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Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility

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Introduction

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows states to use Express Lane Eligibility (ELE) to qualify children for the Children's Health Insurance Program (CHIP) or Medicaid. Through ELE, children become eligible for health coverage based on findings made by other need-based programs (e.g., the Supplemental Nutrition Assistance Program, or "SNAP") or based on data from state income tax records. Louisiana became the first state in the country to implement ELE's option for automatic enrollment. This brief uses data from in-person interviews, focus groups, document review, and state administrative records to review Louisiana's pioneering experience with ELE and evaluate the impact of ELE on coverage, enrollment, and costs.

Background

Express Lane Eligibility

Express Lane Eligibility is a mechanism to streamline and automate enrollment and retention. As stated, ELE allows states to qualify children for health coverage based on the findings of other need-based programs or based on income tax data. A state can use ELE to establish any element of eligibility for Medicaid and CHIP beyond U.S. citizenship, and ELE may be used for the initial determination of eligibility, for renewal, or for both.

In establishing eligibility through ELE, states disregard technical differences in how the various need-based programs define the household member whose needs and earnings are considered in determining eligibility. States can also disregard other methodological differences, such as the income deductions that are used to move from gross to net income. The use of ELE does, however, have certain procedural requirements: States must provide advance notice to parents explaining the state's proposed use of data from non-health programs to qualify children for coverage, and parents must either consent or fail to opt-out before data are used for this purpose. Additionally, in a state implementing ELE's option for automatic enrollment, which eliminates the need to file a formal application, parents must provide affirmative consent before children are enrolled.[1]

State Implementation

Initial Implementation: 2009

Even before CHIPRA was signed, state officials in Louisiana began moving forward with ELE to pass authorizing state legislation. After CHIPRA became law, the state focused its initial efforts on collaborating with SNAP. They chose to begin with SNAP because of the large number of children in Louisiana who received SNAP, the high quality of SNAP eligibility records, and the significant SNAP participation by families with incomes between 50 and 100 percent of the Federal Poverty Level (FPL), who—according to state-sponsored research—comprised the bulk of eligible children not receiving coverage in the states.

Officials matched SNAP and Medicaid records to identify more than 10,000 children who were receiving SNAP but not health coverage. Officials sent letters to the parents of these children explaining ELE procedures and giving the families a chance to opt out of data-matching by calling a toll-free number. In February 2010, the parents of children who did not opt out of data-matching were sent Medicaid cards for the children and invited to consent to enrollment by using the cards to access care, at which point children were formally enrolled into coverage.

Stage Two of Implementation: 2010-2011

In January 2010, the SNAP application form was modified to give families a chance to opt out of data matching (a modification that replaced the opt-out letters sent to the first group of ELE enrollees). The state then conducted several monthly data matches with SNP records. Once children were found eligible, their parents were sent letters and Medicaid cards, using the consent process used with the first group of ELE enrollees.

In January 2011, the SNAP application form was changed again, this time giving parents a chance to "opt in" rather than opt out. The form used the following language:

> "**Don't miss out on No Cost Health Insurance for your children!** If you check the box below, we will share what you put on this form with the Louisiana Department of Health and Hospitals (DHH). DHH will sign up children who qualify and send you a letter with more information about the Medicaid program."

State officials hoped that this opt in process could substitute for *both* the opt out procedure *and* the affirmative consent to enroll via card use, because they wanted to reduce the complexities and administrative costs of ELE renewal under a consent-by-card-use regimen. After the site visit on which this report is based, both data-matching and consent were based on families opting in through the SNAP application. Future research will need to assess these new procedures.

Renewal through ELE

Beginning in November 2010, DHH began automatically renewing eligibility for all families whose Medicaid beneficiaries consisted entirely of children with active SNAP cases. Most such children had not originally enrolled through ELE. At this time, state and local officials also began the renewal process for the more than 10,000 ELE children who had Medicaid cases activated in February 2010. Among these children, 53 percent were terminated because they had never used their cards and did not consent to enrollment at renewal. Five percent were terminated for other reasons, while the remainder—43 percent—successfully renewed coverage.

In the end, most all children whose families had consented to enrollment by using Medicaid cards retained coverage: 92 percent of ELE children who used their cards were renewed. In contrast, most children whose families had not consented to enrollment by card use saw their coverage end: Of the children who had not used Medicaid cards to activate enrollment, only 12 percent were renewed through ELE.

ELE Impacts

Coverage and Access to Care

By December 2010, 20,589 children had been sent Medicaid cards through ELE. Of these, 54 percent (11,149) used the cards in 2010 to obtain care and were thereby formally enrolled into the program.

ELE children differed in a number of ways from non-ELE Medicaid children. For example, the largest category of Medicaid claims for ELE children during May through December 2010 involved dental care, accounting for 21.4 percent of all expenditures. By contrast, dental care consumed just 8.5 percent of spending on non-ELE children. For non-ELE children, hospital care was the largest cost category, encompassing 34.2 percent of all spending; for ELE enrollees, hospital care represented 19.7 percent of all spending.[2]

There were also several demographic differences between ELE and non-ELE children. More ELE children were over age 7 (74%) compared to non-ELE children (57%). ELE children were also more likely to be white than were non-ELE-children (43% vs. 37%) and slightly more likely to be male (51.4% vs. 49.8%; significant at the .01 level).[2] Finally, ELE children were more likely to be from the New Orleans and Shreveport regions (12% and

17%, respectively, vs. 10% and 12%, respectively), the areas of the state whose children were most likely to be uninsured.[2, 3]

Uninsurance

The 2011 Louisiana Household Interview Survey found that the proportion of uninsured among Medicaid-eligible children declined from 5.3 percent to 2.9 percent. Although the proportion of uninsured among other children rose, increased participation in Medicaid was so significant that the total estimated number of uninsured children in the state fell from 58, 201 to 42,011. State officials attributed this reduction to ELE, since ELE implementation represented the only change in state policy from 2009 to 2011.[4] Moreover, the proportion of children and adults receiving employer-sponsored coverage declined from 2009 to 2011, and the proportion of uninsured among low-income adults rose. Put simply, the only group to experience improved coverage during this time was low-income children who qualified for Medicaid

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Medicaid Renewals

ELE was responsible for between 24.3 and 29.1 percent of each month's Medicaid renewals for all children—including those who hadn't originally enrolled through ELE—from November 2010 through October 2011, averaging 25.8 percent for this 12-month period.[2]

Administrative Costs

Infrastructure Development

According to Louisiana officials, start-up and infrastructure development for ELE cost nearly $600,000: Staff time for implementation consumed $46,539, and computer programming and other information technology (IT) investments cost $544,600. The IT costs were covered by the Robert Wood Johnson Foundation's "Maximizing Enrollment" project.

Initial Enrollment

This infrastructure development allowed ELE to reduce state operating costs for both initial eligibility determinations and renewals. State officials report that the average cost of initial enrollment is approximately $116.48 per application when using standard, non-ELE procedures—a cost reflecting the staff time required. The average cost of initial enrollment via ELE, on the other hand, is between $11.59 and $15.45 per successful ELE application.[2, 5]

Based on these cost estimates, if the 11,149 ELE-enrolled children who used their cards in 2010 had instead enrolled using standard procedures, the administrative cost of their enrollment would have been $1.3 million. Assuming an average cost of $11.59 to $15.45 for each of the 20,589 children who qualified for Medicaid through ELE in 2010, including both those who used and those who did not use their cards, ELE initial enrollment cost between $200,000 and $300,000. Accordingly, for Louisiana's implementation of ELE through the end of 2010, net state savings on enrollment costs were between $1.0 and $1.1 million.

This estimate of savings has several limitations: It assumes that all ELE children who used their Medicaid cards would have enrolled using manual methods in the absence of ELE. This assumption overstates cost savings, since some of these children would not have received coverage without ELE. On the other hand, administrative costs for enrollment exceed average levels by a significant amount when enrollment takes place on an expedited basis for children with an urgent medical need. By failing to consider the latter costs, our estimate may *under*state true administrative savings.

Renewals

Staff at DHH estimate that cost of manual renewal for Louisiana's Medicaid program is approximately $76 per child. This cost falls to $51 when staff conduct "ex parte" renewals, using SNAP data to determine eligibility by performing a "cross-walk" that translates from SNAP to Medicaid household definitions and income deductions. ELE went one step further, eliminating the need to cross-walk the information from one system to another by automatically qualifying SNAP recipients as income-eligible for Medicaid; this eliminated the need to use any staff

time for renewal, cutting incremental administrative costs to nothing.[2]

During the first 12 months when ELE renewals were implemented with the entire caseload, 156,279 children were renewed via ELE, based entirely on data matches.[2] Administrative savings achieved via ELE thus totaled between $8.0 million (assuming all children would have been renewed via non-ELE data matches) and $11.9 million (assuming all children would have been renewed through a fully manual process).

Net Administrative Savings

The net administrative savings resulting from the implementation of ELE in Louisiana were considerable. An investment of less than $600,000 yielded first-year savings of between $1.0 million and $1.1 million for enrollment and between $8.0 million and $11.9 million for renewal. Net savings thus totaled between $8.5 million and $12.0 million, with additional renewal savings totaling approximately $8.0 to $11.9 million for each subsequent year (Table 1). Put differently, for each dollar spent to develop ELE infrastructure, between 15 and 22 dollars of administrative cost savings were achieved after one year of full renewal implementation.[2]

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Table 1. Administrative Costs and Savings Resulting from ELE Implementation

		Costs without ELE	Costs with ELE	Net Cost or (Savings) of ELE
Up-Front Infrastructure Development	IT investment	$0	$544,600	$544,600
	Staff time	$0	$ 46,539	$ 46,539
	Combined up-front costs	***$0***	***$591,139***	***$591,139***
Operating Costs	Enrollment of ELE children who consented through card use in 2010	$1,298,636	$238,627 to $318,100	($ 980,536) to ($1,060,009)
	Renewal of Medicaid children, throughout the entire caseload, based on SNAP receipt: first 12 months of full implementation	$ 7,979,229 to $11,877,204	$0	($ 7,979,229) to ($11,877,204)
	Combined operating costs	***$ 9,268,865 to $13,175,840***	***$238,627 to $318,100***	***($ 9,030,238) to ($12,857,740)***
Combined Up-Front and Operating costs (after one full year of ELE renewals)		**$ 9,268,865 to $13,175,840**	**$829,766 to $909,239**	**($ 8,439,099) to ($12,857,740)**

Source: Louisiana Department of Health and Hospitals 2011. *Note:* Amounts listed in parentheses represent administrative cost savings. Costs are those paid by all sources, including the federal government, the state government, and the Robert Wood Johnson Foundation. Estimated costs do not include fixed expenses, such as maintaining the physical plant where staff are housed.

State Dollars Saved

Aside from the IT funds provided through the Robert Wood Johnson Foundation's Maximizing Enrollment project, administrative costs were covered using standard Medicaid rules, which provide a 50 percent federal match in Louisiana. Viewed through the lens of state dollars, Louisiana's investment of $23,270 (half of the $46,539 for initial staff time) resulted in administrative cost savings, during the first year of fully policy implementation, of approximately $500,000 for enrollment and between $4.0 million and $5.9 million for renewal, with comparable renewal savings during each subsequent year. Net state savings thus reached between $4.5 and $6.4 million in the first year, with an additional net savings of $4.0 to $5.9 million in renewals for each subsequent year.

A Note to Other States…

While other states may lack access to foundation funding for their IT investments, CMS is offering 90 percent federal funding for IT investments needed to transition to data-driven eligibility in the context of ACA implementation. Moreover, IT-based enrollment and renewal that uses the infrastructure built with 90 percent matching funds can qualify for 75 percent federal funding of operating costs, rather than the normal 50 percent.[6]

Discussion

Louisiana's experience shows that using ELE to grant Medicaid eligibility based on SNAP records can yield significant administrative savings and can also improve enrollment and access to care. Moreover, given SNAP's reach among very low-income families, SNAP-based ELE appears to be an effective and low-cost method of finding and enrolling some of the poorest uninsured children Finally, the data-based eligibility systems developed for ELE may ultimately help states, hard-pressed for administrative resources, implement the ACA's major Medicaid expansion.

Louisiana's groundbreaking use of SNAP findings to automate enrollment and retention demonstrates the great promise of ELE, in particular, and automated enrollment strategies, more generally. Strategies similar to those used for Louisiana's ELE implementation deserve serious consideration as state and federal policymakers grapple with the daunting challenge of enrolling tens of millions of eligible uninsured into not only Medicaid, but the ACA's other insurance affordability programs as well.

Further Reading…

This brief is a companion to an in-depth report of the same name that is available at http://www.shadac.org/share/grant/assessing-first-use-auto-enrollment-state-coverage-expansion.

References

1. Social Security Act §1902(e)(13)(D)(i).
2. Louisiana Department of Health and Hospitals, 2011.
3. Barnes, et al., op cit., found that, in the New Orleans, Shreveport, and Alexandria regions, 6.3 percent, 6.1 percent, and 6.1 percent of children, respectively, were uninsured—more than in any other region. A higher proportion of ELE children lived in all three regions, but the difference in Alexandria was not statistically significant.
4. Ruth Kennedy, personal communication, February 2011.
5. State officials estimate that, during the average day, 121 children are added to the digital "bridge" between SNAP and Medicaid. For a state employee earning $28.97 an hour, it takes an average of 3 to 4 minutes to dispose of each child's case (for example, ensuring that the child is not already enrolled in Medicaid). Accordingly, to process 122 children for initial enrollment via ELE, it takes between 6.05 and 8.07 hours of work at $28.97 an hour, for a total cost between $175.27 and $233.69. An average of 12.5 percent of these children—i.e., 15.125—wind up qualifying under ELE. So the cost of initial enrollment per ELE child is between $175.27/15.125 and $233.69/15.125, or between $11.59 and $15.45. To the extent that additional children qualified under ELE automatically, without placement on the "bridge," this estimate overstates average ELE administrative costs per child successfully enrolled.

About SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues at a state level, with a focus on state-level implementation of the Affordable Care Act (ACA) and other efforts designed to increase coverage and access. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. More information is available at www.statereformevaluation.org.