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

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Supported by: State Health Access Reform Evaluation,
Robert Wood Johnson Foundation

Presented to: AcademyHealth State Health Research and Policy Interest Group Meeting
Orlando, FL
23 June 2012
Outline of Presentation

• Research methods
• Federal policy and Louisiana’s approach to Express Lane Eligibility
• Results
• Lessons for States and Policymakers
Research methods

• Document review
• Site Visit - Key informant interviews
  – State Medicaid officials
  – State nutrition program officials
  – Local social service agency staff
  – Community-based outreach organizations
• Focus groups with parents of children enrolled via Express Lane Eligibility
• Analysis of state administrative data
Express Lane Eligibility (ELE): federal law

- An option created by CHIPRA (Children’s Health Insurance Program Reauthorization Act of 2009)
- State Medicaid and CHIP programs may use findings of other need-based programs to establish eligibility
  - Irrelevant to such eligibility are technical differences between programs’ eligibility rules
  - ELE can be used to establish any element of Medicaid/CHIP eligibility except for citizenship
Federal ELE law (continued)

• Before data from other program are accessed, family must be given a chance to “opt out”
• Before a child is “automatically enrolled,” family must affirmatively consent
  – By phone, in writing, or through other methods
• Can use ELE for enrollment, renewal, or both
• ELE is one of 8 “best practices” (to qualify for CHIPRA performance bonus, states must implement at least 5 of 8)
Louisiana’s history with eligibility simplification

- Renowned for innovative enrollment simplification
- National leader in automated/ex parte renewal
- Received CHIPRA performance bonuses ($3.6 million in 2010, $1.9 million in 2011) for employing: continuous eligibility, no asset test, automated renewal, no in-person interview, joint Medicaid/CHIP application and renewal forms
- State legislature passed Express Lane Eligibility in 2007, before it was even a federal option
- Formally adopted by state shortly after passage of CHIPRA in ‘09
Louisiana’s approach to ELE

• Grants eligibility based on findings from the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps)
  – SNAP eligibility limited to families with “net incomes” below 100 percent FPL
  – Household definitions, income disregards different from Medicaid’s

• Used for both enrollment and renewal
“It happened one night”

• In February 2010, 10,573 children enrolled into Medicaid in a single night, based on SNAP records -- How did this happen?

• In 2009, data matches with SNAP identified children receiving SNAP but not Medicaid

• State narrowed list of such children to
  – Identify and remove “duplicates” already receiving Medicaid
  – Limit initial enrollment to children already known to Medicaid from prior applications or coverage

• With previously unknown children, manual confirmation needed before enrollment
More lead-up to that magical night

• State sent “opt-out” letters to parents of all children remaining on the list
  – Result: very few parents opted out (<1%)

• Affirmative consent process
  – Sent Medicaid cards to parents, w/ letter indicating that use of the card = consent to enrollment
  – Note: Louisiana Medicaid is fee-for-service
Enrollment: Not just a one-night stand...

- Starting in Jan. 2010, SNAP application forms modified to include ELE “opt-out”
- Except for children who opt out, monthly data matches identify children receiving SNAP but not Medicaid
- State moving towards daily data matches
- SNAP application changed again in Jan. 2011 to have “opt in” check-box
Coming back for more: Renewals

• Renewing eligibility for all children
  – At renewal, if data match shows a Medicaid child is receiving SNAP, the child’s Medicaid eligibility is automatically renewed
  – Does not apply to a family if Medicaid is provided to (a) a parent or (b) a child not receiving SNAP

• Renewing eligibility for ELE children
  – Parents who did not use the card get another chance to consent – very few take advantage of opportunity
Results: Enrollment

• By December 2010, 20,589 children had been sent Medicaid cards via ELE
  – 11,149 of these children (54%) used services

• From 2009 to 2011, the proportion of uninsured among Medicaid-eligible children fell from 5.3 percent to 2.9 percent
  – State officials attributed this to ELE, the only new initiative implemented during this period
  – All other groups of children and adults saw uninsurance increase

• Community outreach groups said:
  – Before ELE, always saw uninsured children at community events
  – After ELE, no uninsured children at these events!

• ELE children more likely to be older and to live in underserved areas, compared to other Medicaid children
Results: Renewal

• Among initial ELE enrollees, renewal varied dramatically based on whether the family ever used the Medicaid card
  – 92% of card users renewed coverage
  – 12% of other ELE children renewed coverage

• ELE is now responsible for 26 percent of all Medicaid renewals for children
Results: administrative savings

• Up-front investment cost $600,000
  – Mostly IT, funded by RWJF through MaxEnroll
  – In future: potential 90 percent FMAP

• Operational savings
  – During the first year of ELE enrollment: between $1.0 and $1.1 million
  – During the first year of ELE retention: between $8.0 million and $11.9 million

• Bottom line: for each $1 to create ELE infrastructure, between $15 and $22 in administrative savings after one year
Focus Group Results:
What do parents say about ELE?

Parents told us they:

• Recalled receiving letter informing them that children were eligible for coverage
• Were initially caught off guard (“This can’t be right?!?”)
• Were thrilled to learn their children were covered
  (“It’s a blessing...” “Like a gift from God...”)
• All obtained services for their kids
• Found renewal to be very easy
  (“It wasn’t even a ‘process’...”)
• Some would not have applied for Medicaid; they didn’t think their kids were eligible
Lessons for States/Policymakers

• “Simplification isn’t simple...but the juice is worth the squeeze...”  Ruth Kennedy

• Express Lane Eligibility is not a “push button” operation

• ELE is an important additional tool for states seeking to expedite enrollment and retention
  – Increases participation, reduces administrative costs, prevents manual errors
  – SNAP is a great candidate for ELE – food is fundamental

• ELE can facilitate states’ move towards data-driven eligibility under the Affordable Care Act
Lessons (continued)

• Why did it work?
  – Culture change occurred over many years
  – Willing partner in SNAP agency (plus, no downside risk for SNAP)
  – MaxEnroll involvement—money for staff, IT programming, and extensive TA
  – Centralized eligibility system is critical
  – Effective messaging to policymakers – stressed efficiency, not increases in enrollment