP, Louisiana, and New Jersey.

Iowa Separate CHIP

At each examined retention point, children enrolled via ELE in Iowa Separate CHIP were less likely to have remained continuously enrolled than were children entering through the standard enrollment process—by 13 to 18 percentage points (Table IV.3, column 2). It is likely that the disparity in rates was partly attributable to Iowa Separate CHIP's cost-sharing requirements; non-ELE enrollees are likely to expect cost-sharing requirements, but ELE enrollees are not likely to do so, given that they applied to Medicaid rather than to Separate CHIP. The different routes into the program may also be associated with characteristics that lead to different retention rates, such as frequently fluctuating household circumstances. Even though we controlled for observed differences in age, race, gender, language, and household size, we did not have information on family income. However, the continuous coverage measure accounted for transfers to the Medicaid program, making it unlikely that the differences resulted from ELE individuals' reapplication to and enrollment in Medicaid after a decline in household income.

Louisiana

Similar to Iowa Separate CHIP, children enrolled via ELE in Louisiana were less likely to have remained continuously enrolled than were children entering through the standard enrollment process. Although differences between the two groups substantially diminished in magnitude after accounting for variation in age and other observed characteristics, the differences remained sizable (15 to 21 percentage points) and significant from month 11 forward (Table IV.3, column 3).

The initial cohort of Louisiana ELE enrollees experienced high early attrition, probably in response to the state's initial approach to ELE, which was an opt-out approach requiring affirmative consent—the family's use of Medicaid coverage (Dorn et al. 2013). As discussed in Chapter II, Louisiana has since changed its SNAP application form to allow an opt-in policy for data matching, replacing the earlier two-step process with an up-front active consent requirement. However, given that the vast majority of all Louisiana ELE enrollees were enrolled under the initial approach, the overall differences are likely to be dominated by enrollees under this early policy. To compare retention outcomes of children enrolling under the current opt-in approach, we reran our models limiting the sample to individuals who enrolled in 2011 and 2012 (Table IV.3, column 4). ELE enrollees under the current opt-in approach were just as likely to remain enrolled for 6 and 12 months as non-ELE enrollees; however, the evidence still suggests that ELE enrollees are less likely to continue their enrollment after their first redetermination date (13- and 15-month variables). Even though the results were markedly smaller in magnitude than were those observed for the early cohorts, sizable differences remained (8 and 17 percentage point differences, respectively).

New Jersey

Both tax- and NSLP-based ELE enrollees in New Jersey were more likely than were non-ELE enrollees to remain enrolled for 6, 11, and 12 months; however, the relationship reversed starting in month 13, with ELE enrollees less likely than non-ELE enrollees to remain enrolled beyond their first redetermination date (Table IV.3, columns 6 and 7). The difference between the two ELE groups and the non-ELE group in 15- and 18-month retention was approximately 10 percentage points. The renewal process in New Jersey is burdensome compared to the ELE application, which is a short form with no documentation requirement; thus, for families who enter via ELE, the standard renewal process might serve as a barrier to remaining covered.

Table IV.3. Retention Outcomes, Average Adjusted Probabilities, ELE versus Non-ELE

	Simplified Procedure				Automatic Processing				Simplified Application					
	Alabama (1)		Iowa Separate CHIP (2)		Louisiana Full Sample[a] (3)		Louisiana Opt-out Sample[b] (4)		Iowa Medicaid (5)		New Jersey (Tax) (6)		New Jersey (NSLP) (7)	
Percentage Still Enrolled	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE
Continuous Coverage: Percent Still Enrolled														
After 6 months	97***	96	77***	90	93***	97	97	97	97***	95	98***	92	97***	92
After 11 months	94***	93	71***	84	78***	93	94	94	89	89	95***	88	94***	88
After 12 months	93***	91	69***	82	73***	90	92***	91	88	87	94***	86	94***	86
After 13 months	83***	80	47***	64	66***	85	77***	85	79***	76	76***	82	81	82
After 15 months	65***	64	46***	64	61***	82	65***	82	75***	69	68***	77	73**	77
After 18 months	64***	63	45***	62	59***	80	--	--	71***	65	62***	73	64***	73
Return Rate: Percent of Disenrollees Churning Back														
Disenroll/churn	42***	39	11	12	9	9	--	--	16	19	17***	21	18	21

Source: Results are based on regressions using state-provided administrative enrollment data.

Note: Results are reported as average adjusted probabilities from logistic regression models. Sample limited to children under age 17. Covariates include available demographics (vary by state): age at enrollment, male indicator, race, language, citizenship, rural indicator, and household size. For Louisiana, we include an indicator for private coverage; for Iowa Medicaid, we control for household income as a percentage of the federal poverty level; in all states, we control for month and year of enrollment.

* Difference between ELE and non-ELE children is statistically significant ($p < 0.10$).
** Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).
*** Difference between ELE and non-ELE children is statistically significant ($p < 0.01$).

[a] Column 4 uses data from Louisiana between February 2010 and December 2012.

[b] Column 5 uses data from Louisiana between January 2011 and December 2012.

-- = Not enough follow-up data to calculate; CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

ELE children were no more likely to experience churn after disenrollment than were other children. We also examined differences in the proportion of children churning back into the program within six months of disenrolling around their first redetermination date (months 12 through 14 after enrollment). This measure is useful for determining whether ELE children who fail to renew eventually return to the programs and how the rates compare to those among non-ELE enrollees. In general, the return rates of ELE enrollees were markedly low in every state except Alabama. In both unadjusted tabulations (not shown) and multivariate findings (Table IV.3, bottom panel), we found modest differences that are rarely statistically significant. The results might alleviate concerns that ELE enrollees are more likely than are non-ELE enrollees to encounter unnecessary disenrollment and churning, which can be administratively burdensome and costly to state agencies. When ELE disenrollees did not renew coverage, they remained disenrolled, at least in the short term.

3. Using ELE for Renewal

States were using ELE to simplify the redetermination process for a sizable number of individuals and a significant proportion of their renewal caseload. Four states use ELE for renewals: Alabama (Medicaid), Louisiana (Medicaid and Medicaid-expansion CHIP), Massachusetts (Medicaid and Medicaid-expansion CHIP for children and Medicaid for adults, both under 150 percent of the FPL), and South Carolina (Medicaid and Medicaid-expansion CHIP). In Massachusetts, which fully implemented its ELE for renewals only recently (October 2012), ELE was used to process renewals for approximately 47,000 children and Medicaid coverage for 30,000 adults in just the first six months of the program.[41] In the other three states, ELE has been used to process an even greater volume of renewals for children: approximately 110,000, 170,000 and 120,000 annually in Alabama, Louisiana, and South Carolina, respectively (Table IV.4).

These totals represented a sizable proportion of all renewals completed by these agencies. In South Carolina, ELE renewals accounted for about 48 percent of all Medicaid and Medicaid-expansion CHIP renewals in the two years since implementation. In Louisiana, where ELE is one component of a set of renewal simplification processes enacted by the state (such as ex parte, telephone, administrative), ELE was used to process approximately 20 percent of all Medicaid and Medicaid-expansion CHIP renewals in the state.[42] In Massachusetts, based on counts of renewals by pathway during the initial six months, we estimated ELE was being used to process

[41] Massachusetts has also used ELE to renew a small number of beneficiaries in other public insurance programs: 84 children renewed via ELE in the MassHealth Limited program (emergency medical coverage for undocumented noncitizens or those otherwise ineligible for MassHealth programs because of immigration status), and 14 renewed in Health Safety Net (coverage of medically necessary services for residents not eligible for MassHealth regardless of income, citizenship, or immigration status). In addition, 125 adults renewed via ELE in the MassHealth Limited program, 270 renewed in Health Safety Net, and 277 renewed in Commonwealth Care (adults-only program for low- and moderate-income residents without health insurance). Massachusetts has an approved Section 1115 waiver to include adults in its ELE renewal process.

[42] Estimates were provided by the state as part of the cost study; the period for the estimates was July 2012 through November 2012.

approximately 37 percent of child renewals in Medicaid and Medicaid-expansion CHIP and 39 percent of adult renewals in Medicaid for families under 150 percent of the FPL.[43]

Table IV.4. Counts of Children and Adults Renewed Through ELE

	Alabama (Manual)	Louisiana	Massachusetts (Children)	Massachusetts (Adults)	South Carolina
Total	327,233	329,415	47,780	30,951	217,632
0 to 6 months	3,246	80,456	47,780	30,951	56,939
7 to 12 months	38,390	87,201	--	--	57,668
13 to 18 months	50,957	88,545	--	--	71,503
19 to 24 months	75,105	73,213	--	--	31,522
25 to 30 months	74,368	--	--	--	--
31 to 36 months	85,167	--	--	--	--
Average per month	9,090	14,322	[a]	[a]	10,363
Average per year	109,078	171,869	[a]	[a]	124,361

Source: Mathematica analysis of state-reported data.

Note: Massachusetts' counts include 541 children and 384 adults enrolled in September, when the state piloted the program prior to full implementation. Because of timing of implementation of ELE in the states, months available for inclusion in the last period varied by state as follows: six months for Alabama, five months for Louisiana, six months for Massachusetts, and three months for South Carolina.

[a] Because of the limited time frame for which Massachusetts data was available for inclusion in this report, monthly and yearly averages were not able to be accurately calculated because there are potential cyclical trends that were not fully captured.

-- = Data not available; ELE = Express Lane Eligibility.

Individuals renewing coverage through ELE and traditional processes differed little in observed characteristics.[44] Based on data from two states, Massachusetts and South Carolina, we observed few substantial differences in the demographic characteristics of those renewing through ELE or traditional processes. In Massachusetts, children renewing coverage via ELE were somewhat older, had lower incomes, and came from families less likely to be employed; however, all these differences were modest in size.[45] For example, we find that ELE renewals were less likely than were non-ELE renewals to be 5 years old or younger by a difference of nearly 10 percentage points. Children renewing via ELE were also approximately 10 percentage points more likely than were their non-ELE counterparts to fall below the poverty line. Finally, we found that parents of children renewing via ELE were 8 percent less likely to be employed than were parents of non-ELE renewals.

[43] Because October and November renewal counts were artificially high while the eligibility system caught up on reviews, only renewal counts from December 2012 through March 2013 were included in this estimation.

[44] Detailed demographic characteristics of both ELE and non-ELE renewals were only available in Massachusetts and South Carolina, states that provided renewal data using aggregated data tables.

[45] In Massachusetts, given that the vast majority of renewals via ELE occur in Medicaid programs, the results focused on Medicaid and Medicaid-expansion CHIP renewals only.

Table IV.5. Selected Demographic Characteristics of Massachusetts and South Carolina Medicaid and Medicaid-expansion CHIP Renewals, ELE versus Non-ELE

	Massachusetts (Children)		Massachusetts (Adults)		South Carolina	
	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE
Age (Children)						
0 to 1	2	7	--	--	0	0
1 to 5	27	32	--	--	35	33
6 to 12	42	36	--	--	40	40
13 to 18	29	26	--	--	25	26
Age (Adults)						
19 to 25	--	--	10	11	--	--
26 to 34	--	--	36	30	--	--
35 to 64	--	--	54	58	--	--
Race/Ethnicity						
Black	7	6	7	6	57	51
Hispanic	25	23	15	9	9	9
White	16	13	30	30	32	36
Other	5	6	6	7	3	4
Unknown	48	52	43	48	0	0
Income (% FPL)						
< 50	29	29	28	30	46	55
50 to 99.9	40	31	42	36	38	26
≥ 100	32	40	29	34	16	19
Employment	56	64	53	56	--	--

Source: Mathematica analysis of state-reported data.

Note: Adult renewals in Massachusetts were in Medicaid only.

-- = Data not available; ELE = Express Lane Eligibility; FPL = Federal Poverty Level;.

Adult ELE Medicaid renewals in Massachusetts were also largely similar to their non-ELE counterparts; again, the exceptions were small differences in age and income. We find that adults renewing via ELE processes were about 5 percentage points less likely to be 35 years old or older than were those renewing via standard processes. Adults renewing via ELE also were about 5 percentage points more likely to be under the poverty line than were their non-ELE counterparts.

For the limited demographic characteristics available for South Carolina Medicaid and Medicaid-expansion CHIP children, we found again that ELE children were mostly similar to their non-ELE counterparts, with exceptions being small differences in income and race. Unlike Massachusetts, where ELE children tended to be from lower income families than were non-ELE renewals, in South Carolina, children renewing via ELE processes tended to be slightly higher income than were non-ELE renewals, with almost 10 percentage points fewer children in families earning less than 50 percent of FPL.

ELE adoption for renewal coincided with a small but statistically significant increase in the probability of remaining continuously covered through the first redetermination. In Table IV.6, we present estimates from models that compare the probability of retaining public coverage for 12 and 15 months after enrolling after ELE implementation to retention outcomes before ELE implementation. We reported estimates from both the unadjusted and fully adjusted models,

restricting the sample to children under age 17 in order to ensure that we did not observe children dropping coverage because they aged out of programs.

Table IV.6. Estimated Effects of Adopting ELE for Renewals on New Enrollees' Public Coverage Retention

Dependent Variable	Unadjusted (1)	Adjusted (2)
Alabama		
12 months of continuous coverage	0.008***	0.019***
	(0.001)	(0.004)
15 months of continuous coverage	0.056***	0.039***
	(0.001)	(0.007)
Return rate: Disenroll and churn	-0.047***	-0.042**
	(0.003)	(0.011)
Louisiana		
12 months of continuous coverage	0.026***	0.039***
	(0.002)	(0.007)
15 months of continuous coverage	0.022***	0.021**
	(0.002)	(0.008)
Return rate: Disenroll and churn	-0.013*	-0.032
	(0.008)	(0.021)

Source: Results based on regressions using state-provided administrative enrollment data.

Note: Results reported as average marginal effects to convert results from logistic regression models into percentage point impacts. Robust standard errors, clustered at the person level, are reported in parentheses. Sample limited to children under age 17. Covariates in Alabama models included age at enrollment, male indicator, race, language, rural indicator, household size, enrollment via ELE, and month and year of enrollment. In Louisiana, we were limited to controls for age at enrollment, enrolling via ELE, and month and year of enrollment because of incomplete data in the pre-ELE period.

*Significantly different from zero at the 0.10 level, two-tailed test.
**Significantly different from zero at the 0.05 level, two-tailed test.
***Significantly different from zero at the 0.01 level, two-tailed test.

ELE = Express Lane Eligibility.

For both Alabama and Louisiana, we found that children whose first renewals occurred in the post-ELE period were more likely to remain covered for 12 and 15 consecutive months than were those in the pre-ELE period. For example, in the fully adjusted model, the point estimates imply that the adoption of ELE for renewal boosted the probability of remaining covered continuously for 15 months by roughly 4 percentage points in Alabama and roughly 2 percentage points in Louisiana.

Table IV.6 also presents findings on whether adopting ELE for renewal also coincided with a decrease in churning (when beneficiaries cycle on and off public coverage, experiencing breaks in coverage) of eligible children in Medicaid and CHIP, with the dependent variable indicating whether individuals churned back into coverage after disenrolling at the renewal period. The estimated coefficient suggests that churning after disenrollment decreased in the post-ELE period, although the result was not statistically significant in Louisiana. The overall pattern was similar to that of the continuous coverage models, where we saw some evidence that adoption of ELE for renewal coincided weakly with improved retention outcomes.

D. Discussion

The ELE enrollment processes examined in this study took three general forms: those designed to *simplify procedures* for processing of applications already received (Alabama and Iowa Separate CHIP); *automatic processes* for enrolling uninsured eligibles (Louisiana); and *simplified applications* used to reach uninsured eligibles (Iowa Medicaid, New Jersey tax and NSLP, and Oregon).

Alabama Medicaid's and Iowa's Separate CHIP both used the ELE process for a large proportion of the new enrollments processed during the study period. This volume was sufficient to have possibly produced considerable administrative savings, a question that we examine in the next chapter. However, given that these children had already applied for coverage, the benefits of this policy for increasing enrollment are much less clear. Indeed, in Alabama, our analysis of both the trend in and characteristics of new enrollees following implementation of the policy offered little descriptive evidence that ELE resulted in measurable enrollment gains. Similarly, in Iowa's Separate CHIP, ELE enrollees were drawn from families that applied to Medicaid. The descriptive data showed little difference in the demographic characteristics of the two groups, providing further evidence that the mechanism is unlikely to enroll a group of families distinct from those who apply directly to the Separate CHIP program.

Contrasting the remaining two approaches—both focused on eligible children who have not applied—the automatic ELE process adopted by Louisiana seems to have enrolled many more children than the less targeted, mailing-based approach used by several states. The adoption of automatic ELE in Louisiana led to a substantial spike in ELE-related enrollments, suggesting that the use of income determination findings from other agencies (SNAP) coupled with a passive enrollment approach can, at least in its early months, enroll a sizable number of new children. In contrast, states using *simplified applications* to reach uninsured eligibles, by using ELE partner agencies' data to target application mailings, generated few ELE-facilitated enrollments, suggesting that this outreach-focused approach to ELE, which requires parents to respond to mailings, may offer less promise as a means for enrolling large numbers of new children.

Although children enrolling through ELE appear to have been similar to other Medicaid and CHIP new enrollees along many characteristics, there was some evidence that ELE is attracting a different group of children than traditional enrollment in some respects. We noted sizable differences in the age profile of ELE enrollees compared to non-ELE enrollees in all states; differences in prior public coverage in states using ELE to reach eligible-but-uninsured children; and differences in race, income, and private coverage in states for which we have complete data on these characteristics.

Taken together, these findings suggest that the most effective enrollment processes for enrolling eligible but uninsured children are those that eliminate, or at least reduce, the need for families to complete paperwork prior to receiving benefits. Processes similar to Louisiana's ELE process, whereby data matches establish eligibility without requiring the completion of paper application forms, hold promise in helping states reach a large proportion of newly eligible individuals under the Affordable Care Act expansion. Simplified application-based ELE processes may hold some unique value as an outreach or enrollment tool by reaching a distinct group of traditionally hard-to-reach beneficiaries and are possibly better to target children who are likely eligible for coverage as compared to blanket outreach campaigns, but they are unlikely to lead to a sizable influx of new enrollees.

Although Alabama's manual ELE process and Iowa Separate CHIP referral process are not used as a mechanism to target and enroll eligible but uninsured children, they may, by simplifying the application process, shorten gaps in coverage that might have otherwise occurred, and in some cases enroll children that might otherwise not finalize the process, in addition to leading to administrative savings and efficiencies. In particular, with Iowa Separate CHIP's ELE processes, for those children found ineligible for Medicaid but eligible for Separate CHIP, ELE reduces the steps and paperwork required of applicants to enroll in that program; by doing so, ELE may lead to improved enrollment outcomes.

As part of our examination of ELE enrollment processes, we also consider whether children enrolled through ELE were more difficult than were non-ELE enrollees to retain in the system at renewal. We can balance the finding on retention against the relative ease of initial enrollment via ELE to determine the overall effectiveness of the ELE mechanism. In Louisiana and New Jersey, we noted significant differences in rates of retention, with ELE enrollees less likely than similar non-ELE enrollees to remain enrolled past their first redetermination date. These findings speak to the challenge of retaining individuals in public coverage, and suggest that simplifying the application process is just the first step in ensuring that hard-to-reach children (and adults) remain covered in the programs for which they are eligible.

Regarding the use of ELE for renewals, we found that states are using ELE to renew a sizable number of individuals: approximately 110,000, 170,000, and 120,000 children per year have had their coverage renewed via ELE in Alabama, Louisiana, and South Carolina, respectively. These numbers point to the potential of implementing ELE for renewal as a means to generate administrative savings and efficiencies, particularly in contrast to using ELE for applications. This result is not too surprising, given the relative size of a state's renewal caseload compared to the applications received.

Whether the adoption of ELE renewal policies leads to enrollment gains is beyond the scope of this analysis, but to the extent that the policies significantly reduce barriers to renewals (proof of income or reverification of information already submitted to Medicaid), we might expect total enrollment to increase. Accordingly, we examined whether the adoption of ELE for renewal in Alabama and Louisiana coincided with an increase in the likelihood of successfully completing a first redetermination. We found a small but statistically significant increase in retention following adoption of ELE renewal policies, suggesting that ELE may hold promise for keeping children enrolled in coverage for which they are eligible. However, as mentioned above, these results must be viewed with caution because our design does not allow us to disentangle the effects of ELE on renewals with any unobserved changes that occurred between the pre- and post-ELE period that also impacted the likelihood of renewal.

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V. ELE ADMINISTRATIVE COSTS AND SAVINGS: RESULTS FROM AN ANALYSIS OF ADMINISTRATIVE DATA

Key Findings:

- Automatic ELE processes in Alabama, Louisiana, Massachusetts, and South Carolina on average save $1,000,000 in administrative costs per year, compared to enrolling or renewing the same number of people via a standard process.
- Simplified application ELE processes in Iowa's Medicaid program and in Maryland, New Jersey, and Oregon, are either cost neutral or incur a net administrative cost of up to $100,000 per year.
- Although automatic ELE processes require the greatest up-front investment to implement, the one-time IT and other technical implementation costs are small compared to the ongoing administrative savings from automatic ELE processes. These administrative costs are largest in states implementing an automatic ELE process for initial enrollments as well as for renewals.

Although ELE has significant potential to introduce efficiencies, the net effect of the policy on administrative costs is not obvious. Using eligibility findings or other data from Express Lane partner agencies may enable a state to reduce the amount of staff time needed to process an application or renewal. Conversely, ELE may introduce new administrative costs as the required data-sharing mechanisms are developed and used.

To evaluate the balance of administrative costs and savings associated with establishing and operating ELE processes, we gathered data focused on two key research questions:

1. What are the marginal administrative savings or costs to the state from processing applications or renewals using ELE rather than the standard process?
2. What are the up-front administrative investment costs associated with implementing ELE?

This chapter answers these questions after briefly reviewing our data and methods. A more detailed description of our methods is in Appendix C.

A. Data Collection and Analysis Methods

Data on the administrative costs of ELE were obtained primarily through telephone consultations with policy, program, information systems, and front-line eligibility staff at state Medicaid and CHIP agencies. We also held brief discussions with Express Lane partner agency staff where relevant. After each interview, state staff reviewed and verified our findings and answered outstanding questions. To supplement information from these discussions, we reviewed publicly available documents.

The semi-structured discussion guide used for these interviews solicited detailed information on the workings of the standard enrollment or renewal process; the marginal administrative costs associated with ELE and standard enrollment or renewal processes; and, the administrative costs of initial ELE implementation (the guide can be found in Appendix A). Cost domains that we

considered included the salary and benefits of state staff, contractor reimbursements, payments to application assistors, modification of information management systems, and other direct administrative costs such as printing and mailing applications to potential enrollees.

Combining these data for each state, we calculated two types of ELE-related administrative costs and savings: (1) ongoing net administrative savings or costs on an annual basis, and (2) initial administrative costs of implementation. Because states vary in the way they divided ELE tasks between the state Medicaid or CHIP agency and Express Lane partner agency, we calculated all three of these measures as the administrative costs or savings to the public sector, regardless of the original funding source. If certain administrative costs or savings were absorbed by private contractors, they are not included in our analysis because they did not affect public sector finances.[46]

Initial administrative costs of implementation. The initial administrative costs of implementation primarily reflect eligibility and policy staff training, as well as information technology (IT) system modifications needed to share data with Express Lane partner agencies. Because they were often working on multiple initiatives and did not contemporaneously document time dedicated specifically to ELE, policy staff in most states struggled to estimate their time spent on ELE design and implementation; however, where available, we present state estimates as well as qualitative descriptions of opportunity costs.

Ongoing (annual) administrative savings and costs. Our calculation of administrative savings or costs assumes that applications or renewals being processed via ELE that resulted in an ELE enrollment would otherwise have been processed the standard way. Given this and other assumptions, detailed in Appendix C, we calculated the time savings per application or renewal by subtracting the minutes taken by staff to process a typical application or renewal via ELE from the minutes taken to process a typical application or renewal via the standard route.

To calculate the annual administrative savings arising from ELE in each state, we then followed a two-step process. First, we multiplied the time saved per ELE application or renewal by the proportional salary and benefits for the relevant eligibility processing staff. In states where application assistance was reduced through an ELE process, we then added to this per-application savings the dollar value of that assistance following similar processes. Similarly, in states where ELE reduced the need for renewal reminders, we added to the per-renewal administrative savings the dollar value of avoided mailings. Second, to arrive at the annual administrative savings in a given state, we multiplied the per-application and per-renewal administrative savings (as appropriate) by the corresponding annual number of standard applications or renewals avoided because of ELE.

To arrive at the net administrative savings or costs in each ELE state, we subtracted two potential new administrative costs from this annual savings estimate—the administrative cost of processing unsuccessful ELE applications and any ongoing expenses associated with ELE. Four ELE processes—Alabama's automatic ELE process, Maryland's income-establishment ELE

[46] For example, New Jersey and Iowa CHIP both use private contractors for eligibility determinations. Both programs confirmed that contracts were not amended to account for any increase in the volume of applications, or any time savings per application, resulting from ELE.

process, Massachusetts' ELE process, and South Carolina's ELE process—had not been in place for as long as a year when this analysis was performed. Consequently, annual administrative costs and savings could only be calculated for these processes by extrapolating the part-year estimates to a full 12 months.

Given the complexity of calculating these administrative costs and savings, the need to depend on respondent recall for many of their components, and the limitations of our analytical approach, the findings below should be considered approximate and interpreted as offering a sense of the direction and magnitude of administrative costs and savings rather than a precise value. (See Appendix C for further detail.)

Administrative costs in this study were narrowly defined to focus on expenses associated with eligibility processing. Our estimates, therefore, do not include the costs and savings of covering children in public health insurance programs who otherwise would not be insured. These coverage costs can be expected to be far higher than the administrative costs of enrolling a child in the first place.

B. Findings

1. Annual Administrative Savings and Costs

All of the automatic ELE processes generate net administrative savings. Taking into account all ongoing administrative savings and costs associated with ELE (detailed below), we find that the fully automatic ELE processes in Alabama, Louisiana, Massachusetts, and South Carolina result in large numbers of ELE eligibility decisions, generating substantial administrative savings (Figure V.1). Louisiana's ELE process saves close to $1 million per year and Alabama's automatic ELE process is projected to save $1.1 million. South Carolina saves $1.6 million from ELE, and in Massachusetts, ELE administrative savings are close to $200,000 per year.[47] Alabama's manual ELE process (the only simplified procedure ELE process for which we have cost data) also generated a small net administrative savings of $68,000 per year.

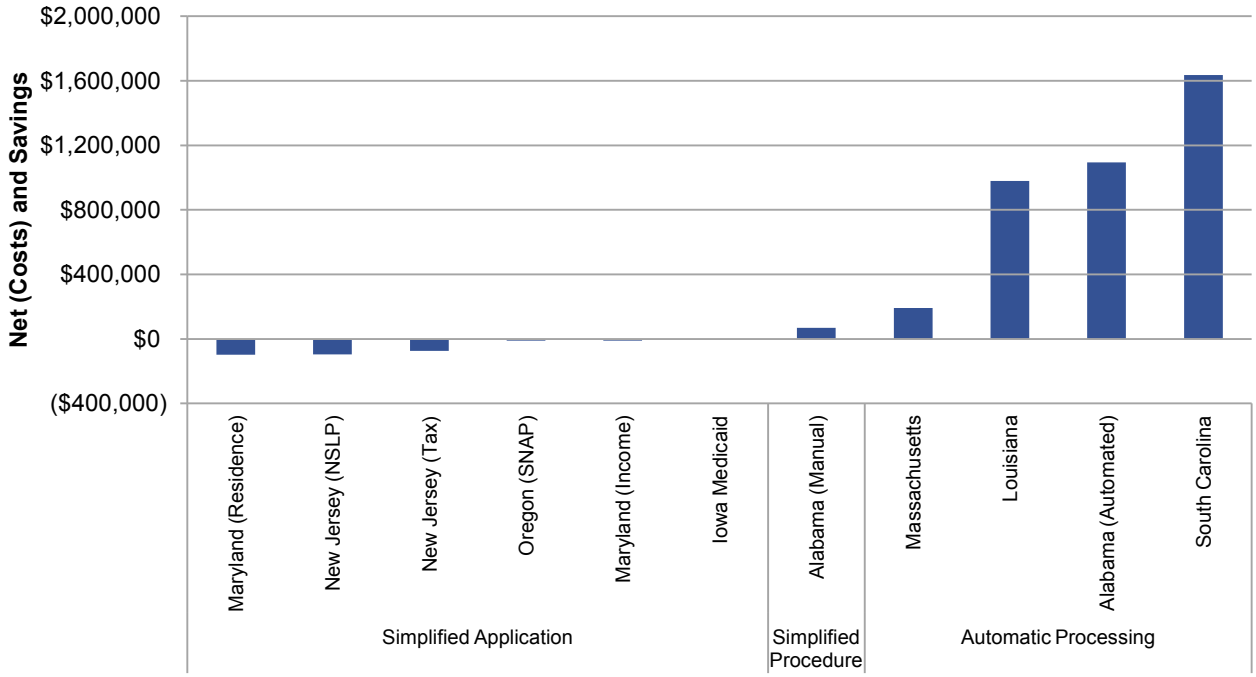
Simplified application processes do not generate net administrative savings. The ELE processes focused on simplifying application forms result in modest net administrative costs each year. These administrative costs, which arise mainly from the use of mailings (described below), range from $2,000 for Iowa Medicaid's ELE process to $98,000 for Maryland's residence-establishment ELE process.[48]

These variations in net administrative costs and savings are driven by differences in a few key factors: staff time saved per ELE application or renewal, volume of applications or renewals processed via ELE, and new administrative costs introduced by the ELE process.

[47] This estimate for Massachusetts may be an upper-bound estimate. Because of confusion among beneficiaries, an unknown number renewed and were processed via the standard renewal process in addition to being processed via ELE, reducing the net savings of ELE.

[48] The estimate for New Jersey's tax ELE process understates first year costs: because of a targeting problem, it incurred mailing costs of $558,000 that year, much higher than in later years. The New Jersey case study report provides more detail on this issue (Hoag and Swinburn 2013).

Figure V.1. Net Annual Administrative Costs and Savings Associated with ELE



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

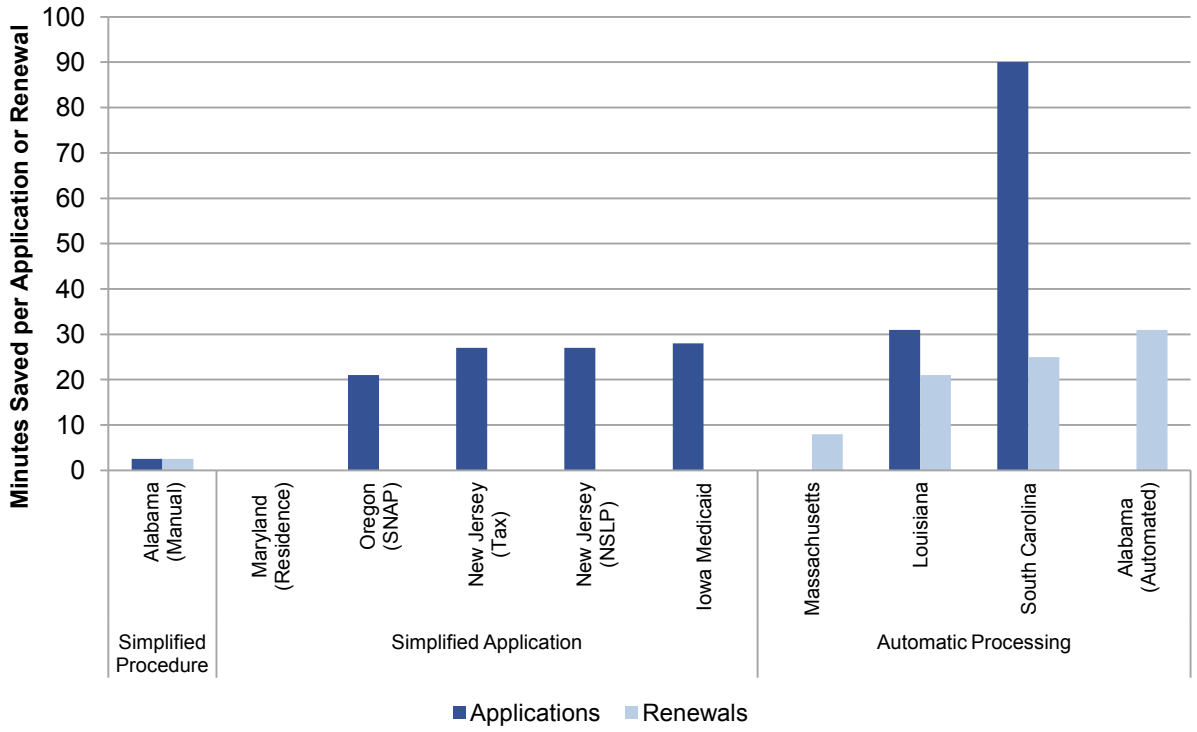
Note: Two ELE processes in the evaluation are excluded from this analysis of net administrative costs and savings. Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible. For Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process, so information about administrative savings and costs per application could not be calculated and are not presented.

ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

2. Components of Annual Administrative Savings and Costs

ELE processes tend to save comparable amounts of time on a per-application or per-renewal basis. Most ELE processes, whether automatic or simplified application processes, cut 21 to 31 minutes off the total time needed to process a standard application or renewal (Figure V.2). Although simplified application ELE processes require hands-on staff time to process applications, most automatic ELE applications and all automatic ELE renewals in Louisiana, Alabama, Massachusetts, and South Carolina require no staff time at all.

Figure V.2. Staff Time Saved per Application or Renewal, by ELE Process



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Three ELE processes in the evaluation are excluded from this graph of time savings. Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible. For Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process, so time saved per application could not be calculated and is not presented. The time saved for Maryland's income establishment ELE process is also not shown, because public sector staff process most standard enrollments and private sector contractors perform ELE enrollments under this process. Thus a comparison of time taken to process an ELE application compared to a standard application conflates ELE effects with other factors.

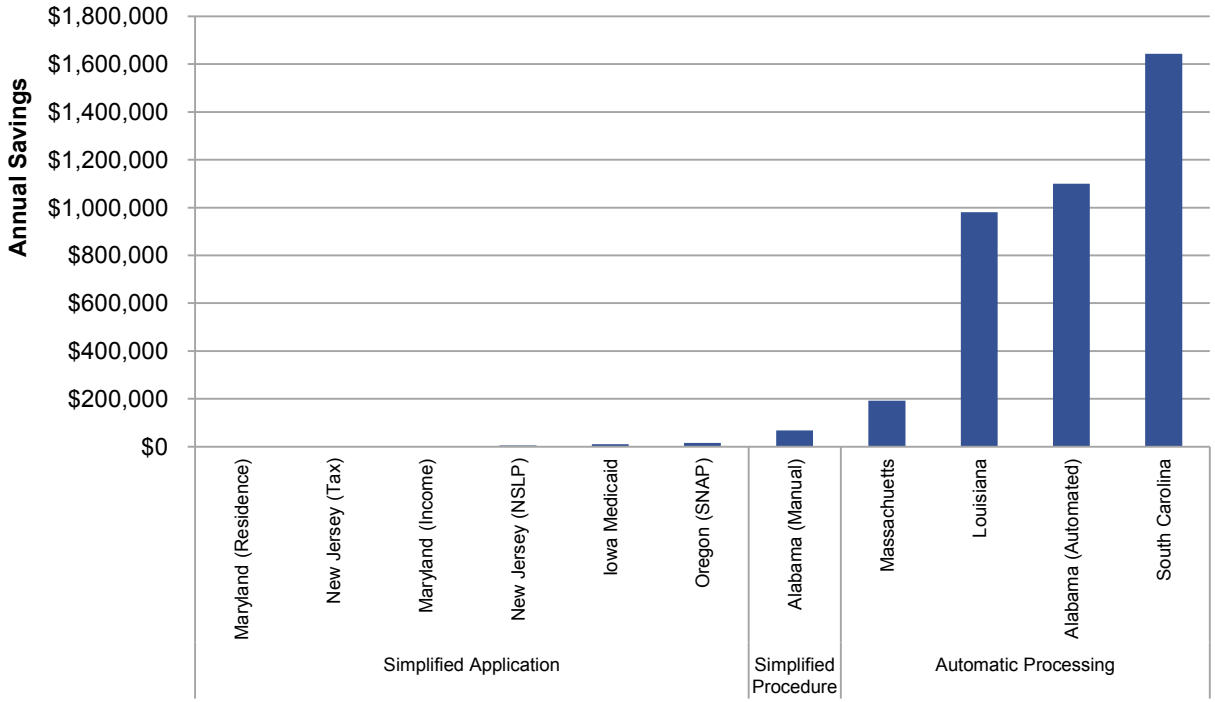
ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

South Carolina stands out in Figure V.2 because its standard application process takes 90 minutes of hands-on staff time, whereas its automatic ELE process requires none. By comparison, Louisiana's automatic ELE application process is similarly efficient, but because its standard process takes slightly more than 30 minutes, Louisiana's time saving per application is much smaller than South Carolina's. At the other end of the scale, Massachusetts saves only 8 minutes per renewal because its standard renewal process requires only 8 minutes of hands-on staff time. Maryland's residence-establishment ELE process saves no time compared to the standard process because staff must follow similar steps to process the two types of application. Alabama's manual ELE process saves fewer than five minutes because staff simply substitute checking one database for another.

The four automatic ELE processes generate gross administrative cost savings of $1,000,000 on average, whereas the simplified application processes save an average of $5,000

in administrative costs. Although most ELE processes generate similar time savings per application or renewal, automatic processes serve a much larger volume of cases and, in turn, yield significantly greater administrative cost savings than do other processes (Figure V.3). For example, as discussed in Chapter IV, Louisiana's automatic process enrolls nearly 10,000 children per year and renews an additional 170,000, and South Carolina's automatic process enrolls around 120,000 children per year and renews an additional 110,000. Thus, for these states, the number of children benefitting from ELE is roughly 50 times more than the numbers of children benefitting from the simplified application processes made possible by ELE in New Jersey, Iowa Medicaid, or Oregon.

Figure V.3. Annualized Value of Administrative Cost Savings



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Two ELE processes in the evaluation are excluded from this analysis of gross administrative cost savings. Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible. For Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process, so information about administrative savings per application could not be calculated and are not presented.

NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

While Alabama's simplified procedure is used to process a large number of enrollments and renewals, it saves less time than do the automatic processes because it saves little staff time per application or renewal, as shown above. In programs where a contractor processes most standard applications (Iowa CHIP and New Jersey Medicaid/CHIP), contracts were not amended to reflect

the relative efficiency of ELE processing, so to date, Iowa CHIP's ELE process has resulted in no countable administrative cost savings to the public sector and New Jersey's ELE processes have only resulted in small administrative savings.[49] In Maryland's income-establishment ELE process, all enrollment processing is done by a contractor, saving significant state staff time for most applications, but this is offset by per-application contractor administrative costs.

Simplified application processes accrue greater recurring administrative costs than automatic processes. In most cases, the largest of these administrative costs are mailing costs, which fall between $7,000 and $98,000 per year, driven largely by the number of potential enrollees who are sent a simplified application form or packet (Figure V.4). In comparison, automatic ELE processes in Alabama, Louisiana, Massachusetts, and South Carolina and Alabama's simplified procedure do not result in very significant new ongoing administrative costs. They do not require any new mailings or much new programming or IT maintenance beyond what would be required for eligibility systems in the absence of ELE. In South Carolina, children are automatically enrolled via ELE without their families requesting coverage in any way, but families are subsequently told how to opt out. A few thousand families have opted out so far. This entails a small amount of staff time to process—five minutes per child—so South Carolina incurs a cost of $9,000 per year.

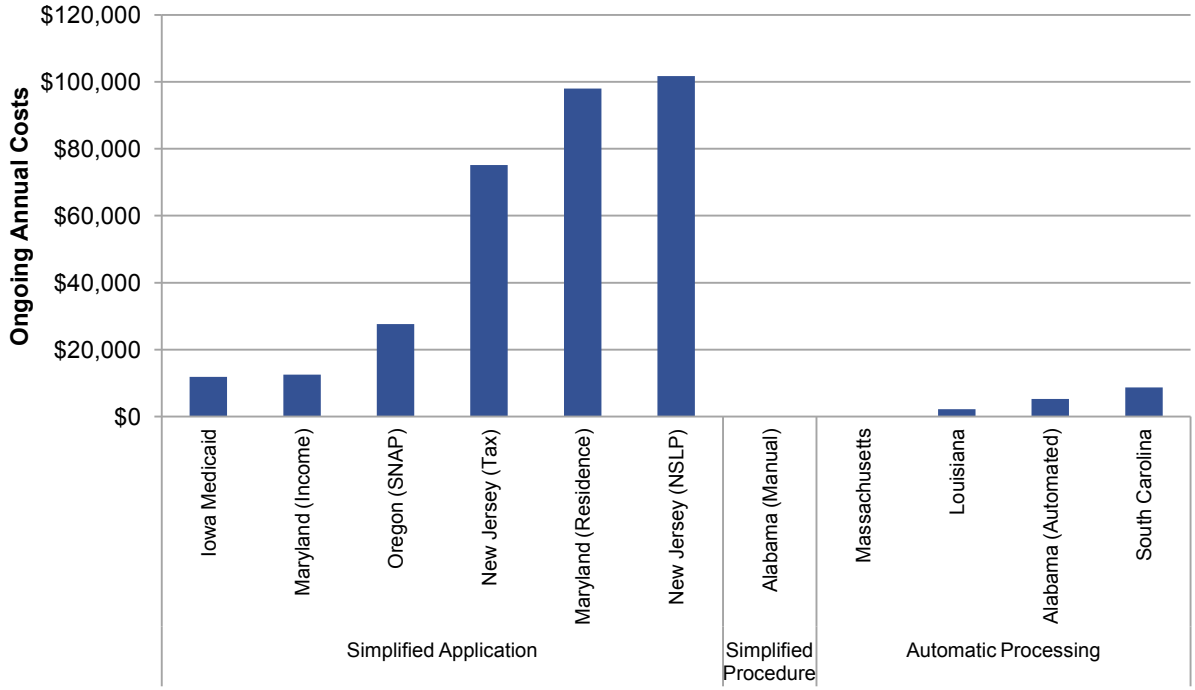
Uniquely, New Jersey's NSLP simplified application process also incurs an additional staff time cost: around $71,000 per year. This additional cost results from school district staff spending a small amount of time submitting data to the Department of Human Services, and the Department of Human Services spending around seven months of staff time per year processing this data into a format that can be used to target ELE mailings. This cost is perhaps not surprising, given the difficulties other states have faced in implementing an NSLP ELE process because of data challenges (discussed further in Chapter VII).

In the context of a state's overall administrative expenditures for eligibility, all of these ongoing ELE administrative costs are quite modest. For example, in fiscal year 2012, Louisiana's budget for Medicaid eligibility field operations was $46 million, Oregon's operations budget for its medical-only applications processing center was $11 million, and Oregon's budget for outreach alone was $3.2 million.[50]

[49] Because all ELE applications in New Jersey are processed by a contractor, and approximately 20 percent of applications submitted by ELE applicants would be processed by County Boards of Social Services if these people applied via the standard route, we estimate that New Jersey saves a small amount of public sector staff time.

[50] Medical-only applications are applications for health programs such as Medicaid and CHIP that are not also for human services programs such as SNAP or TANF.

Figure V.4. New Ongoing Administrative Costs, per Year



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Notes: Two ELE processes in the evaluation are excluded from this analysis of new ongoing administrative costs. Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible. For Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process, so new administrative costs per application could not be calculated and are not presented.

NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

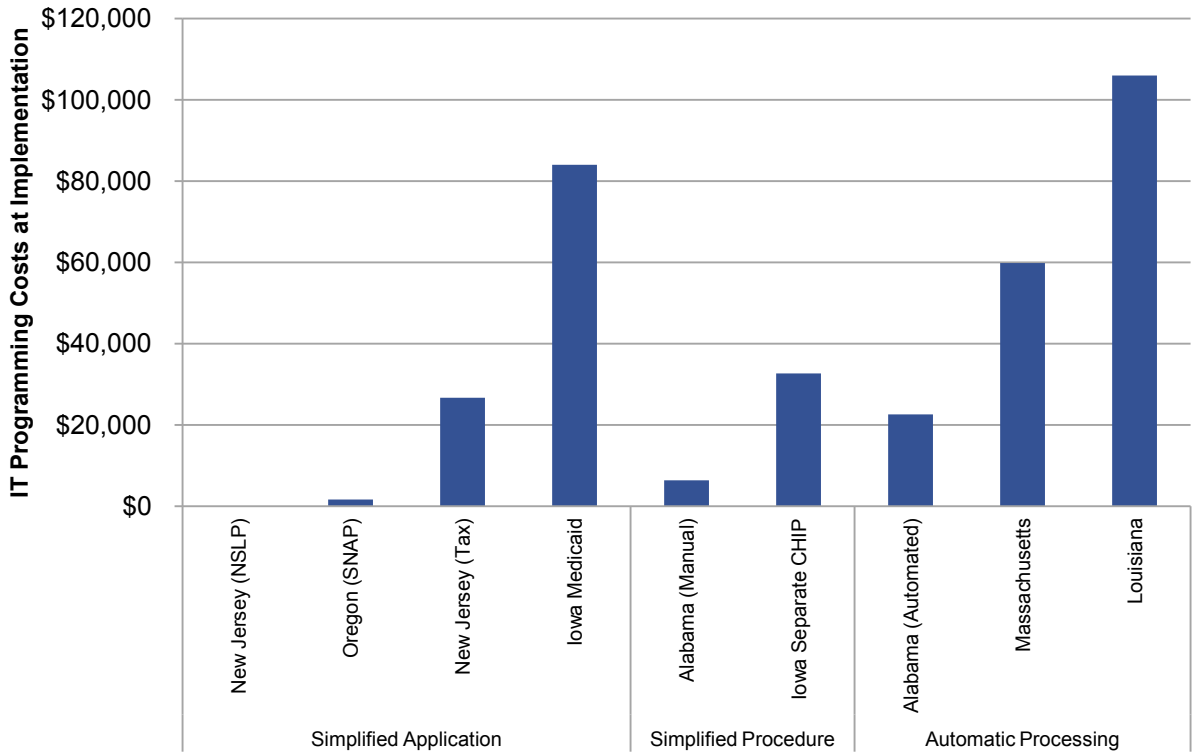
3. Administrative Implementation Costs

The two states that implemented automatic ELE processes for enrollment—Louisiana and South Carolina—experienced the highest administrative implementation costs. Louisiana spent just under $310,000 to resolve matching problems, revise matching algorithms, and manually process ELE cases that could not be processed automatically in the six months following ELE implementation. In addition to the $105,000 spent initially on programming (shown in Figure V.5), this troubleshooting work took Louisiana's total technical administrative implementation costs to $415,000. South Carolina's technical administrative implementation costs, which staff reported to be mostly programming costs, were $538,000; two thirds of this total was for automatic enrollments and one-third was for automatic renewals.

More generally, ELE processes requiring more automation incurred greater IT costs. These processes included not only those that automatically enroll or renew children into coverage, but also two other ELE processes that required significant IT costs to implement. Iowa CHIP's simplified procedure is a partially automated referral process from Medicaid to CHIP, as described in Chapter II. Iowa Medicaid's simplified application uses an automated data match to identify and send application letters to recipients, but processing is not automated. Both of

Iowa's processes therefore cost more in IT programming than did the other simplified procedure or simplified application ELE processes, which did not entail automation.

Figure V.5. IT Programming Costs at Implementation, by ELE Process



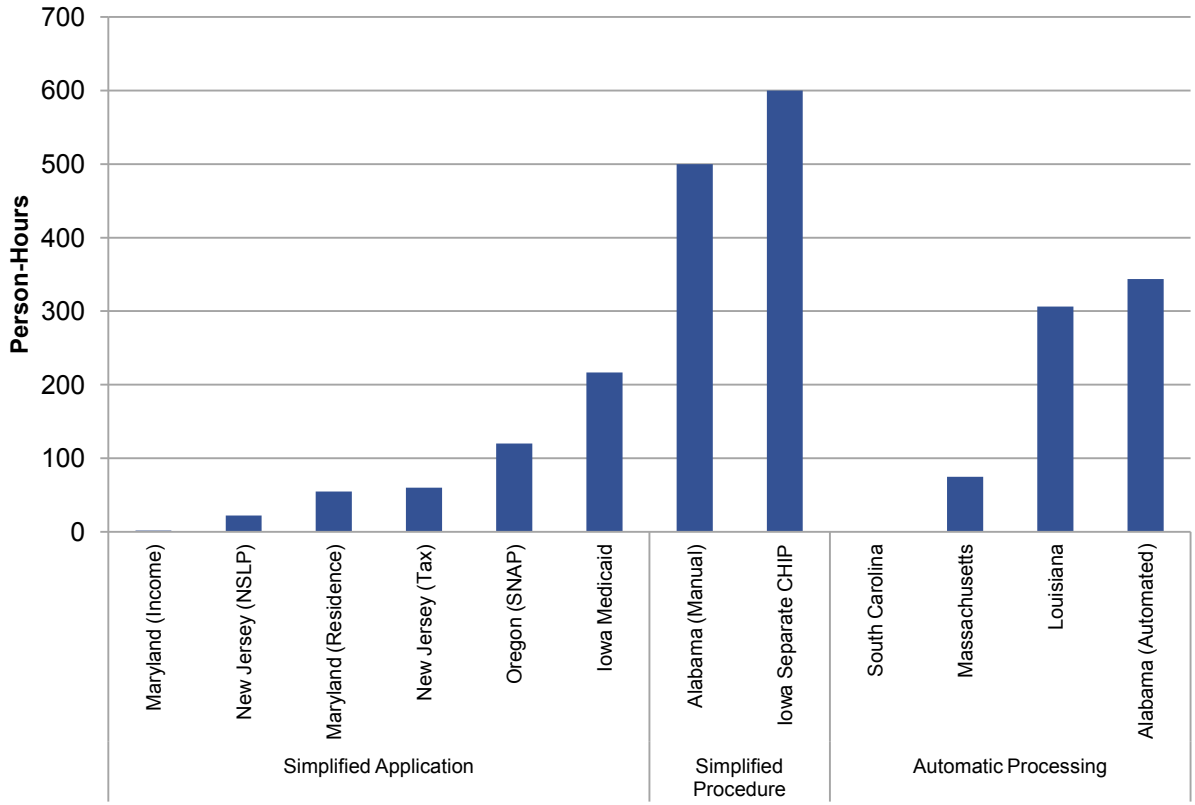
Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: South Carolina's IT programming costs are not shown in Figure V.5 because the state was not able to separate programming costs from the costs of writing technical policy rules, such as those needed for procedure manuals. Similarly, programming costs borne by Maryland's Express Lane partner agency for either of its ELE processes could not be established, and therefore are not shown. Data for Oregon's NSLP ELE process are not shown because the process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; IT = Information Technology; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

Staff training costs are higher in states using ELE to simplify eligibility procedures rather than merely the forms. As shown in Figure V.6, Alabama's and Iowa CHIP's simplified procedure processes easily had the highest training costs (500 and 600 person-hours, respectively). These administrative costs arise because eligibility workers remain involved in ELE application processing (unlike in automatic processing states), so staff need to understand how ELE should be used. States using ELE to simplify applications also need to train staff to understand how to process the specialized forms; however, the low volume of ELE-based applications allows them to be reviewed by a small team. For example, Maryland's income-establishment ELE process entails the training of just one member of contractor staff for each month that ELE applications are received.

Figure V.6. Staff Time Invested in Training at ELE Implementation, by ELE Process



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Data for Oregon's NSLP ELE process are not shown because the process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible.

The time spent on New Jersey's tax preparer outreach effort is not included in Figure V.6. In addition to what is shown here, an unknown number of volunteer tax assistance preparers received about 15 minutes of training per person. Tax preparation companies primarily received guidance through an update to the state's tax preparation guidance booklet.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

Somewhat surprising is that the automatic processes—which typically entail no active role for staff—also required training. Louisiana's ELE process and Alabama's automatic ELE process each involved the training of 250 to 350 staff for an hour or more so that staff would be aware of ELE, understand ELE cases they found in the eligibility system, and would be able to answer questions from beneficiaries. South Carolina held no training, and interviewees there said that in hindsight some training would have been beneficial.

Although in most states training was held in regular or special staff meetings, states also produced training materials such as "frequently asked questions" and updated staff manuals or offered telephone or email "hotlines" for ELE questions. New Jersey's tax ELE process implementation also involved an outreach effort to inform volunteer income tax assistance preparers and tax return preparation companies about correctly answering the ELE question on tax returns. This effort was initiated after the state learned that many tax preparers incorrectly

answered the insurance status question on behalf of their clients in the first year ELE was in place.

States that implement a second ELE process may incur lower training costs as a result of the knowledge already garnered from the first. Compared with its initial tax-based ELE process, New Jersey reported lower training costs and lower programming costs for its NSLP ELE process. From the point at which ELE applications are received by the state, these two ELE processes are almost the same, meaning the state effectively has one ELE process using two different data sources. Therefore, training time for the second ELE process was considerably lower than for the first. New Jersey's experience suggests some other states may have scope to leverage initial investments by implementing additional ELE processes.

Remaining administrative ELE implementation costs—state plan amendment costs, policy development costs, and opportunity costs—appear to be modest. The process to gain approval for ELE was comparable to other SPA processes and rarely laborious. Some states, such as Maryland and South Carolina, found the SPA process very user-friendly, whereas staff in one state said that ELE was more complicated to understand and the requirements for approval less clearly communicated than was the case for other policy changes. Most states were unable to quantify the amount of time spent on the SPA process, in part because this work was intertwined with other policy development; however, data from South Carolina and New Jersey suggest the SPA approval process could be expected to cost $1,000 to $5,000.

In most states, the initial policy development process did not take up a great deal of staff time, but the follow-up policy work sometimes continued for months or years. Because of recall limitations and lack of project-specific time accounting, we have not been able to estimate the administrative time costs of ELE implementation, aside from IT costs, in most states. However, we are able to estimate that in Massachusetts, non-IT staff spent approximately 580 hours on ELE planning, implementation, and the SPA approval process, at a cost of about $35,000. In South Carolina, nontechnical administrative implementation costs are estimated at around $15,000. This evidence supports the idea that, as staff in most states reported, programming costs were usually the largest administrative implementation costs for ELE.[51]

Most state staff did not believe that other work streams or projects had been delayed or deprioritized specifically because of ELE, although there were exceptions. Opportunity costs were identified by staff in some states that implemented more automated ELE processes and therefore required more programmer and other staff time to implement. For example, Louisiana delayed a project to streamline its online enrollment process. Iowa Medicaid reported staff being taken away from early Affordable Care Act preparations. Massachusetts deprioritized some work relating to the transfer to a newer IT system of long-term care information.

[51] In this analysis we have not included the cost of two ELE-relevant but separate pilot programs in New Jersey prior to full implementation of the NSLP ELE process. The cost of each of these pilots was around $1 million. The second of these two pilots could be accurately described as ELE but is excluded from the main body of this analysis because it was significantly different from the ELE process that the state later implemented. More than 70 percent of this ELE pilot's $1 million budget was spent on grants to school districts and community partners to encourage them to participate. A finding from this pilot was that grants would not be necessary when ELE was implemented statewide because the demands of ELE on schools and community partners were low.

C. Discussion

Administrative costs and savings from ELE depend on the way ELE is designed and used. Administrative implementation costs were highest for states developing automatic ELE processes, and automatic and simplified application processes save comparable amounts of staff time on each application or renewal processed. However, automatic ELE processes enroll or renew tens of thousands of people a year with minimal recurring administrative costs. Enrolling or renewing the same number of people in Medicaid or CHIP using standard methods would cost $1 million a year more, on average, across the four automatic ELE states in this study. Thus, the annual administrative savings from automatic ELE processes are much greater than the administrative implementation costs of ELE in any of the states that have adopted automatic ELE processes.

Administrative implementation costs were usually quite low in states implementing simplified application and simplified procedure processes, but the simplified application processes incur ongoing administrative costs. Response rates to ELE mailings range from 5 percent to 13 percent (discussed further in Chapter VII), so ELE letters or packets must be sent to many children in order to enroll one child via one of these ELE processes. Efficiencies in application processing are not great enough to exceed these ongoing administrative costs. Thus, enrolling the same number of people in Medicaid or CHIP using standard processes would cost no more, and in some cases less, than enrolling them through simplified application ELE processes. This is not to say ELE has not worked in these states: indeed, findings in Chapter IV suggest that these simplified application processes have successfully reached at least some eligible-but-uninsured children who can be difficult to enroll, including those without a recent history of public health insurance and teenagers.

VI. UTILIZATION OF SERVICES AMONG ELE AND NON-ELE ENROLLEES: RESULTS FROM AN ANALYSIS OF CLAIMS DATA IN FOUR STATES

Key Findings:

- Most ELE enrollees access Medicaid or CHIP services, and tend to use a variety of services. Data indicate that public health insurance is providing substantial value to most ELE families and provide further support for the expansion of ELE as a simplification tool.
- ELE enrollees are somewhat less likely to use services, and those who use services often do so less intensively than non-ELE enrollees in their state. These patterns result in health care costs that are substantially lower than those of non-ELE enrollees in the states we studied.
- ELE enrollees' use of fewer services may be caused by a variety of reasons that we cannot disentangle. Our results are consistent with the theory that children who are eligible for, but not enrolled in public insurance programs, may simply have lower health care needs.
- Some have raised the concern that ELE enrollees may not access services because they are unaware they are covered or, if they know they are covered, may be unfamiliar with the ways they should begin seeking services. Observed utilization patterns do not support this concern.

A. Background and Motivation

Service utilization among Medicaid and CHIP beneficiaries reflects both their underlying need for care and their propensity to engage with the health care system. Therefore, we examined utilization patterns as an indicator of whether ELE enrollees have different service needs and might engage differently with the health care system than do standard enrollees in Medicaid/CHIP (that is, those who enroll through standard processes in a state), whom we refer to as "non-ELE" children in this analysis.

This analysis addresses two broad research questions:

1. How does the volume and type of service use among ELE children compare with that of children who enroll through standard processes?
2. How does the timing of service use compare across enrollees entering through ELE versus through standard routes?

Lower service utilization might be an indicator that ELE children are generally healthier and have fewer health care needs, and thus have not previously sought out public insurance. This is an important factor for states to consider, particularly those that negotiate capitated payment rates with managed care plans. The timing of service utilization also provides suggestive feedback about new beneficiaries' awareness of how to access services. Evidence that ELE children are substantially slower to use services might warrant additional state investigation—

and potentially new outreach—to ensure that families enrolling through these pathways understand the scope of their benefits and how to access services.

This chapter presents findings on patterns of service utilization and their timing during the first year of coverage among enrollees reached through six ELE processes that have been implemented in four states—Alabama, Iowa, Louisiana, and New Jersey—for initial enrollments into Medicaid or CHIP. These four states were selected because their ELE processes were implemented early enough to allow observation of at least one year of service utilization for a substantial number of ELE enrollees. We briefly discuss data collection and analysis methods, then present utilization patterns among ELE enrollees and a comparison group of non-ELE enrollees in each state.

B. Data Collection and Analysis Methods

1. Data Collection

We obtained individual-level claims and/or encounter data directly from each state (Alabama, Iowa, Louisiana, and New Jersey) for all children ages 0 to 18 enrolled in Medicaid (or CHIP, in New Jersey only) at any point during the period from the first month of ELE implementation through December 2012. States extracted data between January and March 2013, and we allowed three to six months to pass for complete claims reporting, following individual state guidance.

2. Sample Definition

We compare utilization during the first year of coverage for child ELE and non-ELE enrollees. In order to align the ELE and non-ELE enrollees as much as possible, the analytic sample includes only enrollees who qualified for Medicaid or CHIP on the basis of income and who have no prior Medicaid/CHIP coverage or who have a gap in Medicaid/CHIP coverage of at least two months and were continuously enrolled for a minimum of six months (Table VI.1).[52,53] The sample excludes children whose basis of eligibility is inclusion in any of the following groups: deemed infants, blind/disabled, supplemental security income (SSI), institutionalized, foster care, qualified as medically needy, or received partial benefits because of dual eligibility for Medicare or immigrant status.[54] Children in these groups are not expected to be comparable to ELE enrollees in characteristics or utilization patterns: many are enrolled specifically because of high medical need, and Medicaid covers only limited services for others.

[52] In addition, the enrollment analysis uses a two-month gap in coverage to identify the comparison population. Using the same definition aligns the utilization analysis with the enrollment analysis.

[53] Where sample sizes allowed, we also explored patterns for enrollees with at least 12 months of continuous enrollment and found that our results were robust.

[54] These definitions are the same as those used in the enrollment analysis described in Chapter IV.

Table VI.1. Features of ELE Enrollment Processes and Sample Sizes for Utilization Analyses

State and Program	Process Name	Process Description	Express Lane Partner Agency	Implementation Date	ELE Sample Size	Non-ELE Comparison Group Sample Size
Alabama (Medicaid)	Simplified procedure	SNAP and TANF income findings used to establish income after consumer declarations at application and renewal.	SNAP and TANF	April 2010	61,294	164,792
Iowa (Medicaid)	Simplified application	Data match to identify potentially eligible children; shortened application form mailed out. SNAP findings establish income eligibility.	SNAP	June 2010	1,789	104,860
Louisiana (Medicaid)	Automatic processing	Automated enrollment of children based on SNAP findings. Data matching occurs unless families explicitly opt out.	SNAP	February 2010	14,813	49,974
Louisiana (Medicaid)	Automatic processing	Automated enrollment of children based on SNAP findings. Data matching only occurs if families opt in by checking a box on the SNAP application.	SNAP	January 2011	5,040	51,390
New Jersey (Medicaid/ CHIP)	Simplified application	Data match to identify potentially eligible children; shortened application form mailed out. State income tax returns establish income eligibility.	State tax agency	May 2009	4,171	385,787
New Jersey (Medicaid/ CHIP)	Simplified application	Data match with school lunch program to identify potentially eligible children; shortened application form mailed out. School lunch findings establish income eligibility.	NSLP	September 2010	1,950	197,993

Source: Mathematica analysis of enrollment data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

3. Utilization Measures

We created measures of overall service use and cost as well as measures for specific service types. We grouped services into two categories: "core" services, including inpatient, outpatient/physician, and emergency room (ER) visits, and "wraparound" services (which may be covered more generously through Medicaid than through private insurance options), including prescription drugs and, for those older than age 1, vision care, dental care, and behavioral health/substance abuse (BHSA) services. We also examined wellness visits. For each service, we constructed measures of any use, the number of events or visits, length of stay (for inpatient services), cost of care, and exclusive use of that service type without other claims.

We also examined the length of time until service receipt to understand whether there is evidence that ELE enrollees take longer to access services, potentially because of lack of awareness of coverage or how to access care. These calculations exclude non-ELE enrollees who have an inpatient or ER claim within the first month of enrollment because these enrollees may have been enrolled in Medicaid with retroactive coverage following a serious acute event.[55] This analysis aimed to understand how beneficiaries accessed services when they enrolled in

[55] Across the four states in this study, between 6 and 19 percent of comparison group members were excluded because of receipt of ER or inpatient services within the first month of enrollment.

Medicaid under normal circumstances, rather than because of acute and serious medical need.[56] Including children who likely enrolled in Medicaid after seeking hospital services for emergent conditions would bias the results toward finding a larger gap in the time to first service receipt.

Services were defined using procedure codes, diagnosis codes, revenue codes, place of service, and provider type or category of service. Where possible, we used publicly available measures with consensus definitions to inform our measures. For example, the wellness visit and dental visit codes are those used in the CHIPRA core quality measure technical specifications. The American Academy of Pediatrics' Bright Futures coding guidelines provided some of the codes to identify vision services. Previous Mathematica work on the Medicaid Analytic eXtract informed our list of diagnosis and procedure codes used to identify beneficiaries using BHSA services. Although we began with these core definitions, data structure and variables differed across states, and some states made extensive use of state-specific codes. Therefore, we customized the definitions for each state to account for those differences while maintaining as much standardization across states as possible.

There are important data-related limitations in the measures that we present for New Jersey and Iowa. In New Jersey, most services are delivered through capitated managed care contracts; therefore, we could not construct accurate service cost measures. Similarly, in Iowa, BHSA services are provided through managed care contracts and we do not present cost estimates for this service type. Also in Iowa, the outpatient file was missing most of the principal procedure codes, creating the potential to undercount wellness visits, vision, dental, and BHSA services.

4. Regression Adjustment

Demographic differences between ELE and non-ELE children substantially influence utilization patterns. For example, we know that non-ELE children are much more likely to be infants, a group that uses inpatient, emergency room, and physician services much more intensively than do other children while using fewer dental, vision, and BHSA services. Because of these known demographic differences, this chapter focuses on regression-adjusted utilization measures (unadjusted rates are presented in Appendix D). By netting out known demographic characteristics that drive utilization, we can more clearly address the key questions in this analysis—is there any evidence that ELE children have different service needs and is there any evidence that ELE enrollees are slower to access services and might need more intensive outreach? If differences between ELE and non-ELE children disappear after controlling for the known characteristics of each group, we could conclude that ELE children likely have similar service needs and are not in need of more intensive outreach.

We have taken a two-step estimation approach (following Duan et al. 1983), first assessing the probability of any service use and then the volume of service use among those who use some

[56] In some states, enrollees may be granted as many as three months of retroactive coverage; however, we do not have a way of identifying which beneficiaries received retroactive coverage. We feel confident that a significant proportion of non-ELE children with an inpatient or emergency room visit within the first month likely enrolled during a health crisis point, and so we exclude them from time-to-service receipt calculations. However, if we excluded non-ELE enrollees with inpatient and emergency room events within the first *three* months of coverage—the full potential period for retroactive coverage—we would likely exclude many beneficiaries who enrolled under normal circumstances, but then developed a critical health care need.

services. Because we exclude children who did not access services from the second set of models, the measures we present for volume of service use are censored. We chose this approach to shed further light on whether ELE children have different service needs and/or might need more intensive outreach to access services. If ELE children were less likely to use any services but used equal volumes of care once they began accessing services, we might be concerned that lower utilization rates were driven by an incomplete understanding of access to benefits.

To compute regression-adjusted utilization rates that account for demographic characteristics, we used a set of control variables that varied by state based on data availability. In all four states, we had information on age, gender, and household size or income, and for three states (see Table D.2 in Appendix D) we included geographic information and race/ethnicity. Our tables present regression-adjusted measures for each outcome of interest; we calculated expected utilization if ELE enrollees had the same demographic profile as non-ELE enrollees. We report significant results at the $p < 0.05$ level. Appendix D provides further details on our regression methods.

C. Findings

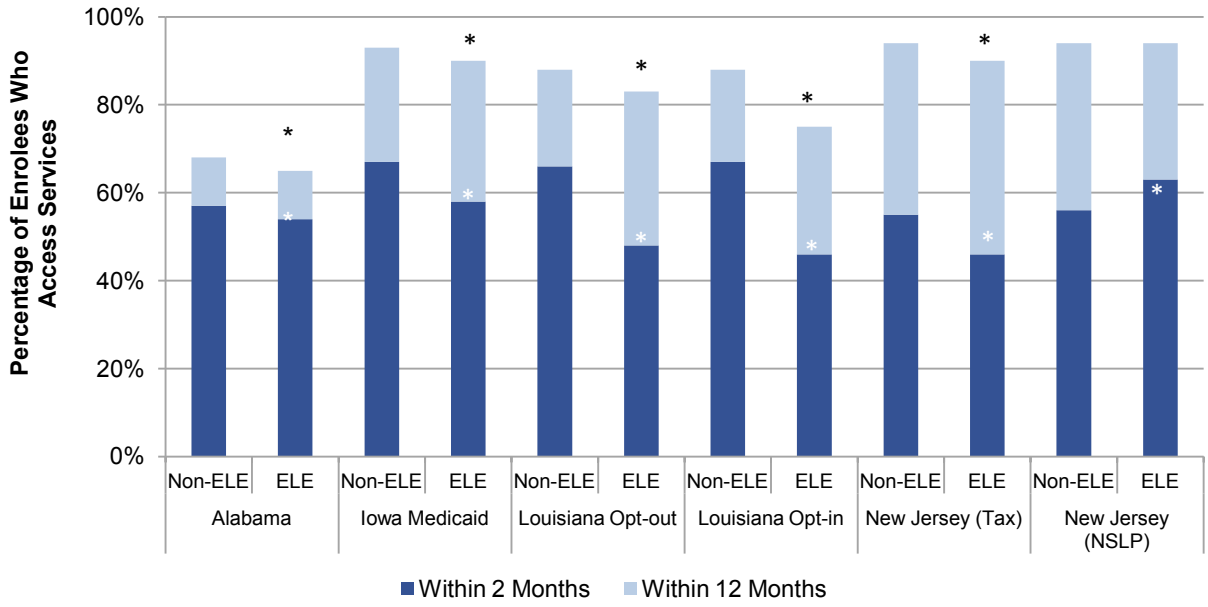
1. Overall Service Use and Timing of Service Receipt

Most ELE enrollees accessed services within their first year of enrollment. More than half of ELE enrollees in each state accessed services in their first year of enrollment, ranging from 65 percent of ELE enrollees in Alabama to 94 percent of ELE enrollees in New Jersey's NSLP ELE process. However, in five of six ELE processes examined—Alabama, Iowa, Louisiana opt in and opt out, and New Jersey tax-based ELE—ELE enrollees were less likely to do so by small but significant margins when compared to non-ELE enrollees (Figure VI.1). For example, in Louisiana, ELE enrollees were less likely than non-ELE enrollees to use services during both the opt-out and opt-in periods.[57] If the demographic profile of ELE enrollees matched that of non-ELE enrollees, we predict that 83 percent of opt-out ELE enrollees and 75 percent of opt-in ELE enrollees would use services, as compared to 88 percent of non-ELE enrollees. The gap in predicted service utilization between ELE and non-ELE enrollees during the first year was much smaller in Alabama, Iowa, and New Jersey's tax-based ELE process—just two to four percentage points.

For ELE enrollees via four of these processes—Iowa, Louisiana opt in and opt out, and New Jersey tax-based ELE—the gap between ELE and non-ELE enrollees in accessing services within the first two months of enrollment was much larger than the gap after one year of enrollment, suggesting that ELE enrollees were somewhat delayed in accessing services. For example, in Iowa, 58 percent of ELE enrollees had accessed services within two months, compared to 67 percent of non-ELE enrollees. Though the difference for ELE and non-ELE enrollees in Alabama was significant at the two-month mark, the gap between these groups is consistent and small (three percentage points) regardless of the time point observed. New Jersey's ELE partnership with NSLP was a notable exception to this trend. NSLP ELE enrollees were equally likely to use any services—and seven percentage points more likely to access services within two months of enrollment—relative to non-ELE enrollees.

[57] Chapter II discusses Louisiana's opt-in and opt-out consent processes in more detail.

Figure VI.1. Most ELE Enrollees Access Services in First Year



Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

Note: Regression-adjusted estimates.

ELE = Express Lane Eligibility; NSLP = National School Lunch Program

* Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).

2. Use of Core Services: Inpatient, Outpatient/Physician, ER

ELE enrollees are less likely to use core services, and among those who used core services, ELE enrollees likewise had fewer visits. For all six ELE processes examined, ELE enrollees were significantly less likely to use some core services—inpatient, emergency room, and outpatient/physician care—when compared with non-ELE enrollees (Table VI.2). For example, in Iowa, 36 percent of non-ELE enrollees used emergency room services, compared to 30 percent of ELE enrollees.

The largest difference in service use was for outpatient and physician services. ELE enrollees who used services averaged 10 to 44 percent fewer outpatient and physician visits when compared to non-ELE enrollees; however, the frequency with which enrollees exclusively used well-child visits did not differ by enrollment pathway (data not shown).

Among those using services, inpatient utilization rates were similar in all states, and there were no significant differences for ELE versus non-ELE. In addition, ER utilization rates were similar for ELE and non-ELE enrollees in Alabama, Iowa, and New Jersey. ER utilization rates were 10 percent lower for ELE enrollees versus non-ELE enrollees in Louisiana. Exclusive use of the ER was rare; fewer than 3 percent of beneficiaries exclusively used ER services (data not shown).

Table VI.2. ELE Enrollees Are Less Likely to Use Core Services

	Alabama		Iowa Medicaid		Louisiana Opt-Out		Louisiana Opt-In		New Jersey Tax		New Jersey NSLP	
	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE
Likelihood of Using Services (%)												
ER services	32	32	36	30*	32	24*	31	20*	38	36*	39	35*
Inpatient admissions	7	5*	13	8*	7	2*	5	2*	19	11*	19	15*
Physician/ outpatient services	66	64*	89	86*	86	77*	84	68*	91	87*	91	91
Average Number of Visits Among Those with Service Use												
ER services	2.1	2.1*	2.0	1.8	1.7	1.5*	1.7	1.6*	2.0	1.9	2.0	2.0
Inpatient admissions	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.2	1.2	1.3	1.2	1.0
Physician/ outpatient services	10.5	9.5*	9.2	7.4*	8.7	4.9*	8.1	5.0*	9.7	7.8*	9.8	8.3*

Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

Note: Regression-adjusted estimates.

ELE = Express Lane Eligibility; ER= Emergency Room NSLP = National School Lunch Program.

* Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).

3. Use of Wraparound Services: Pharmacy, BHSA, Dental, Vision

ELE enrollees are less likely to use wraparound services. For five of the six ELE processes examined, ELE enrollees were significantly less likely to use several types of wraparound services within 12 months, after controlling for demographic differences (Table VI.3). For example, in Louisiana, about 70 percent of non-ELE enrollees filled prescriptions and half used vision or dental services. However, only about 50 percent of ELE enrollees filled prescriptions, with slightly more than one third using vision or dental services. Use of BHSA services was much less common, but, again, ELE enrollees were about half as likely to use any of these services relative to non-ELE enrollees in Louisiana. Margins were much smaller in Iowa, Alabama, and New Jersey. For example, among New Jersey tax ELE enrollees, 68 percent filled prescriptions, compared to 73 percent of non-ELE enrollees. New Jersey NSLP ELE enrollees were an important exception to this trend—they were equally likely to fill prescriptions and use vision and dental services.

Among those who filled prescriptions or accessed BHSA services, ELE enrollees tended to do so less intensively. For example, in Iowa Medicaid, ELE enrollees filled an average of 9.3 prescriptions, whereas non-ELE enrollees on average filled 10.4 prescriptions. In Louisiana, for both opt out and opt in, ELE enrollees averaged fewer days of BHSA service than did non-ELE enrollees. In contrast, dental and vision service volume was generally comparable between ELE and non-ELE enrollees that accessed those services.

Table VI.3. ELE Enrollees Are Less Likely to Use Wraparound Services

	Alabama		Iowa Medicaid		Louisiana Opt-Out		Louisiana Opt-In		New Jersey Tax		New Jersey NSLP	
	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE
Likelihood of Using Services (%)												
Prescription fills	57	54*	67	64*	71	54*	69	49*	73	68*	72	71
BHSA services	11	10	18	14*	12	6*	13	6*	15	13*	16	14*
Dental services	28	26*	51	42*	48	36*	49	36*	46	40*	47	48
Vision services	18	16*	26	22*	51	38*	45	33*	34	29*	36	34
Exclusive use of wraparound services	3	3	7	8*	5	9*	6	9*	4	5*	4	4
Average Number of Uses Among Those with Service Use												
Prescription fills	7.7	7.7	10.4	9.3*	9.7	6.7*	9.3	6.9*	5.1	4.3*	5.1	4.6*
BHSA service days	5.9	4.8*	15.4	13.3	7.9	4.9*	8.7	5.9*	10.5	7.3*	10.8	7.5
Dental services	2.4	2.4	2.2	2.1	2.4	2.4	2.3	2.2*	2.3	2.4	2.3	2.4
Vision services	1.4	1.4	1.2	1.1	1.8	1.5*	1.7	1.6	1.3	1.3	1.3	1.4

Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

Note: Regression-adjusted estimates.

BHSA = Behavioral Health and Substance Abuse; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

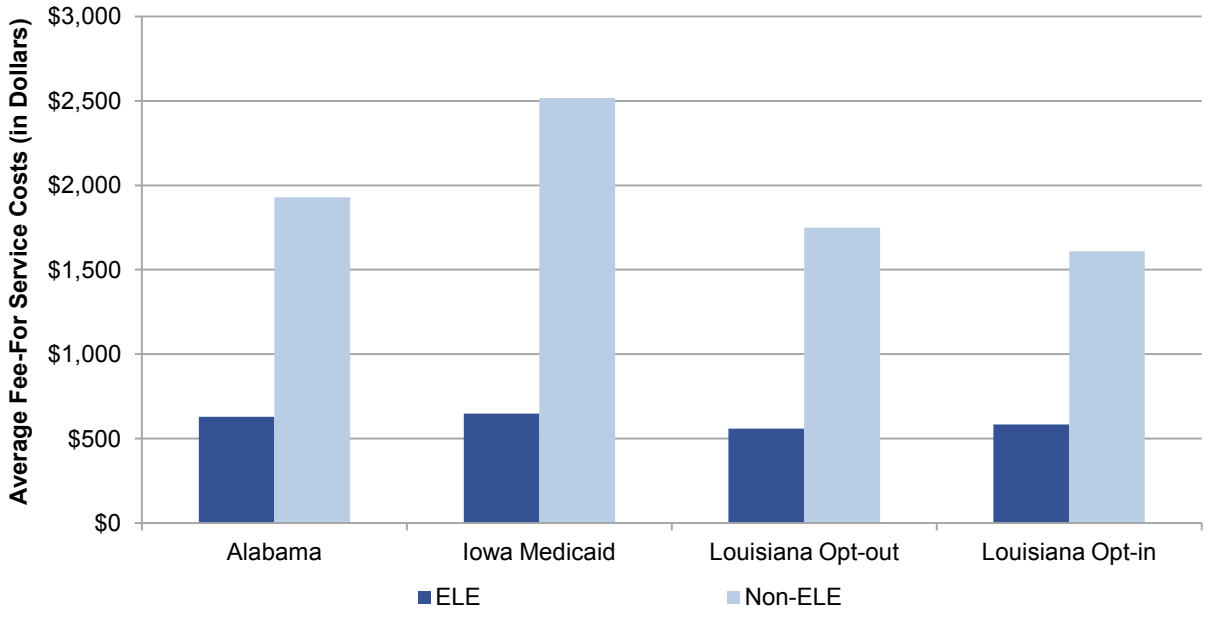
* Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).

Exclusive use of wraparound services was relatively uncommon among both ELE and non-ELE enrollees, occurring among less than 10 percent of enrollees in any state. Although ELE enrollees were statistically more likely to make exclusive use of these services among four of the processes examined, differences were small, from just one to four percentage points.

4. Costs of Services

ELE enrollees have lower average fee-for-service costs within their first 12 months of coverage. The gap in actual unadjusted average costs across all ELE and non-ELE enrollees was large, reflecting demographic differences and the lower propensity of ELE enrollees to use services. For example, in Iowa, average unadjusted overall fee-for-service costs were $649 for ELE enrollees versus $2,517 for non-ELE enrollees (Figure VI.2; recall that costs were not available in New Jersey).

Figure VI.2. Average Fee-for-Service Costs Within 12 Months Are Lower for ELE Enrollees Among All Enrollees, Including Non-Users



Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

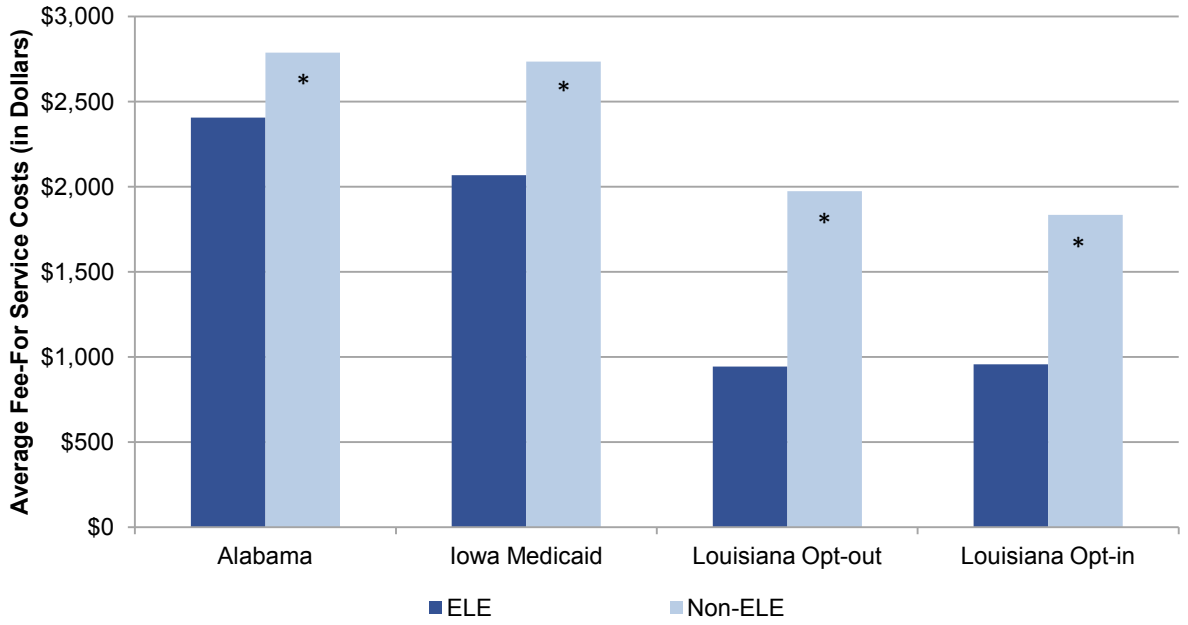
Notes: Estimates are not regression adjusted. Cost data are not available for New Jersey.

ELE = Express Lane Eligibility.

Among those who use services, average fee-for-service costs are lower for ELE enrollees. Consistent with the unadjusted findings on service use, regression-adjusted service costs for the first 12 months of coverage are lower for ELE enrollees using services in all three states for which costs were available (Figure VI.3). For example, among enrollees using services in Alabama, regression-adjusted costs were $2,406 for ELE enrollees and $2,786 among non-ELE enrollees. Associated costs for outpatient and physician care were notably lower for ELE enrollees who used services; this was a key driver of overall lower costs among ELE enrollees.[58] For example, in Iowa, the predicted cost of physician and outpatient services was 23 percent lower for ELE versus non-ELE enrollees.

[58] More detail is available in Appendix D.

Figure VI.3. Average Fee-for-Service Costs Within 12 Months Are Lower for ELE Enrollees Among Those Who Use Services



Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

Notes: Regression-adjusted estimates. Cost data are not available for New Jersey.

ELE = Express Lane Eligibility.

* Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).

D. Discussion

Most ELE enrollees access Medicaid or CHIP services, use a variety of services, and rarely make exclusive use of wraparound services such as prescription medications. This suggests that public health insurance is providing substantial value to most ELE families well beyond supplemental coverage and provides further support for the expansion of ELE as a simplification tool.

However, we do find that ELE enrollees are somewhat less likely to use services, and those who do use them tend to do so less intensively, when compared to non-ELE enrollees in their state. These patterns result in health care costs that are substantially lower than non-ELE enrollees in the states we studied. States considering ELE as an option—especially those that might negotiate contracts and rates with capitated managed care organizations to deliver services—may reasonably expect that ELE children will be not be more expensive and may even be less expensive to cover than are their existing beneficiaries.

The lower service use among ELE enrollees may have several explanations, which we cannot disentangle through this analysis. Our results are consistent with the theory that even though their families may be seeking other social support services, children who are eligible for but not enrolled in public insurance programs may simply be healthier than their enrolled peers and have lower health care needs. Some have raised the concern that ELE enrollees—especially those enrolled through automated, passive processes—may not access services because they are unaware they are covered or, if they know they are covered, may be unfamiliar with the ways

they should begin seeking services. The fact that most ELE enrollees use a variety of services, and the consistency of our results across states that use diverse ELE mechanisms, as well as within a state (Louisiana) that changed its ELE process, mitigate these concerns.

Finally, we caution that the utilization study focused only on children, and states may not have comparable experiences if they chose to extend ELE policies to adults following the implementation of health reform. In each of the states we analyzed, ELE represents a mechanism to enroll a limited group of children who remain uninsured, despite longstanding program eligibility policies and outreach practices—arguably, these children simply have a lower demand for care. In many states, the Medicaid expansions occurring as part of health care reform will substantially broaden the group of adults eligible for coverage, and many of these adults may have existing unmet health care needs.

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VII. FINDINGS FROM ELE CASE STUDIES

Key Findings:

- ELE is adaptable to state circumstances. It can be phased in over time, and it can be adopted for enrollment, renewal or both.
- ELE's effectiveness depends on both the choice of Express Lane partner agency and how partner agency data are used. The states that experienced the greatest enrollment or renewal gains and administrative savings implemented automatic ELE processes.
- ELE saves time for staff who process applications and/or renewals; as a result, ELE has helped states deal with hiring freezes and staff layoffs. Because ELE is more efficient than standard application or renewal processes, it expedites coverage for beneficiaries.

A. Background and Motivation

Integrating the findings from the descriptive studies of ELE enrollment, cost, and utilization with findings from the site visits helps to form a complete picture of ELE's effects in Medicaid and CHIP programs. In this chapter, we synthesize these findings to help Congress understand the benefits and challenges related to ELE implementation and ongoing operations.

B. Findings

1. ELE is Adaptable to State Circumstances

ELE can be phased in, allowing states to test it and resolve operational issues or to expand it as resources and support permit. Half the states in the study thought it was advantageous to phase ELE in over time, either geographically (implementing in a few counties at a time before going statewide) or programmatically (such as implementing ELE for renewal before doing so for enrollment). Perceived advantages include the following:

- **Identifying and resolving operational hurdles.** In New Jersey, state officials piloted an ELE partnership with NSLP in 25 of the state's 590 school districts over two school years to assess the feasibility of this process before launching a statewide ELE partnership with NSLP. New Jersey did not invest any resources pursuing an ELE state plan amendment to implement the partnership until it was certain it could implement the process statewide, to avoid investing resources in a plan that might not work in practice. In fact, the state did amend its NSLP-based ELE process based on pilot results.

  Similarly, when South Carolina implemented ELE for enrollment, the state phased it in because of concerns about how providers would react if they experienced a sudden influx of Medicaid children due to the ELE enrollment process. To prepare providers, the Medicaid agency programmed its eligibility system to approve ELE eligibility cases incrementally, and decided to implement ELE in one region of the state at a time. Before each regional rollout, South Carolina's Medicaid agency sent staff to the region to educate providers about the ELE process and to assess their willingness to

see the new enrollees. The agency determined the order of the rollout based on physician capacity.

- **Allowing time to gather necessary resources.** Alabama has pursued an ambitious ELE strategy, requiring time to plan and to gather resources before it can be fully implemented. The state has therefore followed a five-phase process for ELE implementation. This process began in October 2009 with a manual ELE process that the state could implement quickly, with no costly technology upgrades or other large investments. By February 2013, Alabama had reached its third ELE phase, an automated process for Medicaid renewal using SNAP and TANF eligibility findings. In the fourth and fifth phases, the state plans to partially automate ELE for new enrollments and expand ELE to include other Express Lane partner agencies.
- **Obtaining eligibility workers' buy-in.** Alabama officials believe phasing in ELE over time helped gain buy-in from state staff. Alabama eligibility workers were key actors in implementing the state's first manual ELE process. After finding that the manual process worked well, they had confidence in the later automation of this process.
- **Encouraging political support.** Louisiana and South Carolina each implemented one ELE process before expanding to another. Louisiana implemented ELE for enrollment and then for renewal; South Carolina implemented ELE for renewal and then for enrollment. The phased approach enabled these states to resolve operational issues and helped them build political support for the second process because legislators and other stakeholders were reassured that ELE worked as expected.

States that did not phase in ELE could skip this step because they had sufficient resources and support, and/or an operational process that was straightforward. For example, in New Jersey, the state legislature passed a new outreach initiative in 2008 requiring families to indicate on state income tax returns whether the taxpayer's dependents had health insurance coverage. Families without coverage who appeared to be eligible based on income were then sent an application for public coverage. This reform measure became the state's (and the country's) first approved ELE process, which New Jersey implemented using the tax agency as its Express Lane partner. Although the agencies needed to work together, no buy-in was necessary because state law prescribed the process.

State circumstances are an important consideration when determining the viability of ELE for enrollment and/or renewal. Before Louisiana implemented ELE, the uninsured rate for children in the state was considered low, at about 5 percent (Barnes et al. 2011). However, officials were frustrated that despite intense efforts, they had been unable to find and enroll those remaining uninsured children through traditional outreach methods. Louisiana therefore pursued ELE for enrollment first; its ELE renewal process was implemented about nine months later. In hindsight, Louisiana officials might have implemented renewals first because they learned that the ELE renewal process serves more children than the ELE enrollment process. (As discussed in Chapter IV, ELE has enrolled about 27,000 children and renewed about 330,000.) South Carolina officials decided that using ELE for enrollment might be perceived as a coverage expansion, unlike ELE renewals, since children being renewed had already been determined eligible by Medicaid. Thus, South Carolina started with renewal and subsequently implemented ELE for enrollment, phasing in the process by regions until it was available statewide.

In some other states, officials believed that using ELE for renewal would be more controversial than using it for enrollment because using ELE at renewal could be the basis for insuring a child for many years (or at least, through September 30, 2014 if not extended by Congress) if the child's information available from the Express Lane partner agency continued to allow for ELE eligibility during that time period. For example, Iowa Medicaid and New Jersey officials wanted to confirm eligibility at renewal using their traditional rules. In addition, New Jersey had already streamlined its renewal processes saw no need to implement ELE for renewal.

These findings underscore the importance of allowing states flexibility to tailor their ELE approach to their circumstances. ELE is not a one-size-fits-all policy, and states in the study have tailored ELE to fit their environment.

States can obtain consent for ELE in different ways; some consent processes appear to make enrollment easier. Federal rules offer several protections for families who might be subject to ELE. One of these rules involves parental consent: Express Lane partner agencies must notify families that their information will be shared with the Medicaid or CHIP agencies solely to determine Medicaid or CHIP eligibility, and families must be given the opportunity to opt out of sharing this information. States that use automatic enrollment options must obtain the family's consent to enroll the child in coverage, although automatic renewal processes do not require consent as long as the parent provided consent at initial enrollment (Center for Medicaid and State Operations 2010).

States using ELE to simplify the application form have fulfilled the consent requirement through a statement on the form. For example, in New Jersey's tax ELE process, the signature line on the shortened application sent to families identified as having an uninsured child whose income qualifies for public coverage reads, "I hereby authorize the New Jersey Division of Taxation to release my tax return information to NJ FamilyCare." Some states have added a consent statement on the Express Lane partner's benefit application. For example, in both New Jersey and Oregon, which partnered with NSLP, a statement was added to the NSLP form that permitted parents to check a box to opt out of having their information shared with the Medicaid and CHIP agency; not checking the box gave consent to share their information.

To support their automatic enrollment ELE processes, South Carolina and initially Louisiana obtained consent to ELE enrollment by mailing beneficiaries Medicaid cards. If the family used the card for services (or in South Carolina, actively enrolled in a Medicaid managed care plan), they were deemed to have consented to enrollment. There are concerns that, under such an approach, families might not understand their children are enrolled in coverage and therefore not use their benefits. We have some evidence that these concerns may be overstated. As described in Chapter VI, we find that an estimated 83 percent of children enrolling through this consent process in Louisiana obtained services during their first 12 months of coverage, compared to 88 percent of children who enrolled through standard routes. Regardless, Louisiana subsequently switched to using an opt-in check box on the SNAP application. It did so for practical reasons: because its utilization data and enrollment data systems were not linked, staff had to manually check whether a family had obtained care and thus consented, a process that took considerable staff time and proved unsustainable.

2. ELE's Effectiveness Depends on Both the Choice of Express Lane Partner and How Partner Data are Used

States need to choose their Express Lane partner carefully when implementing ELE. Some agencies that appear ideal for ELE because they have data on likely eligible children have proven to be quite challenging Express Lane partners. Many states have attempted to partner with the National School Lunch Program. As one official reasoned, "that is where the kids are," and NSLP income eligibility levels align well with those of Medicaid and CHIP. In practice, however, NSLP partnerships have been challenging because NSLP data are decentralized—maintained either at the individual school or school district level—and are not always automated or uniform. New Jersey found that many schools keep handwritten records for NSLP, and record formats vary from district to district. In fact, such challenges led New Jersey to make its NSLP ELE partnership voluntary for school districts; although a large proportion (about 75 percent of the state's 590 districts) do participate. Similar factors led Oregon to abandon its NSLP ELE partnership.

State tax agencies can also be challenging Express Lane partners. Although tax agencies have access to income data, they cannot identify uninsured children—a critical impediment for ELE purposes. In New Jersey and Maryland, Medicaid officials worked with their respective state tax agencies to add a question about insurance status to the state tax return. In both states, the question initially confused residents and required modification in subsequent years to clarify it. However, both of these states also adopted processes that rely on the return of simplified applications. The rate of returned applications and enrollments through tax ELE partnerships in both states has been low, with less than 5 percent of mailed applications returned in either state.[59] In New Jersey there have been about 5,000 enrollments from 2009 to 2012; in Maryland's second ELE partnership with the tax agency, which uses tax data to establish residency and income, only 113 children are estimated to have been enrolled in the first year. Although these enrollments suggest states should be cautious about the potential of ELE partnerships with tax agencies, as was shown in Chapter IV, children who enroll through these processes can be among the more difficult to reach. For example, in New Jersey, children enrolling through its ELE partnership with the tax agency are more likely to be teens and less likely to have been previously enrolled in public coverage than are children who come in through the state's standard enrollment routes.

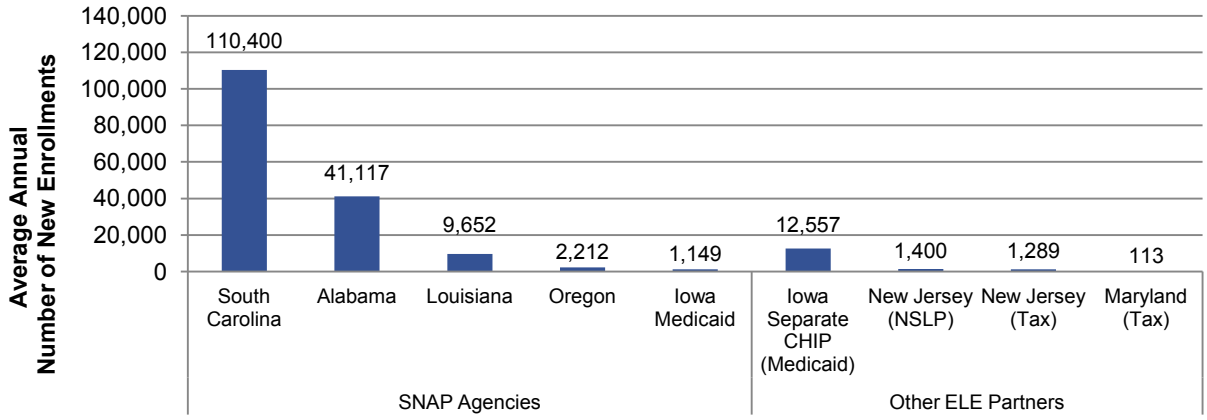
The way in which Express Lane partner data are used can greatly affect ELE's effectiveness, regardless of the partner agency. Six of the eight study states partnered with SNAP (often in combination with TANF) for one or more ELE processes. In part, states chose SNAP because the Medicaid and/or CHIP staff were familiar with SNAP agency staff and their operations and in some cases had existing data use agreements that could be easily modified to accommodate ELE. Moreover, SNAP's income eligibility limits are similar to Medicaid's, its

[59] For Maryland, this represents the return rate for the state's second ELE partnership with the tax agency; statistics on the first ELE partnership with the tax agency are not available.

eligibility redeterminations happen often (typically every six months), and U.S. Department of Agriculture analyses have found the fraud rate for SNAP is low.[60]

However, partnering with SNAP alone is not enough to guarantee that a large number of children will be processed through ELE. Rather, states' methods of using SNAP data make the difference. ELE partnerships with SNAP in Alabama, Louisiana, and South Carolina have resulted in many ELE enrollments, but Iowa Medicaid and Oregon have not enrolled many children through the process (Figure VII.1).[61] The difference is the process: Louisiana and South Carolina enroll children into coverage automatically based on SNAP income findings, whereas Alabama uses ELE to process applications already received. In contrast, Iowa Medicaid and Oregon use SNAP data to identify income-eligible children, but families must still complete and return an application form (albeit a simplified form) to be enrolled. This difference in the process for using SNAP data has a greater effect on the levels of child enrollments than the fact that SNAP is the Express Lane partner.

Figure VII.1. Average Annual Number of New Enrollments Processed via Express Lane Eligibility, by Express Lane Partner Agency



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: In the "Other ELE Partners" group, the Express Lane partner name is in parentheses following the state name. Because states have administered ELE for different time periods, we annualized the numbers for comparison. Findings for South Carolina are shown only in this chapter; because the state's ELE process for enrollment began only recently, we were not able to access data and so have not included it in the full enrollment analysis presented in Chapter IV. Numbers shown here, like those used in the cost study, are based on state staff reports.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

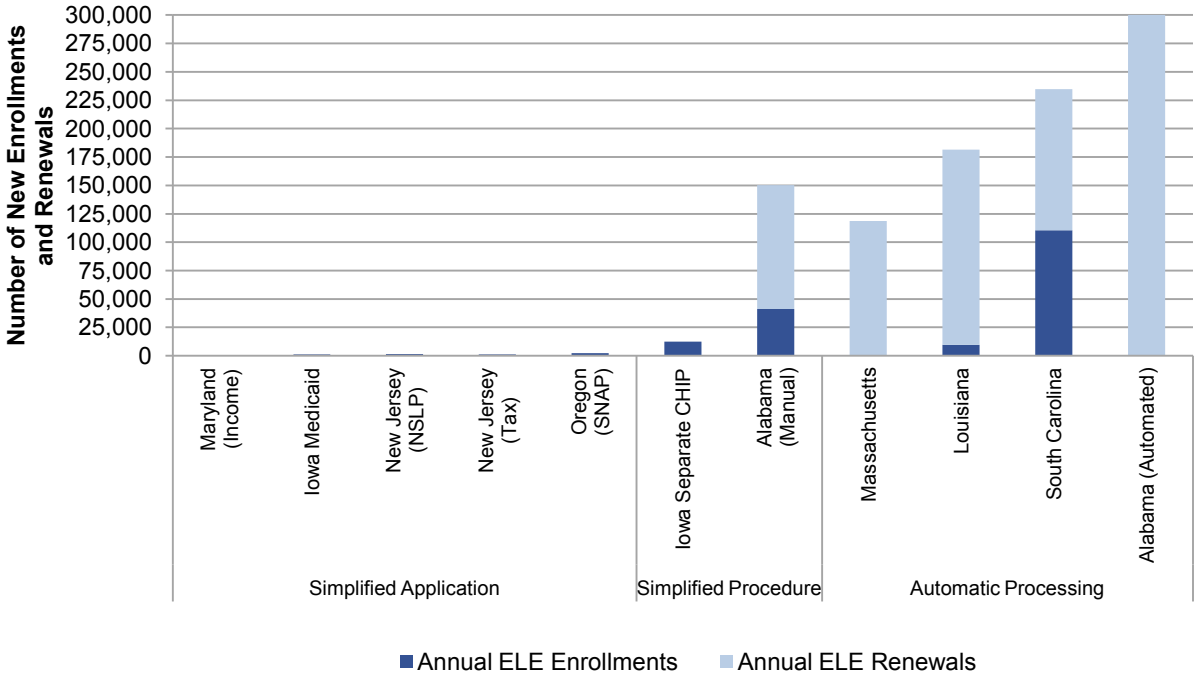
States that experienced the greatest enrollment or renewal gains and administrative cost savings implemented automatic ELE processes. The success of the four automatic process ELE states appears directly tied to the close alignment between reducing enrollment or renewal barriers and reducing administrative costs. In all four states, officials sought to use ELE to

[60] According to a recent analysis, SNAP reached a payment accuracy of 96 percent in 2012, the highest that the program has ever seen (U.S. Department of Agriculture n.d.).

[61] We do not present renewals here for comparison because all states using ELE for renewals are using SNAP in a similar fashion.

improve the efficiency of the eligibility process, moving away from manual, labor-intensive methods toward an automatic process; as a result, families of children subject to this process were required to take no additional steps to see that their eligible child had coverage (although, as discussed later in this chapter, the use of a letter in Massachusetts may have confused some families, leading fewer to be processed through ELE than expected). The approach led these states to annually enroll or retain a larger volume of children (and adults in Alabama's automated renewal and in Massachusetts, which both have Section 1115 waivers to renew these populations using ELE) in coverage than did states taking other approaches (such as mailing simplified application forms) (Figure VII.2) and, in turn, achieve the greatest administrative savings from ELE among the states studied (Figure VII.3).

Figure VII.2. Annual Number of Children and Adults Enrolled or Renewed through ELE, by State and Type of ELE Process



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

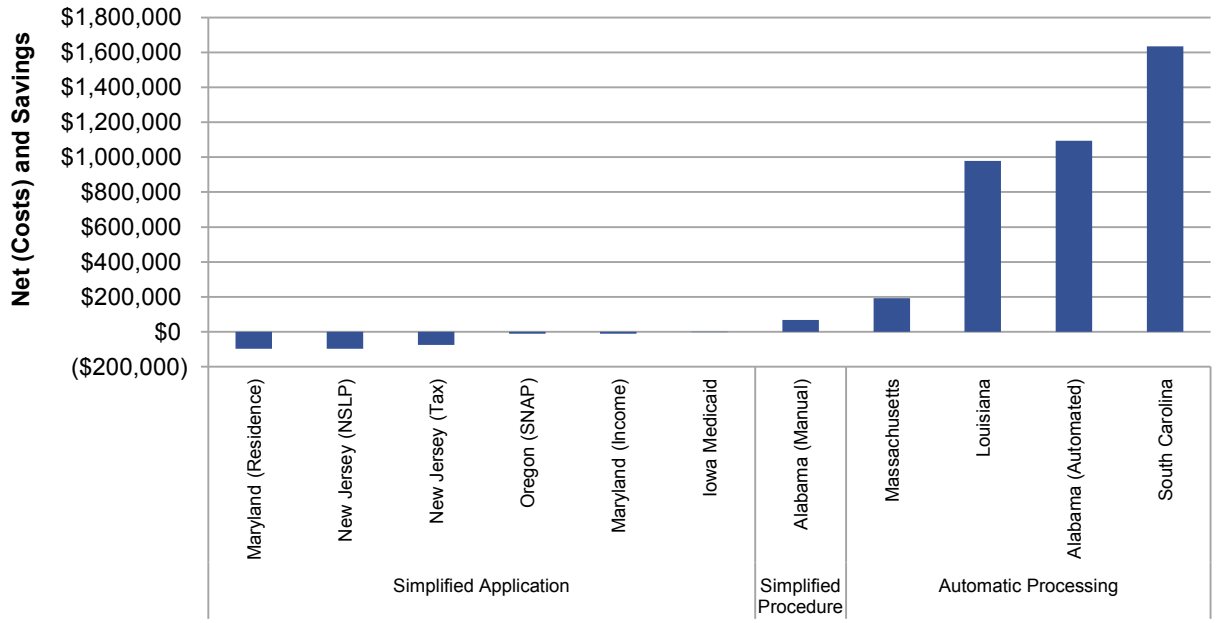
Note: Massachusetts and Alabama's automated ELE processes renew children and some adults through ELE (the states have Section 1115 waivers permitting use of ELE for adults). The Massachusetts figure represents a projection of total annual renewals based on child and adult renewals processed October 2012 and March 2013. Likewise, the number of annual enrollments in South Carolina is an estimate based on 92,000 children renewed in the first ten months of using ELE for enrollment. Alabama's automatic ELE renewal process is also new, but we estimate that it will renew 300,000 individuals per year based on its early experience. In addition to children, Alabama's automatic ELE renewal process includes women eligible for family planning services coverage. Data for Maryland's residence-establishment ELE process are not available so are not shown on this chart. Oregon's NSLP ELE process was never fully implemented so enrollment data are not shown here.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

States attracted by the potential administrative savings from ELE should still consider how the administrative costs of implementing it will be supported. States looking to automate processes may be able to take advantage of the Affordable Care Act's 90 percent matching rate

for eligibility and enrollment systems and 75 percent matching rates for system maintenance and operations.[62] Also, states may find that the systems improvements they have already made to comply with Affordable Care Act rules would make automated ELE processes less costly to implement now than they were for early ELE implementers, yielding even greater net administrative savings. None of the ELE states in the study amended their third-party administrator contracts to extract administrative savings from new ELE processes, such as faster application processing times, but this also might be a source of implementation funds.

Figure VII.3. Net Annual Administrative Costs and Savings Associated with ELE



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Two ELE processes in the evaluation are excluded from this analysis of net administrative costs and savings. Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible. For Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process, so information about administrative savings and costs per application could not be calculated and are not presented.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

Finally, the full effects of ELE on costs requires consideration of administrative costs or savings and the cost of providing health care to newly enrolled or renewed children through Medicaid or CHIP, but this was not part of the assessment in this evaluation. Although evidence presented in Chapter VI suggests ELE enrollees may use somewhat fewer services and therefore cost less to cover than traditional enrollees, any positive impact of ELE on Medicaid or CHIP enrollment will likely increase at least the short-term costs of proving care to children on these

[62] The 90 percent match for design, development, and installation or enhancement of eligibility determination IT systems is available for services incurred through December 31, 2015 (Weiss et al. 2013). There is no time limit on the 75 percent matching rates for system maintenance and operations.

programs. Effects on health care costs in the longer term are more ambiguous because coverage may encourage the use of preventive care and other services that promote children's longer-term health and, in turn, yield possible administrative cost savings. These potential long-term effects of ELE are well outside the scope of this study.

As a means of outreach, simplified application ELE processes appear on par, or even favorably, with other approaches. Four of the states studied—Iowa, Maryland, New Jersey, and Oregon—use ELE at least in part to populate and mail a simplified application to families identified with possible eligible-but-uninsured children. This process, which closely parallels various types of mail-based outreach that states conduct, yields relatively low return rates, averaging from 5 to 13 percent of mailed applications (Table VII.1). Nevertheless, the added administrative costs of these efforts appear roughly on par with outreach efforts used more generally. For example, New Jersey's NSLP-ELE process costs the public sector about $50 per enrollment above normal administrative processing costs, its tax-ELE process costs about $170 more, and Maryland's income verification ELE process costs about $100 per enrollment above normal administrative processing costs. By comparison, the state of Oregon pays contracted application assistors $75 for each completed (standard) application leading to an enrollment, and Illinois pays $50 to these assistors. And in Louisiana, officials reported that the state spent $650,000 on outreach grants during 2009–2011 that resulted in 329 children receiving coverage—a cost of about $1,975 per child enrolled.

Table VII.1. Average Return Rates from States Using a Simplified Application ELE Process

	Iowa Medicaid	Maryland Tax (Residence and Income)	New Jersey (NSLP)	New Jersey (Tax)	Oregon
Average Response Rate	13 percent	5 percent	13 percent	5 percent	5 percent

Source: ELE Evaluation Case Study Reports; Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011-2013.

Note: Rate for New Jersey tax-ELE partnership is the average of four years; the New Jersey NSLP-ELE partnership return rate is an average of the past two years. Other rates are state-reported averages. The return rate for Maryland's partnership with the state taxation agency, which establishes only residency, is not available.

ELE processes requiring family involvement must be well communicated. Several states using ELE to populate and mail simplified application or renewal forms struggled with its initial implementation because of unclear instructions. For example, when New Jersey implemented its ELE partnership with the state tax agency, the question that was added to tax returns about whether dependent children were insured was so confusing that the state sent out more than 300,000 shortened applications to families as a result—more than the number of children estimated to be uninsured in New Jersey at the time.[63] Maryland had a similar experience with confusion about its question about dependents' insurance status; like New Jersey, it has since revised this question.

[63] See Hoag and Swinburn (2013) for more detail on this issue.

In Massachusetts, the use of a renewal notification letter that includes a renewal form has hampered the state's ELE renewal process. Massachusetts sends families renewed through ELE a cover letter with a renewal form, telling them that the state has used SNAP data to determine that they are still eligible for MassHealth coverage. The letter instructs families to take action (via completing and submitting the enclosed renewal form) if they feel they might be eligible for a more complete benefit (for example, to qualify for a lower-cost or no cost plan). In focus groups, parents reported that the renewal form instructions were unclear; none of them understood that the letter was telling them they were already renewed through the ELE process. Other states should carefully decide whether written materials are needed for ELE processes and, if so, consider testing them to see how recipients interpret the materials to make sure they are clear.

State investments in staff training and support are critical to the success of ELE. Regardless of the type of ELE process implemented, states need to invest in training for ELE to function as intended. Some of the states in the study did not anticipate this need. For example, because South Carolina's ELE process was automated and designed to remove eligibility workers from the process, state officials did not think they needed to train eligibility workers. However, a misunderstanding about the automated ELE process led eligibility workers to manually handle about 4,000 cases needlessly when ELE was first implemented. In hindsight, the agency realized that providing training for eligibility workers could have prevented this error.

When switching to ELE, sustained training and education on new processes may support eligibility staff better than a one-time approach. For example, Oregon officials widely distributed training materials before implementing ELE and provided more intensive, one- to two-hour training sessions for the six eligibility workers who would handle the state's ELE applications. Stakeholders agreed the training was well designed, but when ELE began, these eligibility workers still had concerns that ELE was permitting children to be enrolled without following appropriate or fair procedures because it differed from standard Medicaid procedures. Although the state ameliorated the situation through further instruction, this result suggests that these eligibility workers might have benefited from ongoing support after implementation.

Finally, states should anticipate that a variety of stakeholders may need instruction on ELE processes, not just Medicaid or CHIP eligibility staff. For example, in Maryland, officials incorporated information about the ELE mailings into their standard trainings for eligibility caseworkers and call center staff at local health departments so that these individuals would be prepared to answer questions from families about the mailings. However, state officials acknowledged that educating tax preparers was not part of its ELE strategy, noting that "it wasn't even on the radar" that the Medicaid- and CHIP-eligible population might use tax preparers. Similarly, New Jersey did not train tax preparers on the question on health insurance added to the tax form the first year; as a result, preparers often incorrectly responded on behalf of their clients. Realizing the problem, New Jersey officials conducted outreach to tax preparers such as TurboTax and H&R Block the following year.

3. ELE Saves Time

Many ELE enrollment processes can speed coverage of eligible children. Allowing states to rely on eligibility determination findings from other programs, ELE supporters note, can cut down on staff time checking additional databases or reviewing grantee paperwork and similarly reduce the time needed by families to produce documentation. In turn, the policy can reduce the

time families need to wait before their eligible children gain coverage. Our study findings show significant evidence to support this conjecture.

As shown in Table VII.2, ELE processes—whether automated or not—generally enroll children two to four weeks faster than standard application processes. Two exceptions are Maryland, where ELE saves no time, and Oregon, where the process saves only 6 days on average (although the standard processing time in Oregon—9 days—was already fast, compared to nearly 30 days in most states).

Table VII.2. Most ELE Enrollment Processes Expedite Coverage

State and Program	ELE Process	Decrease in Time to Coverage Compared to Standard Processes
Iowa Medicaid	Simplified application	28 days faster
Louisiana Medicaid	Automatic processing	23 days faster
New Jersey Medicaid/CHIP	Simplified application	23 days faster
Alabama Medicaid	Simplified procedure	19 days faster
Iowa Separate CHIP	Simplified procedure	15 days faster
Oregon Medicaid/CHIP	Simplified application	6 days faster
Maryland Medicaid	Simplified application	0 days faster

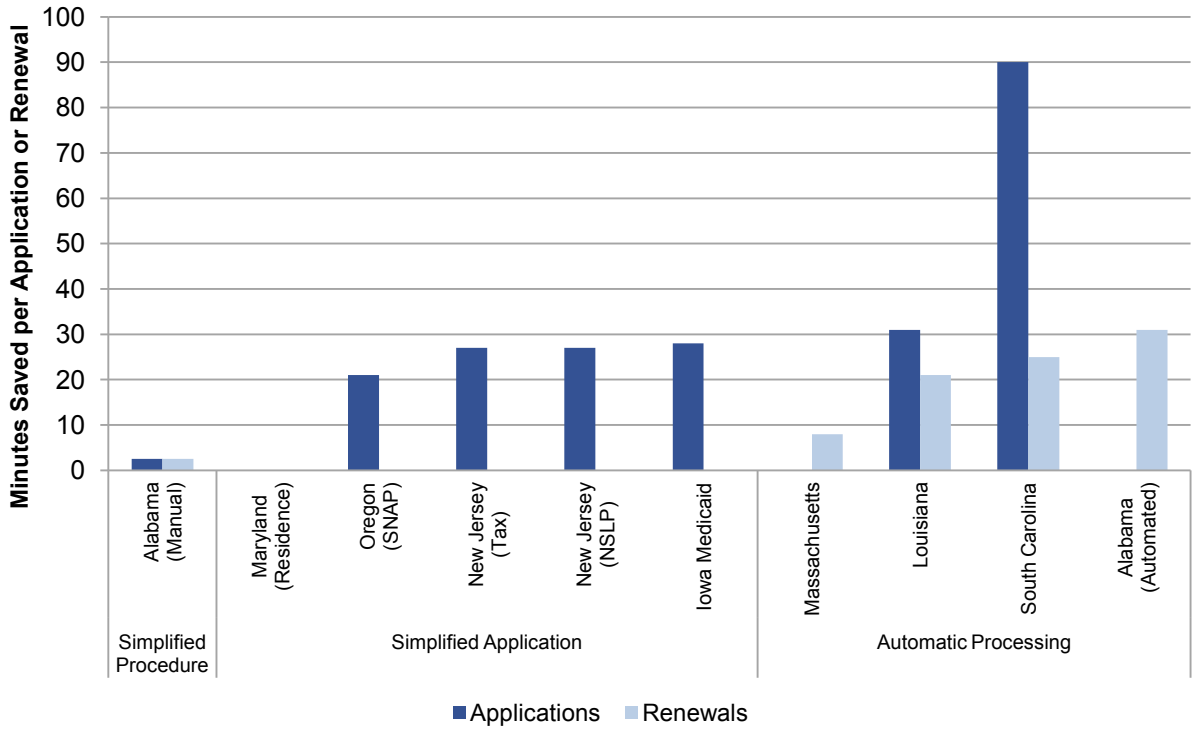
Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011-2013.

Note: Data for South Carolina are not available. Massachusetts is excluded because they only use ELE for renewals, and this is an analysis of ELE enrollment effects.

ELE can reduce staff time for processing applications and renewals. During the national recession from December 2007 to January 2011, 44 states either eliminated staff positions, furloughed employees, or implemented hiring freezes in response to shrinking state budgets (Johnson et al. 2011). Against this backdrop, eight states were able to implement ELE in large part because the policy required hiring no new staff to implement ELE. In fact, with the exception of one state (Maryland), ELE reduced the time needed by eligibility staff in these states to process an application or renewal compared with the state's traditional process (Figure VII.4).

This reduction enabled states to offset staff cutbacks without disrupting other services and sometimes led to improvements for non-ELE applicants. For example, although its administrative savings per application/renewal is similar to other states, Louisiana's ELE processes have affected such a large volume of cases that the overall staff time saved is striking—about 33,000 staff hours per year, the equivalent of 16 full time staff. In Alabama's manual ELE process, staff still handle ELE applications, but those applications can be processed more quickly because of ELE, giving staff more time to address non-ELE applications. Staff in both states suggested that the time saved from ELE has meant that standard processing times are shorter than they would be otherwise. Finally, South Carolina is processing so many enrollments and renewals through ELE that it is preparing to train some of its current eligibility workers to focus on connecting new members to medical homes after enrollment.

Figure VII.4. Staff Time Saved per Application or Renewal, by ELE Process



Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Three ELE processes in the evaluation are excluded from this graph of time savings. Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year, so producing a meaningful analysis of this process is not possible. For Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process, so time saved per application could not be calculated and is not presented. The time saved for Maryland's income establishment ELE process is also not shown, because public sector staff process most standard enrollments and private sector contractors perform ELE enrollments under this process; thus a comparison of time taken to process an ELE application compared to a standard application conflates ELE effects with other factors.

ELE = Express Lane Eligibility; NSLP National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

C. Discussion

ELE can be an effective tool for enrolling children and renewing their coverage. Findings from our evaluation show quite clearly that there is no single way to implement ELE and that how a state decides to implement ELE can profoundly affect its potential benefits. These findings reflect an inherent value of ELE; the policy is adaptable and states that have used it did so in ways that suited their circumstances, whether that meant phasing it in over time or using it as a new outreach mechanism. Importantly, although some observers may equate ELE with automation, ELE does not have to be automated to find and enroll or renew children eligible for coverage. The most efficient ELE processes do use automation, but non-automated ELE processes are viable options. In fact, states that used ELE to mail out simplified applications to children identified as eligible for coverage may find this approach to be as or more cost effective compared to traditional outreach methods.

Selecting an appropriate Express Lane agency partner is important for ELE to work well, but we found that the process for using Express Lane partner data has a greater effect on ELE success. States that pursued ELE as a business process improvement reaped the most coverage gains and the most administrative savings. Nevertheless, partner selection matters as well, and programs such as NSLP and state tax agencies have proven to be challenging partners. To date, states have had more success working with SNAP (often in combination with TANF). The consent process adopted also appears to have an effect on enrollment, with processes that require less effort from families leading to greater enrollment.

ELE does require state investment in areas such as information technology improvements and training to help stakeholders understand ELE and their role in it. States that have implemented ELE have not needed new staff to implement it; in fact, ELE helped states deal with hiring freezes and staff layoffs at a time when more children were enrolling in public coverage. Investment in simple messaging can be critical to gaining support for adopting and implementing ELE and for avoiding confusion among eligibility workers, key stakeholders, and even beneficiaries. Beyond simplifying processes for beneficiaries, ELE expedites receipt of coverage, an important efficiency for families.

VIII. FINDINGS ON OTHER SIMPLIFICATIONS IMPLEMENTED IN THREE STATES

Key Findings:

- Based on available qualitative evidence, all three of the other simplification processes studied simplify enrollment and renewal processes for families. In terms of reducing family burden at application or renewal, none of these other processes are as streamlined as automatic ELE processes.
- Much as they did across different ELE processes and states, the number of enrollments and renewals served by these other processes varied, as did their administrative costs and savings. Oklahoma's online enrollment system process was, by design, the pathway for far more enrollments and renewals than were any of the processes studied for this report, including ELE. In contrast, Michigan's presumptive eligibility process served a narrower population, uninsured children and pregnant women seeking services at a Medicaid provider. New York's phone renewal process falls between these two states' programs, accounting for about half of all renewals in the counties where the process has been in place.
- Like some of the ELE processes studied, the presumptive eligibility process in Michigan may be beneficial for reaching difficult-to-enroll populations, including those who are non-English speaking.

A. Motivation

The evaluation also assessed other approaches to streamlining or otherwise simplifying enrollment or renewal processes in Medicaid and CHIP. This assessment has two goals: first, to provide context for how other simplifications compare to ELE in terms of administrative costs or enrollment effects and, second, to share lessons on other simplifications that might help enroll or retain newly eligible adults when coverage requirements of the Affordable Care Act go into effect in 2014.

This chapter provides an assessment of three enrollment and renewal simplifications: Michigan's presumptive eligibility process, New York's telephone renewal process, and Oklahoma's online enrollment system. All three simplifications offer potential benefit to states under the Affordable Care Act. In fact, beginning in 2014, online and telephone enrollment and renewal are required under the Affordable Care Act; and all states must allow for presumptive eligibility if a hospital within the state wants to use it.

Our approach combines qualitative and quantitative findings to describe the processes and compares these three other approaches to those of the ELE processes studied. We first describe the three other policies studied and then review the data collection and analysis methods before providing details on the findings about other processes studied in the three states.

B. Policies and States Selected

The policy selection and state recruiting process led to the inclusion of three other simplifications in the study:

1. **Presumptive eligibility.** This simplification permits states to give temporary Medicaid coverage to those who appear eligible for coverage. Presumptive eligibility was studied in Michigan's Medicaid program.
2. **Telephone renewals.** Rather than submit paper documentation or renewal forms**,** this simplification allows families to call to have their child's eligibility for ongoing coverage assessed. Telephone renewals were studied in New York's Medicaid program.
3. **Online enrollment and renewal.** An online system, this simplification makes real-time eligibility decisions, permitting families to know immediately whether they or their children have coverage. This simplification was studied in Oklahoma's Medicaid and CHIP programs.

Table VIII.1 summarizes key features of these three processes.

Table VIII.1. Key Features and Aims of Other Simplifications Adopted in Three States

	Features				Aims			
State and Program	Process Name	Implemented	Used for Initial Enrollments	Used for Renewals	Reduce Staff Time	Reduce Time to Coverage	Simplify Enrollment Experience	Simplify Renewal Experience
Michigan (Medicaid)	Presumptive eligibility	2005	X			X	X	
New York (Medicaid)	Telephone renewals	Varies by county, starting in September 2011		X				X
Oklahoma (Medicaid/ CHIP)	Online enrollment	September 2010	X	X	X	X	X	X

Source: Evaluation team interviews with state staff, between December 2012 and July 2013.

CHIP = Children's Health Insurance Program.

C. Data Collection and Analysis Methods

The study of other simplifications included three overlapping analyses: (1) an in-depth study of the process implemented; (2) an enrollment analysis, to try to descriptively understand the effects of the process implemented; and, (3) an analysis of effects on administrative costs. Table VIII.2 summarizes these methods; full methods are provided in Appendix E.

Table VIII.2. Data and Methods for Study Components

State and Process Name	Process Analysis	Enrollment Analysis	Administrative Cost Analysis
Michigan – Presumptive Eligibility	Same methods as in ELE states: • Document review • Site visits • In-depth phone interviews • Focus groups	State's enrollment contractor provided aggregate monthly data on referrals from presumptive agencies to Medicaid.	As with ELE, we conducted a document review and interviews with state staff on administrative costs incurred.
New York – Phone Renewals		Site visit team collected monthly counts from state staff.	State staff were unable to provide any administrative cost data, so this process is not included in the analysis.
Oklahoma – Online Enrollment		State staff provided aggregate monthly enrollment and renewal counts, stratified by whether the application or renewal was entered through the "home view" or "agency view."	As with ELE, we conducted a document review and interviews with state staff on administrative costs incurred.

Note: ELE = Express Lane Eligibility.

D. Findings

1. Presumptive Eligibility in Michigan's Medicaid Program

Presumptive Eligibility in Michigan's Medicaid Program Provides a Helpful Pathway to Coverage for Children and Pregnant Women from Underserved Families at a Relative Low Administrative Investment

In deciding to adopt presumptive eligibility, Medicaid administrators thought that the policy could be an effective tool to reach remaining uninsured children in the state. According to Current Population Survey data for 2004 and 2005, about 9.5 percent of low-income children were uninsured in Michigan (Arjun 2007). Michigan expected that presumptive eligibility would make it easier and more convenient for individuals to apply for coverage. The new approach would open up many more sites where families could submit applications—particularly clinics where low-income families normally go for care—and eliminate the need to arrange transportation and child care for a separate trip to a local social services office if applicants needed assistance in completing their applications.

The state also expected that presumptive eligibility would reduce administrative costs related to hiring out-stationed eligibility workers because providers would be more willing to assist with applications: they received real-time confirmation of coverage and were guaranteed reimbursement for that day's services and short-term follow-up appointments through presumptive eligibility. Provider participation as application assistors would in turn help address the backlog of applications in some communities and improve overall timeliness of enrollment. Michigan's Medicaid administrators also expected that assuring providers of reimbursement would improve access to care by making them more willing to see low-income patients.

The presumptive eligibility process implemented in Michigan allows children who appear to be eligible for Medicaid to receive two months' immediate temporary coverage while the state processes a full determination for the child. Implemented in January 2005, the presumptive eligibility process works through Medicaid providers, who are trained and certified to be "qualified agencies" on behalf of families seeking Medicaid coverage. In this capacity, providers submit an online application for the child and the system automatically assesses the information; if the child appears to be Medicaid eligible (based on self-attested income, age, citizenship, and

other factors), coverage is granted immediately (in the provider's office) for the current month and the next calendar month. This process not only allows families to access coverage immediately for their children, but it also ensures payment to the provider for the health care provided at the time of the application.

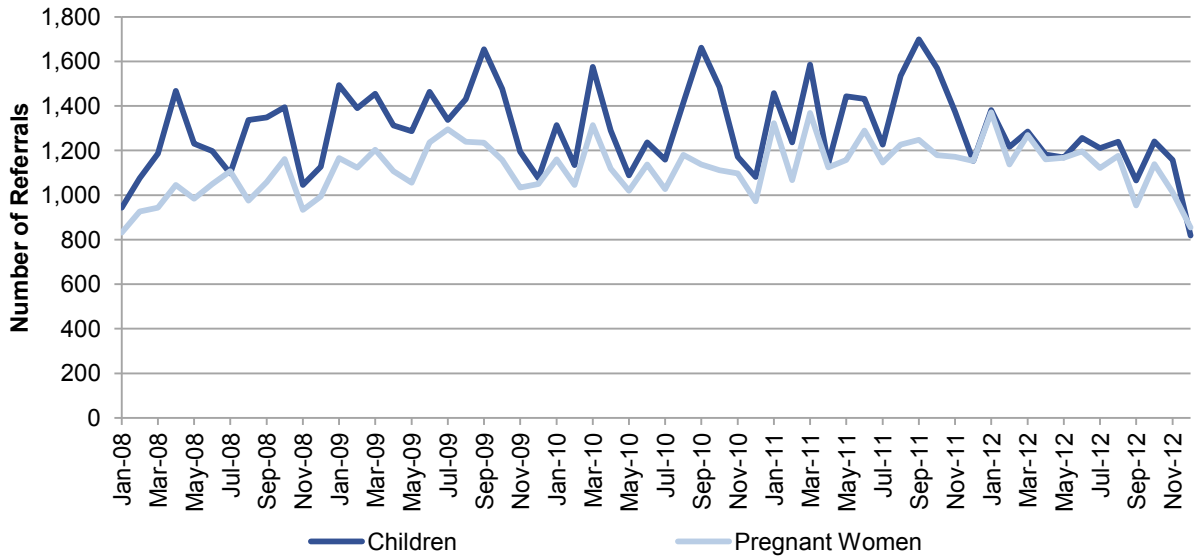
Approval of the presumptive eligibility application triggers an assessment by the Medicaid agency as to whether the child qualifies for full Medicaid eligibility. If the child is determined eligible, the family is sent a letter and a Medicaid coverage card for the child within 45 days; the state also forwards the new enrollment information to the state's enrollment broker, which sends the family a "Michigan Enrolls" packet with health plan choices (during the two-month period of presumptive coverage, care is reimbursed through fee-for-service). If there is insufficient or conflicting information about any condition of eligibility (income, residency, or other items), the state sends a letter to the family requesting additional documentation. If the family sends back appropriate documentation, the state approves ongoing Medicaid enrollment and notifies the enrollment broker so that an enrollment packet is sent as described above. If the family does not return documentation, or if the documentation indicates ineligibility, the family is notified that ongoing coverage, after the full two months of presumptive coverage ends, is denied, along with the reason for denial.

Presumptive eligibility was not a difficult policy to implement. Officials believe part of the ease of implementation was because it was able to piggyback the presumptive eligibility process onto the state's online enrollment system rather than rely on a paper process. Medicaid providers were receptive to offering this new option, in part because it assures payment for services but also because it helps the beneficiaries they serve, who no longer had to arrange child care and transportation to a separate local human services office. There are also several advantages for the state. For example, the state no longer needed to pay for separate, out-stationed eligibility workers; staff at the presumptive eligibility agencies took on this role. Also, state staff reported that they believe presumptive eligibility determinations result in a lower percentage of denials for ongoing coverage than is the case for regular applications because trained staff do not submit ineligible or incomplete applications, although data to confirm this conclusion were not available.

a. Enrollment Analysis

Data provided by Michigan showed that, from January 2008 through December 2012, qualified agencies referred 77,709 child applications and 67,243 pregnant women applications to Medicaid through the presumptive eligibility process. The flow of referrals was stable over the five-year period, averaging 1,295 child referrals per month and 1,121 pregnant women referrals per month (Figure VIII.1). Children and pregnant women referred through Michigan's presumptive eligibility program represent a small fraction of Medicaid enrollees: for example, approximately 900,000 children were covered under the state's Medicaid program in July 2011 (Snyder and Rudowitz 2012).

Figure VIII.1. New Child and Pregnant Women Medicaid Referrals from a Qualified Agency in Michigan



Source: Mathematica analysis of state-reported data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

The profile of presumptive eligibility referrals is notable for race and ethnicity, language, and income distribution (Table VIII.3). Relatively large proportions of presumptive eligibility referrals with available ethnic and language information were non-white and non-English-speaking, respectively. Of those with available data, about 25 percent of referrals were identified as Hispanic and another 30 percent as black or African American. In addition, about one in six referrals with available language information was primarily Spanish speaking, and nearly 30 percent of pregnant women referrals were noncitizens. Also, 55 percent of pregnant women referrals and the parents of about half of child referrals had incomes below 50 percent of the federal poverty level.

These findings suggest that presumptive eligibility, though somewhat limited in its reach, may provide a helpful pathway to medical coverage for both children and pregnant women from traditionally underserved families. A significant limitation of our analysis is that we have no information on whether a person referred to Medicaid resulted in Medicaid enrollment or, by extension, the length of time the person was enrolled. However, key informants interviewed as part of the site visits reported that most presumptive eligibility referrals result in enrollment.[64]

[64] Common reasons that people are denied ongoing coverage are residency requirements (e.g., an individual is in the United States on a student visa and lacks U.S. citizenship) or the applicant failed to disclose all of the household income to the qualified agency.

Table VIII.3. Percentage of New Child and Pregnant Women Medicaid Referrals from a Qualified Agency in Michigan, by Selected Demographic Characteristics

	Children	Pregnant Women
Race/Ethnicity		
Black	17	16
Hispanic	14	14
White	20	30
Other	6	6
Unknown	42	34
Primary Language		
English	49	53
Spanish	11	11
Other	3	5
Missing/unknown	36	31
Citizenship		
Citizen	94	72
Other	6	28
Missing/unknown	0	0
Income (% FPL)		
< 50	48	55
50 - 9.9	33	29
≥ 100	19	16
Missing/Unknown	0	0

Source: Mathematica analysis of state-reported data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

FPL = federal poverty level.

b. Cost Analysis

Although state staff were unable to recall the administrative costs of presumptive eligibility implementation, they said that in its early years, a substantial training effort was required to provide training to all the qualified agencies that would use the new process. Staff also noted that the process became much more efficient and far easier to manage after the implementation of the state's online application system, which occurred in October 2005 (the same year that presumptive eligibility was introduced). In the first nine months, the state identified problems with the paper-based system, primarily related to backlogs among caseworkers and mailing delays. The move to the online system resolved these problems. Although the state's online application system was not introduced because of presumptive eligibility, Michigan officials believe other states considering implementing presumptive eligibility might consider an online application system as a beneficial precursor to a presumptive eligibility process.

Because a standard eligibility assessment must be completed for each presumptive eligibility application, this policy saves no staff time and yields no administrative savings compared to an individual enrolling via the standard route. A small amount of additional time is expended to open cases for individuals who ultimately do not provide information or documentation that may be required for full enrollment following their presumptive eligibility period and for individuals who complete the standard application process and are found ineligible. In the absence of presumptive eligibility, these individuals may never have applied for coverage, so the staff time spent on assessing eligibility for these individuals is a new cost that would otherwise not have

been incurred. However, state staff indicate cases like this are few; based on state estimates, we estimate the annual cost of processing these cases is less than $7,000. Additionally, the state runs a training program to train staff at qualified agencies who can assist individuals with completing presumptive eligibility applications, at a cost of six hours of state staff time per month, which translates to $3,000 a year. Because there are no savings from presumptive eligibility, this yields net administrative costs for running this process of less than $10,000 a year.

2. Phone Renewal in New York's Medicaid Program

While Challenging to Implement, Phone Renewals are Now Being Used by Half of Beneficiaries in Counties Where it is an Option; Moreover, Phone Renewals are More Likely to be Complete and Require Less Follow-up than Paper Renewals

The implementation of New York's centralized renewal processing policy (the enrollment center) represents a notable simplification of the state's Medicaid renewal process. Historically, New York used county social services agencies to process Medicaid enrollment and renewals. Leaders concluded that moving to a centralized renewal process would help standardize renewal practices, which varied among counties, and would allow the state to implement telephone renewals for Medicaid. In 2008, when New York first started exploring simplified renewal options, the state estimated that about 30,000 eligible people were losing Medicaid coverage every month because they did not complete the renewal process; the state noted that many of these individuals returned to coverage within a few months. In developing the enrollment center, the state explored barriers to renewal by conducting focus groups with English-, Spanish-, and Chinese-speaking participants who had lost coverage despite being eligible. Participants thought telephone renewal would be a valuable addition to the mail-in and in-person renewals that had historically been offered, and they preferred it to the option of online renewal because of concerns about privacy.

Telephone renewal also aligned well with a concurrent New York initiative to shift Medicaid administration to the state level. Recognizing it would be easier for the state to implement certain process improvements that promote enrollment, in addition to gaining efficiencies from consolidating and standardizing renewal practices, the 2010-2011 New York state budget included language requiring the state to develop a plan to take over administration of Medicaid from counties.

The enrollment center was launched in June 2011 for mailed renewals; in September 2011, the phone renewal process began, permitting certain Medicaid, Family Health Plus (New York's waiver program for parents with incomes above Medicaid eligibility and childless adults), and Family Planning Benefit recipients in four counties to renew their coverage by phone if they choose. By March 2013, the telephone renewal option had expanded to 32 of the state's 62 counties (excluding New York City, which administers its own eligibility and renewal system apart from the rest of the state; residents of New York City's five boroughs constitute about two-thirds of Medicaid renewals in the state). In counties that use this option, the state identifies on a monthly basis eligible households whose Medicaid coverage will end within 90 days. A paper renewal notice with pre-populated contact information is mailed to the family, with instructions that they may sign and mail back the form and any required information or may call a toll-free number to renew their coverage by telephone. In addition, any time a Medicaid enrollee calls the enrollment center for any reason, the worker checks the person's name against a monthly list of

enrollees due for renewal; if the person is found to be up for renewal, the worker asks whether the individual would like to complete the renewal process by telephone.

In the phone renewal process, beneficiaries attest to their residency and income and may add children to their household or attest to another change in household composition on the call. They may also attest to their child care or adult care expenses. One adult in the household "signs" the renewal form over the telephone by verbal agreement. During the renewal call, the worker checks whether available wage data match the caller's attestation. If income appears to exceed eligibility or there is another discrepancy that would affect eligibility, the worker asks for documentation, which must be mailed in to complete the renewal.

New York experienced several challenges implementing the new system. First, the development of phone renewals took longer to implement than expected, due in part to programming delays for the new online system that phone workers would use, and in part because the state's contractor needed more time to test telephone scripts. In the first months the phone renewal process was operational, some disenrollments occurred even though coverage was supposed to continue while the renewal was being processed. There were also communication challenges; because the process was being phased-in across counties, the state did not market or publicize it, sometimes leading to confusion for both enrollees as well as county staff who had previously handled renewals. There were also challenges in getting counties to participate because initial technical problems raised concerns about switching processes.

Despite delays and early complaints and concerns from counties, Department of Health and enrollment center staff believe that implementation issues have been addressed and telephone renewal has been a success. They cite evidence of this success:

- **Substantial volume.** About half of renewals in counties where phone renewal is an option are conducted by telephone, which the state believes shows strong consumer interest in using this option (Table VIII.4). It is worth noting that because New York City runs its own enrollment and renewal system, this volume still represents a small volume of renewals for the state (about two-thirds of all renewals are from beneficiaries who live in New York City).

Table VIII.4. Comparative Renewals by Source in Telephone Renewal Counties

Month	Number of Counties Where Telephone Renewal is an Option	Total Number of Renewals in These Counties	Number of Telephone Renewals	Proportion of Telephone Renewals %	Proportion of Mail In/Fax Renewals %
Oct. 2012	18	11,907	6,115	49	51
Nov. 2012	18	11,764	6,200	47	53
Dec. 2012	25	11,594	6,110	47	53
Jan. 2013	25	18,493	9,681	48	52
Feb. 2013	25	16,677	8,450	49	51
Mar. 2013	32	16,733	8,309	50	50

Source: New York Department of Health, 2013.

Note: New York City operates its own eligibility system covering its five boroughs and is therefore excluded from participation in the phone renewal option. Medicaid recipients from New York City's five boroughs constitute about two thirds of all Medicaid renewals in the state.

- **High completion rate.** Telephone renewal forms are more likely to be complete than are forms sent by mail, and they require less follow-up. All required renewal information can be collected on the telephone for 95 percent of telephone renewals, whereas only 78 percent of renewal forms received by mail contain all required information. The enrollment center contractor reported that telephone renewals reach a determination decision in 36 percent less time, on average, than mail-in renewals.
- **Convenience and client satisfaction.** Enrollment center staff report positive feedback from clients about phone renewal, and they have received no complaints from consumers or advocates. Parents who participated in focus groups also reported satisfaction with the phone renewal process.

Because the Affordable Care Act requires telephone enrollment as an option for Medicaid, CHIP, and premium subsidy applications, New York's experience with telephone renewal offers several lessons for health reform implementation. For example, the telephone process is more effective than is the mail-in process at acquiring all necessary eligibility information quickly, which lessens the burden on the client and reduces the time needed to make eligibility decisions. New York found that its phased-in approach allowed the state to test out scripts, technologies, and protocols and make necessary adjustments before expanding the program. However, the gradual approach also made it impractical for the state to launch major public campaigns to educate beneficiaries about the new telephone option because few people were included in each phase of phone renewal implementation.

3. Online Enrollment in Oklahoma's Medicaid and CHIP Programs

Oklahoma's Implementation of a Real-Time Enrollment System Processes Applications and Renewals in Minutes; While it Required a Substantial Investment to Implement, It Saves the State About $1.5 Million Annually in Administrative Costs

In September 2010, the Oklahoma Health Care Authority (OHCA) implemented the first real-time online enrollment system for Medicaid and CHIP. Oklahoma's system functions as an online application and uses a sophisticated rules engine that provides an eligibility determination instantly. The online enrollment initiative was motivated by a number of policy changes and operational challenges. First, the Personal Responsibility and Work Opportunity Reconciliation Act, passed in 1996, delinked cash assistance from Medicaid receipt, eliminating the need to keep enrollment for those programs together at the Oklahoma Department of Human Services (OKDHS). Second, in an effort to streamline the enrollment process, OHCA staff created a 2-page application for SoonerCare (the name of its Medicaid and CHIP programs) in 1997, but OKDHS remained committed to a 21-page application that covered all public benefits (although OKDHS permitted families to submit the 2-page paper application if they were applying only for medical coverage). Third, in the early 2000s, OHCA staff analyzed the length of time between application for coverage and eligibility determination at OKDHS and found that approval for an average SoonerCare-only application took 20 days; if a family applied for SoonerCare and food stamps, approval of the application took up to 30 days. Because the agency focused on customer service, OHCA administrators wanted to speed up the processing time, but this was not something over which they had control. Fourth, enrollment analyses revealed that the profile of the SoonerCare population had changed by 2002: the percentage of families with children found eligible for SoonerCare but not certified for other OKDHS programs was growing. Finally, SoonerCare enrollment was rising, and OHCA administrators were concerned about being able

to serve a larger population more efficiently. Considering all of these factors, OHCA staff became convinced that keeping SoonerCare enrollment with OKDHS no longer made sense and began examining how they could make further strides in improving the SoonerCare application process.

The SoonerCare online enrollment system permits real-time enrollment with a post-enrollment eligibility review of income and, if needed, a review of documentation of other eligibility criteria, such as pregnancy verification. The system reviews most eligibility data in real time, reducing an application and enrollment process that used to take 20 days or more to complete to just minutes (beyond the time the applicant took to complete the online application). Families can access the system from home or any public computer through the "home view" portal. If a family needs help with an application or does not have access to a personal computer, parents can complete an application with the help of an application assistor at certain clinics as well as at OKDHS and Oklahoma State Department of Health offices. Application assistors enter applicant data through an "agency view" portal in the online system.

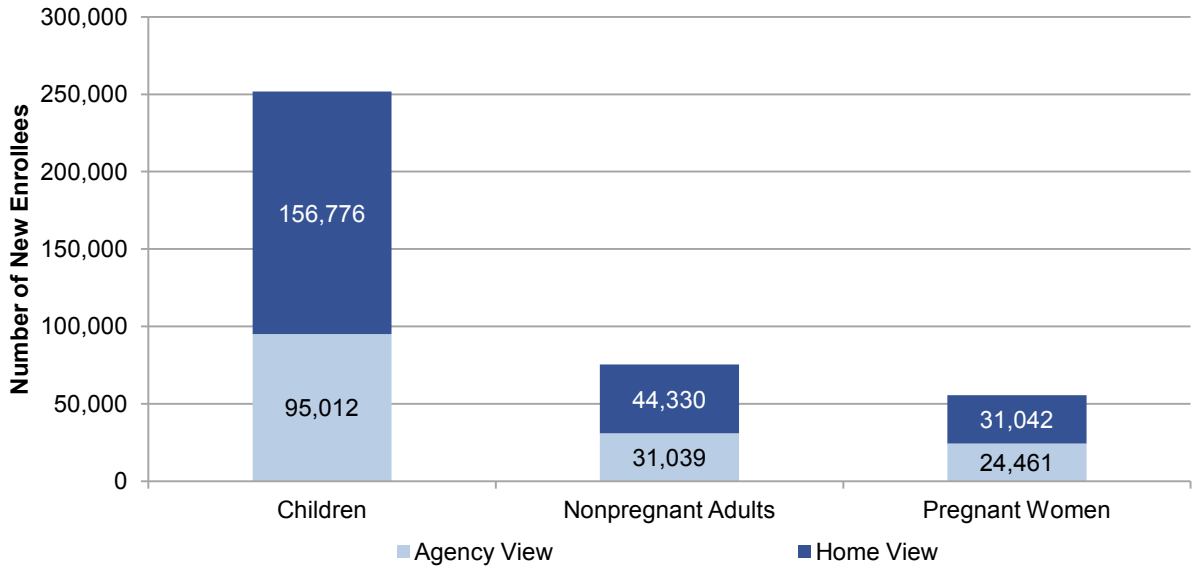
The online enrollment system also allows for renewals on a rolling basis; when applicants log on to the system, they have the option of redetermining their coverage eligibility rather than waiting until the end of the eligibility period. Individuals enter only information that has changed, which results in a renewal process that takes beneficiaries between five to eight minutes to complete. For comparison, under the prior system, families had to complete renewal paperwork, submit it, and after submission, wait on average 15 days for their renewal to be processed.

Considering the scope of the changes made during the design phase, some implementation challenges were likely to emerge and staff we interviewed for this study cited four of them while also expressing their belief that the transition went relatively smoothly. First, implementation was delayed several times as systems issues were corrected. Second, there was almost no budget to make families aware of the new online system, and training local staff to assist with the new system did not happen as planned; this led to confusion at implementation. Third, the state underestimated how many people would call for assistance in the first months the online system was operational, leading to long wait times initially. Fourth, although changing the culture was a slow and difficult process for the state agencies involved in implementing the online system, the public readily embraced the culture change introduced by the new system; within two months of implementation, online enrollment was the dominant method of applying for SoonerCare.

a. Enrollment Analysis

In Figure VIII.2, we show the overall number of children, nonpregnant adults, and pregnant women who newly enrolled from September 2010 through December 2012 and the relative percentage that used the home view and agency view. Overall, the online system has enrolled 251,788 children, 75,369 nonpregnant adults, and 55,503 pregnant women, with a majority of applications started at home (62 percent of all child enrollments, 59 percent of nonpregnant adults, and 56 percent of pregnant women).

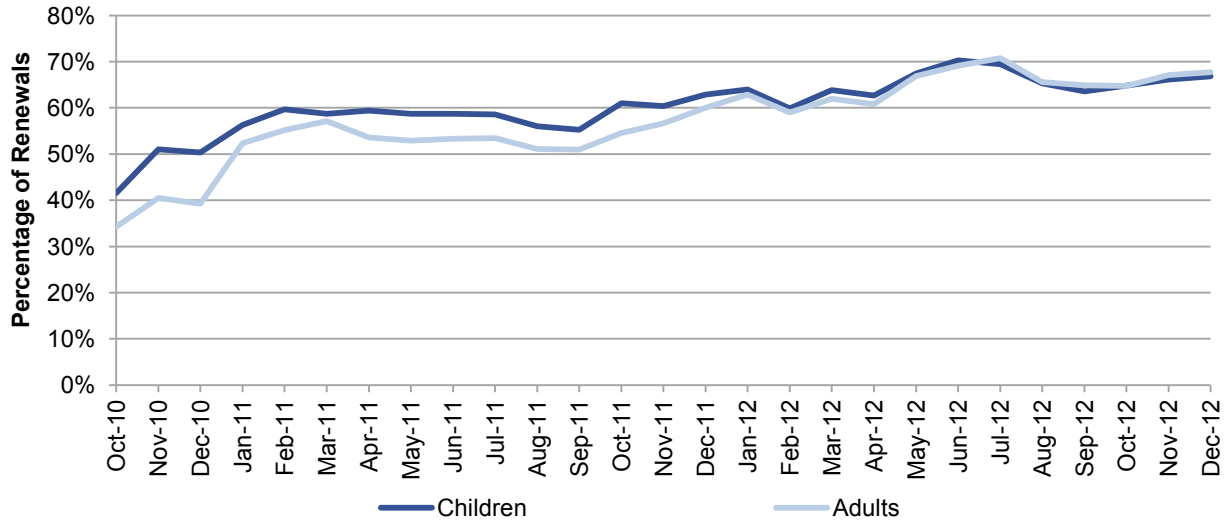
Figure VIII.2. Medicaid Enrollees Using Home and Agency Views, September 2010–December 2012



Source: Mathematica analysis of state-reported data, 2013.

Since October 2010,[65] Oklahoma's online enrollment system has processed 808,306 child renewals and 92,995 adult renewals. Most families—60 percent—renew coverage though the home view. The trend in home renewals is increasing slightly for both children and adults, as demonstrated in Figure VIII.3.

Figure VIII.3. Proportion of Children and Adult Medicaid Renewals Using Home View, October 2010-December 2012



Source: Mathematica analysis of state-reported data, 2013.

[65] Because of a large batch submission of renewals in the agency view at the onset of online enrollment, results from September 2010 are excluded from this analysis.

Those using the home view versus agency view are largely similar in their prior public coverage and their demographics, with some small differences in race and income distribution (Table VIII.5). We find a lower percentage of home view users, regardless of group (child, nonpregnant adults, or pregnant women), self-identified as American Indian compared to those using application assistors: 18 percent of agency view enrollees are American Indian compared to 10 percent of home view applicants. In addition, we note that both child and pregnant women agency view users come from lower-income households; that is, 58 percent of agency view child enrollees, 57 percent of agency view pregnant women enrollees, and 55 percent of agency view child renewals report incomes below 50 percent of the federal poverty line compared to 48, 51, and 47 percent of home view users, respectively. There is evidence that some groups—low-income, rural, and non-English speaking individuals—are less likely to complete an online enrollment process than other enrollees (Brooks and Kendall 2012). Although a majority of families may find the online enrollment application and renewal process easy to navigate, these results suggest that some families may need or prefer person-to-person contacts to help with the application and renewal process.

Table VIII.5. New Enrollees and Renewals in Oklahoma, by Selected Demographic Characteristics, October 2010–December 2012

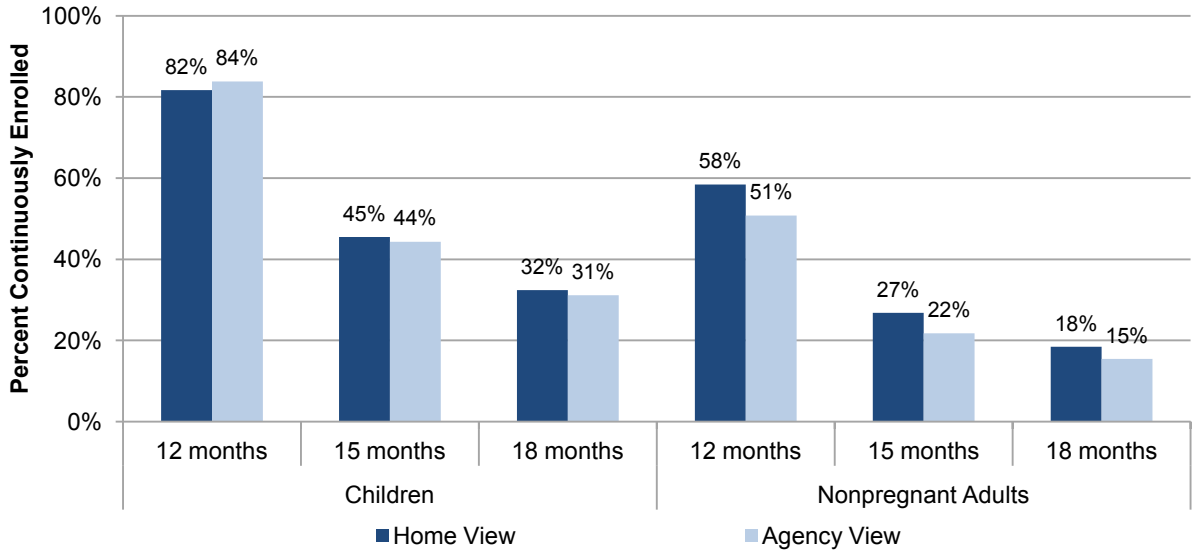
	Percentage of New Enrollees						Percentage of Renewals			
	Children		Nonpregnant Adults		Pregnant Women		Children		Nonpregnant Adults	
	Home	Agency	Home	Agency	Home	Agency	Home	Agency	Home	Agency
Age (Children)										
0–1	9	11	--	--	--	--	6	10	--	--
1–5	32	34	--	--	--	--	34	37	--	--
6–12	35	32	--	--	--	--	38	34	--	--
13–18	24	22	--	--	--	--	22	19	--	--
Age (Adults)										
Under 25	--	--	25	29	60	64	--	--	29	33
26–34	--	--	41	38	34	30	--	--	40	37
35–64	--	--	35	33	7	6	--	--	32	30
Race/Ethnicity										
Black	12	9	14	11	11	6	11	9	14	14
Hispanic	18	21	8	9	20	22	18	25	7	8
AI/AN	10	18	9	13	8	15	10	13	8	13
White	49	41	63	61	53	49	52	43	65	60
Other	10	11	6	6	7	8	10	9	6	6
Income (% FPL)										
< 50	48	58	95	96	51	57	47	55	90	92
50 - 9.9	25	22	1	2	25	25	26	25	5	4
≥ 100	27	19	1	1	22	17	25	19	3	3
Unknown	1	1	2	1	1	1	2	1	2	1
Private Insurance Coverage	12	10	5	6	19	15	10	7	5	5
Prior Public Coverage										
6 months	31	35	14	15	9	10	--	--	--	--
12 months	45	50	26	26	18	22	--	--	--	--

Source: Mathematica analysis of state-reported data, 2013.

AI/AN = person identified as American Indian or Alaska Native; FPL = federal poverty level.

Although we note no difference in retention between children enrolling via home view and agency view enrollees, we do find small difference among nonpregnant adults. For example, home view new enrollees are 7 percentage points more likely to stay enrolled than those using agency view after 12 months (Figure VIII.4). This might be due to differences between the two groups; home view users may be better able to navigate the renewal process than are individuals that enrolled via an application agency perhaps because of greater familiarity/comfort with the online portal (given they applied using the portal). The difference might also provide suggestive evidence that the convenience of the home view option holds promise in boosting retention.

Figure VIII.4. Proportion of Children and Nonpregnant Adults Continuously Enrolled in SoonerCare After 12, 15, and 18 Months



Source: Mathematica analysis of state-reported data, 2013.

b. Cost Analysis

Online enrollment targets a much larger group of eligible individuals compared to ELE programs; the new enrollment and renewal system is available to two out of every three Medicaid-eligible people in Oklahoma.[66] In turn, Oklahoma's online enrollment process investment in IT and staff training was correspondingly many times greater than for any ELE process. Implementing online enrollment in Oklahoma included building a new eligibility system, making connections with multiple provider agency systems, and developing customer-facing portals. Staff report administrative costs of more than $15 million for IT work before and during the first few months following implementation.[67] Staff training was also a large

[66] Not every Medicaid beneficiary is eligible to use the online system; certain groups subject to nonstandard eligibility rules (for example, uninsured women younger than 65 with cervical or breast cancer) cannot use the online system.

[67] This estimate for online enrollment only includes costs to the Oklahoma Health Care Authority, the lead agency for online enrollment; it excludes costs borne by partner agencies, which are unknown but likely much lower, for connecting to the online enrollment system.

undertaking. Although 420 hours were invested in training OHCA staff, OHCA also initiated an extensive train-the-trainer program and webinars to reach front-line eligibility staff in OKDHS, Department of Health, and other partner organizations. Training involved more than 10,000 person-hours.

Online enrollment also required a large amount of planning and policy change at the state level, with multiple agencies involved. However, no SPA was needed because the state plan was sufficiently flexible to allow the necessary process changes without changing eligibility policy from a federal perspective.

Online enrollment saves about $1.5 million per year, comparable to automatic ELE processes. Savings are fueled by the volume processed by the new system: although Oklahoma staff spend a similar amount of time per application or renewal compared to automatic ELE processes, gross savings from the system have been much higher—about $4.4 million per year—because of the large volume of applicants and renewals served. However, online enrollment also incurs much greater ongoing administrative costs than do any of the ELE processes that we studied. IT maintenance costs around $600,000 per year, and new administrative costs to the state for running a telephone helpdesk are around $2.3 million. Management and analyst time used exclusively for running the online enrollment process costs the state around $100,000 per year, taking the annual ongoing administrative costs for online enrollment to $2.9 million.

E. Comparing Other Simplifications and ELE

Like ELE processes, all of the other simplifications studied simplify the enrollment or renewal processes for families, improving the consumer experience. Moreover, the two focused on enrollment (presumptive eligibility and online enrollment) also expedite coverage. These other simplifications studied still require families to spend time either to apply for or renew their coverage, so they are less streamlined compared to automatic ELE processes. However, the time spent by families to enroll or renew is similar to that of families in the states that adopted simplified application and simplified procedure ELE processes.

As with ELE, enrollment and renewal results from the other simplifications vary. Oklahoma's online system processes far more enrollments and renewals than any of the ELE processes studied, but that was as the state intended: online enrollment was meant to be a simplification for nearly all Medicaid and CHIP beneficiaries in Oklahoma (about 72 percent of enrollees qualify to use the system, and they are required to use it for enrollment or renewal). Michigan's presumptive eligibility process is more similar to simplified application ELE processes in that it provides a pathway to enrollment for populations that may not be reached through traditional means. Michigan's presumptive eligibility leads to more annual enrollments compared to states that adopted simplified application ELE, but fewer annual enrollments compared to states that adopted either simplified procedure or automatic processing ELE. Importantly, the presumptive eligibility process may be picking up some families that are traditionally hard to reach in Michigan. In New York, half of renewals in counties where phone renewal is an option are processed through the phone center (but because New York City is excluded from phone center renewals, renewals processed through the phone center represent a small proportion of all renewals). By comparison, states using ELE for renewal are processing between 15 and 48 percent of their statewide monthly renewals through the ELE process.

Table VIII.6. Annual Enrollments, Renewals, and Net Administrative Savings or Costs from Other Simplifications

State	Simplification Implemented	Annual New Enrollments	Annual Renewals	Net Annual Administrative Savings (Costs) Estimate from Implementing Process
Michigan	Presumptive eligibility in Medicaid for children and pregnant women	28,992	NA	($10,000)
New York	Phone renewals	NA	89,736	NA
Oklahoma	Online enrollment and renewal system	142,572	400,584	$1,500,000

Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Cost data was not available for New York's phone renewal process. Data were not available to present these enrollments and renewals as a proportion of all enrollments/renewals in each state. The number of enrollments shown for Michigan is the number of referrals from the presumptive eligibility process to Medicaid; not all of these referrals result in enrollment, although officials believe most referrals result in enrollment.

NA = Not applicable.

The presumptive eligibility process as employed in Michigan may be easier for families than some of the ELE processes studied, particularly those focused on simplifying application forms for targeted families. For example, some parents whose children were enrolled in coverage through ELE processes in Maryland and New Jersey were confused by the mail communication they received from the state about coverage through the ELE process; some others did not understand how the ELE process worked or that the shortened application represented a change from the standard process. Parents who participated in Michigan focus groups found the presumptive eligibility enrollment process to be straightforward and easy to understand, and they liked that their child had Medicaid coverage immediately.

New York's phone renewal and Oklahoma's online enrollment system represent much larger process changes compared to ELE. First, they were larger in scope than ELE: these simplifications were designed to affect nearly all beneficiaries,[68] whereas ELE is only targeting the subset of users who can be identified by the Express Lane partner agency as meeting coverage eligibility criteria. Both also took several years to implement these new technology tools in efforts to transform these state's enrollment and renewal processes; in contrast, most of the ELE states studied were able to implement their ELE processes within a few months. Oklahoma's new process required more extensive training compared to ELE; Oklahoma staff estimated they spent more than 10,000 person-hours for training, compared to 600 or fewer hours in the ELE states (New York could not provide an estimate for training hours).

All three other simplifications still require families to spend time either to apply for or renew coverage, so compared to automatic ELE processes, phone renewal and online enrollment are not as streamlined. The time spent by families to renew or enroll is more

[68] New York's process is not currently operating statewide because it adopted a phased approach to implementation.

similar to the experiences of families in states that adopted simplified processing or simplified application ELE approaches.

As with different ELE processes, new administrative savings or costs from the other simplifications studied likewise vary. For example, Oklahoma's online enrollment and renewal system saves the state about $1.5 million per year, on par with automated ELE processes. Michigan's presumptive eligibility was inexpensive to implement, but the process incurs annual administrative costs, similar to the administrative costs for ELE processes that mail simplified applications to families. Although Oklahoma's online enrollment costs $2.9 million annual to operate, it saves $4.4 million annually, leading to net savings of $1.5 million per year—50 percent more than the average savings of states that adopted automatic ELE processes.

IX. SYNTHESIS OF EVALUATION FINDINGS

Building on research efforts demonstrating that enrollment and retention simplification policies could lead to coverage gains for children and potential efficiency gains for states and the federal government, CHIPRA offered states new policy options and new incentives to find, enroll, and retain eligible children in Medicaid and CHIP. This report has focused on one of the new options CHIPRA afforded to states—Express Lane Eligibility (ELE)—which permits states to use findings from other public agencies to determine Medicaid or CHIP eligibility. Our evaluation focused on three key aspects of ELE—enrollment and retention outcomes, administrative costs and savings, and utilization patterns among those served by the policy. We also reviewed three other simplifications—presumptive eligibility, phone renewals, and online enrollment—to understand how they compare to ELE and to give states insights about how they work.

In this chapter, we summarize the key findings of our ELE evaluation and discuss their implications for national and state policy. Because few states have adopted ELE (and some of those have adopted it only very recently) and few ELE processes operate identically, ELE is challenging to evaluate. Although we are confident about our findings to date, examining a longer post-implementation period could provide more or different insights about long-term effects of the policy.

A. Summary of Key Evaluation Findings

As summarized in Table IX.1, findings from the Congressionally-mandated evaluation of ELE support the promise of the ELE policy for increasing enrollment of eligible children and yielding administrative savings compared with standard processes. However, as detailed further below, the extent of these gains appears to depend on how states specifically implement the policy.

Table IX.1. Key Findings from the ELE Evaluation

1. ELE adoption can increase enrollment.
2. States have adopted ELE differently and those differences can affect its potential benefits.
3. Automatic ELE processes serve the most individuals, yield the greatest administrative savings, and eliminate procedural barriers to coverage.
4. Simplified procedure and simplified application ELE processes, which rely on families initiating or returning an application for coverage, produce little to no administrative savings and show more modest descriptive evidence of increasing enrollment.
5. Given the size of renewal caseloads compared to new enrollment caseloads and the recurring nature of renewal, using ELE for renewals holds great promise for administrative savings and keeping kids covered.
6. ELE enrollees use health care services, though fewer than those who enroll through standard routes.
7. Like ELE, all three of the other simplifications studied can help simplify the enrollment or renewal process for families, but they differ in their reach and impact.

Finding 1: ELE adoption can increase enrollment.

After we control for multiple economic and state policy changes over the period, our formal impact analysis finds significant evidence that ELE increased children's enrollment in Medicaid by about 6 percent on average among the ELE states in the study. This estimate is robust to several robustness tests; however, its certainty should not be overstated given the complex factors that can drive enrollment across states. For example, the estimate could be overstated due to other beneficial policy or procedural changes taking place in states that cannot be fully accounted for. Our descriptive analyses and case studies find that in all states, ELE contributed to enrolling or retaining children in Medicaid and CHIP, although the magnitude varied greatly depending on the type of ELE process used. It also finds that children who enroll through ELE were no more likely to experience churn after disenrollment than were other children.

Finding 2: States have adopted ELE differently and those differences can affect its potential benefits.

The eight states in this study adopted three types of ELE processes:

1. **Automatic processing.** Used in Alabama, Louisiana, Massachusetts, and South Carolina, this ELE process enables states to use eligibility findings from Express Lane partner agencies to automatically enroll or renew children in Medicaid or CHIP who are also receiving SNAP or TANF benefits, without any additional action by the family (beyond enrolling in SNAP or TANF). In the states using ELE for initial enrollment (which requires consent), South Carolina obtains consent from families through use of Medicaid services or enrollment in a managed care plan; Louisiana initially used a similar approach but later switched to obtain consent on the SNAP application.
2. **Simplified procedure.** This ELE process includes Alabama's manual ELE process (in which Medicaid eligibility workers manually check SNAP or TANF databases for income determination rather than using standard Medicaid financial eligibility methodologies) and the ELE process used by Iowa's Separate CHIP program (in which children found with income higher than the Medicaid threshold but income eligible for CHIP are electronically referred to the Separate CHIP program). Since these ELE processes use standard applications submitted by families, consent to coverage is obtained through standard means.
3. **Simplified application.** Used by Iowa Medicaid, Maryland, New Jersey, and Oregon, this ELE process uses findings from Express Lane partner agencies to identify children who are likely to be eligible for Medicaid or CHIP and sends them a shortened application that must be processed manually. Because of ELE, these forms can be simplified, and when families complete them, they sign a consent statement permitting Medicaid and/or CHIP agencies to base eligibility factors on findings from the Express Lane partner agencies, rather than obtaining additional information from applicants.

In addition to the type of ELE process, the choice of the Express Lane partner agency, and how partner data are used, can differ and affect the efficacy of ELE. Some agencies that would

seem to be ideal for ELE, because they have data on likely eligible children, have proven to be quite challenging partners. For example, many states have attempted to partner with the National School Lunch Program (NSLP), but these ELE partnerships have been difficult to implement because NSLP data are decentralized, maintained at either the individual school or school district, and are not always in a standard format or easily accessed. Likewise, the state tax agency seemed a natural partner for identifying children who are income eligible, and two of the states in the study changed their tax returns to obtain information about uninsured children. However, data sharing with tax agencies is challenging. In addition, states using the tax agency as a partner have relied on simplified application ELE processes, resulting in few enrollments.

ELE processes that partner with SNAP (sometimes in combination with TANF) or create a CHIP-Medicaid partnership (as in Iowa) show the most promising enrollment results to date. However, partnering with SNAP alone is not enough to guarantee that a large number of children will be processed through ELE. Rather, states' methods of using SNAP data make the difference. ELE partnerships with SNAP in Alabama, Louisiana, and South Carolina have resulted in many ELE enrollments, but Iowa Medicaid and Oregon have not enrolled many children through the process. The difference is the process: Louisiana and South Carolina enroll children into coverage automatically based on SNAP income findings, whereas Alabama uses ELE to process applications already received. In contrast, Iowa Medicaid and Oregon use SNAP data to identify income-eligible children, but families must still complete and return an application form (albeit a simplified form) to be enrolled. This difference in the process for using SNAP data has a greater effect on the levels of child enrollments than the fact that SNAP is the Express Lane partner.

Finding 3: Automatic ELE processes serve the most individuals, yield the greatest administrative savings, and eliminate procedural barriers to coverage.

All of the ELE processes studied serve as a means of enrolling or renewing children in coverage, but the descriptive analysis found that its importance for coverage and cost varies (Table IX.2). Compared to the other ELE processes studied, automatic processing serves the most individuals. For example, through its new automatic renewal ELE process, Alabama expects to renew 300,000 individuals per year, accounting for more than 40 percent of all Medicaid renewals, based on its first four months of operation. The automatic ELE renewal process in South Carolina renews coverage for nearly 125,000 children a year and has accounted for nearly half of all Medicaid and Medicaid-expansion CHIP renewals in the two years it has been in place. In Louisiana, nearly 10,000 children are enrolled through ELE each year. Louisiana's automatic renewal process renews coverage for more than 170,000 children per year, representing about 20 percent of all Medicaid and Medicaid-expansion CHIP renewals in the state. Based on its first six months of experience, we expect Massachusetts to renew roughly 72,000 children and 46,500 adults annually through its automatic ELE renewal process—about one third of the child and adult renewals under 150 percent of the federal poverty level in the state's MassHealth program.

Table IX.2. Annual Number of Children and Adults Newly Enrolled or Renewed in Medicaid and/or CHIP Through ELE and Net Annual Administrative Costs and Savings Associated with ELE, by State and Type of ELE Process

State (Express Lane Partners)	Annual New ELE Enrollments (Percent of Annual New Enrollments)	Annual ELE Renewals (Percent of Annual Renewals)	Annual Administrative Savings (Costs) Estimate from Implementing ELE
Automatic ELE Processes			
Alabama (SNAP, TANF) (Automated)	NA	300,000 (44 percent)	$1,100,000
South Carolina (SNAP, TANF)	110,440 (Unknown)[a]	124,361 (48 percent)	$1,600,000
Louisiana (SNAP, TANF)	9,652 (10 percent)	171,869 (20 percent)	$979,000
Massachusetts (SNAP, TANF)	NA	118,545 (38 percent)	$192,000
Simplified Procedure ELE			
Alabama (SNAP, TANF) (Manual)	41,117 (28 percent)	109,078 (16 percent)	$68,000
Iowa Separate CHIP (Medicaid)	12,557 (53 percent)	NA	NA
Simplified Application ELE Processes			
Oregon (SNAP)	2,212 (Unknown)[a]	NA	($12,000)
New Jersey (NSLP)	1,400 (Less than 1 percent)	NA	($96,000)
New Jersey (Tax)	1,289 (Less than 1 percent)	NA	($74,000)
Iowa Medicaid (SNAP)	1,149 (2 percent)	NA	($2,000)
Maryland (Income)	113 (Less than 1 percent)	NA	NA
Maryland (Residence)	--	NA	($96,000)

Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

[a] The denominator total new enrollments is not available for this state, thus the percentage cannot be calculated.

Note: Massachusetts renews both children and adults through ELE (adults are renewed through an approved Section 1115 waiver). Alabama's automatic ELE renewal process includes women eligible for family planning services coverage (also approved through a Section 1115 waiver). The annual renewal figures shown for Massachusetts, South Carolina, and Alabama's automatic ELE process are projected estimates based on the early experiences from each state (ranging from 4 months of experience in Alabama's automatic ELE process to 10 months in South Carolina). Data were not available to include Oregon's NSLP ELE process in this table.

-- = Not available; CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NA= Not Applicable; NSLP = National School Lunch Program; SNAP = Supplemental Nutrition Assistance Program.

Automatic processing ELE succeeds in large part because of up-front investments that permit the state's information systems, rather than eligibility workers and other state staff, to do the work of determining initial or ongoing eligibility. The recurring administrative costs for automatic ELE processes also are minimal. As a result, automatic processing ELE has led to substantial administrative savings—an average of $1 million per year in recurring net gains in the four states using automatic ELE processes, compared to what the states would have spent to

enroll and renew the same number of people via standard enrollment and renewal methods (Table IX.2).

Finding 4: Simplified procedure and simplified application ELE processes, which rely on families initiating or returning an application for coverage, produce little to no administrative savings and show more modest descriptive evidence of increasing enrollment.

Although some observers may equate ELE with automation, ELE does not have to be automated to find and enroll or renew children eligible for coverage. Although the most efficient ELE processes use automation, they also required the largest up-front investments. Non-automated ELE processes, including simplified procedure and simplified application ELE processes, can also work for states.

With simplified procedure ELE, states are able to expedite eligibility determinations for families that have already applied; because it affects so many applications, it saves money for the state and presumably results in a better experience for the family because applications are processed more quickly. For example, Alabama's simplified procedure ELE process is used to enroll more than 41,000 and to renew 110,000 individuals per year, saving the state about $68,000 annually. It also shortens families' wait for coverage by 19 days, from up to 25 days under standard processes to less than 6 days using this ELE process. However, in contrast to automatic processing, this type of ELE does not identify new, eligible applicants or remove the family's application burden.

Despite the limitations of the simplified application ELE method in terms of enrollment, states using ELE to mail out simplified applications to children identified as eligible for coverage may find this approach as cost effective as traditional outreach methods. States using ELE to mail out simplified applications to children identified as eligible for coverage may find this approach as cost effective as traditional outreach methods. Moreover, it offers advantages over traditional outreach because ELE allows states to use the findings of the Express Lane partner agency to establish eligibility for returned applications. However, simplified application ELE processes are either cost neutral or incur a net cost of nearly $100,000 per year.

With simplified application ELE processes, states do identify eligible-but-uninsured children, drawing on existing information to reduce the amount of information needed from the family (sending families a shortened application form). In turn, the process has significant potential both to enroll children who might not otherwise obtain CHIP or Medicaid coverage and to produce administrative cost savings in much the same way as simplified procedure ELE. However, this process has to date relied on a mail-based outreach approach to reach families, which has not resulted in much enrollment—less than one percent of each state's Medicaid and/or CHIP enrollment—compared to other types of ELE. Across the five ELE processes using the simplified application ELE approach, between 5 and 13 percent of families completed and returned the simplified applications. Perhaps not surprisingly, therefore, we find the least descriptive evidence of meaningful administrative savings or enrollment gains from this process: enrollments have ranged from 113 children per year in Maryland to about 1,400 children per year through New Jersey's NSLP ELE partnership (see Table IX.2).

Despite their relatively modest numbers, the simplified application ELE approaches show promise in reaching certain key target populations. For example, the evaluation found that children enrolling through ELE were more likely to be teens. Given that teenagers are traditionally the most likely among all children to be uninsured, this finding suggests that even ELE processes that reach a small proportion of the target population may be useful for reaching and enrolling older children. We also found that simplified application ELE processes, which focus on identifying children who have not applied for coverage, were more likely to reach children who did not have recent spells of public coverage. These findings suggest that simplified application ELE processes hold promise for identifying and enrolling children disconnected from coverage.

Finding 5: Given the size of renewal caseloads compared to new enrollment caseloads and the recurring nature of renewal, using ELE for renewals holds great promise for administrative savings and keeping kids covered.

Approximately 170,000 and 120,000 children each year in Louisiana and South Carolina, respectively, nearly 80,000 children and adults in the first six months of Massachusetts' ELE process, and more than 90,000 children and adults in the first four months of Alabama's automatic ELE process have had their coverage renewed via ELE. These sizable numbers demonstrate the potential of implementing ELE for renewal as a means to generate administrative savings and efficiencies, particularly in contrast to using ELE for applications. Although this result is not surprising, given the relative size of a state's renewal caseload compared to the applications received, ELE for renewal has not been as widely adopted as has ELE used for processing applications.

Finding 6: ELE enrollees use health care services, though fewer than those who enroll through standard routes.

Our analysis of utilization data in four states finds that most ELE enrollees accessed a variety of health care services through their coverage and rarely used only wraparound services such as vision care. This finding was consistent across states and across the three types of ELE employed (automatic processing, simplified procedure, and simplified application).

The evaluation also found that ELE enrollees are somewhat less likely to use services, and those who do use services do so less intensively compared to similar enrollees who did not enter through ELE. The lower service use among ELE enrollees may have several explanations, which we cannot disentangle through this analysis. Our results are consistent with the theory that even though their families may be seeking other social support services, children who are eligible for but not enrolled in public insurance programs may simply be healthier than their enrolled peers and have lower health care needs. Some have raised the concern that ELE enrollees—especially those enrolled through automated, passive processes—may not access services because they are unaware they are covered or, if they know they are covered, may be unfamiliar with the ways they should begin seeking services. The fact that most ELE enrollees use a variety of services, and the consistency of our results across states that use diverse ELE mechanisms, mitigate these concerns. These findings also suggest that states adopting ELE may find the children who enroll through the process are less expensive to cover than are their typical beneficiaries.

Finding 7: Like ELE, all of the other simplifications studied help simplify the enrollment or renewal process for families, but they differ in their reach and in the magnitude of effects.

Three other simplifications were studied: presumptive eligibility in Michigan; phone renewals in New York; and online enrollment in Oklahoma (Table IX.3). All of the other simplifications studied simplify the enrollment or renewal processes for families, improving the consumer experience. Moreover, the two focused on enrollment (presumptive eligibility and online enrollment) also expedite coverage. These other simplifications we studied still require families to spend time either to apply for or renew their coverage, so they are less streamlined compared to automatic ELE processes. However, the time spent by families to enroll or renew is similar to that of families in the states that adopted simplified application and simplified procedure ELE processes.

Enrollment and renewal results from the other simplifications vary. Oklahoma's online system processes far more enrollments and renewals than any of the ELE processes studied, but that was as the state intended: online enrollment was meant to be a simplification for nearly all Medicaid and CHIP beneficiaries in Oklahoma (about 72 percent of enrollees qualify to use the system, and they are required to use it for enrollment or renewal). Michigan's presumptive eligibility process is more similar to simplified application ELE processes in that it provides a pathway to enrollment for populations that may not be reached through traditional means. Michigan's presumptive eligibility leads to more annual enrollments compared to states that adopted simplified application ELE, but fewer annual enrollments compared to states that adopted either simplified procedure or automatic processing ELE. In New York, half of renewals in counties where phone renewal is an option are processed through the phone center (but because New York City is excluded from phone center renewals, renewals processed through the phone center represent a small proportion of all renewals). By comparison, states using ELE for renewal are processing between 16 and 48 percent of their statewide monthly renewals through the ELE process.

Table IX.3. Annual Enrollments, Renewals, and Net Administrative Savings or Costs from Other Simplifications

State	Simplification Implemented	Annual New Enrollments	Annual Renewals	Net Annual Administrative Savings (Costs) Estimate from Implementing Process
Michigan	Presumptive eligibility in Medicaid for children and pregnant women	28,992	NA	($10,000)
New York	Phone renewals	NA	89,736	NA
Oklahoma	Online enrollment and renewal system	142,572	400,584	$1,500,000

Source: Mathematica analysis of data collected through the CHIPRA mandated evaluation of ELE, 2011–2013.

Note: Cost data was not available for New York's phone renewal process. Data were not available to present these enrollments and renewals as a proportion of all enrollments/renewals in each state. The number of enrollments shown for Michigan is the number of referrals from the presumptive eligibility process to Medicaid; not all of these referrals result in enrollment, although officials believe most referrals result in enrollment.

NA = Not applicable

New administrative savings or costs from these processes likewise vary. For example, Oklahoma's online enrollment and renewal system saves the state about $1.5 million per year, on par with automated ELE processes; Michigan's presumptive eligibility process incurs small administrative costs, similar to some of the simplified application ELE processes.

B. Conclusions

Findings from the Congressionally-mandated ELE evaluation show quite clearly that there is no one way to implement ELE and that how a state decides to implement ELE can profoundly affect its potential benefits. These findings reflect an inherent value of ELE: the policy is adaptable and states that have used it did so in ways that suited their circumstances, whether that meant phasing it in over time or using it as a new outreach mechanism.

Nevertheless, for states wishing to maximize coverage through ELE in the most efficient manner, the evaluation findings suggest adopting these ELE best practices:

Evaluation Findings Suggest Four ELE Best Practices to Maximize Coverage:

1. Adopt automated ELE processes.
2. Use ELE for renewal.
3. Choose Express Lane partners with centralized, linkable data.
4. Consider ELE processes that remove administrative barriers for families.

The most efficient ELE processes are automated. Although these types of ELE processes cost the most to implement, the efficiencies gained means they can be used to process large numbers of individuals. In turn, they yield the greatest administrative savings. Using automated ELE processes for renewal show the most promise for maximizing coverage, as states already adopting these processes are capturing one-fifth to one-half of their renewal caseloads through ELE. Moreover, most automated renewal processes remove all administrative barriers for families; removal of administrative barriers has been demonstrated to maximize coverage and reduce churn. Partner selection matters as well, and programs such as NSLP and state tax agencies can be challenging partners. To date, states have had more success working with SNAP, although states also should consider other agencies with centralized, linkable data.

Evaluation findings also suggest further policy implications for states considering implementing ELE. They include:

Data-based verification processes can work well for states and consumers. ELE and the online enrollment system studied in Oklahoma are both forerunners to the types of data matching required under Affordable Care Act provisions that will enroll newly eligible individuals into either Medicaid or Marketplace plans beginning in 2014. These experiences demonstrate how data matching may improve the accuracy of eligibility determinations and can remove barriers for families. The efficiencies gained by using data-based eligibility methods are substantial, resulting in labor savings and, in turn, administrative savings for states. For consumers, these methods expedite coverage and reduce paperwork burdens for families; parents who participated in focus groups reported that they appreciated both of these benefits.

ELE may be less costly to implement among states that have already invested in new eligibility and management information systems. One of the biggest drivers of administrative ELE implementation costs is the investment in technology upgrades needed to make ELE work. For example, Iowa Medicaid invested about $84,000 in programming costs, whereas in South Carolina, information technology appears to have cost between $400,000 and $500,000 at implementation (officials could not provide an exact number). Both states were using legacy Medicaid management information systems (MMISs), which made programming more cumbersome than it would have been for newer systems. Findings from other states were mixed. For example, Louisiana spent more than $100,000 on programming, but officials there think the higher costs were because the ELE process they were implementing was highly automated rather than because of the age of their MMIS (which was also a legacy system). In Oklahoma, which invested $15 million in its new MMIS, officials observed that programming changes are far less costly in the new system, primarily because they can be implemented quickly and easily and therefore do not use substantial staff time. Given federal incentives available under the Affordable Care Act to invest in modernizing eligibility systems, many states are in the process of upgrading their systems, which may bring down the costs of programming the changes needed to implement ELE.

Continuing ELE as a policy option will benefit states that have enacted an ELE process and will potentially expand its use, ideally drawing on lessons learned. Continuing ELE as a policy option will ensure that states already enacting the policy do not need to return to standard processing methods. Although administrative savings and costs have varied, in states using automatic ELE processes, the administrative savings generated from ELE have been substantial: on average, these states are saving $1,000,000 per year. Because ELE saves so much time in these states, remaining eligibility staff have been able to process standard applications and renewals more quickly, typically saving 20 to 30 minutes per application or renewal. In South Carolina, officials reported that they plan to redirect staff resources previously required for application processing toward future program improvements for more rapidly connecting children with appropriate services, such as well-child visits. In Louisiana, state staff reported that ELE enabled them to stay on top of workloads despite staffing reductions caused by state budget cuts. In all of the states except Maryland, ELE has expedited coverage, which benefits consumers.

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APPENDIX A

DISCUSSION GUIDE FOR STUDY OF

ADMINISTRATIVE COSTS ASSOCIATED WITH ELE

AND FOCUS GROUP MODERATOR GUIDE

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A. State Planning for ELE

1. What planning activities occurred in your state before deciding to implement ELE?
   a) How did your state determine the agencies with which you would partner?
   b) Did the state complete any cost-benefit analyses before implementing ELE? If so, are you able to share those with us?

B. Understanding State Enrollment Processes

1. Do you have a flow chart of the standard enrollment process that you could share with us? By standard enrollment process, we mean the one that most children who qualify primarily on the basis of income would complete.
   a) How long has this standard enrollment pathway been established?
   b) Have there been any major changes in this pathway in the past three years? If so, please describe these changes, when they occurred, and why they were implemented.
2. If no flow chart is available, please talk us through the different steps that someone must complete to enroll in your state's Medicaid and/or CHIP program through standard pathways.
   a) Please think about the different people who must review an application, enter or verify data in a computer system, or have contact with an applicant. If your state uses both electronic and paper application pathways, we are interested in developing (or obtaining) a process flow chart for both methods.
   b) Please include any steps that are completed by contracted vendors, as well as those completed by state staff.
   c) Please also consider any steps that occur in passing an application between the Medicaid and CHIP programs.
3. Please walk us through the steps of the standard enrollment pathway(s) and indicate which steps are different for beneficiaries who enroll through the ELE pathway. In what ways do these steps differ?
   a) Has the ELE enrollment process changed since ELE was first implemented? If so, please describe the ways this process has changed.
4. For children who primarily qualify on the basis of income, does your state offer any other facilitated enrollment pathways, aside from ELE, that would follow a different set of steps and processes?
   a) What are these alternate enrollment pathways, and how do they differ from the standard route? When were these alternate pathways implemented?
5. If your state has also implemented ELE for renewals, please talk us through the standard renewal pathway, and any differences for an ELE renewal.

C. Marginal Impacts on Contracted Costs and Staff Time

1. Which of the steps in the standard enrollment process (if any) are completed by a contracted vendor?
    a) Which steps in the ELE enrollment process are completed by a contracted vendor?
2. How are those contractors reimbursed? Some potential examples include—on a per-application basis, a fixed contract price, or a cost-plus-fee basis.
    a) What changes in contractor reimbursement have occurred, if any, as a result of ELE?
3. About how much time do staff spend completing each step in the standard application process?
    a) For steps that are unique to ELE, about how much time do staff spend completing each step for a new ELE application?
4. What is the salary range for a staff member who processes enrollment applications (standard or ELE)?
5. How many staff members are dedicated to managing ELE applications full time?
    a) How many staff members spend part of their time managing ELE applications? About what percentage of their time would you estimate is spent in managing ELE applications?
    b) Were any staff members newly hired to support ELE? Are there plans to hire anyone for such a position?
6. Are there any new ongoing direct expenses associated with ELE enrollment? Some potential examples include new mailing expenses or printing costs for customized enrollment forms.

D. Implementation Costs

1. Thinking back to when ELE was first implemented, what data system changes, if any, were needed to implement ELE?
    a) About how many staff days (or what contractor costs) were required to make those changes?
    b) What is the salary range for a staff member responsible for data systems management?
    c) Are there any other reasons why these systems changes were made, or were they done solely to support ELE?
    d) Would any of these data systems changes be necessary to implement provisions of the Affordable Care Act?

2. Please describe any training concerning ELE that occurred at implementation.
    a) How many people were involved in the training? What types of staff?
    b) How long did the training take to complete?
3. Aside from staff training and data system enhancements, did any other major activities or processes occur in order to implement ELE?
4. Please describe other eligibility or enrollment process initiatives (if any) that were implemented concurrently with or around the same time as ELE.
5. Did ELE implementation take resources away from other activities? If so, what types of resources were diverted and which activities were postponed or deprioritized?

E. ELE Impacts on Partner Agencies

1. Please describe any data-sharing or outreach coordination that you conducted with your ELE partner agency before implementing ELE.
2. Have your data-sharing and outreach coordination activities changed because of the implementation of ELE? If so, how?
3. Are you aware of any process or staffing changes your partner agency has made to enable ELE?
4. Who should we contact at your partner agency to better understand how its costs or staffing might have changed?

F. Overall Enrollment and Outreach Costs

1. What is your annual budget for all enrollment activities for the current year? What is the size of that budget in comparison to the last two years?
2. Please tell us about your major outreach strategies (aside from ELE) to enroll children who would qualify primarily on the basis of income.
3. What is your annual budget for these activities for the current year? What is the size of that budget in comparison to the last two years?
4. How do you evaluate the success of those investments in outreach? Do you know or have an estimate of how many children are contacted and/or enrolled through direct outreach?

G. Impacts for Beneficiaries

1. From the beneficiary perspective, how does the application experience change when they enroll through ELE, rather than through standard enrollment routes?
    a) Are there changes in the total days necessary to process an application?
    b) Does the number of interactions with state staff or contractors that are required change?
    c) Does the type of documentation or number of different documents that they must provide change?

2. From your observations, how easy is the ELE enrollment process relative to the standard enrollment process?
3. Do you have a sense of how many children have been successfully enrolled in Medicaid or CHIP as a result of ELE?

H. Concluding Thoughts

1. Are there other aspects of your ELE program that we should know about to understand how financial and staff time costs differ under ELE?
2. Do you anticipate any changes to the cost of ELE in the next year? For example, because fixed-price contracts will be renegotiated to accommodate changes in work flow, because new staff will need to be hired, or because some aspects of ELE will become newly automated?
3. Are there additional staff members within your agency with whom we should follow up for additional detail on any of the topics we have discussed?

Express Lane Eligibility Evaluation:
Moderator's Guide: Parents of Children Enrolled via ELE

Introduction and Overview of Purpose for Focus Groups[69]

Hello and welcome to our focus group. I'd like to begin by thanking each of you for taking time out of your day to be here. We appreciate it.

My name is _____, and my partner here is _____. We have been hired to conduct this focus group to talk with you about your experiences obtaining health insurance coverage and care for your children through the [Medicaid/CHIP] program.

Each of you has been invited here because one or more of your children is currently enrolled in [Medicaid/CHIP]. In particular, you've been invited because your child was enrolled through a new system called "Express Lane Eligibility," which is a system that automatically enrolls your children into [Medicaid/CHIP] if you already qualify for [SNAP, WIC, Other Program]. Over the next hour or so, we want to talk with you about your experiences having your children enrolled in [Medicaid/CHIP] through this new system. We are having additional focus groups like this one in *[other town].* We are interested in learning about your various experiences with [Medicaid/CHIP], ranging from how you heard about it, how your children were enrolled in the program, and how well you can access health care services with [Medicaid/CHIP] coverage. This will allow us to better understand how well (or not) this program works for enrollees. Also, it will allow us to help policymakers and providers improve their programs for health care consumers like you. So let's get started.

Background Questions

1) Let's start by going around the table and introducing ourselves. I'd like each of you to tell us your first name. Then, to break the ice, why don't you share with all of us a little bit about your children. Why don't you tell me how many children you have, and share with us one of the things you love about them.

2) What are some of the biggest concerns you have right now related to your kids? What do you worry about the most as a parent?

3) Does anyone else in your family have health insurance? And if so, what kind? (By "insurance," I mean either private insurance that you get from your employer like Blue Cross, or a public health coverage program like *Medicaid*.)

   You?
   Your spouse?
   Your children?

4) For those of you who don't have insurance, what are some of the reasons why you (and/or your family members) don't have it?

[69] A similar guide was used for parents of children who enrolled through the other simplifications studied in Michigan, New York and Oklahoma. Before the start of each focus group, consent procedures were fully described, and consent to participate obtained.

Outreach

Okay, let's turn our discussion to [Medicaid/CHIP]. I'd like you to think back to a time perhaps before you even had your children enrolled in the program.

5) Can you remember how you first heard about [Medicaid/CHIP]?

   - At your children's school?
   - From friends?
   - At a clinic or from a doctor?
   - At another place in the community?
   - At another program, like Food Stamps/SNAP?
   - From advertisements on TV, radio, or a brochure/flyer?

6) Can you remember *what*, if anything, you heard about the program before you signed your child up?

   - Did you hear that it was hard, or easy, to sign up for?
   - Did you hear that it had good benefits (or not)?
   - Did you hear that it had good doctors (or not), and whether it was easy (or difficult) to get care in the program?

III. Eligibility Determination, Enrollment, and Renewal

Let's now talk about the systems that [Medicaid/CHIP] uses to establish children's eligibility for the program, and the processes that families like you have to go through to sign their kids up. Once again, each of you is here because you have one or more children enrolled in [Medicaid/CHIP].

7) Once again, you're each here because you have a child that's been enrolled through this new system called "Express Lane Eligibility." We'll talk specifically about that in a minute. But first, I'd like to take you back in time, if that's possible.

   How many of you had your children enrolled in [Medicaid/CHIP] in a prior time—perhaps one or two, or even more years ago?

   For those of you who raised your hand: can you tell me why you enrolled your children in [Medicaid/CHIP] back then*?*

   - Did he or she become sick?
   - Did someone recommend that you enroll in [Medicaid/CHIP]?
   - Did you need a specialist's care?
   - Did your children need dental care?

8) Back at that time, can you remember what the application process was like?

   - Did you fill out an application and mail it in?
   - Did you visit a county eligibility office?
   - Did you apply at a doctor's office or a hospital?
   - Did you apply at a community based organization?
   - Did you apply online?
   - Did anyone help you through the process by helping you complete the form?

9) In general, how would you describe that process?

   - Was it easy and/or convenient?
   - Was it difficult? Why? How so?
   - Was the application form short and user-friendly? Or was it long and difficult?
   - Did you have to gather and submit documentation of income or assets?

10) Back then, do you remember whether your child ever lost their coverage under [Medicaid/CHIP]*?* In other words, such programs require families to renew their coverage every now and then (like once each year).

    - Do you recall going through that process?
    - Did your child end up losing their coverage at that point? If so, do you know why?
    - Do you recall why that might have happened? For example,

      - Did you intentionally decide to *not* renew the coverage?
      - Or, was the process a hassle?
      - Or, had you had bad experiences with doctors or clinics, and decided it wasn't worth renewing?
      - Or, did you think your child wasn't eligible?
      - Or, was there some other reason?

11) My final "back in time" question relates to [other social services program, e.g. SNAP, WIC, other]. How many of you are currently receiving [Other] for your family? Can you tell me what *that* application process was like?

    - Was it easy and/or convenient?
    - Was it difficult? Why? How so?
    - Was the application form short and user-friendly? Or was it long and difficult?
    - Do you have to gather and submit documentation of income or assets?
    - Did anyone help you through the process?

12) How would you compare the two application processes—[Medicaid/CHIP and Other]?

    - Which one was easier (or more difficult)?
    - Why was it easier (or harder)?

OK, that's enough looking back in time. Let's now turn to the present. As I said earlier, you're all here because your child was enrolled in this program through this new system called "Express Lane Eligibility." Let's spend the next chunk of time talking about that experience.

13) Do any of you remember receiving a letter from the [Department of Health/Social Services] saying that, because you [get (Other Program) or qualified through your tax return information], your child might be eligible for Medicaid or CHIP coverage*?*

    - Can you remember what the letter said?
    - Do you remember if it asked you to *do* anything in response, such as call the Department to give them permission to share your [Other Program] information with Medicaid/CHIP?
    - Or perhaps, did it ask you to call them only if you *did not* want your information shared?
    - What did you think about that letter?

        - Did it strike you as odd that the state was telling you that your child was eligible for [Medicaid/CHIP]*,* and you hadn't even filled out an application?
        - Was that weird?
        - Did you like the idea that you didn't need to apply?
        - Or were any of you hesitant to grant the state permission to use your [Other Program] information for Medicaid/CHIP eligibility?
        - Did any of you call the number on the letter to ask for help, or to better understand what was going on? How did that go?

14) [Alternate Question:] Do you remember checking a box (or otherwise indicating) on your application for [Other Program] to give permission to the [Other Program Agency] to share your personal/application information with [Medicaid/CHIP] so that your eligibility for health coverage could be considered?

    - What did you think of that?
    - Did you like the idea of having your [Other Program] application also serve as an application for health coverage?
    - Or were you hesitant to allow the [Other Program] to share your information with [Medicaid/CHIP]?

15) Let's talk about what happened next. Did you receive a *second* letter that included a card, which told you your child was enrolled in [Medicaid/CHIP]?

    - When did that happen; in other words, how much time passed between the first and the second letter?
    - Do you remember what the letter said?
    - What did you think about that letter?

        - Did it strike you as odd that the state was telling you that your child was eligible for [Medicaid/CHIP]*,* and you hadn't even filled out an application?
        - Was that weird?
        - Did you like the idea that you didn't need to apply?

- Did it say anything about what kind of services your child was covered for?
- Did it say anything about whether you needed to choose a doctor?
- Did it give you an option to accept or decline the coverage?

16) How did you feel when you learned that your child was enrolled in [Medicaid/CHIP]*?*

- Did it make you happy and/or relieved?
- Or did it feel strange, or confusing, to receive something that you had not asked for? (Since you hadn't actually applied for Medicaid/CHIP*?*)

17) How long have your children been enrolled in [Medicaid/CHIP]?

18) For those of you with children who have been in [Medicaid/CHIP] for over 12 months, have you ever had to renew your coverage?

19) What was it like to renew your coverage?

- Did you have to do anything (or was it automatic)?
- What did you have to do?
- Send in a renewal application? By mail? Online?
- Show up in person?
- Or was renewal "automatic," where you really didn't need to do anything?
- What did you think of this?

Okay, now I'd like to spend a little time talking with you about how the two eligibility processes compare with each other. Recall that we started by talking about what it was like to apply for and enroll in Medicaid/CHIP before Express Lane Eligibility…and then we talked about what it was like under this new system of Express Lane Eligibility.

20) Overall, what did you think of Express Lane Eligibility, where you were just mailed a card for your child, compared to the older system of enrolling in [Medicaid/CHIP]*?*

- Did you like the "automatic" nature of the new system? Why? Why not?
- Was it at all confusing or disorienting? Tell me about that…

21) Do you think that you would have ended up applying for [Medicaid/CHIP] anyway, if there was no automatic "Express Lane" system?

- If yes, why? Would you have just applied the next time your child needed care?
- If no, why not? Was the old process too much of a hassle, or too difficult or confusing?

IV. Access to Care and Benefits

I'd like to spend just a little time talking with you about going getting health care for your child under [Medicaid/CHIP].

22) First of all, were you ever unsure about whether or not your child actually had [Medicaid/CHIP] coverage? In other words, did this "automatic" or "express lane" eligibility confuse you about when or if your child was actually covered?

23) How many of you have used your child's [Medicaid/CHIP] card in the last year to obtain care for your child?

24) Where did you go to get health care for your children when they were sick or injured?

- A doctor's office?
- A clinic?
- A hospital?

25) Was it easy to get in to see this provider? Or, did you have any trouble getting your children in to receive care? For example, do you ever have:

- Trouble getting appointments (or long delays in getting appointments)?
- Long travel time/distance to doctor's office?
- Long waits in the doctor's office?
- No care available "after hours," when you're not working?

26) Generally, are you happy and satisfied with the quality of health care your child receives through [Medicaid/CHIP]?

- Why? Why not?

Let's now discuss your experiences obtaining other kinds of care while your children have been on [Medicaid/CHIP].

27) Have any of you ever used your [Medicaid/CHIP] card to get dental care for your child?

- How did that go? Was it easy to find and get in to see a dentist?
- Did you feel like you received high quality dental care from this provider?

28) Have any of you used your [Medicaid/CHIP] card to bring your child to the eye doctor?

- How did that go?

29) Have any of you used your [Medicaid/CHIP] card to get medicine for your child?

- How did that go? Did your child get what he/she needed?

Sometimes our regular doctors may refer our children to other doctors for more care, or more specialized care.

30) Have any of you used your [Medicaid/CHIP] card to get specialist care for your child?

- How did that go?
- What kind of specialist did you visit?
- Was it easy to find and get an appointment with this specialist?
- Did you feel like you received high quality care from this provider? Why? Why not?

Sometimes our children need help with their development, or behavior problems. For example, a child that is not talking enough, or a child or is having a hard time learning or getting along with other children.

31) Have any of you used your [Medicaid/CHIP] card to get your child developmental care? (By developmental provider I mean a developmental specialist, a speech therapist, occupational therapist, physical therapist, or special education provider.)

- How did that go?
- Was it easy to find and get an appointment with this provider?
- Did you feel like you received high quality care from this provider? Why? Why not?

32) Overall, what do you think of the benefits covered by [Medicaid/CHIP]?

- Do they meet the needs of your children?
- Have your children ever needed a service that was not covered by the program? If so, what service was not covered?

IV. Overall impacts on daily life

Okay, we're almost done.

33) We've spent the last hour or so talking about your children's health coverage under the [Medicaid/CHIP]. In closing, I'd like to ask you: How do you feel, knowing your child has health insurance? Does having health insurance make a difference in your life, your family's life, and your children's lives? How so?

- If yes, listen for:
  (1) Peace of mind/sense of security?
  (2) Easier access to care? (e.g., more providers available? Easier to see a provider?)
  (3) Better quality of care?
  (4) Lower cost?
  (5) What else?

- If no, listen for:
  (1) I can get care for my kids without insurance
  (2) It costs too much
  (3) Afraid of public charge
  (4) What else?

V. Lessons Learned

34) Finally, tonight we've discussed two different systems for getting our children into [Medicaid/CHIP]. In the old system, you filled out an application and submitted it to the state. In the new system, the state automatically determines your eligibility, based on information you already gave the [Other Program]. Once more,

- What do you think of these two approaches? Which one do you like better? Why?

- Do you think that one approach is better for getting health insurance to kids? Why?

35) Is there anything that the state could do to make the process of getting [Medicaid/CHIP] coverage for children work better? What?

36) Have you heard about changes that are coming in 2014 to health coverage, sometimes called health reform or federal health reform?

    - If so, do you know that if you do not have health insurance, you might become eligible for this coverage in 2014? Is that something you already have and don't need, or something you would look forward to having for yourself?
    - Would it be easy if you could enroll "automatically" like through the Express Lane Eligibility process your child enrolled through?

37) Is there anything else that you'd like to talk about tonight? Anything that we haven't discussed that you'd like to?

If that's all, I'll just say "THANKS" for all your helpful participation today! You've been a great group…

APPENDIX B

DATA COLLECTION METHODS FOR THE

DESCRIPTIVE ANALYSIS OF ENROLLMENT

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The data used to support the ELE analyses described in Chapter IV and those of the non-ELE case study states in Chapter VIII consist of a mix of individual-level enrollment data and monthly aggregate data obtained from each state's Medicaid and/or Separate CHIP data administrators.

A. Individual-Level Data Collection

To assess the ELE enrollment processes in Alabama, Iowa, Louisiana, and New Jersey; the renewal processes in Alabama and Louisiana; and the centralized processing of renewals adopted in New York, we used individual-level administrative enrollment data provided by the states. The data typically reside in one of two administrative sources: the Medicaid or Separate CHIP management information systems (MISs). The types of information we needed from the systems include the timing of Medicaid and Separate CHIP coverage for each child enrolled in the program over the study period; the eligibility category for each spell of coverage; a unique identifier that can be used to link the child across several coverage spells (as relevant); and the child's date of birth, child and household characteristics, and information to allow us to identify individuals enrolled via ELE. In Louisiana and New Jersey, the data come from a single system because the two states have integrated their Separate CHIP and Medicaid enrollment data into a single MIS. In Iowa, Alabama and New York, we received enrollment data from both the CHIP MIS and Medicaid MIS. Because the separate agency data systems in Iowa and Alabama do not share a common unique identification field other than Social Security numbers (SSNs), we linked the two files by using a combination of SSNs and date of birth.

An important step in the data processing task involved the creation of one longitudinal enrollment record for each individual ever enrolled in the relevant program over the study period. The single record detailed, for each month of the period, whether the child was enrolled in Medicaid expansion CHIP, Separate CHIP, or the state's Medicaid program. The creation of the enrollment record was dictated by the available information and its format as provided by the states. For Medicaid or combined Medicaid/CHIP files, we used eligibility group and aid category variables, which describe the child's pathway to eligibility. For example, to separate children enrolled under Medicaid expansion from children enrolled under regular Medicaid eligibility criteria, we used eligibility codes and a crosswalk provided by the states that indicated the category of eligibility pertaining to that month or spell of coverage. For Separate CHIP–only files (Alabama Separate CHIP, Iowa Separate CHIP, New York Separate CHIP), which required no differentiation between programs, the states did not provide any program type variable, and we took the presence of a monthly observation to indicate that the child was enrolled in the state's Separate CHIP program in that month.

1. Enrollment Measures

After converting the state enrollment files into an individual-level longitudinal file, we constructed a series of measures developed under the Maximizing Enrollment project to help states assess their performance in administering public insurance programs (Trenholm et al. 2011). The measures spanned the course of children's coverage—from program entry and retention to eventual program disenrollment and possible return (either through transfer between programs or churning back into the same program following a gap in coverage). We constructed all measures on a monthly basis over the enrollment period, creating a substantial time series from which to investigate trends in coverage. We created the following key measures:

- Total monthly number of individuals newly enrolled by month. A "new enrollee" is a child enrolled in the specified program (CHIP or Medicaid) for two consecutive months but not in the previous two months.
- Previous public coverage (Medicaid or CHIP) rates of new enrollees who are at least one year old (6, 12, and 24 months).
- Continuous coverage rates of new enrollees (6, 11, 12, 13, 15, and 18 months, if applicable). To be considered continuously covered, a child must not have a break in *public coverage* since his or her new enrollment month (that is, we consider a child who transferred between programs without a break in coverage to have been continuously enrolled though that period).
- "Return rates" or churning of new enrollees, whereby we calculate the return rate as the proportion of children who drop coverage at the renewal period (months 12 through 14) but reenroll within six months.

2. Sample Sizes of ELE Enrollments

For our assessment of ELE on enrollment, we restricted our file to all new enrollments in the relevant program observed during the study period. We used state-provided information on ELE status to identify whether a new enrollment occurred via ELE.[70] The total row in Appendix Table B.1 indicates the total number of ELE and non-ELE enrollments identified in each state during the post-implementation period. Given that the ELE enrollment processes of interest are largely targeted at *Medicaid- or CHIP-eligible but uninsured children* who participate in other public programs or children identified with the use of partner agency data, we further limit the sample to children who had no public coverage in the preceding two months (rows 2 and 4) when comparing ELE to non-ELE enrollees on demographic and prior public coverage characteristics and retention outcomes. Further, to make valid comparisons across the two groups (rows 3 and 6) in analyses comparing ELE to non-ELE in Medicaid programs, we restrict the sample to children who primarily qualify for Medicaid on the basis of income (rather than on the basis of disability, foster care status, and so on).[71]

[70] In Alabama, Iowa Medicaid, and Iowa Separate CHIP, the information took the form of a separate variable provided in the file. Louisiana has established a unique state eligibility group code identifying ELE enrollees in the eligibility system. New Jersey provided a flat file of all ELE applications processed by its state vendor, which we merged into the enrollment file provided by the state.

[71] In Louisiana, we also excluded children deemed eligible for Medicaid (children born to a woman who is Medicaid eligible when the child is born) from our income-based sample because we did not consider such children a valid comparison group for ELE-enrolled children.

Table B.1. Sample Size

		Iowa (Separate CHIP)				New Jersey (Medicaid/CHIP)	
	Alabama (Medicaid)	Referrals	Transfers	Iowa (Medicaid)	Louisiana (Medicaid)	Tax ELE	NSLP ELE
Start Date	April 2010	August 2009	August 2009	June 2010	February 2010	May 2009	September 2010
New Enrollments in Program Since Start Date							
Total	394,422	79,218	-	186,785	275,980	697,970	433,686
Plus new to public coverage	371,620	43,471	35,747	166,820	273,614	579,932	356,337
Plus income-based new enrollments	360,803	43,471	35,747	145,113	149,183	546,489	264,869
ELE Enrollments in Program Since Start Date							
Total	109,645	41,858	-	2,872	27,347	4,619	3,150
Plus new to public coverage	103,593	10,169	31,689	2,414	27,332	4,431	3,084
Plus income-based new enrollments	101,262	10,169	31,689	2,387	27,332	4,430	3,081

Source: Mathematica analysis of state-provided administrative data.

Notes: Start date is the date ELE was implemented for applications.

Medicaid includes Medicaid and Medicaid expansion CHIP, where applicable.

Some ELE new enrollments occurred before the ELE start date: 179 in Alabama, 4 in Iowa Medicaid, 59 in New Jersey (tax), and 89 in New Jersey (NSLP). They are excluded from the above counts and, except for New Jersey (NSLP), excluded from analyses.

CHIP = Children's Health Insurance Program; ELE = Express Lane Eligibility; NSLP = National School Lunch Program.

B. Aggregate Data Tables

Among the states not submitting individual data—Massachusetts, Michigan, South Carolina, and Oklahoma—we requested aggregate data tables from each state's Medicaid or Separate CHIP data administrators. We submitted shells for these tables to states along with information about how to populate them. For renewals, we requested one set of tables be populated; for applications, there was an additional set of tables designed to capture retention outcomes of new enrollees.

For the first set of data tables, we asked the states to provide counts of monthly ELE (or other simplification process) new enrollments or renewals and traditional new enrollments or renewals for children who primarily qualify for Medicaid or another public insurance program on the basis of income (rather than on the basis of disability, foster care status, and so on).[72] The

[72] Table shells for the state using simplified measures to facilitate enrollments only (Michigan) keyed off the **number of enrollments** processed each month over the relevant period. Table shells for states using simplified measures to facilitate renewals only (Massachusetts and South Carolina) keyed off the **number of renewals** processed each month over the relevant period. Table shells for the state using simplified measures to facilitate both enrollments and renewals (Oklahoma) had separate shells to key off both the **number of enrollments** processed and the **number of renewals** processed each month over the relevant period.

requested data ranged from the year before the state adopted ELE (or other simplified process) through December 2012. Next, we asked states to provide the monthly enrollment or renewal counts disaggregated by several demographic characteristics, including the beneficiaries' age, race/ethnicity, household income, and urban/rural status. For Oklahoma's new enrollment tables, we also asked that they review past enrollment records to look for a recent period of prior public coverage in Medicaid or CHIP, to help address whether enrollees are truly new to the system and how recently they might have had contact.

For Oklahoma's use of online enrollment for applications, a second data table requested information on continuous coverage, disenrollments, and transfers, stratified by use of Online Enrollment at home or agency view. For example for each monthly cohort of new enrollees in the specified program, we requested data on the number of beneficiaries who remained enrolled in public coverage 12, 15, and 18 months after initial enrollment; how many had disenrolled from the program at those time points; and how many had transferred to the other program at those times points.

We shared the table shells with states in December 2012 and scheduled an orientation call, including both policy staff and the information systems staff directly responsible for compiling the data request, to walk through the table shells and guidebook and to answer any immediate questions. We had further follow-up with the states as needed, both to provide support until the data had been submitted and to ensure that we understood the data that states had reported.

APPENDIX C

DETAILED DESCRIPTION OF METHODS FOR

THE ELE COST AND SAVINGS STUDY

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A. Data Collection

Data on the administrative costs of ELE were obtained primarily through telephone consultations with state staff. Initial conversations with six ELE states—Alabama, Iowa, Louisiana, Maryland, New Jersey, and Oregon—were conducted between January and March 2012. State staff subsequently reviewed and verified the notes from these discussions and answered outstanding questions. We held another round of interviews with staff in these six states between December 2012 and July 2013 to determine whether ELE processes had changed as they became more established and to further develop our understanding of these processes' costs. Also in this time period, we conducted initial interviews with staff in Massachusetts and South Carolina, which both implemented ELE in 2012, to understand their ELE processes and the associated costs to implement it. With all states, we repeated the verification and follow-up approach used in the first year, either by submitting notes to the states to review or by asking them to review site visit reports and asking further clarifying questions.

The semi-structured discussion guides used for these interviews solicited detailed information on the standard enrollment or renewal process; the steps that are abbreviated, omitted, or added through the ELE process; the marginal costs associated with ELE and standard enrollment or renewal processes; and the costs of initial ELE implementation (this guide is found in Appendix A). Cost domains that we considered included the salary and benefits of state staff; contractor reimbursements; payments to application assistors; modification of information management systems; and other direct costs, such as printing or mailing applications to potential enrollees. We also sought to understand contextual factors that might affect cost estimates, such as other concurrent changes in enrollment processes and prior data-sharing relationships with partner agencies that may have impacted the relative cost and ease of formalizing ELE data-sharing arrangements.

To assess changes to these cost domains caused by ELE, we sought information from policy, program, information systems, and front-line eligibility workers at state Medicaid and/or CHIP agencies. We also held brief discussions with ELE partner agency staff where possible. For states with ELE processes for both initial applications and renewals, we explored both processes relative to the standard processes. To supplement information obtained through discussions with state staff, we reviewed publicly available documents including state plan amendments, ELE and standard application forms, and state budget and performance reports.

B. Data Analysis

Combining data from all cost discussions with staff in a given state, we calculated three types of ELE-related costs and savings: (1) the initial costs of implementation, (2) the savings and costs for the marginal application, and (3) the net savings or costs on an annual basis. Because states vary in the way they divided ELE tasks between the state Medicaid or CHIP agency and ELE partner agency, we calculated all three of these measures as the costs or savings to the public sector, regardless of the original funding source. If certain costs or savings were

absorbed by private contractors, they are not included in our analysis because they did not affect public sector finances.[73] Below, we provide additional details on each measure.

Initial costs of implementation. The initial costs of implementation primarily reflect eligibility and policy staff training as well as information systems modifications needed to share data with ELE partner agencies. Because they were often working on multiple initiatives and did not contemporaneously document time dedicated specifically to ELE, policy staff in most states struggled to estimate their efforts on ELE design and implementation; however, where available, we present state estimates. Some states were able to describe the opportunity costs of prioritizing ELE over other initiatives. Staff training costs are presented in person-hours spent. Cost estimates of information systems modifications and computer programming were obtained from public health insurance and/or partner agency staff (as applicable). Because programming costs were often documented on a "per job" basis, states were generally able to supply reliable estimates. It is important to note that since some states either used state staff or existing IT contracts to do ELE programming and other implementation work, ELE costs are best interpreted as opportunity costs: the same people may have been employed at the same rate in the absence of ELE, but other work was deprioritized in order for ELE to be implemented.

In this analysis we have not included the cost of two ELE-relevant but separate pilot programs in New Jersey prior to full implementation of the NSLP ELE process. The cost of each of these pilots was around $1 million. The second of these two pilots could be accurately described as ELE but is excluded from the main body of this analysis because it was significantly different from the ELE process that the state later implemented.[74]

Savings and costs for the marginal application or renewal. Our calculation of savings or costs per marginal application or renewal assumes that applications or renewals being processed via ELE that resulted in an ELE enrollment would otherwise have been processed the standard way. We also assume that ELE applications that do not result in an enrollment under Oregon's SNAP ELE process, Maryland's income-establishment ELE process, and Iowa Medicaid's ELE process represent new costs to the states. Unsuccessful ELE applications in these processes entail the use of staff time or the payment of contractor fees to process those applications without bringing time savings relative to the standard process. Anyone found ineligible through ELE can still apply via the standard route, so ELE processing of applications that are ultimately unsuccessful does not replace the standard processing of an application and does not save any time or money. Rather, it adds an extra process, leaving applicants in the same position in which they started. This second assumption only applies to these three processes. Under the automated ELE processes, ineligible applicants do not pass the automated data match process so they do not use any staff time; in Alabama's manual ELE process and Maryland's residence-establishment ELE process, the ELE process costs no additional staff time, and in New Jersey, extra time spent

[73] New Jersey and Iowa CHIP both use private contractors for eligibility determinations. Both programs confirmed that contracts were not amended to account for any increase in the volume of applications or any time savings per application resulting from ELE.

[74] More than 70 percent of this ELE pilot's $1 million budget was spent on grants to school districts and community partners to encourage them to participate. A finding from this pilot was that grants would not be necessary when ELE was implemented statewide because the demands of ELE on schools and community partners were low.

processing unsuccessful ELE applications is absorbed by the third-party contractor, whose contracts were not adjusted to account for changes introduced by ELE.

Given these assumptions, we began by calculating the time savings per application by subtracting the minutes taken by each type of staff member to process a typical application or renewal via ELE from the minutes taken by each type of staff member to process a typical application or renewal via the standard route. Some states provided a range of times for the ELE process, the standard process, or both because time per application depends on factors such as the number of individuals per application and the complexity of household relationships as well as whether an application was mailed in or submitted via a local social services office. In some cases where states provided a range of times, we had enough information to weight time estimates to produce an approximate average (mean) time per application. In other states, we took the midpoint of the range as our estimate. Where a state uses ELE for renewals, we calculated "time saving per ELE renewal" using a similar method.

To calculate the dollar value of time saved per ELE application or renewal, we multiplied the time saving per ELE application or renewal by the proportional salary and benefits for the relevant eligibility processing staff. If the state provided a salary range, we used the midpoint. In states where application assistance costs under the standard route would be avoided by the ELE process—such as in Louisiana, where one third of initial applications in the standard process are submitted by contracted application assistors paid on a per-application basis—we included those savings in our per-application savings estimate. Similarly, where an ELE renewal process reduced the need for a state to send renewal reminders, we included the avoided mailing cost as an ELE saving. Our savings calculation does not include possible overhead costs (including any managerial staff time or non-payroll costs such as rent or utility costs), and it does not include other possible savings such as avoided outreach costs.[75]

The calculation described above yields an estimate of the value of staff time and other savings by processing successful applications or renewals via ELE rather than the standard route. From this estimate, we subtracted the cost of processing unsuccessful ELE applications (where applicable) and, in South Carolina, the costs of disenrolling individuals who were automatically enrolled via ELE and then opted out of Medicaid coverage. We also subtracted the cost of other new ongoing expenses associated with ELE—such as per-application contractor fees paid for each ELE application in Maryland's income-establishment ELE process or mailing costs incurred by mailings-based ELE processes. The difference between savings and new costs reflects the change in administrative expenses associated with the marginal ELE application.

Net annual savings or costs. To calculate net annual savings or costs in each state, we used the number of people enrolled or renewed over the course of a year or, in some cases, households renewed over the course of a year, to estimate the number of standard applications or renewals that ELE avoided. For example, for Alabama's automated ELE process, which can be used for children and some adults, the state provided the number of household-level (or "case-level") ELE renewals. Because an ELE renewal in Alabama thus covers approximately the same number

[75] Managerial staff time was excluded from calculations because comparable data were not available across states. The amount of managerial time spent per application is also typically very small because direct managerial oversight is not required on most cases.

of people that would be covered by a standard renewal, we assumed that each household renewal done via ELE avoided one standard household renewal. Meanwhile, states like New Jersey provided the number of person-enrollments done via ELE, and because the state reported that standard applications typically cover approximately two children, we calculated that the number of avoided standard applications was half the number of individuals enrolled via ELE. For South Carolina, we used the same methodology as for states like New Jersey, but we subtracted the number of immediate opt-out disenrollments as the basis for this per-year calculation because anyone who was enrolled via ELE and then opted out did not represent a saving to the state: in the absence of ELE, they would not have chosen to enroll via the standard route, so ELE has saved no money with respect to these individuals. We multiplied the average number of avoided standard applications or renewals per year in a given state by our estimate of the savings and costs for the marginal application. We also subtracted any new costs introduced by ELE that were not attributable to the marginal application—for example, in New Jersey's NSLP ELE process, where staff spend time cleaning data before sending out ELE application forms.

The average number of avoided standard applications or renewals per year is generally based on data over the longest time period available, usually from process implementation through November 2012. This assumption evens out month-to-month fluctuations in enrollment; however, we note that some states enrolled many more people in the first months of ELE than in later months (see Chapter IV). One exception to this use of the longest time period available is in the analysis of New Jersey's Tax ELE process, where an exceptionally large number of ELE letters were mailed in the first year after implementation because of an error in implementation. Because these mailing costs do not reflect the ongoing costs of New Jersey's tax ELE process, they are excluded from calculations but are footnoted in the appropriate place.

Four ELE processes—Alabama's automated ELE process, Maryland's income-establishment ELE process, Massachusetts' ELE process, and South Carolina's ELE process—had not been in place for as long as a year when this analysis was performed. Consequently, annual costs and savings could only be calculated for these processes by extrapolation. Since Maryland's income-establishment ELE process, like its residence-establishment ELE process, is based on mailings driven by annual tax returns, we based our calculations on one ELE mailing per year and the number of ELE applications and enrollments that resulted from the mailing in winter 2012–2013. For the automated processes, where enrollments and renewals occur every month, we multiplied the average number of enrollments or renewals per month to date by 12 to reach an annual number of enrollments or renewals. In Massachusetts, we revised this figure downward to reflect a disproportionately large number of renewals occurring in the first months after implementation that state staff believed would otherwise distort our data.

C. Limitations

Data for this analysis may be subject to significant recall bias because they are based on individuals' recollection of complex events and activities, most of which occurred more than a year prior to our data collection. This is particularly true where ELE was adopted as part of a broader initiative. For example, in Oregon, requirements for income documentation were simplified, 12-month continuous eligibility was introduced, and the mailing of redetermination notices was automated around the same time that ELE was introduced. With the exception of programming costs, which many states document on a "per-job" basis, staff members were unlikely to have documented their time spent on ELE implementation. In short, although we have made estimates using the best available information, we acknowledge that in every state,

some information is likely to be missing or inaccurate, which may in turn lead our estimates to overstate or understate the true costs of ELE.

For three ELE processes, we have excluded certain estimates from our findings. First, Oregon's NSLP ELE process was never implemented in more than four school districts and was discontinued after one year in those districts, so producing a meaningful analysis of what this process could have looked like once it was up and running is not possible. Second, in Maryland, initial programming costs are not presented here since estimates were not available. Third, for Iowa CHIP, the process now called ELE has been in place since 2004 and has completely replaced the most relevant counterfactual process—a manual referral procedure—against which ELE costs and savings should be measured. Consequently, information about savings and costs per application for Iowa CHIP could not be calculated and are not presented.

In a number of states, standard enrollment processes have changed as a result of ELE, complicating the comparison and possibly understating the savings associated with ELE. Differences between ELE and non-ELE enrollment processes are still apparent, but it is important to recognize that, in some cases, ELE and the standard enrollment pathways are now more similar than ELE and the pathways in place before ELE.

As described above, our approach has been to compare the costs of processing an ELE application or renewal with the costs of processing a standard application or renewal. This approach provides analytical transparency and fulfills the CHIPRA mandate that the evaluation compare costs of ELE to costs of the standard application process. In some cases, however, the simplifying approach may mean the actual costs or benefits to a state are over- or understated. The following are cases where our methodology may produce different numbers from what the actual administrative costs or savings may be:

1. *ELE increases total number of enrollments.* ELE may not only replace standard enrollments that would have otherwise occurred: in the absence of ELE, some ELE enrollments might have been processed the standard way, but others might not have been processed at all, if the applications were prompted by the ELE process. This would mean that savings estimated here on the basis of avoided standard applications are overstated. Additionally, mailings-based ELE processes require hands-on staff time, so an increase in the total number of enrollments could mean that ELE actually adds to staff workloads rather than reducing them and increases absolute administrative costs.
2. *ELE renewals replace standard applications because of churning.* Under standard renewal processes, beneficiaries generally have to provide information to states in order to be renewed, and many possibly eligible beneficiaries do not do so before their current eligibility periods expire. They are then disenrolled. In the automated ELE processes in Alabama, Louisiana, Massachusetts, and South Carolina, ELE renews beneficiaries before their eligibility period has a chance to expire, which likely prevents some disenrollments. Because some eligible disenrollees submit a new application, and because processing a new application takes state staff more time than processing a renewal, an ELE renewal, by avoiding disenrollment in the first place, may save the amount of staff time it would take to process a new application. In some states, such as South Carolina, the time difference is substantial—new enrollments take 90 minutes to process via the standard route, whereas standard renewals take

only 25 minutes. Taking into account the proportion of ELE renewals that are likely to avoid the need for standard enrollments in South Carolina, instead of replacing standard renewals, would increase the total savings from ELE stated herein for that state by around 10 percent.

3. *Non-ELE renewals in Louisiana are more complex.* The standard process for renewals in Louisiana's Medicaid program, which includes paper applications being mailed in or completed by phone for manual processing, is used for only about one in four non-ELE renewals. Other non-ELE renewals include administrative renewals and ex parte renewals, which both require less hands-on staff time than standard renewals, and administrative renewals are fully automatic, like ELE renewals. Consequently, although an ELE renewal saves 21 minutes compared to Louisiana Medicaid's standard renewal process, it saves no time compared to an administrative renewal. If ELE renewals replace other renewal methods in proportion to the numbers that each of these other methods are currently used, instead of just replacing renewals via the standard method, then the time saving from ELE is only 10 minutes per renewal, and the savings estimates for Louisiana herein should roughly be halved.
4. *Parental behavior may change when children are enrolled via ELE*. In states where ELE is used for children only, we have no evidence of the effect of ELE on parents. Under standard enrollment processes in most states, a single application is required for a family, and all individuals in the family can be assessed for eligibility. Under ELE in most states, parents are not assessed for eligibility when their children are. Thus there is a question as to what parents do next after their children are ELE enrolled. They could be less likely to apply for Medicaid or CHIP because once the children are covered, applying is less of a priority. (The relative importance parents place on getting their children covered rather than getting themselves covered was evident in some of the focus groups for this evaluation.) Alternatively, seeing that their children have been found eligible for free or inexpensive health insurance, and having ready access to contact information for a state Medicaid or CHIP program, parents may be more likely to apply for coverage themselves. The former scenario may mean administrative savings from ELE are slightly greater than estimated herein; the latter scenario would mean ELE savings are less than we estimate.

Administrative costs in this study were narrowly defined to focus on expenses associated with eligibility processing. Our estimates, therefore, do not include the costs and savings of covering children in public health insurance programs who otherwise would not be insured. In 2006, nationwide average Medicaid costs for non-disabled children were $249 per member per month (Lipson et al. 2010). Chapter VI suggests these costs for ELE children are likely to be lower, on average, than for other Medicaid children, but they can be expected to be far higher than the administrative costs of enrolling the child in the first place.

APPENDIX D

METHODS AND SUPPLEMENTAL TABLES/DATA

FOR THE UTILIZATION ANALYSIS

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A. Detailed Regression-Adjustment Methods

We computed regression-adjusted utilization rates that account for demographic characteristics for the population of ELE and non-ELE enrollees. The regressions follow a general model, with the utilization characteristic for person p in spell s as a function of the enrollment pathway, a vector (DEMO) of demographic characteristics, and a vector of fixed effects for the initial enrollment month. A dummy variable (0/1), ELE, indicates whether a beneficiary enrolled through the ELE or through a standard, non-ELE pathway. The general regression model is

$$\text{Utilization Characteristic}_{p,s} = \beta_0 + \beta_1 ELE + \text{DEMO}\alpha + \text{Enrollment Month}_{\gamma} + \varepsilon_p$$

Table D.1 shows the regression model type that we used for each outcome measure. All models account for clustering of standard errors at the person level because some individuals (< 5 percent) contribute multiple person-spells to the analysis. Table D.2 indicates the control variables we used for each state.

Table D.1. Model Type and Sample Restrictions by Outcome Measure Group

	Outcome	Model Type	Sample Restrictions
A	Time to initial service receipt	OLS	Inclusion criterion: Received at least some services Exclude: Non-ELE enrollees with inpatient or ER claims in the first month of enrollment
B	Service receipt (0/1): Within 2 months Within 6 months	Logistic Model Y = 1	Exclude: Non-ELE enrollees with inpatient or ER claims in the first month of enrollment
C	Service receipt (0/1): Any Any ER Any inpatient Any outpatient/physician Any well visits Any prescription Exclusive use of ER Exclusive use of well visits Exclusive use of Rx Exclusive use wraparound	Logistic Model Y = 1	
D	Service receipt (0/1): Any BHSA Any dental Any vision Exclusive use of BHSA Exclusive use of dental Exclusive use of Vision	Logistic Model Y = 1	Inclusion criterion: Age > 1
E	Number of uses/events: ER Inpatient Outpatient/medical Pharmacy	Poisson	Inclusion criterion: Received at least one unit of specified service
F	Number of uses/events: Dental BHSA Vision	Poisson	Inclusion criteria: Age > 1; received at least one unit of specified service

Table D.1 (*Continued*)

	Outcome	Model Type	Sample Restrictions
G	Costs: Total ER Inpatient Outpatient Pharmacy	GEE, gamma distribution with log link	Inclusion criterion: Received at least one unit of specified service
H	Costs: Dental BHSA Vision	GEE, gamma distribution with log link	Inclusion criteria: Age>1; received at least one unit of specified service
I	Inpatient admission length of stay	OLS	Inclusion criterion: Received at least one inpatient service

BHSA = behavioral health and substance abuse; ELE = Express Lane Eligibility; ER = emergency room; GEE= generalized estimating equation; OLS = ordinary least squares; Rx = prescription.

Table D.2. Demographic Control Variables by State

	State			
Variable	Alabama	Iowa	Louisiana	New Jersey
Age	X	X	X	X
Gender	X	X	X	X
Race/ethnicity	X		X	X
Geographic Area	X	X	X	
Urban/rural Classification	X	X	X	
Household Income (% FPL)		X		
Household Income (dollar amount)			X	
Program Type (Medicaid, MCHIP, SCHIP)				X
Household Size	X		X	
Language	X			
Plan Enrollment				X
Private Insurance			X	

CHIP = Children's Health Insurance Program; FPL = federal poverty level; MCHIP = Medicaid expansion CHIP; SCHIP = Separate CHIP.

Using the results from each model, we calculated two estimates: (1) the average predicted outcome for non-ELE spells included in the model and (2) the average predicted outcome for non-ELE spells included in the model after adding the estimated coefficient for ELE. This second estimate gives us the regression-adjusted outcome, if ELE enrollees had the same demographic profile as non-ELE enrollees.

The first estimate can be computed by simply taking the average predicted outcome across all non-ELE spells. The method to accurately compute the second estimate differs based on the model type:

OLS models (A, I): Add the estimated coefficient for ELE to estimate (1).

Logistic, Poisson, GEE models (B–H): Add the estimated coefficient for ELE to the estimated linear predictor for each non-ELE spell. Transform the result into a predicted value for each individual spell and compute the average predicted value across all non-ELE spells.

Table D.3. Unadjusted Utilization Rates

	Alabama		Iowa Medicaid		Louisiana Opt-out		Louisiana Opt-in		New Jersey Tax		New Jersey NSLP	
	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE
Likelihood of Using Any Services (%)												
Within 2 months	57	34	67	45	66	33	67	44	55	42	56	47
Within 6 months	63	42	86	75	82	53	82	60	84	74	84	78
Within 12 months	68	47	93	85	88	64	88	69	94	85	94	89
Likelihood of Using Specific Service Types Within 12 Months (%)												
ER services	32	20	36	23	32	19	31	21	38	26	39	22
Inpatient admissions	7	2	13	2	7	2	5	2	19	2	19	2
Physician/outpatient services	66	44	89	77	86	59	84	61	91	81	91	84
Prescription fills	57	36	67	56	71	39	69	46	73	59	72	58
BHSA services	11	10	18	15	12	6	13	7	15	11	16	13
Dental services	28	25	51	41	48	26	49	31	46	40	41	49
Vision services	18	15	26	23	51	30	45	25	34	29	36	39
Exclusive use of wraparound services	3	4	7	13	5	8	6	12	4	8	4	8
Average Number of Visits/Uses Within 12 Months Among Those with Service Use												
ER services	2.1	1.9	2.0	1.5	1.7	1.5	1.7	1.6	2.0	1.6	2.0	1.5
Inpatient admissions	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.2	1.2	1.4	1.2	1.1
Physician/outpatient services	10.5	6.3	9.2	4.3	8.7	5.0	8.1	5.1	9.7	5.4	9.8	5.4
Prescription fills	7.7	6.7	10.4	8.3	9.7	6.9	9.3	7.3	5.1	3.7	5.1	3.6
BHSA service days	5.8	4.5	15.4	15.3	7.9	5.9	8.7	7.0	10.5	6.9	10.8	7.9
Dental services	2.4	2.2	2.2	2.1	2.4	2.4	2.3	2.1	2.3	2.5	2.3	2.4
Vision services	1.4	1.4	1.2	1.1	1.8	1.5	1.7	1.5	1.3	1.3	1.3	1.3

Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

BHSA = behavioral health and substance abuse; ELE = Express Lane Eligibility; ER = emergency room; GEE= generalized estimating equation; OLS = ordinary least squares; Rx = prescription.

Table D.4. Cost of Core Services and Overall Fee-for-Service Costs Within 12 Months

	Alabama		Iowa Medicaid		Louisiana Opt Out		Louisiana Opt In	
	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE	Non-ELE	ELE
Predicted Costs Among Those Who Use Services ($)[a]								
ER services	563	542	631	487	413	299*	375	247*
Inpatient services	10,047	8,969	10,311	10,854	6,664	6,406	8,433	4,174
Physician/outpatient services	1,357	1,200*	1,134	880*	905	444*	782	466*
All fee-for-service care[b]	2,786	2406*	2,735	2,067*	1,973	943*	1,835	956*
Actual Average Costs for All Enrollees, Including Nonusers ($)								
ER services	179	72	220	69	128	39	99	39
Inpatient services	737	118	1,266	137	361	69	355	42
Physician/outpatient services	908	325	993	326	773	247	630	230
All fee-for-service care[b]	1,929	630	2,517	649	1,749	559	1,609	584

Source: Mathematica analysis of claims and encounter data for Alabama, Iowa, Louisiana, and New Jersey, 2013.

Note: New Jersey cost data were not available.

[a] Regression-adjusted estimates.

[b] Rows are not additive. Cost of all fee-for-service care includes other services beyond ER, inpatient, and physician/outpatient services.

* Difference between ELE and non-ELE children is statistically significant ($p < 0.05$).

APPENDIX E

DATA COLLECTION AND ANALYSIS METHODS FOR

OTHER SIMPLIFICATIONS STUDIED

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1. Process Analysis Data and Methods

To understand the simplified enrollment and renewal processes adopted in these three states, we conducted case studies, including document reviews, site visits, and in-depth telephone interviews, analogous to those described for the ELE processes in Chapter II. These case studies were conducted between December 2012 and June 2013.[76]

2. Enrollment Analysis Data and Methods

a. Michigan

We assessed Michigan's presumptive eligibility initiative using aggregated data tables requested from the state's Separate CHIP contractor. We analyzed monthly information on the numbers and demographic characteristics of pregnant women and child online applications submitted by a qualified agency (offering a presumptive eligibility decision) referred to Medicaid.

b. New York

Information on the process and the enrollment outcomes following adoption of the program are taken from the case study.

c. Oklahoma

For Oklahoma, state officials provided monthly information on the number of enrollments and renewals processed by the online enrollment system from September 2010 (when the system was first implemented) through December 2012. We stratified the data into two groups: "home view" enrollments and renewals, whereby a beneficiary submits his or her application or renewal to the online system from a home computer, and "agency view" enrollments and renewals, whereby an application assistor helps an applicant use the online system. A detailed description of data collection methods can be found in Appendix A. Our approach to assessing the reach of the online enrollment system in Oklahoma is descriptive, drawing inferences from a comparison of unadjusted enrollment and retention trends, counts, and proportions for home view and agency view new enrollees and renewals.

3. Costs Analysis Data and Methods

a. Michigan

Michigan's presumptive eligibility process in Medicaid was implemented in 2005. Although we asked state staff about implementation costs, recall was a problem; staff were not able to estimate the costs of implementing presumptive eligibility. For the same reason, the data used to calculate the ongoing costs and savings from presumptive eligibility are not representative of presumptive eligibility in its earliest years, when staff estimate that much more training was

[76] Each case study resulted in a report that we sent to state staff for review and verification; each is cited in the references list.

necessary on a regular basis. Thus the costs presented here should be interpreted as the costs associated with Michigan's mature presumptive eligibility process.

Costs were assessed using the same methodology used for ELE, described in Chapter V (full methods are listed in Appendix C). This methodology included document review, conducting interviews focused on costs with key state staff during the site visit in May 2013, and following up with state staff to verify the data collected and to obtain additional information where needed.

b. New York

Staff in New York were unable to provide data for the cost analysis, so we are not able to estimate either the implementation costs, or ongoing costs or savings, associated with New York's telephone renewals process.

c. Oklahoma

As in Michigan, we assessed costs for Oklahoma's online enrollment process using a methodology similar to that described for ELE processes in Chapter V (and Appendix C). This included a review of documents relating to the development and usage of online enrollment, and we also conducted cost interviews as part of site visits to the state in December 2012. Because of the complexity of the online enrollment process and associated costs, we analyzed the data and then submitted a memo to the state explaining our key assumptions and calculations that state staff reviewed and responded to.

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