State Coverage Initiatives

Using 21st-Century Information Technology to Help Eligible People Receive Health Coverage:

State and Local Case Studies

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Introduction

American households and institutions are trying to adapt to rising mountains of ever more accessible personal data. For years, such data have been used to verify assertions made by applicants seeking public benefits. But officials responsible for administering public benefit programs are increasingly investigating whether they can also use personal data about income and other matters to identify potentially eligible individuals and help them receive benefits for which they qualify. Such strategies, which involve a strongly proactive role for public agencies, offer the hope of increasing the percentage of eligible individuals who receive benefits; cutting red tape for families; lowering the ongoing administrative cost of eligibility determination; and preventing errors.

In using data to facilitate the provision of means-tested subsidies for health coverage, Medicare has blazed a remarkable trail since the passage of the Medicare Modernization Act of 2003. Starting in 2006, subsidies for Part D coverage of prescription drugs have been granted based on data matches showing receipt of Medicaid or Supplemental Security Income (SSI) during the previous calendar year. Individuals can file paper applications for Part D subsidies if data matches do not demonstrate eligibility, but most enrollment is based on data. As a result, 74 percent of eligible beneficiaries received low-income subsidies before the new program's sixth month.[1] No federally funded means-tested benefit had ever achieved anything near this level of take-up within its first several years of implementation, much less its first several months.[2]

Federal officials shattered this new record in less than a year. Subsidies for Part B premiums were means-tested for the first time in 2007. Beneficiaries' incomes were determined based not on application forms, but on federal income tax data from two years in the past – for example, 2005 income tax data established eligibility for premium subsidies in 2007. Beneficiaries whose incomes fell since the baseline year could apply for increased subsidies, but income increases were disregarded in determining eligibility. By using tax data to drive eligibility determinations, every Part B beneficiary received an interim income determination and a corresponding subsidy—without filing a single application form—during the first month that premiums were means-tested.

State officials have also been exploring whether similar uses of 21st-century information technology can provide health coverage to low-income, uninsured residents who qualify for Medicaid and the State Children's Health Insurance Program (SCHIP). These efforts have taken place without encouragement from federal officials. In fact, the federal environment in which states operate has grown increasingly challenging in recent years. The President vetoed SCHIP reauthorization legislation that would have facilitated data-driven enrollment methods,[3] while new federal procedures impose financial penalties for state errors,[4] new rules limit states' ability to cover uninsured children in moderate-income families,[5] and federal authorities increasingly make decisions through non-transparent, state-specific negotiations, with changing standards and without articulating general policies on which states can rely when making plans.[6]

The following case studies tell a remarkable story of state and local officials pushing the envelope to provide health coverage to eligible families despite the absence of federal encouragement, emerging state budget woes, and the inherent challenges of shifting from paper-based to data-driven eligibility systems. Given those obstacles, it is not surprising that complete success has not been achieved overnight. What is startling is the distance that state policymakers have traveled in a short time and the positive results that appear within reach if, as seems likely, these efforts continue to gather momentum.

These case studies are presented in alphabetical order.

Chicago and the School Lunch Program

Like most states, Illinois provides extra resources to school districts with many low-income students.[7] Illinois' education law[8] allots these resources, in significant part, based on the number of children in each district who receive Medicaid, SCHIP, Food Stamps, and Temporary Assistance to Needy Families (TANF). This arrangement gives local school districts strong financial incentives to maximize eligible children's receipt of these services, including health care.

As a result, the Chicago school district helps eligible children enroll in Medicaid and SCHIP as well as other programs. Among other initiatives, the school system has become a repository of local eligibility records for each means-tested benefit program that affects the amount of aid received by Chicago schools.

According to school officials, this level of data sharing has required years to develop through building relationships of trust with other agencies. As those relationships have strengthened, school officials have become increasingly nimble in using data sharing to target outreach. For example, data matches between the National School Lunch Program (NSLP) and Medicaid/SCHIP have identified schools with particularly large numbers of children who receive NSLP but not health coverage. Those schools have then become the target of intensive outreach and enrollment campaigns. For example, at one target school, the proportion of students receiving NSLP but not health coverage fell from 42 percent to 17 percent in two years. More typical results involve reductions of 5 to 10 percentage points in the proportion of children receiving NSLP but not health coverage.

School officials would like to take these strategies further, using income information from NSLP files to establish income eligibility for health coverage. However, the considerable administrative work required to structure and apply such strategies requires more administrative staff than the Chicago school system has at its command.

Maryland and the State Income Tax

At the request of Howard County health officials in 2007, the state comptroller sent a letter to all county residents whose incomes—as shown on their state income tax returns—were sufficiently low for their children to qualify for Medicaid or SCHIP (in Maryland, 300 percent of the federal poverty level, or FPL).[9] The letter stated that, based on their tax returns, household members without health insurance might qualify for free or reduced-cost health coverage. For further information, households were asked to either call the county's "help" line or provide the county with contact information online. The letter was sent to approximately 20,000 county residents. No effort was made to identify and exclude people who already had health coverage. The County Health Department paid roughly $10,000 in mailing costs.

During the first three weeks after the comptroller sent the letter, the county's help line received several thousand calls. Typically, callers left voice mail messages, and county workers returned those calls within 24 hours. Staff took applications over the phone, without asking families to complete paperwork, and approximately 1,200 callers received health coverage.[10] According to county officials, allowing families to provide information by phone rather than requiring them to fill out forms was essential to this strategy's success.

Building on this initiative, the 2008 session of the Maryland legislature saw the enactment of the Kids First Act,[11] which takes important steps toward establishing statewide connections

between Maryland's income tax and health coverage systems. For tax year 2007,[12] the Maryland comptroller will identify households whose income, as shown on state tax forms, is sufficiently low for their children to qualify for Medicaid or SCHIP. The comptroller will send those households a letter stating that household members may qualify for free or low-cost health coverage. The letter will encourage the recipients to apply for coverage by calling a toll-free number. To reduce the administrative burden of taking the calls, the mailing will be staggered geographically, rather than go to all low-income residents simultaneously. This effort is a collaboration between the comptroller and the state's Department of Health and Mental Hygiene (DHMH), which runs the state's Medicaid and SCHIP programs.

For tax year 2008 and beyond, the income tax form will ask taxpayers to describe health coverage for each dependent child. When families identify their children as uninsured, and their tax data show likely income-eligibility for health coverage, the comptroller will send them Medicaid/SCHIP application forms. DHMH will evaluate the effects of this outreach strategy and investigate other possible strategies to expedite enrollment of uninsured, eligible children through matches with third-party data.

State officials in both the comptroller's office and DHMH are exploring the possibility of the two agencies sharing additional information to identify eligible, uninsured children and to enroll them into health coverage. For example, DHMH data could identify children who are already enrolled in Medicaid and SCHIP, allowing a better targeting of the comptroller's outreach; and income tax data could help establish income eligibility for uninsured children, reducing the burden placed on families and potentially increasing the number of children who enroll.

New Jersey and Food Stamps, State Income Tax Records, Prior Health Applications, and the National School Lunch Program

To identify eligible, uninsured children and adults and enroll them into health coverage, New Jersey is using data from many sources, including Food Stamp files, the state income tax system, prior health coverage applications, and NSLP.[13]

Food Stamps

In 2005, state officials matched enrollment data from Food Stamps and Medicaid files, identifying children who received food stamps but not health coverage. County officials, who administer Medicaid eligibility in New Jersey, were asked to examine each child's Food Stamp records and, without asking for additional information from families, to determine whether the child was eligible for Medicaid.

When children qualified, their families were contacted to see if other health coverage was available. Unless case records indicated that families did not want Medicaid or SCHIP, eligible children were enrolled into short-term, fee-for-service coverage. State officials sent families information about the coverage their children received, encouraging them to access care. This information emphasized services like eyeglasses, dental care, and prescription drugs, for which parents often perceive an immediate need. Families were asked to select a managed care plan for their children by a certain date. When families failed to make a timely choice, state officials randomly assigned the children to a plan.

Altogether, roughly 17,000 previously uninsured children received health coverage through this initiative. These children's continued eligibility for Medicaid was renewed at the time of their Food Stamp eligibility redetermination, ensuring that the income data establishing Medicaid eligibility did not grow stale.

Since then, county officials have used Food Stamp applications to initiate conversations with families about their possible desire for health coverage. When families wanted health coverage, their Food Stamp application forms have been used to make Medicaid eligibility determinations, without asking families to submit additional paperwork.

State income tax

New Jersey's innovative use of state income tax data began when audits showed that several ineligible people received Medicaid because their applications failed to report significant self-employment earnings that were listed on their most recent state income tax returns. This prompted administrative action to develop a new interface between state income tax records and New Jersey's Medicaid and SCHIP programs, through which prior income tax records would be automatically analyzed as a routine part of the application process.

Rather than develop a direct interface between tax and health programs, the state's information technology agency is creating an independent hub through which both tax and health programs will exchange data. This facilitates the application of strong privacy and data security safeguards. Most of the work to create this hub was complete after slightly more than a month, and officials believe the system will be operational before the end of the year. Officials will apply this new system first to SCHIP applications, then to Medicaid applications, and finally to renewals for both programs.

Although safeguarding public integrity was the main motivation for developing the new interface, state health officials also plan to use this data exchange mechanism to lessen the burden on families who seek coverage, thereby increasing the number who complete application and renewal procedures to obtain coverage successfully.

As state agencies were taking these steps, the state legislature was passing broad health reform legislation that included aggressive use of the income tax system to facilitate enrollment in health coverage. Among other provisions, S. 1557[14] requires that every child under age 19 must have health coverage within one year of the bill's enactment. To help achieve that goal as well as to reduce the number of uninsured adults, state income tax forms beginning with tax year 2008 will ask each taxpayer to indicate whether each household member has health coverage. The State Treasury Department will transmit data to the Department of Human Services (DHS) that allow DHS to identify taxpayers who are uninsured and who may qualify for health coverage. DHS will then use this information as part of its health coverage outreach and enrollment program.

The legislation also uses a second method of leveraging income tax data to facilitate enrollment into health coverage. As part of streamlined application procedures for Medicaid and SCHIP, no more than one pay stub can be required to document income. If applicants provide no income documentation, DHS can determine income eligibility based on matches with data maintained by the state labor agency and, when authorized by the applicant for health coverage, state income tax records.

In implementing this legislation, DHS faces several obstacles. The first involves information technology. Importing income tax data directly into DHS case files would require a major systems change that the state is not currently positioned to carry out. Second, Medicaid eligibility is determined by counties, which lack the ability to query income tax records. This may limit early implementation to SCHIP, for which the state determines eligibility. However, the state is exploring methods through which, in the future,

a county provides the state with identifying information about an applicant; the state uses that information to match with income tax data; and the state conveys the pertinent income tax data to the county. Third, the state's revenue officials are concerned about conveying private tax information without the taxpayer's permission. Accordingly, for the 2008 tax year, the Treasury Department is likely to send materials prepared by DHS to taxpayers who identify their children as uninsured and who, based on the Treasury Department's in-house analysis of the family's tax data, may be income-eligible for Medicaid or SCHIP. State officials see these as initial steps and hope, over time, to make increasing use of tax data to facilitate enrollment and retention by eligible individuals.

Information from Previous Applications for Health Coverage

The recent state legislation also increases Medicaid eligibility for parents from 133 percent FPL to 200 percent, effective September 1, 2008. State officials have developed a strategy through which many of these newly eligible parents will be enrolled without the need to file applications. Thousands of eligible parents have been identified based on health coverage applications they submitted for either themselves or their children after November 1, 2007. These parents are being sent letters asking if they are interested in health coverage, in which case they will be enrolled.

The enrollment period will last until the 12th month following the month of the initial application. For example, consider a father with income between 133 and 200 percent FPL who applied for his daughter's health coverage in November 2007. The father will be enrolled in Medicaid, based on information on the November 2007 child health application. However, his eligibility will be re-determined in October 2008—the same month his eligibility would have been re-determined if he had received the state's standard, 12-month eligibility when he filed the November 2007 application. Income data will thus be no staler for parents covered through this data-driven mechanism than if they had enrolled using standard procedures.

NSLP information

The above-described legislation also directs education and health officials to work together to develop a process through which parents applying for NSLP can both request health coverage for their children and authorize the use of information on the NSLP form to establish their children's eligibility for Medicaid or SCHIP.

New York, the State Income Tax, and Food Stamps

The governor of New York has convened a Children's Cabinet of state agencies to achieve several goals, including maximizing the coverage of eligible, uninsured children.[15] To reach this objective, state officials are exploring several strategies, including data matches with state income tax and Food Stamp records.

During the past year, health and revenue officials have worked collaboratively to develop procedures for matching income tax and health coverage data, both to prevent eligibility errors and to simplify application and renewal procedures, thereby increasing the number of eligible individuals with coverage. The Health Department sought legislative provisions in the state fiscal year 2008-2009 budget authorizing the required data exchange. As a result of budget negotiations, the enacted language permits the Tax Department to indicate no more than whether or not individuals identified by the latter department appear income-eligible for health coverage, based on data from individual tax returns and eligibility criteria supplied by the Health Department. The state's tax agency may have considerable difficulty applying the complex income eligibility rules of New York's health programs. Accordingly, state officials are seeking further discussions with legislative staff to develop consensus around a different approach that would permit the Tax Department to share particular data elements that the Health Department could then use to assess eligibility. Such data elements would include information on such topics as wage income and self-employment income. A similar data matching arrangement already exists for the state's program to help low-income seniors with prescription drug costs.

As a second data exchange strategy, state officials matched enrollment records of Food Stamps and Medicaid. They found more than 430,000 people, including roughly 170,000 children, who received food stamps but not Medicaid.[16] Surprised by these high numbers, state health officials are analyzing how to move forward. Complicating this issue are the multiplicity of the state's health programs and the complexity of the state's administrative arrangements. Medicaid, for which eligibility determination is handled by counties, covers children under age 1 up to 200 percent FPL; age 1 through 5 up to 133 percent FPL; and age 6 through 18 up to 100 percent FPL. Above those income thresholds, children receive Child Health Plus, New York's SCHIP program. Childless adults and "empty nesters" with incomes up to 100 percent FPL and custodial parents up to 150 percent FPL are covered through Medicaid or Family Health Plus, a Medicaid waiver program.[17] Child Health Plus is largely administered by health plans under contract with the state, but community-based facilitated enrollers play a major role, and counties make the final eligibility decisions for Medicaid and Family Health Plus. Accordingly, a single family can have its members divided between programs and responsible agencies of state and local government.

To provide additional insights into the characteristics of affected families, officials randomly sampled 25 households whose members, according to data matches, appeared to receive food stamps but not Medicaid. The sample came from a single county. The 25 households included 54 children and 35 adults. Based on the Food Stamp records, all of the children appeared to qualify for premium-free health coverage, including 47 who were eligible for Medicaid and seven who qualified for Child Health Plus without premiums, an eligibility category that extends to 160 percent FPL. Among the 35 adults, only two appeared to be ineligible for health coverage. Of the remaining 33 adults, 15 qualified for Medicaid, 15 were eligible for Family Health Plus, and three received SSI and already were covered through Medicaid.

These households exhibited some diversity in terms of their prior relationship to the state's health programs:

- 3 households had some or all family members already enrolled in Medicaid;
- 15 households either received or applied for Medicaid in the last two years, and nearly two-thirds of those households lost coverage at renewal; and
- 7 had neither sought nor received health coverage in recent years.

In deciding how to proceed with the hundreds of thousands of people who receive Food Stamps but not health coverage, state officials are mindful of the need to avoid imposing significant new administrative burdens on county eligibility offices. At the same time, a key priority for the near future is developing a statewide enrollment center, which will initially focus on expediting

renewals. New York will continue working with the county that participated in the above-described sample review to develop pilots that test how Food Stamp application and renewal procedures can serve as a platform for enrollment into health coverage. With limited administrative resources and a complex set of coverage options and institutional responsibilities, the state is sorting through its priorities in deciding how to integrate data matches as part of a comprehensive strategy for increasing enrollment and retention of eligible children and adults.

Pennsylvania, the State Income Tax, and Food Stamps

Pennsylvania officials have been investigating opportunities to provide information about the availability of health care in combination with the annual requirement for individuals to file their state income tax forms. For people who file electronically, an opportunity under consideration would apply when they submit their completed forms. At that point, they would be asked whether any of their children are uninsured and, if so, whether they would like to have their tax information used to begin an application for health coverage.[18] In such cases, their tax information would automatically prepopulate the state's on-line "COMPASS" application used to seek health coverage and other public benefits. Families could then provide any additional information and enroll their eligible, uninsured children into health care coverage. Interagency discussions about this strategy have been fruitful, determining that the costs of implementing such a system would be modest. As a result of these conversations, state income tax informational materials will be modified to reflect the opportunity to apply online for health care and other benefits. Further interagency discussions may take place in 2008-2009.

State health officials are also investigating the use of Food Stamp data to identify and enroll eligible uninsured children. After matching Food Stamp, Medicaid, and SCHIP eligibility files, state officials identified nearly 18,000 children who receive food stamps but not health coverage. Pennsylvania's Medicaid program is analyzing the Food Stamp files to determine which children appear to qualify for Medicaid. The other children will have their eligibility records shared with the state's SCHIP agency for analysis of possible SCHIP eligibility. Depending on the coverage for which each child appears eligible, the relevant state agency will contact families to resolve open eligibility questions and to confirm that the parents want health coverage for their children, after which eligible children will be enrolled.

Washington, Unemployment Insurance, Schools, and Child Care

Several bills enacted during the 2008 legislative session encourage the development of linkages between the state's health programs and other state agencies.[19] One state budget proviso[20] directs the state unemployment insurance (UI) agency to work with health officials to develop a procedure through which applicants for UI can request subsidized health coverage. A report that analyzes possible methods of information exchange between UI and health agencies and the provision of health coverage to laid-off workers and their dependents is due to the governor and the legislature by November 15, 2008.

Some stakeholders in Washington have discussed giving laid-off workers a chance to request health coverage, not just on the initial UI application form, but also later UI reporting forms that UI recipients must file every two weeks to show their compliance with UI job search requirements.[21] This would give these workers a chance to ask for help after the period immediately following job loss has passed. During that initial period, workers are coping with the loss of a regular paycheck, figuring out how to get a new job, and receiving an enormous volume of information about available benefits. That is a challenging context in which to provide information about health coverage.

A second budget proviso[22] requests a report by December 15, 2008 concerning possible data linkages between the state's health programs and the NSLP and child care subsidy programs. The goal is to use enrollment information from the latter programs to facilitate identification and enrollment of eligible, uninsured children into health coverage.

Finally, legislation enacted outside the budget[23] authorizes pilot projects in six diverse school districts, which will use the annual forms that parents complete when their children start school to ask whether each child has health coverage. The forms will authorize parents of uninsured children to share information so an outreach worker may contact the family to discuss options for health coverage. Information gathered by these forms will be recorded in the district's school information system. When authorized by the parents, contact information will be shared with local outreach organizations, which will contact the family and help the children enroll.

As yet, few districts are seeking to operate such pilot projects. Most local education officials are focused on other urgent priorities during the current economic slowdown, which is reducing local property tax revenue as well as state funding for elementary- and secondary-school education.[24]

Conclusion

Before SCHIP's 1997 enactment, a coterie of states used options available under a creative interpretation of federal law to expand children's coverage above mandatory income levels.[25] These efforts took place without federal encouragement, often in the face of economic downturn. Not only did children in these states benefit, such innovations paved the way for broader, national policy change that now offers subsidized health coverage to nearly all poor and near-poor children.

State and local policymakers may currently be in a similar period of breaking new ground. This time, states are exploring the use of 21st-century information technology to provide health coverage to eligible uninsured children and adults. Whether or not national policy changes result, these are promising strategies to help state coverage expansions reach their most fundamental goal of providing the uninsured with health coverage.

About the author

Stan Dorn, J.D., senior research associate at the Urban Institute's Health Policy Center, has more than 20 years of experience working on health policy issues at the state and national levels. He is currently one of the nation's leading experts on automated enrollment systems as applied to Medicaid and the State Children's Health Insurance Program (SCHIP), as well as the novel Health Coverage Tax Credit enacted in 2002. Before working at the Urban Institute, Mr. Dorn was a senior policy analyst at the Economic and Social Research Institute, where he specialized in complex, innovative policy design to expand health coverage, including the development of incremental reform options as part of the Covering America project, funded by the Robert Wood Johnson Foundation; and working with diverse, national stakeholders to develop a consensus around innovative health coverage expansion proposals. Mr. Dorn previously served as managing attorney at the National Health Law Program's Washington

office, health division director at the Children's Defense Fund during its successful national campaign to enact SCHIP in 1996-97, state policy director at the Alliance for Young Families in Boston, and health consumer alliance director and staff attorney working on California issues at the National Health Law Program.

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Endnotes

1 Dorn, S. *Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals*. Prepared by the Urban Institute for the State Coverage Initiatives Program of Academy Health, August 2007.

2 For example, after its second year of full implementation, Food Stamps reached only 31 percent of eligible households. Government Accountability Office. *Medicare Part D Low-Income Subsidy: Progress Made in Approving Applications, but Ability to Identify Remaining Individuals is Limited.* May 8, 2007. GAO-07-858T. After five years, SCHIP covered 60 percent of eligible children. J.L. Hudson and T.M. Selden. "Children's Eligibility and Coverage: Recent Trends And A Look Ahead." *Health Affairs*. Web Exclusive. August 16, 2007.

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7 The primary source of information for this section of the paper is Annie Lionberger of the Chicago school system.

8 105 ILCS 5/18-8.05 (H)(1.10).

9 The information about the Howard County initiative comes from Peter Beilenson, the Howard County Health Officer.

10 Enrollees were almost evenly divided between children and adults. In Maryland, adults with incomes up to 116 percent of FPL qualify for either Medicaid or state-funded health coverage.

11 H.B 1391 was enacted during the 2008 Regular Legislative Session and signed by the governor, to become Chapter 692 of the Laws of Maryland of 2008.

12 Much of the information describing the state's implementation of this statute comes from Alice Burton and Cheryl Camillo of the State of Maryland.

13 Much of the information in this section of the paper comes from Elliot Fishman, John R. Guhl, Valerie J. Harr, Richard H. Hurd, Kim A. Hatch, Heather Howard, Elena M. Josephick, Heidi J. Smith, and Jennifer Velez of the State of New Jersey as well as Ann Kohler, formerly of the State of New Jersey and now at the National Association of State Medicaid Directors.

14 P.L. 2008, chapter 38.

15 The information in this section of the paper comes from Judith A. Arnold, Ralph Bielefeldt, and Anne Marie Costello of New York State.

16 For purposes of increasing food stamp enrollment, they also identified people who received Medicaid and SCHIP but not food stamps, finding an even larger number.

17 Community Service Society of New York, *Medicaid Income and Resource Levels: April 2008*, calculations by author.

18 Information in this section of the paper comes from George Hoover of the Commonwealth of Pennsylvania.

19 Information about implementation of this legislation comes from MaryAnne Lindeblad of the State of Washington, and Jane Beyer of the Washington State Legislature.

20 Budget for 2009-2010, Sec. 209(19)(b).

21 Cassie Sauer, personal communication, November 2007.

22 Budget for 2009-2010, Sec. 209(19)(a)(ii).

23 S.B. 1500, 2008 Regular Legislative Session.

24 MaryAnne Lindeblad and Jane Beyer, personal communication, August 7, 2008.

25 See discussion of Social Security Act Section 1902(r)(2) in Ullman, F. *MCH Update September 1996: Medicaid Coverage of Pregnant Women*. National Governors Association Center for Best Practices. September 1996.