

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

Stan Dorn
Ian Hill
Fiona Adams

The Urban Institute
2100 M St. NW
Washington, DC 20037

Revised April 2012



Table of Contents

Executive Summary.....	ii
I. Background	1
Federal law.....	1
Louisiana’s tradition of innovation	2
II. Methodology.....	3
III. State implementation	4
State policy: a general overview	4
An implementation chronology	7
The initial large ELE enrollment	7
Enrollment becomes more routine: 2010-2011	8
Renewal	9
IV. Effects of state policy.....	10
Coverage and access to care	10
Using ELE to renew coverage for Medicaid children as a whole	14
Administrative costs.....	15
Focus group results.....	18
V. Lessons learned	21
Process lessons	21
Policy lessons	22
Conclusion.....	23
About the authors and acknowledgements	24
About the Urban Institute.....	24
About the SHARE Initiative	24
Endnotes	25

Executive Summary

On February 11, 2010, Louisiana enrolled more than 10,000 children into Medicaid, based on data matches showing that the Supplemental Nutrition Assistance Program (SNAP, formerly known as “Food Stamps”) had already found them to have low income. As the first state to implement automatic enrollment under Express Lane Eligibility (ELE), an option created by the Children’s Health Insurance Program Reauthorization Act of 2009, Louisiana sent parents Medicaid cards if their children qualified based on SNAP records. Children were formally enrolled into coverage when the cards were used to seek care. In a program that had been serving nearly 480,000 children a month, ELE reached 20,589 children by December 2010, of whom 11,149 (54%) obtained Medicaid services. When the first group of ELE children needed their eligibility renewed, 92 percent of those who had used their cards retained Medicaid based on their continuing receipt of SNAP. By contrast, 88 percent of those who had not used their cards failed to take advantage of a final opportunity to consent and so had their coverage end.

Even without this initiative, many children reached by ELE likely would have applied for and received Medicaid after they developed health problems. However, some ELE children would not have otherwise enrolled, in some cases because parents of ELE children did not know their children qualified for Medicaid. When community-based outreach groups at public gatherings asked low-income parents whether their children were uninsured, some always raised their hands before ELE; after ELE was implemented, none did. Further illustrating that some ELE children may not have otherwise enrolled, significant differences between ELE and other Medicaid children include the following:

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

State surveys showed that, from 2009 to 2011, the proportion of uninsured among children who qualified for Medicaid dropped from 5.3 percent to 2.9 percent. State officials attributed this reduction to ELE, since ELE implementation represented the only change in state policy over this period, during which uninsurance grew more prevalent among all adults and children in the state except those who qualified for Medicaid.

The state also used ELE to renew Medicaid in each family where all Medicaid beneficiaries were children who received SNAP. During the 12 months after this process was taken to scale, ELE was responsible for 25.8 percent of all Medicaid renewals for Louisiana children.

These policies generated substantial administrative savings. Start-up costs totaled almost \$600,000, most of which involved information technology (IT) development funded through the Robert Wood Johnson Foundation’s “Maximizing Enrollment” project. However, initial qualification for Medicaid through ELE costs between \$12 and \$15 per successful application,

compared to \$116 through traditional methods. This differential let the state save between \$1.0 and \$1.1 million on enrollment costs during ELE's first year. Savings on renewal were greater, totaling between \$8.0 million and \$11.9 million annually. Put differently, for each dollar spent to create ELE infrastructure, Louisiana's Medicaid program realized between \$15 and \$22 in administrative savings after one year of ELE renewals.

While it took considerable work to implement ELE, state officials believed the results—increased enrollment of eligible children, administrative savings, fewer eligibility errors, and building an infrastructure that can help implement the major Medicaid expansion slated for 2014—more than justified the effort. With automatic enrollment, many families received coverage they understood, valued, and used to access care for their children. Similar strategies deserve serious consideration from state and federal policymakers implementing future health reforms.

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

Louisiana's health coverage programs are well-known nationally for their innovative strategies to streamline and automate enrollment and retention. Such efforts succeed on multiple levels by cutting red tape for families, increasing participation rates among eligible residents, lowering administrative costs, and preventing erroneous eligibility decisions. As one further step down this road, Louisiana became the first state in the country to implement the new Express Lane Eligibility (ELE) option, created by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), to qualify children and enroll them automatically into health coverage based on the findings of other need-based programs.

As part of the State Health Access Reform Evaluation (SHARE) project, researchers from the Urban Institute conducted a site visit to Louisiana to gather information about the effects of this groundbreaking policy. The site visit involved interviews with state officials, local agency staff, and community organizations that conduct outreach to low-income families. It also included focus groups with parents of children who were covered through ELE. That qualitative research, along with an analysis of state administrative data, forms the basis of this report.

I. Background

Federal law

Enacted through CHIPRA, ELE is an option for state coverage of children through Medicaid and the Children's Health Insurance Program (CHIP). It is one of eight "best practices" for enrollment and retention listed in CHIPRA, of which a state must implement at least five in order to receive performance bonuses for increased enrollment of eligible children.

Through ELE, a state qualifies children for health coverage based on findings made by other need-based programs or based on state income tax records. States can disregard technical differences in how these programs define the household members 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. For example, if the Supplemental Nutrition Assistance Program (SNAP, formerly known as "Food Stamps") finds a child to have net income below the federal poverty level (FPL), Medicaid can use ELE to automatically qualify the child as income-eligible, even though Medicaid does not use SNAP's income deduction for "excess shelter costs" and the two programs apply differing household definitions.

A state can use ELE to establish almost any element of eligibility for Medicaid and CHIP— income, state residence, even satisfactory immigration status. The only eligibility element to which ELE may not apply is U.S. citizenship, for which Medicaid and CHIP must use normal verification methods. A state may use ELE for the initial establishment of eligibility, for renewal, or for both.

A state implementing ELE must meet various procedural requirements. It must provide advance notice to parents explaining the state's proposed use of data from non-health programs to qualify children for health coverage. Before data are used for this purpose, parents must either consent or fail to opt out after receiving a reasonable opportunity to do so.

A state implementing ELE can institute “automatic enrollment” through which children are covered without filing a formal application for Medicaid or CHIP. However, parents’ affirmative consent is required before children receive coverage. Such consent may be given “in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary ...”¹ Further information about ELE is available elsewhere.²

Louisiana’s tradition of innovation

Louisiana is widely viewed as a national leader improving eligibility determination, enrollment, and retention for low-income children and families. The state has pursued a range of innovative strategies that have lowered administrative costs, cut red tape for families, increased enrollment of eligible children, and secured one of the country’s lowest federally-certified error rates.³ In addition to approaches used by many other states,⁴ Louisiana’s strategies have included:

- Moving from paper to electronic case records;
- Using data matches from reliable sources to renew eligibility whenever possible;⁵
- Encouraging families to provide necessary information by phone, rather than in writing;
- Expediting renewal for families living on fixed incomes and other households who are highly unlikely to experience changes that terminate eligibility;
- Permitting families to use electronic signatures when applying or renewing coverage on-line;
- Using a “reasonable certainty” test to determine whether reliable data are sufficient to qualify children for coverage;
- Re-engineering business processes and work flows in local eligibility offices to increase efficiency and to reduce processing delays; and
- Intensively focusing on changing caseworker culture and habits, encouraging proactive efforts to help all eligible families receive coverage.

Through these and other measures, Louisiana reduced the proportion of its low-income children without coverage from 25.5 percent in 1997-1998—the 15th-highest state percentage in the U.S.— to 11.8 percent in 2009-2010—the 21st-lowest state percentage, according to Census Bureau data.⁶ Put differently, the state moved from having one of the country’s highest proportions of uninsured low-income children to better than the national mid-point.

The Louisiana Health Interview Survey (LHIS) shows a much smaller percentage of uninsured, low-income children within the state, but it paints same basic picture of remarkable progress. According to LHIS data, from 2003 through 2009 the number of uninsured children in Louisiana fell by nearly 60 percent, from 143,173 to 58,201, and the proportion of uninsured among Medicaid-eligible children declined from 12.0 percent to 5.3 percent.⁷ At the same time, federal audits found that, after implementing the above-described measures to streamline enrollment and renewal, Louisiana had a Medicaid eligibility error rate of 1.54 percent—far below the national average of 6.74 percent.⁸

In terms of renewals, procedural terminations now affect less than 1 percent of children in Medicaid and Louisiana’s CHIP program, LaCHIP. Fewer than 5 percent lose coverage for any reason.⁹ By contrast, in the nation as a whole, approximately 29 percent of Medicaid and CHIP

children lose coverage at renewal, even though 44 percent of the terminated children continue to qualify.¹⁰

Louisiana's implementation of Express Lane Eligibility continues this tradition of innovation. In 2010, Louisiana became the first state in the country to take advantage of ELE's auto-enrollment option, which is the subject of this research.

II. Methodology

This project used a case study approach to investigate the evolution of Express Lane Eligibility in Louisiana and its effects on coverage, access to care, enrollment and renewal outcomes, and administrative costs. Researchers from the Urban Institute conducted a two-day site visit to Baton Rouge and Alexandria, Louisiana, in March 2011. This report includes data from four main sources:

- In-person interviews conducted with state- and local-level key informants in Louisiana;
- Focus groups with parents of children enrolled in Medicaid through ELE;
- Review of documents related to ELE implementation in Louisiana; and
- Analysis of state administrative data.

Key informant interviews

During the site visit to Louisiana, six interviews, each approximately two hours in length, were conducted with more than fifteen key informants in Baton Rouge, the state capital, and Alexandria, Louisiana. Interviewees included senior Medicaid officials, state staff responsible for Medicaid eligibility policy and operations, senior officials from the state's SNAP program, local eligibility field operations staff, and community-based outreach workers. All interviews were conducted using tailored, semi-structured interview protocols by Urban Institute researchers. Notes from each interview were reviewed, summarized, and synthesized by research staff.

Focus groups

To understand the experiences of families whose children were covered through ELE, researchers also conducted focus groups in Baton Rouge and Alexandria. The two groups included a total of 11 parents of children who received Medicaid through ELE and who consented to enrollment via card use. Urban Institute staff recruited participants by telephone from an encrypted list of Medicaid client names and phone numbers received from the Louisiana Department of Health and Hospitals (DHH), which administers Medicaid and LaCHIP. Most of the participants' children received Medicaid during the first wave of ELE enrollment in February 2010.

Each focus group lasted approximately two hours. Participants received a \$50 cash payment in appreciation for their participation. All focus group participants signed an informed consent form, which emphasized that participation was voluntary and that participants' privacy would be protected. Proceedings were digitally recorded and transcribed.

Focus groups were directed using a moderator's guide that asked questions about ELE, Medicaid, and SNAP. To analyze focus group results, researchers reviewed transcripts and field

notes; categorized participant responses; summarized dominant themes and divergent views; and selected quotations that illustrated common perspectives.

Document review

Urban Institute research staff conducted an extensive review of documents from Louisiana DHH to supplement the information collected during the site visit. These documents included copies of:

- Sample DHH letters to ELE-enrolled Medicaid clients;
- Medicaid eligibility policy memos related to ELE;
- State Plan Amendment documents involving ELE implementation;
- Medicaid eligibility policy training materials used during ELE implementation;
- ELE enrollment procedure manuals; and
- Other relevant summary reports and documentation.

Analysis of state administrative data

Urban Institute researchers received and analyzed state administrative data from Louisiana DHH, including summary data on client demographics, enrollment, claims, and renewal outcomes. Research staff conducted two analyses to explore differences between ELE and non-ELE children in terms of their (1) demographic profile and (2) utilization of services. Demographic profiles of ELE and non-ELE children used monthly average enrollment from May through December 2010 to compare region of residence, race/ethnicity, age, and gender. Chi-squared tests were used to test for statistically significant differences between ELE and non-ELE children at the .01 and .05 level. The second analysis compared the distribution of total claims expenditures for the highest-cost service categories for both ELE and non-ELE Medicaid children.

DHH officials also provided financial estimates of costs associated with traditional Medicaid enrollment and renewal and those incurred as a result of ELE implementation. Urban Institute researchers used those data to estimate administrative costs and savings associated with ELE.

III. State implementation

This section of the paper begins by providing an overview of state policy, followed by a more detailed, chronological description of how ELE developed and unfolded.

State policy: a general overview

At the time of our site visit, Louisiana policymakers were implementing a policy with several key elements. Once SNAP found a child eligible for benefits, the state's Medicaid program granted eligibility based on the SNAP program's findings about net income, state residence, identity, and Social Security Number, despite differences between standard SNAP and Medicaid income methodologies. By contrast, the SNAP program's evidence of a child's citizenship or satisfactory immigration status applied to Medicaid only if that evidence met standard Medicaid requirements. ELE thus involved the former use of SNAP findings, but not the latter.

Louisiana applied ELE to both initial eligibility determinations and renewals in Medicaid. If a family did not “opt out” of data-matching with SNAP records, and children qualified for Medicaid based on SNAP’s eligibility determinations, the family was sent a Medicaid card for each child. State letters explained that using the card constituted consent to enrollment.

At the time of our visit, policymakers were planning to transition from the state’s fee-for-service Medicaid program, which used a Primary Care Case Management approach dubbed “CommunityCARE,” to a system of capitated payments to Managed Care Organizations (MCOs). That transition has taken longer than originally anticipated. Officials expected that, in the new system, MCO enrollment would begin for ELE children only after a family used the child’s Medicaid card to access fee-for-service care. Following a brief fee-for-service coverage period, the child would be enrolled into an MCO.

DHH used ELE to renew Medicaid for children, regardless of how they originally qualified. As a general rule, children receiving SNAP at the time of their Medicaid renewal had their coverage renewed automatically, at essentially zero administrative cost for the state. However, ELE-based renewal did not apply to families where either: (a) parents received Medicaid; or (b) siblings received Medicaid but not SNAP. For such parents and siblings, household income needed to be redetermined, and those redeterminations also applied to SNAP-recipient children within those households.

When it came time to renew eligibility for children who originally qualified through ELE, procedures were more complex:

- If a family had consented to enrollment by using a child’s Medicaid card, renewal was handled no differently than for other Medicaid children—that is, renewal would be automatic if the family qualified for administrative renewal or ELE renewal; in other cases, renewal would be based on caseworker review of available third-party data sources; if such data did not demonstrate a reasonable certainty of eligibility, families would be encouraged to provide missing information by phone; and if all else failed, families would be sent renewal forms to complete.
- If an ELE family had not consented to enrollment by using a Medicaid card, what happened depended on whether the children were still receiving SNAP at the time of renewal. If not, the case was closed. If so, the state gave parents another chance to consent to enrollment through letters and phone calls. When parents consented, their children’s coverage could be renewed. When parents either declined or failed to respond, their children’s coverage was terminated. Coverage was also terminated for children who had turned 19. See Table 1 for a display of state renewal procedures involving ELE.

Table 1. ELE-related renewals for children

What are the characteristics of the household members who receive Medicaid?			What happens to the children in the household who come up for Medicaid renewal?			
Original basis for child's eligibility	Other characteristics of household members		Automatically renewed, based on SNAP receipt	Standard, non-ELE renewal procedures apply	Eligibility terminates	
Something other than ELE	Some Medicaid children do not receive SNAP			✓		
	All Medicaid children receive SNAP	One or more adults receive Medicaid		✓		
		No adults receive Medicaid	✓			
ELE	Family consented to enrollment by using Medicaid card	Child still receives SNAP and is under age 19		✓		
		Child does not receive SNAP			✓	
		Child turned 19				✓
	Family has never used Medicaid card	Family consents to enrollment after receiving calls and letters from DHH	Child still receives SNAP and is under age 19		✓	
			Child not receiving SNAP			✓
		Child turned 19				✓
		Family either rejects enrollment or does not respond to calls and letters				✓

Note: Some children whose original eligibility is not based on ELE—for example, those in fixed income households—are renewed administratively, without any attempt to determine whether they receive SNAP.

An implementation chronology

The initial large ELE enrollment

By 2007, federal policymakers were debating reauthorization of the federal CHIP program. Express Lane Eligibility was very much in the mix, with versions included in pending legislative proposals. Believing that ELE could be a useful addition to the state's existing strategies for enrolling and retaining eligible children, Louisiana policymakers enacted state legislation in 2007 authorizing ELE implementation whenever it was permitted by federal law.

Soon after CHIPRA was signed into law in 2009, state officials began conversations with the Centers for Medicare and Medicaid Services (CMS) about moving forward on ELE. The state focused its initial ELE efforts on working with SNAP as a partner agency, given the large number of children who received SNAP, the high quality of SNAP eligibility records, and significant SNAP participation by families with incomes between 50 and 100 percent FPL, whom state-sponsored research had shown comprised the bulk of eligible children not yet receiving coverage. The state further decided to implement ELE's auto-enrollment option.

Officials at DHH reached out to the agency that administers SNAP, the Department of Social Services (since reorganized into the Department of Children and Family Services, or DCFS). DHH made clear that it would reduce the burdens ELE implementation might otherwise place on DCFS. For example, DHH drafted and paid for all mailings to SNAP recipients, thereby reducing the cost and effort required from DCFS for what was a health rather than a nutrition initiative. For their part, DCFS officials did not view ELE as unduly burdensome. In fact, they supported ELE as helping to fulfill objectives shared by both state agencies—namely, meeting the basic needs of low-income residents while achieving administrative savings for taxpayers.

In late 2009, officials matched SNAP and Medicaid records to identify the first group of children who would receive coverage through ELE. This match identified children who:

- were receiving SNAP;
- were not receiving health coverage; and
- had eligibility records indicating prior receipt of Medicaid or LaCHIP.

The latter constraint was imposed by DHH as an initial screen to prevent duplicate enrollment. These officials expected that some beneficiaries would be described differently in SNAP records than in DHH case files. For example, the two programs might have different primary addresses for the same child if the child's parents were not living together; or a child's name might be recorded slightly differently by the two programs. These possibilities could be ruled out if a SNAP child was known to be a former Medicaid or LaCHIP enrollee.

In some cases, DHH and SNAP records differed only slightly. For example, two digits in a Social Security Number or address might be transposed; or a child's middle name could be spelled out in one agency's records but reduced to an initial by the other program. State officials developed rules to determine when files would be deemed to match, notwithstanding such minor differences. When these methods failed to match a child receiving SNAP to a current or former recipient of health coverage, state officials intervened to check for possible duplicate enrollment. If this follow-up showed that, in fact, the SNAP child was new to Medicaid, the child was added manually to the ELE enrollment group.

By December 2009, the state had identified more than 10,000 children who were receiving SNAP but not Medicaid. 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. Less than 1 percent of letter recipients chose to opt out.

If parents did not opt out by a specified date, their children would be enrolled into coverage, according to the letters. This message was based on early advice the state received from the CMS Regional Office. However, CMS national officials took a different view. While the “opt out” notice let the state *qualify* children for Medicaid, it did not permit eligible children to be *enrolled* into coverage, according to the CMS central office. Rather, such enrollment needed advance, affirmative consent from the parents.

According to longstanding principles of contract law, an offer can be accepted through behavior specified in the offer. For example, courts have repeatedly held that, when an internet web site clearly states that, by taking a specified action (such as downloading software), a consumer consents to various terms, the consumer who takes that action thereby assents to and is contractually bound by such terms.¹¹ Applying this doctrine to ELE consent, state officials sent the parents Medicaid cards, preceded and accompanied by letters explaining that using the card would constitute acceptance of the offer to enroll their children into Medicaid.

After CMS agreed to this approach, the state activated Medicaid cases for 10,573 children on February 11, 2010. These cases were assigned a December 2009 start date, reflecting the timing of the data-matching that had established their eligibility. Parents were sent Medicaid cards for their children and invited to consent to enrollment by using the cards to access care.

Enrollment becomes more routine: 2010-2011

In January 2010, the SNAP application form was altered to give families a chance to “opt out” of data-matching for ELE purposes. For new ELE children, this procedure replaced the above-described opt-out letters that were sent to the first group of ELE enrollees.

The state then conducted several monthly data matches with SNAP records. As with the initial group of ELE children, only those known to have previously received health coverage had Medicaid cases opened automatically. Others required manual intervention by state staff to prevent duplicate enrollment. Once children were found eligible, their parents were sent letters and Medicaid cards, using the consent process described earlier.

A year later, in January 2011, the SNAP application form changed again. The new form gave parents a chance to “opt in,” rather than opt out. The language was placed prominently at the top of the SNAP application’s second page, with key words bolded (including some highlighted in red):

“**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 could substitute for *both* the former “opt out” letter *and* the process through which parents affirmatively consented to enrollment by using Medicaid cards to obtain care. Officials were motivated to take this step primarily by the complexities and administrative costs of ELE renewal under a consent-by-card-use regimen. The state’s earlier approach required

distinguishing between children who had and had not used their Medicaid cards as well as between children who were and were not continuing to receive SNAP. Officials also took into account the administrative costs of mailing letters and cards to parents and opening cases for children who did not ultimately enroll.

At the time of our visit, this new mechanism had not yet replaced the state's former approach. Questions had emerged about whether caseworkers at DCFS were encouraging families to complete the "opt-in" question on the SNAP application and how those caseworkers were recording the answers. Since our visit, state officials completed the move to daily data matches and eliminated the process of obtaining consent through card use. Instead, both data-matching and consent are now based on families "opting-in" on the SNAP application form. Early results show significant numbers of children signing up through the new ELE enrollment process.

Renewal

In using ELE to renew Medicaid children's coverage, DHH began by applying largely manual procedures to small groups of children to make sure that state staff understood all the "moving parts." In November 2010, DHH took ELE renewal "to scale," 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.

November 2010 was also the month in which state and local officials began the renewal process for the more than 10,000 ELE children who had Medicaid cases activated in February, based on data matches that took place in December 2009. Among these children, 53 percent were terminated because they had never used their cards and did not consent to enrollment at renewal. Only 5 percent were terminated for other reasons. The remainder (43 percent) successfully renewed coverage.

Some observers have pointed to the large number of ELE terminations in November 2010 as evidence of policy failure. But the true story is subtler and more positive. Almost all children whose families had consented to enrollment by using Medicaid cards retained coverage; but most who had not taken that step saw their coverage end. To be specific:

- Among ELE children who had used their cards, 92 percent were renewed through ELE. Some of the remaining 8 percent may have had Medicaid renewed through other categories.
- Among parents who had not previously used ELE Medicaid cards to obtain care for their children, 88 percent had their coverage end; the others continued to qualify, based on SNAP receipt, and consented to enrollment.

IV. Effects of state policy

Coverage and access to care

As indicated above, more than 10,000 children had Medicaid cases activated in February 2010, and others continued to join the program via ELE data matches. By December 2010, 20,589 children had been sent Medicaid cards through ELE. Fifty-four percent of these children (11,149) used the cards in 2010 to obtain care and therefore were formally enrolled into the program. To place these findings in context—

- 89 percent of all Medicaid children in Louisiana used services at some point during 2010; and
- Medicaid covered 473,872 children as of February 2, 2010, according to state administrative records, including 397,150 who qualified based on family income at or below 100 or 133 percent FPL, depending on age.

Even without this new initiative, some of the ELE children who used their Medicaid cards would have enrolled once they needed care. ELE nevertheless yielded gains for these families and the state. ELE provided some parents with peace of mind, because they knew their children could get care if necessary. ELE also meant that emergency procedures were not required to obtain a Medicaid eligibility determination and access care. This saved state administrative dollars for both expedited eligibility determination and payment of retroactive health care claims. Such non-emergency establishment of eligibility may also have allowed some care to be provided in less costly, non-emergency settings or at earlier points in the development of illness. Parents of these children may have been able to access services more rapidly than if a Medicaid application needed to be filed after their children developed an urgent need for care.

However, without ELE, some children would not have enrolled, in many cases because their parents did not know the children qualified for Medicaid. For example, parents who received health coverage through their employers often did not understand that Medicaid fills gaps in employer-sponsored insurance (ESI). This gap-filling role includes coverage of dental care and other services that are typically quite restricted in ESI and payment of cost-sharing imposed by employer plans. See the discussion of focus group results, below.

It seems likely that many ELE children for whom Medicaid supplemented ESI would not have otherwise enrolled. Fully 12.3 percent of ELE children who used their cards were also enrolled in ESI during February through June 2010. By contrast, in 2007, when ESI was less prevalent than during the current economic downturn, 4.7 percent of Medicaid children as a whole received ESI.¹²

ELE children also differed in other important ways from non-ELE Medicaid children, further suggesting that some ELE children would not have otherwise received coverage. 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. Hospital care represented 19.7 percent of all spending on ELE children. But for non-ELE children, it was the largest cost category, encompassing 34.2 percent of all spending (Figure 1).

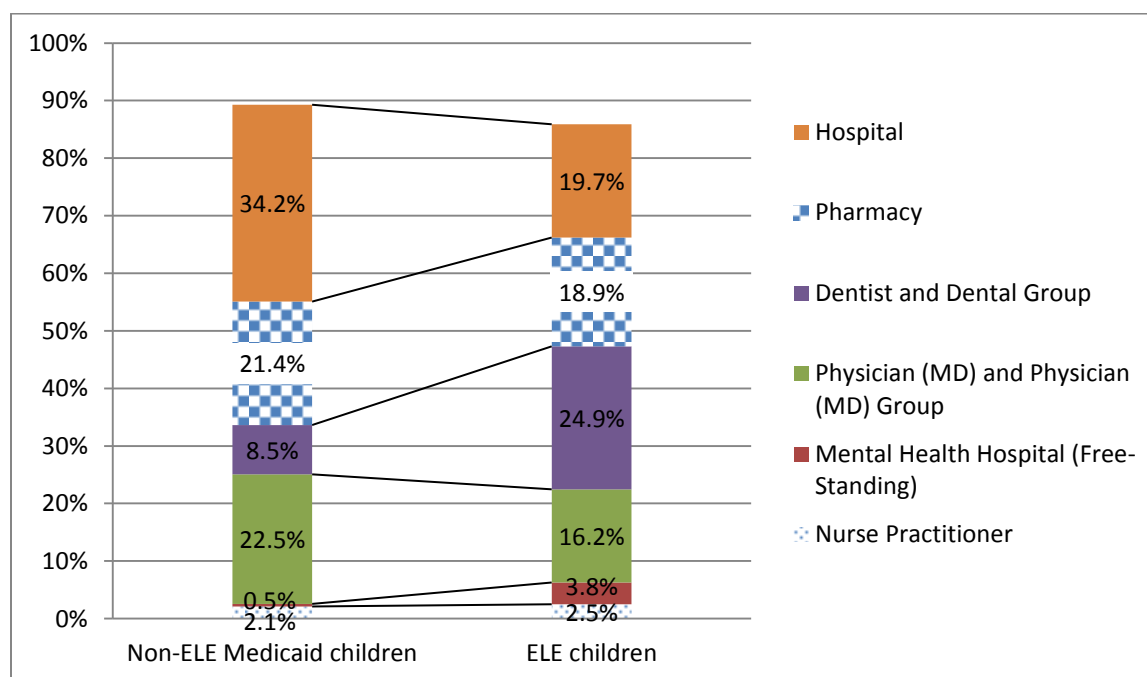
In terms of age, 57 percent of non-ELE Medicaid children were over age 7. Among ELE children, 74 percent fell into this range (Figure 2). According to tabulations of federal survey

data for 2009-2010, 8.8 percent of Louisiana children ages 7 through 18 were uninsured, compared to 7.2 percent at ages 0 through 7—a 22 percent relative difference.¹³

Geographic differences applied as well. Compared to other Medicaid coverage, ELE more effectively reached areas of the state whose children who were most likely to be uninsured—namely, the New Orleans and Shreveport regions.¹⁴ For example, 12 percent of ELE children lived in the New Orleans region, compared to 10 percent of non-ELE children; and 17 percent of ELE children lived in the Shreveport area, compared to 12 percent of other children (Figure 3).

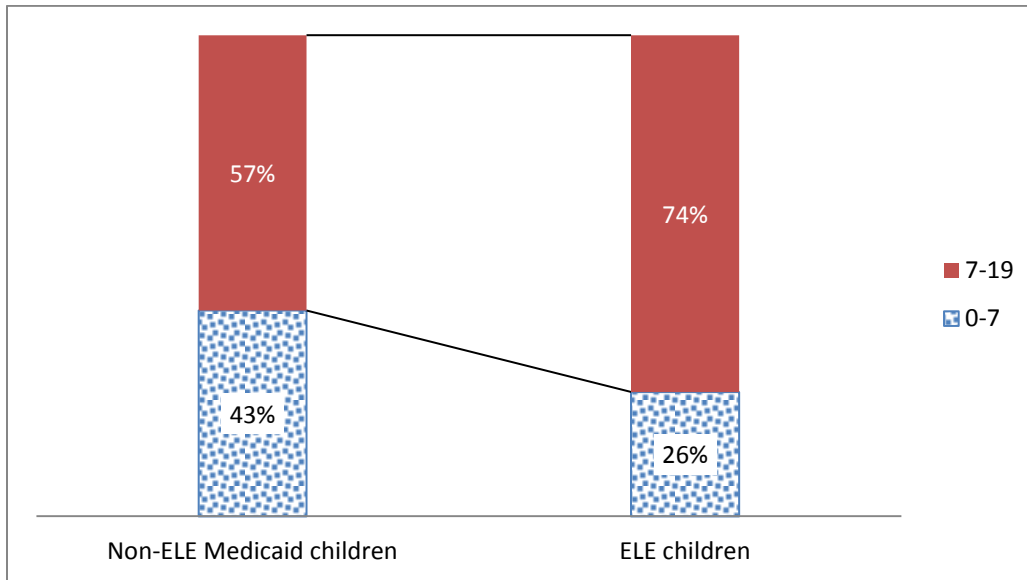
In terms of race, 37 percent of non-ELE children were White; the same was true of 43 percent of ELE children (Figure 4). Gender distributions varied as well, by statistically significant amounts, with boys comprising 49.8 percent of non-ELE children and 51.4 percent of ELE children (Figure 5).

Figure 1. Service categories with highest total claim costs, for ELE and non-ELE children, by percentage of total claims: May through December 2010



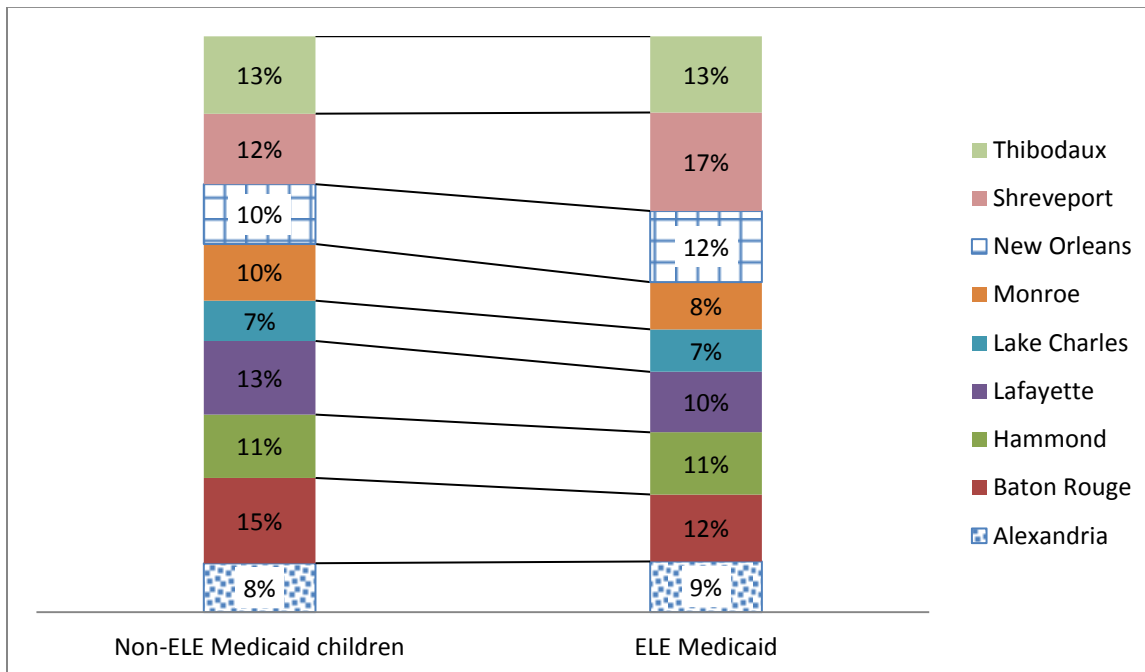
Source: Louisiana Department of Health and Hospitals, 2011. Note: Service categories include the five with highest average monthly claims for ELE children and the five highest for non-ELE Medicaid children.

Figure 2. ELE and non-ELE children, by age: May through December 2010



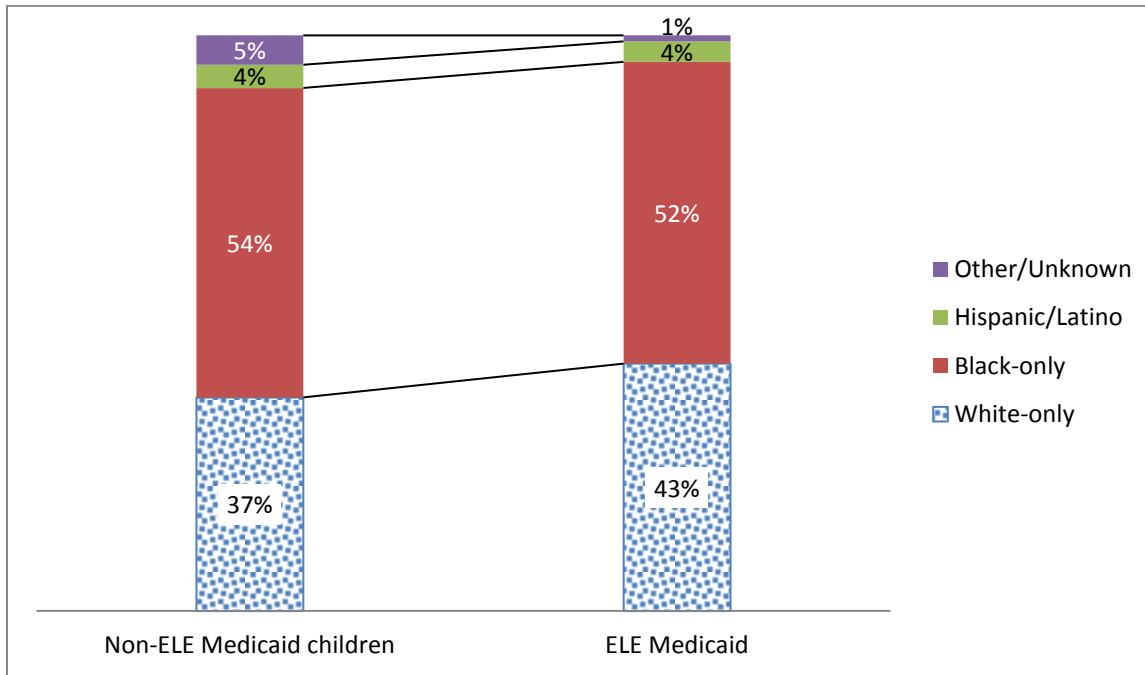
Source: Louisiana Department of Health and Hospitals, 2011. Note: All differences between ELE and non-ELE children are statistically significant at the .01 level.

Figure 3. ELE and non-ELE children, by region of residence: May through December 2010



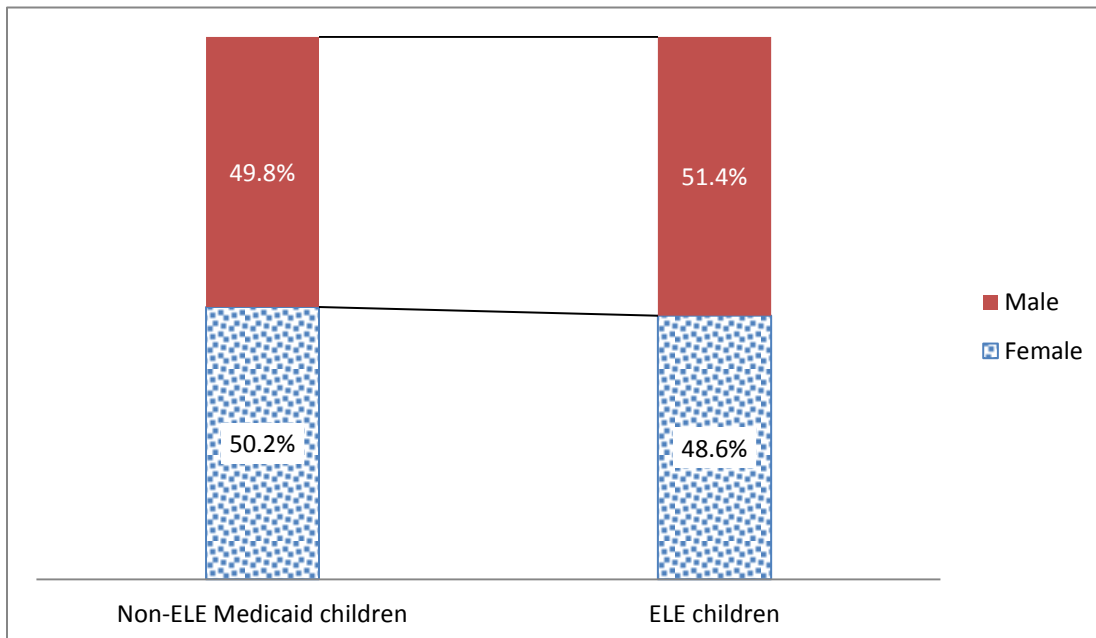
Source: Louisiana Department of Health and Hospitals, 2011. Note: All differences between ELE and non-ELE children are statistically significant at the .01 level, except for the following counties, as to which differences are not statistically significant: Alexandria, Hammond, and Thibodaux.

Figure 4. ELE and non-ELE children, by race and ethnicity: May through December 2010



Source: Louisiana Department of Health and Hospitals, 2011. Note: All differences between ELE and non-ELE children are statistically significant at the .01 level, except as to the proportion of ELE and non-ELE children who are Black. The latter difference is statistically significant at the .05 level.

Figure 5. ELE and non-ELE children, by gender: May through December 2010



Source: Louisiana Department of Health and Hospitals, 2011. Note: All differences between ELE and non-ELE children are statistically significant at the .01 level.

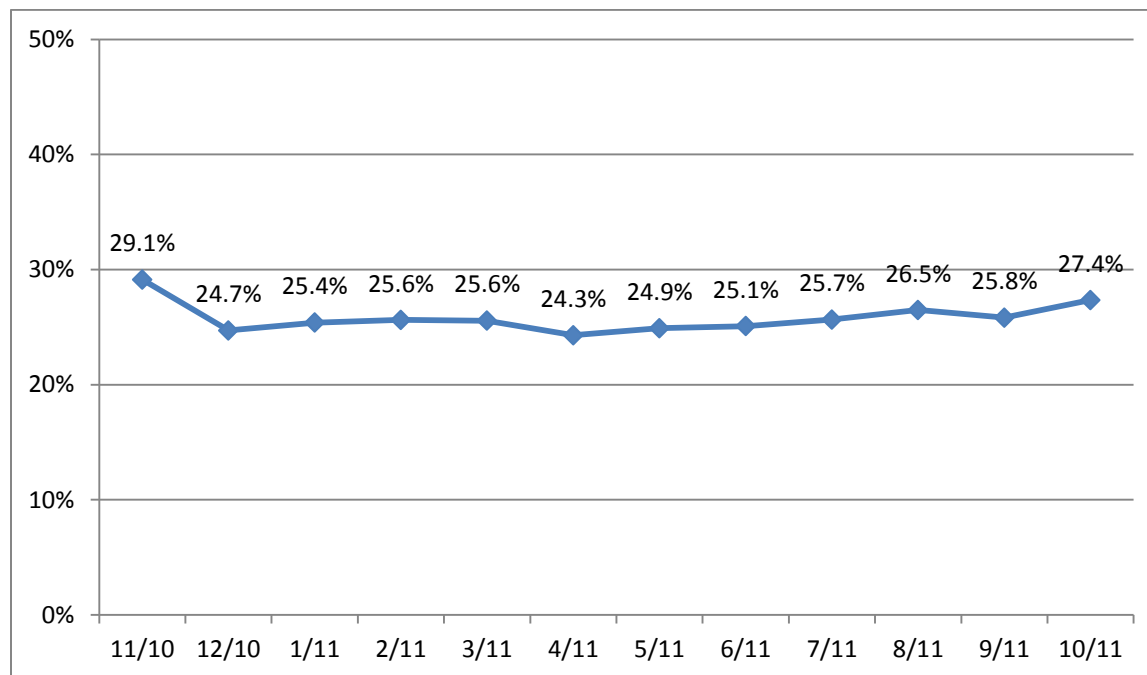
Providing further evidence of impact, community-based outreach workers observed a significant change following ELE implementation. Before ELE, when such workers would ask parents with uninsured children to raise their hands at school functions, fairs, and other events in low-income communities, some would always do so. After ELE implementation, no parents raised their hands. These outreach workers believed that ELE had made an important difference enrolling the poor, eligible but uninsured children who had not been reached by the state's earlier initiatives.

These observations were confirmed by the recent release of 2011 LHIS survey results. Noting that the state's remarkable increase in child health coverage seemed to stall as of the 2009 survey, researchers "questioned whether Louisiana had effectively hit a floor where further reduction in uninsured rates for children would be difficult to achieve. This year those questions were answered as the 2011 LHIS estimates another significant decline in the number and percent of uninsured children."¹⁵ From 2009 to 2011, 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 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 2011.¹⁶ And outside the domain of health coverage capable of being affected by state action, uninsurance grew more prevalent. From 2009 to 2011, the proportion of children and adults receiving employer-sponsored insurance declined, and the proportion of uninsured among low-income adults rose. Put simply, the only group to experience improved coverage was low-income children who qualified for Medicaid.

Using ELE to renew coverage for Medicaid children as a whole

As explained above, the state "went to scale" in November 2010, using ELE to renew eligibility automatically for Medicaid children across the entire caseload, regardless of how or when they first gained coverage. Children whose 12-month Medicaid eligibility periods were drawing to a close and who were currently receiving SNAP were automatically renewed. However, such renewals did not apply to children whose parents received Medicaid or whose siblings received Medicaid without SNAP, as noted earlier. Despite the latter exclusion, ELE was responsible for between 24.3 and 29.1 percent of each month's Medicaid renewals for all children from November 2010 through October 2011 (Figure 6), averaging 25.8 percent for this 12-month period.

Figure 6. Among all renewals for Medicaid children, the percentage who were renewed via ELE: November 2010 through October 2011



Source: Louisiana Department of Health and Hospitals 2011.

Administrative costs

According to state officials, start-up and infrastructure development for ELE cost nearly \$600,000. Staff time required to implement ELE consumed \$46,539, conservatively estimated. Computer programming and other information technology (IT) investments cost \$544,600, an amount paid by the “Maximizing Enrollment” project, funded by the Robert Wood Johnson Foundation, with the National Academy for State Health Policy serving as national program office.

That infrastructure development allowed ELE to reduce state operating costs for initial eligibility determinations and for renewals. According to state officials, the average cost of initial enrollment is approximately \$116.48 per application processed using standard, non-ELE procedures, reflecting necessary staff time. Taking into account the manual intervention required to prevent duplicative enrollment, the average cost of initial enrollment via ELE is between \$11.59 and \$15.45 per successful ELE application.¹⁷ Accordingly:

- If the 11,149 ELE-enrolled children who used their cards in 2010 to obtain services 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 equaled between \$1.0 and \$1.1 million.

This estimate 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 overestimates cost savings since some of these children would not have received coverage without ELE. On the other hand, as noted earlier, administrative costs exceed average levels when enrollment takes place on an expedited basis for children with an urgent, medical need. Accordingly, for ELE children who, without ELE, would have enrolled after developing such a need, costs per application would have exceeded average levels by a significant amount. By failing to take into account these increased costs for expedited enrollment, our estimate may understate true administrative cost savings.

Savings were even more dramatic for renewals:

- DHH staff estimates that the cost of manual renewal is approximately \$76 per child.
- To use data matches for renewal without the simplification afforded by ELE costs an average of \$51 per child, according to state officials. For example, before implementing ELE, if a child slated for renewal received SNAP, DHH staff had to “cross-walk” the information from SNAP records into Medicaid’s different household definitions and income deductions. ELE let Louisiana eliminate the need for this manual intervention by automatically deeming SNAP recipients income-eligible for Medicaid.
- 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, at no incremental administrative cost to the state.
- Administrative savings thus totaled between \$8.0 million and \$11.9 million for the first year of full implementation of ELE renewal. The former savings would have resulted if all children had been renewed via data matches, using the procedures that applied before ELE; the latter would have resulted if all renewals would have been fully manual without ELE.

The net administrative savings resulting from ELE were thus 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 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 2). 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.

These cost savings estimates primarily reflect the differences in wages paid to state staff under ELE compared to more time-intensive approaches to eligibility determination. They may understate savings by excluding staff benefit costs. They do not include the fixed costs of eligibility determination (the cost of the building infrastructure where eligibility staff are housed, for example), which are not affected by whether a child qualifies via ELE or other eligibility determination methods.

Table 2. 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	\$7,970,229 to \$11,877,204	\$0	(\$7,970,229) 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, or staff benefits.

Focusing on state spending alone yields an even more favorable ratio between infrastructure development costs and operational savings. That is because the IT investments allowing ELE implementation were funded by the Robert Wood Johnson Foundation, through the Maximizing Enrollment project. Remaining administrative costs were covered using standard Medicaid rules, which provide a 50 percent federal match. Viewed through the lens of state dollars, Louisiana’s investment of \$23,270 resulted in administrative cost savings, during the first year of full 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 annual state savings thus reached between \$4.5 and \$6.4 million, with an addition net savings of \$4.0 to \$5.9 million in renewals for each subsequent year.

Of course, other states may lack access to foundation funding of their IT investments. That said, in the context of ACA implementation, CMS is offering 90 percent federal funding for IT investments needed to transition to data-driven eligibility; and IT-based enrollment and renewal can qualify for 75 percent federal funding of administrative costs, rather than the normal 50 percent.¹⁸ States taking advantage of these new resources to implement ELE data-matching systems might be able to realize considerable administrative savings in terms of state dollars alone, even if their administrative savings per dollar of infrastructure development involves a lower ratio than the more than 190 to 1 level achieved by Louisiana.

Focus group results

In conducting focus groups, Urban Institute researchers heard directly from parents about their experiences with and impressions of ELE. Key issues included whether parents thought ELE was a good approach for extending coverage to children, whether its automatic nature led to any confusion or misunderstanding, and more generally, whether having children covered made a difference in their families' lives.

As summarized earlier, two focus groups were held, one in the state capital of Baton Rouge and the other in Alexandria, a small city in rural central Louisiana. Across the two groups, a total of 11 parents participated, including eight women and three men. These participants, most of whom were African American, had a total of 37 children, ranging in age from infants to college-age young adults. In most cases, the parents were uninsured but their children received Medicaid. These parents were recruited because their children had gained coverage through Louisiana's new ELE system and the parents used Medicaid cards to obtain care for their children.

Focus group participants were roughly evenly split between those who first heard about Medicaid from a health care provider (such as staff at a hospital or clinic) and those who heard about it from workers at a local SNAP or Medicaid office.

Before delving into participants' experiences with ELE, researchers asked about prior applications for public benefits. Most parents had previously sought Medicaid, either for themselves or their children. These experiences were generally described in positive terms—parents explained that applying for health coverage was relatively “easy” and “hassle free.”

In contrast, parents mostly described the SNAP process as much more difficult, with longer application forms, more verification and paperwork, and significantly longer waits to learn whether they qualified for assistance. One gentleman, who had never before applied for public assistance but who suffered an injury, lost his job, and therefore needed help, said the process was “difficult.”

“[I was not] accustomed to doing that type of thing... [it was difficult] because of my pride, not necessarily because of the paperwork, but because my pride was standing in the way...and I never had to do that before.”

One mother explained that her bad feelings about applying for SNAP were more about the staff she encountered.

“It's their attitude...the people that work in the system, they make you feel low, degraded...like [benefits] are coming out of their pockets. It varies worker to worker...”

After discussing these past experiences, the focus groups turned to a discussion of ELE. A key concern of policymakers regarding Express Lane Eligibility is that, if CHIP or Medicaid is granted automatically based on another program's eligibility determination, parents may not fully realize that their children are enrolled in health coverage, particularly when, as in Louisiana during our site visit, parents need not consent before they are sent Medicaid cards. Encouragingly, however, when parents were asked how they learned of their children's health coverage, many remembered receiving a letter from the state informing them that their children had qualified for Medicaid and understood that using a Medicaid card would enroll their children into coverage.

“[I received] a letter that said...your child is now enrolled in the program.”

“I think [the letter] may have said, ‘your child is eligible for CHIP.’”

“I got a letter saying they were eligible for it and if you don’t want it, call us and let us know.”

“They sent the card in the mail. If you used your card, you were automatically enrolled.”

When asked how they felt about receiving this automatic coverage, parents expressed great excitement and relief.

“I thought it was a gift from God!”

“[I said] thank you God. It was a blessing...a financial blessing.”

“I was jumping for joy.”

Some parents were surprised and pleased to receive coverage for which they had not explicitly applied.

“I was excited! And I didn’t do anything...”

“It really caught me off guard...I know we hadn’t applied for it...”

“I was like, ‘Why am I receiving this?’ [But] I was kind of happy because my husband was the only one working then. So I put the letter to the side and a week later, I got a card in the mail...”

“Yes, it was [weird]... I was like, ‘This can’t be right!’ But it really felt good that they sent you that letter...”

When asked if they trusted that the coverage was real, all parents replied affirmatively. One responded:

“Yes. It was official.”

Many parents also remembered receiving additional correspondence from the state instructing them to select a primary care provider for their child.

“You have to pick your primary care doctor. If you don’t...they automatically pick one for you.”

“They said I need to call a number to inform them who my primary doctor is. I did it on the phone.”

Most parents’ children had been on Medicaid for more than a year, so they had also experienced renewing coverage under ELE. When asked to describe renewal—a process where, if a child is still enrolled in SNAP at the time of redetermination, their Medicaid coverage is automatically renewed, but that in other cases, additional work may be needed—parents again remarked about how easy it was.

“It wasn’t even a process!”

“It was just a phone call.”

Researchers sought to learn whether ELE, through automatic enrollment, reached families who might not otherwise apply for Medicaid or CHIP. The focus groups shed some light on this

question. A single parent with multiple children thought, mistakenly, that all her children were already enrolled. When one man who recently lost employment was asked whether he would have applied for Medicaid without ELE or whether health benefits were “off his radar screen” and so his children would have remained uninsured, he replied:

“Everything was off my radar...”

On the subject of Medicaid’s ability to supplement employer-sponsored insurance, another participant said,

“I definitely didn’t think it was an option... I didn’t think Medicaid would be an option at all since [my son was] on my husband’s coverage.”

After receiving a Medicaid card for his child, one parent asked incredulously,

“You can use your wife’s insurance and Medicaid together?!?”

Participants were asked to comment on changes to the ELE process that were then under consideration (and which the state later implemented). After learning that, under the new system, applicants would be required to check a box on the SNAP application, parents expressed various opinions. Many thought the new approach would work fine and would be clear to applicants.

“To me, it makes sense...”

“You’re automatically being enrolled, instead of second-guessing myself [and wondering] if I’m eligible...”

“It’s basically common sense...”

Some parents, however, were concerned that that waiting for parents to proactively check a consent box could introduce confusion and prevent some children from receiving coverage.

“I think it’s another needless complication...adding a check box... You have some people who [won’t] check that box and miss out on services that they should otherwise get... The fact is, I’d be willing to bet that 99% of people who have Food Stamps need this service!”

Researchers were also curious whether parents were actually using Medicaid coverage to obtain services for their children. By virtue of the sampling procedures employed to select focus group participants, all had used their Medicaid cards at least once. Beyond that, parents were asked if they had any trouble finding providers to care for their kids. Most parents had good news to report—finding a pediatrician was not a problem, and care was scheduled and obtained rapidly.

“The time to get a visit has been getting shorter. They are able to fit you in right away...”

“My children go to a pediatrician. There are about six doctors in the group, and if I call on short notice, I won’t get the doctor of my choice... But it’s okay for me...we just go for that.”

“Both were fairly easy—finding a doctor and making an appointment.”

In Baton Rouge, parents reported similarly good experiences finding dentists for their children. But in rural Alexandria, one parent told us, “It was harder to find a dentist that would accept [Medicaid].”

Access to prescription drugs appeared to be more problematic for several parents, either because they were required to get additional prior approval for certain drugs, or because pharmacies told them that Medicaid wouldn't cover the cost of drugs their children had been prescribed.

“Yes, sometimes I have trouble getting prescriptions filled... They told me that Medicaid won't pay for it...that prior authorization is needed. They'll contact my doctor, and nothing...nothing...nothing...”

“They would not cover our generic brand; they only covered the regular brand.”

We finished our groups by asking what it meant to receive health coverage for their children. Without exception, parents shared heartfelt comments on how important it was to them.

“[Coverage] makes you feel comfortable, like if something was going to happen to your child...you're going to get the best health care that you could get.”

“You just feel good...security...”

“If you don't have insurance, they don't have to give you the best care...”

“You have something to back you up... They put more effort in to make sure everything goes fine... [Health insurance] is just a little cushion...”

Finally, parents overwhelmingly supported the goals and the simplified process of gaining coverage through Express Lane Eligibility. In fact, one parent called for it to be expanded:

“They need to expand the program to low-income adults!”

The focus group results were consistent with many findings from key informant interviews, document reviews, and administrative data analysis. According to participants, ELE was a welcome, comprehensible, and easy process for parents; many families reached by the strategy may not have otherwise enrolled, since they did not realize their children qualified for Medicaid or mistakenly thought they were already enrolled; many parents were largely successful in gaining access to care for their ELE-enrolled children; and even before they used Medicaid cards to obtain care, parents valued the peace of mind that came from knowing their children were insured.

V. Lessons learned

Important lessons can be gleaned from Louisiana's experience with ELE. These lessons involve both the process for successful innovation as well as substantive health policy.

Process lessons

One important lesson is that “simplification isn't simple,” in the words of Ruth Kennedy, a longstanding leader of Louisiana's Medicaid program, but “the juice is worth the squeeze.” It took staff considerable time and patience to iron out relevant details of policy and operations. As they spent months working through the ground-rules for ELE implementation, state officials typically met twice weekly. In generalizing from their experience, Louisiana's agency staff suggested that, in a state where Medicaid and SNAP are administered by the same agency, implementation may be simpler than in Louisiana (in part because of fewer concerns about duplicate enrollment).

In terms of strategies that other states can consider in implementing ELE, lessons from Louisiana include the following:

- Successful implementation of an innovation like ELE requires a state-level team that includes leaders in policy, communications, field offices, and information technology, as took place in Louisiana. These change components are interdependent; none can be addressed in isolation.
- Upon reflection, state policymakers believed that they may have been able to move more quickly if, in addition to a collaborative “team of equals,” a single project manager had the authority to make final decisions once issues had been thoroughly explored.
- Arguments in support of ELE can focus on administrative savings and efficiency, not just increased enrollment of eligible children.
- Implementation is likely to be smoother if demands on the partner agency are kept to a minimum. At the same time, it is important to track relevant actions taken by the partner agency to avoid confusion and mixed signals. Collaboration can be facilitated by a sense of shared mission—namely, providing low-income residents with necessary services, while eliminating needless taxpayer costs.
- In training caseworkers, it is important to clarify that differences in program rules are legitimate. In Louisiana, some caseworker concerns were triggered by varying SNAP and Medicaid definitions of the household members whose needs and earnings are considered in determining eligibility.

Louisiana was able to succeed with ELE in part because of the state’s earlier work developing a modern infrastructure for eligibility determination, including electronic case records and centralized program administration with the capacity to determine eligibility at the state level. More broadly, state officials have focused considerable attention on cultural change within DHH, at multiple levels. Both among state staff and local caseworkers, researchers observed a remarkable level of comfort with change and a striking openness to innovation and experimentation. Frequent caseworker trainings are taken for granted, and front-line workers are consulted in developing policy and can be rapidly promoted to positions of leadership.

Finally, outside support was critically important in helping Louisiana implement ELE. The “Maximizing Enrollment” project, funded by the Robert Wood Johnson Foundation and administered by the National Academy for State Health Policy, played a central role by furnishing technical assistance and paying for necessary IT development.

Policy lessons

Louisiana’s experience shows that using ELE to grant Medicaid eligibility based on SNAP records can yield significant administrative savings, even though ELE requires some ongoing staff involvement (albeit at a greatly reduced level). Along with other streamlining measures, ELE helped the state absorb a 20 percent reduction in eligibility staff without slowing the processing of applications and renewals or increasing the error rate.

SNAP-based ELE can also improve enrollment and access to care while preventing manual errors in qualifying families for coverage. 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 major Medicaid expansion required by the Patient Protection and Affordable Care Act (ACA). DHH officials believed that, unless data matches play a major role in qualifying both adults and children for Medicaid under the ACA, their existing staff could have extreme difficulty coping with the forthcoming flood of Medicaid applications as eligibility for all adults rises to 138 percent of FPL.

More broadly, Louisiana's experience shows that automated enrollment into health coverage can result in consumers who:

- Understand the coverage they have received;
- Achieve some peace of mind from knowing they have insurance; and
- More often than not, use their coverage to obtain services.

Louisiana's first auto-enrollment approach involved:

- Qualifying people for subsidized coverage based entirely on data matches after failure to "opt-out;"
- Activating fee-for-service coverage when enrollees use insurance cards; and
- Potentially triggering enrollment into capitated systems of managed care soon thereafter.

Similar strategies deserves serious consideration as state and federal policymakers grapple with the daunting challenge of enrolling tens of millions of eligible uninsured into the ACA's insurance affordability programs. That said, following our site visit state officials reported success with a new approach through which Medicaid enrollment begins after consumers opt into health coverage on SNAP application forms. Future research will need to investigate why this particular opt-in process has been effective in reaching children, unlike many past opt-in procedures that failed to enroll eligible children and adults into public and private benefit programs.¹⁹

Conclusion

With its implementation of ELE, Louisiana has begun a new chapter in the state's already remarkable history of innovations to streamline enrollment and retention of eligible children, lower administrative costs, and prevent eligibility errors. 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.

About the authors and acknowledgements

Stan Dorn and Ian Hill are senior fellows and Fiona Adams is a research assistant at the Urban Institute. Before this study, Mr. Dorn furnished technical assistance to Louisiana officials implementing ELE as part of his work on the “Maximizing Enrollment” project. The authors thank the many state officials in Louisiana who generously gave of their time and effort to provide the information on which this report is based. They are also grateful to the Robert Wood Johnson Foundation and its national program office, the State Health Access Data Assistance Center, for supporting our research. The authors also thank their Urban Institute colleague, Dean Resnick, for his help analyzing data about the differences between ELE children and other children covered by Medicaid. Neither Dr. Resnick, state officials, the funders for our research, the Urban Institute, nor its funders and trustees are responsible for the opinions expressed in this report, which are the authors’.

About the Urban Institute

The Urban Institute builds knowledge about the nation’s social and fiscal challenges, practicing open-minded, evidence-based research to diagnose problems and figure out which policies and programs work best, for whom, and how.

About the SHARE Initiative

The State Health Access Reform Evaluation (SHARE) is a national program of the Robert Wood Johnson Foundation that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. 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.

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

More information about SHARE is available at www.shadac.org/share.

Endnotes

¹ Social Security Act §1902(e)(13)(D)(i).

² E.g., Beth Morrow and Julia Paradise, *Explaining Health Reform: Uses of Express Lane Strategies to Promote Participation in Coverage*, The Children’s Partnership and The Kaiser Commission on Medicaid and the Uninsured, July 2011, downloaded on 1/24/2012 from <http://www.kff.org/healthreform/upload/8212.pdf>; and Stan Dorn, *Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, April 2009, downloaded on 1/24/2012 from http://www.urban.org/UploadedPDF/411879_eligible_children.pdf.

³ Louisiana Department of Health and Hospitals. 2009. “Louisiana Medicaid Recognized as a National Best Practice for Administrative Efficiency,” downloaded on 2/9/2012 from <http://www.dhh.la.gov/news.asp?Detail=1556>.

⁴ For example, Louisiana, like most other states, does not use asset tests to determine children’s eligibility; does not require families to make in-person visits to social services offices to enroll or to renew; contracts with community-based organizations to educate low-income families about available coverage and to help them renew; and uses a common application for all forms of children’s health coverage. Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, and Jessica Stephens, *Performing Under Pressure: Annual Findings Of A 50-State Survey Of Eligibility, Enrollment, Renewal, And Cost-Sharing Policies In Medicaid And CHIP, 2011-2012*, the Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, January 2012, downloaded on 1/24/2012 from <http://www.kff.org/medicaid/upload/8272.pdf>.

⁵ The state’s earlier use of data to renew coverage “ex parte”—that is, through the efforts of Medicaid staff, without any action required from enrollees—differed from ELE. Without ELE, DHH staff analyzed available data in terms of Medicaid’s detailed income rules. Accordingly, even after SNAP found a family to be poor, DHH needed to reconfigure SNAP households into Medicaid households, recalculate income levels by applying Medicaid income deductions rather than SNAP deductions, etc. By contrast, ELE allowed Louisiana’s Medicaid program to rely on SNAP’s findings, notwithstanding differences between the two program’s technical eligibility rules.

⁶ State Health Access Data Assistance Center (SHADAC), U.S. Census Bureau, Current Population Survey - Annual Social and Economic Supplement (CPS-ASEC) tabulations, health coverage for children under 200 percent FPL, averages for 1997-1999 and 2009-2010, incorporating SHADAC adjustments to Census Bureau data.

⁷ Stephen Barnes, Kirby Goidel, and Dek Terrell, *Louisiana’s Uninsured Population: A Report from the 2009 Louisiana Health Insurance Survey*, prepared by Louisiana State University for the Louisiana Department of Health and Hospitals, December 2009, downloaded in 2/6/2012 from <http://new.dhh.louisiana.gov/assets/medicaid/LHIS/2009LHIS/2009LHISReportFeb.pdf>.

⁸ Louisiana Department of Health and Hospitals. 2009, op cit.

⁹ Estimates are from state administrative data for December 2009.

¹⁰ Author’s calculations from Benjamin D. Sommers, The Impact Of Program Structure On Children’s Disenrollment From Medicaid And SCHIP, *Health Affairs*, 24, no.6 (2005):1611-1618.

¹¹ E.g., *Register.Com, Inc.*, op cit.; *PDC Laboratories, Inc., v. Hach Company*, 2009 WL 2605270 (C.D.Ill. Aug. 25, 2009) (not reported in F.Supp.2d); *Druyan v. Jagger*, 508 F.Supp.2d 228, 237 (S.D.N.Y.2007); *Hubbert v. Dell Corporation*, 359 Ill.App.3d 976, 987 (5th Dist. 2005). So long as the notice is clear and prominent, the contract is enforceable without any proof that the consumer actually read such notice. *Druyan*, op cit.

¹² The former estimate comes from state administrative records. The latter comes from Urban Institute calculations, Medical Statistical Information System (MSIS) data for 2007.

¹³ These numbers represent simple tabulations of data from the CPS-ASEC, without adjustment for the Medicaid undercount or other factors.

¹⁴ 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. As indicated in Figure 3, a higher proportion of ELE children lived in all three regions, but the difference in Alexandria was not statistically significant.

¹⁵ Kirby Goidel, Stephen Barnes, and Dek Terrell, *Louisiana’s Uninsured Population: A Report from the 2011 Louisiana Health Insurance Survey*, prepared by Louisiana State University for the Louisiana Department of Health and Hospitals, February 2012.

¹⁶ Ruth Kennedy, personal communication, February 2011.

¹⁷ 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 121 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.

¹⁸ CMS, “Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities,” *Federal Register* 76(75): 21950-21975, April 19, 2011.

¹⁹ See, e.g., John Guhl and Eliot Fishman, *New Jersey Family Care: Express Lane Eligibility*, State Coverage Initiatives Program National Conference, July 2009; David Laibson, “Impatience and Savings,” *National Bureau of Economic Research Reporter*, Fall 2005: 6–8; John Beshears, James J. Choi, David Laibson, and Brigitte C. Madrian, *The Importance Of Default Options For Retirement Savings Outcomes: Evidence From The United States*, National Bureau of Economic Research Working Paper 12009, January 2006; Johnson, E. J., Hershey, J., Meszaros, J., & Kunreuther, H., “Framing, Probability Distortions, and Insurance Decisions,” *Journal of Risk and Uncertainty*, 7:35-51, 2003; Eric J. Johnson, Steven Bellman, and Gerald L. Lohse, “Defaults, Framing and Privacy: Why Opting In-Opting Out,” *Marketing Letters* 13(1):5–15, 2002.