MATHEMATICA
Policy Research

CHIPRA Express Lane Eligibility Evaluation

Case Study of Oregon's Express Lane Eligibility Process

Final Report

April 30, 2013

Maggie Colby
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URBAN INSTITUTE

HEALTH MANAGEMENT ASSOCIATES

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EXECUTIVE SUMMARY

In September 2010, Oregon implemented an Express Lane Eligibility (ELE) partnership to support enrollment of children into Medicaid and the Children's Health Insurance Program (CHIP). The Oregon Health Authority (OHA) conducts a data match to identify children with active Supplemental Nutrition Assistance Program (SNAP) benefits who are not enrolled in public health insurance programs; it then mails shortened applications to families. They may complete the application and enroll by mail or by telephone, generally without additional verifications. Through January 2013, about 84,000 shortened applications have been mailed, and 4,463 have been returned (a response rate of 5 percent), resulting in 6,636 new enrollments through Oregon's SNAP-ELE partnership.

The partnership among Medicaid, CHIP, and SNAP reflects longstanding ties across the agencies, which were all managed within the Oregon Department of Human Services (DHS) until 2011. Given these existing relationships, Oregon experienced a smooth ELE implementation process that involved relatively minor information technology updates, designing new client communication materials, and staff training for selected eligibility workers at OHA's centralized processing unit, which handles health insurance applications exclusively and processes all ELE cases.

Table ES.1. Key Facts about Oregon's ELE Program

Policy Simplification Adopted	ELE
Policy in Medicaid, CHIP, or Both	Both Medicaid and CHIP
Processes Affected	Enrollment
Eligibility Factors Addressed by ELE	Income, household size, Social Security number, residency
Implementation Date	September 2010
Partner Agencies	DHS (SNAP) An ELE partnership with the National School Lunch Program (NSLP) was also pilot tested but has been discontinued.
Time Savings for Enrollees/Applicants	Applicant paperwork burden is reduced and time from application submission to enrollment is reduced from an average of 9 to 3 days.
Time Savings for the State	Eligibility workers save about 15 minutes processing each ELE application, relative to a regular application.
Estimated Cost to Implement	Policy staff developed new client communication and eligibility worker training materials for ELE. Oregon reported less than $2,000 in direct costs to implement information technology modifications. Monthly, the state spends approximately $2,000 to mail ELE applications.
Estimated Savings	Mathematica Policy Research's analysis, as presented in the Interim Report to Congress, indicates that Oregon's ELE program is essentially cost-neutral.
Is Process Different from View of the Enrollee/Applicant?	Yes. Families enrolled in SNAP, but not public health insurance, are mailed a shortened application form. ELE applicants may enroll via telephone or by mailing back the form, generally without additional verifications.
Program Goals	Goals of ELE were to reduce the number of uninsured children, reduce staff time spent processing applications, and simplify the application experience.

Pursuing ELE in Oregon was consistent with many concurrent policy and procedural changes designed to enhance outreach, simplify the enrollment process, increase enrollment, and improve retention. This includes the Oregon Healthy Kids initiative, which launched in July 2009 with the aim of ensuring 95 percent of Oregon's children had access to affordable coverage and featured joint marketing of Medicaid, the separate CHIP, and a private market insurance program. About the

same time, OHA introduced 12 months of continuous eligibility, reduced income verification requirements, and aligned SNAP and public health insurance renewal dates. To reduce the number of pending applications, the agency also began encouraging eligibility staff to contact applicants by telephone to resolve outstanding questions more quickly than possible through the process of issuing paper notices. Given these concurrent activities, key informants found it difficult to pinpoint the particular effects of ELE. However, the program clearly led to new enrollments, and eligibility staff reported improved productivity for ELE applications.

Given the smooth implementation experience for children, and positive (though modest) enrollment outcomes, OHA and DHS officials currently plan to expand ELE to include adults receiving SNAP, pending 1115 waiver negotiations with the Centers for Medicare & Medicaid Services (CMS). SNAP-ELE for adults will play a particularly critical role should Oregon move forward with Medicaid expansion under the Affordable Care Act (ACA). OHA analyses completed in July 2012 indicated that most adults who would be newly eligible for Medicaid in 2014 are already part of the SNAP caseload.

In 2010, OHA also piloted an ELE partnership with the National School Lunch Program (NLSP) in four school districts, modeled after the SNAP-ELE program. OHA planned to gather data on children receiving NSLP who were not already enrolled in public insurance or receiving SNAP, and to mail them a shortened application, using NSLP-reported income to determine Medicaid and CHIP eligibility. Although NSLP was a promising partner, it is administered by 200 separate school districts and does not maintain a centralized database of information on enrolled children. Operational challenges in compiling data from individual school districts have led the state to discontinue this program. ELE partnerships might be more successful when they build on existing data infrastructure or can draw on centrally stored and uniformly formatted data.

Two additional lessons for both ELE and ACA implementation can be drawn from Oregon's experiences. First, an ELE program that relies on mailed applications that families must return (versus an automatic enrollment process that does not require separate applicant action) might have limited success in reaching the target population. Although respondents partially attributed low ELE enrollments to the success of other concurrent OHA initiatives, the low response rate to mailings suggests that the need to return an application was a significant procedural hurdle limiting the effectiveness of ELE.

Second, the CMS requirement to use a 30 percentage point disregard when establishing Medicaid and CHIP eligibility using SNAP income has resulted in the loss of federal matching funds when children who are income-eligible for CHIP are instead enrolled in Medicaid. This rule satisfies CHIP "screen and enroll" requirements, which dictate that children do not qualify for CHIP unless they have been screened for Medicaid and found ineligible. Oregon's analyses suggest that a disregard of this magnitude is unwarranted, and concerns about lost funds have discouraged the state from pursuing ELE for renewals.

1. Introduction

The Children's Health Insurance Program (CHIP), a landmark legislative initiative passed in 1997 to help close the health insurance coverage gap for low-income children, was reauthorized with bipartisan support in 2009. Although CHIP had helped to fuel a substantial increase in health insurance coverage among children, Congress remained concerned about the many children—estimated at 4.4 million in 2010—who are eligible for but not enrolled in coverage (Kenney, Lynch, et al. 2012). In the CHIP Reauthorization Act (CHIPRA) of 2009, Congress gave states new tools to address enrollment and retention shortfalls, along with new incentives to do so.

One of these new options is a policy called Express Lane Eligibility (ELE). With ELE, a state's Medicaid and/or CHIP program can rely on another agency's eligibility findings to qualify children for public health insurance coverage, even when programs use different methods to assess income or otherwise determine eligibility. ELE thus gives states another way to try to identify, enroll, and retain children who are eligible for Medicaid or CHIP but who remain uninsured. The concept of using data from existing government databases and other means-tested programs to expedite and simplify enrollment in CHIP and Medicaid has been promoted for more than a decade; before CHIPRA, however, federal law limited state reliance on information from other agencies by requiring such information to be cross-walked into the Medicaid and CHIP eligibility methodologies (Families USA 2010; The Children's Partnership n.d.). To promote adoption of ELE, Congress made it one of eight simplifications states could implement to qualify for performance bonus payments. These were new funds available to states that implemented five of the eight named simplifications and that also increased Medicaid enrollment (CHIPRA Section 104).

Federal and state policymakers are keenly interested in understanding the full implications of ELE as a route to enrolling children, or keeping them enrolled, in public coverage. To that end, Congress mandated an evaluation of ELE in the CHIPRA legislation. In addition to reviewing states that implemented ELE, the evaluation provides an opportunity to study other methods of simplified or streamlined enrollment or renewal (termed *non-ELE strategies*) that states have pursued, and to assess the benefits and potential costs of these methods compared with those of ELE. Taken together, findings from the study will help Congress and the nation better understand and assess the value of ELE and related strategies.

This report summarizes findings from a case study of Oregon's ELE program, which uses income data from the Supplemental Nutrition Assistance Program (SNAP) to determine eligibility for Medicaid and CHIP, which the state jointly markets as "Healthy Kids." The state also piloted an ELE partnership with the National School Lunch Program (NSLP), but has discontinued that effort.

To learn about Oregon's ELE program and its NSLP pilot, staff from Mathematica Policy Research conducted a site visit in January 2013, interviewing 11 key informants over a two-day visit to the state and four staff by telephone in January and February (see Appendix A). While on site, the research team conducted one focus group with four Portland-area parents whose children were enrolled in Healthy Kids via ELE. Parents shared their experiences with ELE and traditional enrollments for Healthy Kids and SNAP, as well as their experiences obtaining health care services for their children.

2. State Context: Why pursue ELE?

In September 2010, Oregon implemented an ELE program to facilitate initial enrollments into Medicaid and CHIP. The Oregon Health Authority (OHA) conducts a data match to identify

children with active SNAP benefits who are not enrolled in public health insurance programs; families identified through this process are sent shortened applications. They may complete the application and enroll by mail or telephone, generally without additional verifications.

Pursuing ELE in Oregon was consistent with many concurrent policy and procedural changes designed to smooth the enrollment process and improve retention. Top agency leadership prioritized the goal of universal enrollment for children, launching the Healthy Kids initiative in July 2009 with large-scale joint marketing of Medicaid, the separate CHIP, and a private market insurance program for children at higher income levels. The three components are collectively known as "Oregon Healthy Kids." The goal of the program is to ensure that at least 95 percent of Oregon children have access to affordable health coverage (Oregon Healthy Kids 2010).

Table 1. Key Facts About Oregon Healthy Kids

Program Name	• Medicaid, CHIP, and Healthy Kids Connect, collectively known as Oregon Healthy Kids • Medicaid sometimes still called Oregon Health Plan Plus
Medicaid Upper Income Limit	133% of FPL (ages 0–5); 100% FPL (ages 6–19)
CHIP Type and Upper Income Limits	Regular Separate CHIP Component • Children from families with incomes up to 200% of FPL at no cost to family Premium Assistance CHIP Component (Healthy Kids Connect) • Children from 201–300% of FPL, with subsidized premium
Additional Children's Coverage	• Children from families with incomes above 300% of FPL, full cost buy-in option through Healthy Kids Connect
Delivery System	• Oregon began moving Oregon Health Plan beneficiaries (including children from families with incomes up to 200% FPL) into coordinated care organizations (CCOs) in August 2012. CCOs are networks of providers that deliver physical, mental, and dental health, working with a global budget allotment. • Healthy Kids Connect is a private market insurance program.
12 Months Continuous Eligibility?	Yes
Presumptive Eligibility for Children?	No
In-Person Interview Required?	No
Asset Test?	No
Joint Medicaid and CHIP Application and Renewal Forms?	Yes
Premium Assistance Subsidies?	Yes (in Healthy Kids Connect)
Adult Coverage	• Adults with incomes up to 100% of FPL are eligible for limited coverage under the Oregon Health Plan Standard waiver program, but enrollment is currently closed. • Adults with incomes up to 201% of FPL are eligible for premium assistance under the Family Health Insurance Assistance Program waiver, but enrollment is currently open only to children.
Renewal Processes	Enrollees receive a pre-populated renewal form; income verification is completed again at renewal, but can often be done by telephone

Sources: Site visit interviews; Oregon Healthy Kids 2010; Heberlein et al. 2013.

FPL = federal poverty level.

At the same time, Oregon pursued several streamlining initiatives to improve the enrollment experience for families, including providing 12 months of continuous eligibility for children (regardless of fluctuations in family income), reducing income verification requirements, aligning SNAP and public health insurance renewal dates, allowing a verbal signature during telephone application and renewal, and creating an online application. To reduce the number of pending applications, the agency also began encouraging eligibility staff to contact applicants by telephone to resolve outstanding questions more quickly than the process of issuing paper notices. The state also considered but did not implement presumptive eligibility policies, due to concerns about the financial liability of enrolling ineligible individuals. Eligibility processing staff, policy staff, and advocates identified the reduction in income verification requirements, alignment of SNAP and Medicaid/CHIP renewal processes, and the campaign to reduce pend rates as the most effective concurrent policy changes. We describe each of these efforts below.

- **Reducing income verification requirements.** To calculate an applicant's income, eligibility workers previously had to verify three months of income data, which they would average to create a monthly estimate to determine eligibility. Applicants often did not have appropriate documentation dating back three months, resulting in delayed applications or denials if the applicant was unable to produce the documentation. Oregon first reduced the requirement to two months of income verification and then to one month only, which is the current policy. If applicants cannot supply a recent pay stub, Oregon looks at their quarterly wages as reported by the state Employment Department.

- **Aligning SNAP and Healthy Kids renewal.** Many families are enrolled in both SNAP and Healthy Kids, but the renewal processes occurred separately. To maintain SNAP benefits, enrollees must resubmit paperwork and complete an interview (in person at DHS offices, or by telephone) every six months; Medicaid and CHIP enrollees are required to renew their coverage annually. To reduce the number of times families had to complete forms and visit DHS offices, state officials merged SNAP and Healthy Kids renewal dates. Jointly enrolled families now receive a single letter notifying them of their annual Medicaid/CHIP renewal and semiannual SNAP renewal (the second semiannual SNAP renewal still occurs separately). One of our focus group members remarked that simplifying this renewal process made it much easier to maintain continued benefits.

- **Effort to reduce the pend rate.** [1] Before ELE, an internal study found that eligibility workers were frequently pending applications. This practice increased overall application processing times, created additional work for eligibility staff by requiring them to work on a case multiple times, and likely resulted in some denials of eligible people who failed to respond to the pend notice. Following an effort to encourage eligibility staff to call applicants and try to resolve issues on the telephone before issuing a paper notice, overall pend rates have dropped by 25 percent. Although ELE was not directly connected with the effort to reduce pend rates, some applications were pended because

[1] Eligibility workers pend, or place on hold, applications that they can neither accept nor deny. This usually occurs because they have to verify information on the application, such as income or insurance status. When this happens, a letter is sent to the client explaining that his or her application cannot be processed due to missing or incomplete information. The onus is then on the applicant to follow up with the agency and provide the necessary answers, clarification, and/or verification.

workers had to verify income. Because ELE enabled the use of SNAP-verified income data, it complemented the state's effort to reduce the pend rate.

In the context of these diverse initiatives to reduce the number of uninsured children and simplify the enrollment experience, ELE was something that "just made sense," in the words of one respondent. It was seen as a valuable additional strategy that would reduce unnecessary enrollment barriers. Officials noted that CHIPRA performance bonuses were important—they tried to implement as many CHIPRA-rewarded strategies as possible—but financial incentives were not the primary motivation for pursing ELE. When it later became clear that Oregon qualified for CHIPRA performance bonuses independent of the ELE program, officials continued to support ELE because they believed it reached uninsured children and streamlined the enrollment process.[2]

The partnership among Medicaid, CHIP, and SNAP reflects longstanding ties across the agencies. When ELE policies were developed and first implemented, the Oregon Department of Human Services (DHS) administered all three programs. Medicaid and CHIP were subsequently split off to be administered by the Oregon Health Authority (OHA) in 2011, but the two agencies have maintained a close working relationship. DHS continues to administer SNAP and a variety of other welfare programs and OHA focuses on medical programs, but the agencies occupy the same building, have routine meetings to discuss aligning enrollment policies and procedures, and have ready access to each other's data systems.

Why Pursue ELE?

When we spoke with Oregon officials, they reflected on both cultural and procedural reasons that ELE was a good fit for their state. To them, the adoption of ELE seemed natural for a variety of reasons.

The state has a high value on medical coverage for kids and medical coverage for families in the state.… So that's something you just know as being part of the state. That's a value we have, and we will keep driving for getting people covered with medical insurance so they can get the care they need and prevent bad outcomes from occurring.

The same agency determines eligibility for all these different programs, and they have different rules. It's an administrative nightmare when you have to do three different income calculations for three different programs. Many times they turn out to be very similar, but we still have to do three different calculations. It's burdensome for clients and staff to have to do that. Anything that would make things easier and that makes sense, we want to do.

Oregon's SNAP program was also a natural choice for ELE because its income-eligibility criteria are similar to those of public health insurance. SNAP covers children in families with incomes up to 185 percent of the federal poverty level (FPL), so there is considerable overlap with Medicaid and CHIP. In addition, SNAP participation rates were 99 percent in 2009, the second highest in the country (Cunnyngham 2011). With SNAP's large client base and near saturation of the eligible population in Oregon, an ELE partnership with SNAP promised to be an efficient way of reaching children who were not yet insured.[3]

Oregon also considered the NSLP as a potentially promising ELE partnership, enabling Healthy Kids to reach low-income

[2] Even without ELE, Oregon qualified for $1.6 million in CHIPRA performance bonus payments in fiscal year 2009 and $10.6 million in fiscal year 2010. The state received credit for implementing continuous eligibility, liberalization of asset requirements, elimination of in-person interviews, having the same application and renewal form, and automatic/administrative renewal (Insurekidsnow.gov n.d; CMS 2012).

[3] As of September 2011, 12 percent of all Oregon households were on SNAP, 50 percent of which included children younger than 18.

uninsured children who were not already receiving SNAP benefits.[4] OHA piloted an NSLP-ELE program with four school districts, but encountered a variety of problems related to data sharing and communication, as discussed in the implementation section of this report.

3. Planning and Design: What was needed to develop the policy?

Because ELE aligned closely with Oregon's goals to maximize coverage and could capitalize on strong existing ties among Medicaid, CHIP, and SNAP staffers, the development of ELE policy proceeded smoothly. However, given the number of other eligibility simplifications and policy changes underway in 2009 and 2010, the state did not immediately pursue the detailed planning activities needed to obtain a state plan amendment (SPA) for ELE. Overall, the process of ELE policy development and SPA negotiations with CMS occurred over about six months. Oregon received CMS approval for its ELE program in October 2010, with a back-dated effective date of August 2010.

The Division of Medical Assistance Programs (DMAP), the unit within DHS that oversaw Medicaid and CHIP when ELE was first considered, reviewed all the policy options incentivized by CHIPRA performance bonuses and spoke with other states that had implemented ELE, including Alabama and Louisiana. Its review included a financial analysis of the impact of ELE as well as potential partners. DMAP produced a policy paper on different options for implementation, which included the recommendation to work with SNAP. Analyses conducted while planning for ELE estimated that there were about 64,000 children with active SNAP cases who were not enrolled in public insurance and assumed that 34,000 of those—or about 53 percent—would enroll via ELE.

One of Oregon's most significant concerns emerging from the financial analysis was that some CHIP-eligible children would be enrolled in Medicaid due to the CMS requirement that all states add 30 percentage points to income eligibility levels when implementing ELE. This rule satisfies CHIP "screen and enroll" requirements, which dictate that children do not qualify for CHIP unless they have been screened for Medicaid and found ineligible. States may also choose to temporarily enroll children in CHIP if the child appears CHIP-eligible using the Express Lane agency findings; however, during the temporary enrollment period, states must conduct a full eligibility determination to establish either Medicaid or CHIP eligibility (Center for Medicaid and State Operations 2010).

Through ELE, children in families with incomes up to 163 percent of the FPL are enrolled in Medicaid (133 percent + 30 percent, as permitted by CHIPRA section 203), whereas those with incomes from 163 to 185 percent of the FPL (the income cap for SNAP) are enrolled in CHIP. Oregon's fiscal year (FY) 2012 enhanced Federal Matching Assistance Percentage (eFMAP) rate for CHIP was 74.04 percent, whereas the Federal Matching Assistance Percentage (FMAP) rate for Medicaid was only 62.91 percent (U.S. Department of Health and Human Services 2010). Therefore, each child enrolled through ELE who is income-eligible for CHIP but is instead enrolled in Medicaid represents lost revenue to the state. Indeed, DMAP analysts estimated costs to the state of $1.3 million over the period from 2010 to 2013 due to the reduced FMAP amount. Concern about the repeated loss of matching funds due to enrollment of CHIP-eligible children in Medicaid led

[4] SNAP beneficiaries are directly certified to receive NSLP. SNAP enrollees who were not enrolled in public insurance would be considered through the SNAP-ELE route. Therefore, the NSLP-ELE partnership would reach children who were enrolled in NSLP but not enrolled in SNAP or public health insurance.

Oregon to use ELE only for enrollments, rather than for renewals.[5] Current ELE enrollments complete the normal renewal process after 12 months, and children are appropriately enrolled in Medicaid or CHIP using the normal income-eligibility cutoffs. Ultimately, state officials decided that ELE was a worthwhile policy that justified the increased first-year costs to the state for some new enrollments of children from families with incomes from 133 to 163 percent of the FPL.

When the state decided to move forward with ELE, the SPA writing and approval process primarily involved two staff members. Key informants reported that an important point in negotiations was the CMS requirement that separate agencies and staff conduct the eligibility determinations for SNAP and ELE. OHA satisfied this requirement as follows: DHS Self-Sufficiency Offices that serve each county in Oregon would continue to handle applications for SNAP, Temporary Assistance for Needy Families (TANF), day care, other social service programs, and standard medical applications. OHA's centralized processing unit, Branch 5503, which handles public health insurance applications exclusively, would process all ELE cases.

Partnering with OHA was not a complicated decision from the perspective of SNAP officials. DHS was supportive of the mission of ELE—"It sounded like this would be good for kids and it would ease workload for workers, both of which are important"—and saw the program as budget neutral. The Department's main role in ELE, sharing data with OHA, was already routinely done. In addition, the Department already had data routines in place that were straightforward to modify to support ELE processes: for example, it supplies the Department of Education with data on SNAP children to support direct certification for the NSLP.

DHS also had no reason to anticipate increased eligibility processing costs at its local Self-Sufficiency Offices. All ELE applications would be handled by staff at OHA's Branch 5503. In addition, the costs of any ELE-related inquiries that occurred at Self-Sufficiency Offices would be appropriately attributed to OHA's budget, given the standard reimbursement processes that Oregon has in place. To determine the distribution of labor costs, DHS takes a random sample survey of the activities of Self-Sufficiency Office workers. If the survey results indicate that workers spend 25 percent of their time on medical applications (including ELE inquiries), OHA is assigned 25 percent of costs for field office staff.

No state legislative approval was required, and opposition to ELE was minimal in Oregon. Although some legislators expressed concern about enrolling ineligible children, most state leaders supported policies that simplified enrollment, subject to the dominant concern about limited state budgets. CHIPRA performance bonuses created the political opportunity to overcome their financial concerns. In the words of one respondent, "Health care reform in Oregon was fabulous because it took advantage of the financial incentive [available through CHIPRA] and made policy changes. We could talk about the financial case, and not just the moral case."

[5] Some staff also expressed concern that the 30 percentage point disregard allows some families who have already been assessed for CHIP and found ineligible due to concurrent enrollment in private health insurance to enroll in Medicaid via ELE. For example, a family with income at 150 percent of the FPL might apply for both SNAP and medical benefits at a DHS Self-Sufficiency Office. Because the family's income places it at CHIP eligibility levels, if the children were already enrolled in private health insurance, they would not be enrolled in CHIP. Then, because these children would have an open SNAP enrollment, but no record of public health insurance, they would be identified through the ELE process. Because their family income is less than 163 percent of the FPL, they would be enrolled in Medicaid, which allows concurrent enrollment in private health insurance.

4. Implementation: What happened?

ELE Partnership with SNAP

The first SNAP-ELE enrollments occurred in September 2010, following a smooth implementation process that involved relatively minor information technology updates, designing new client communication materials, and staff training for eligibility workers at Branch 5503.[6] Since implementation, policies and procedures for ELE have remained the same.

Focus Group Findings:
How did you feel about getting the letter?

We asked focus group members how they felt about being contacted by Healthy Kids, based on their enrollment in SNAP.

I was ecstatic.

My son's father's union lost his insurance, so he couldn't insure my son anymore. I thought it was cool. It was easy. I thought it was great that they had a self-addressed stamped envelope. It was big.

To generate targeted ELE mailings, SNAP officials pull data from their client list on a monthly basis, including children who are in their second month after SNAP certification or recertification. OHA runs an automated data match that identifies children who are not enrolled in public health insurance coverage and mails these households a two-page application explaining the opportunity to enroll in Healthy Kids.[7] State staff reported that the initial systems modifications to conduct data matching and create an administrative flag to track ELE enrollments cost approximately $1,600, and that approximately 3,500 mailings are sent each month at a cost of about $2,000.

The process for designing the ELE applications, which are shorter than traditional Healthy Kids applications and request less information, was a joint effort between DHS and OHA staff. Officials worked together to develop a letter that was "brief, understandable, and simplif[ied] the procedure as much as possible." Because Oregon uses SNAP findings to establish income, household size, Social Security number, and residency, these questions are not included on the ELE application. ELE households are asked to select a medical and dental plan; to identify any absent parents; and to report the following for each child: Alaska Native/American Indian status, current/recent health coverage, and disability status. By contrast, the regular Healthy Kids application is nine pages long, including two pages of income and asset questions (Table 2).

[6] The timing of the first round of ELE enrollments reflects efforts by OHA officials to avoid overtaxing eligibility workers. In October 2010, the state planned to randomly draw 20,000 names from the reservation list for Oregon Health Plan Standard, the Medicaid package for non-pregnant low-income adults. Selected individuals would be offered the opportunity to apply for health coverage (Oregon Center for Public Policy 2010). Because Branch 5503 would also handle these applications, state staff sought to launch ELE before this major open enrollment period began.

[7] In keeping with their efforts to streamline and simplify enrollment processes, OHA staff decided to exclude certain families from the ELE process. Families in which some children in the household are already enrolled in Medicaid are not processed using ELE because of a desire to maintain aligned renewal dates for all household members. Families whose incomes are below 31 percent of the FPL—the eligibility threshold for TANF—are not processed via ELE because they are eligible for Medical Assistance Assumed (MAA) or Medical Assistance to Families (MAF), which might also provide coverage for some adult family members.

Table 2. Data Requested on ELE and Standard Healthy Kids Applications

Data Element	SNAP-ELE Healthy Kids Application	Standard Healthy Kids Application
Social Security Number for All Applicants		X
Citizenship Status for All Applicants		X
Names and Demographic Information for All Household Members		X
Alaskan Native or Member of Federally Recognized American Indian Tribe	X	X
Educational Enrollment for All Household Members		X
Income (wages, rent, child support, disability benefits, and so on)		X
Assets (vehicles, stocks and bonds, savings accounts, and so on)		X
Pregnancy Status and Cohabitation Status of Father		X
Perceived Danger from Partner/Spouse		X
Medical/Dental Plan Choices	X	X
Health Coverage Within the Past Two Months, and If Ended, Why	X	X
Disability or Life-Threatening Medical Condition	X	X
Absent Parent: Last Known Address and Employer	X	X
Absent Parent: Demographics, Social Security Number, Visitation Schedule		X

Source: Mathematica review of SNAP-ELE letter mailed to the child's parent/guardian and the Oregon Health Plan/Healthy Kids application available for standard enrollment (OHA 7210 [Rev 6/12]).

Families can complete the shortened ELE application via telephone or mail.[8] Mailed applications are routed to Branch 5503, where they are automatically imaged and placed in a queue for eligibility workers to process. Applications completed by telephone bank staff enter the same queue. ELE applications are prioritized so that workers process them before completing other daily work. By comparison, the standard Healthy Kids form can be submitted online, by mail, by fax, or in person at one of the DHS Self-Sufficiency Offices. Online applicants must fax or mail supporting documentation, such as proof of income.

Policy analysts at OHA led the training efforts to prepare for ELE implementation. They sent policy transmittals describing ELE to eligibility workers, included ELE information in newsletters, and prepared skill challenges to test staff knowledge of appropriate procedures. Because six specialized staff at Branch 5503 conducted all ELE processing, training for DHS Self-Sufficiency Offices was minimal. It ensured that staff recognized ELE applications, knew to forward them to Branch 5503 (in case clients incorrectly returned them to the field offices), and understood the system code used to identify ELE enrollments. The six staff members who piloted ELE at Branch 5503—and who still work on the program—underwent more intensive training, including a review of federal guidelines on ELE, how to look at the SNAP information screen, where to locate income information, and how to add this to the Medicaid/CHIP record. This training lasted one to two hours and was well-designed from the staff perspective.

[8] ELE applications are postmarked to be returned to Branch 5503. If applicants return these forms in person to a Self-Sufficiency Office, the form is re-routed to Branch 5503.

When ELE began, Branch 5503 eligibility workers were concerned that certain applicants would be enrolled in Healthy Kids without following appropriate or fair procedures. However, when they realized that ELE involved reusing income determinations made by SNAP, and that they would still verify other elements (such as enrollment in third-party insurance), they were more comfortable with the process. Workers also appreciated that, by using SNAP income, they would be less likely to pend applications, consistent with the statewide effort to reduce the pend rate. There was some concern that time spent on ELE applications would not count toward their daily goals for application processing, but the Branch 5503 management team decided to count ELE applications the same way as traditional applications for purposes of staff productivity targets. Staff are able to process about six or seven ELE applications per hour, relative to two or three traditional applications.

About 84,000 SNAP ELE applications were mailed from September 2010 through January 2013. Most were delivered to valid addresses; slightly less than 5 percent were returned by the U.S. Postal Service. Overall 4,463 applications have been returned to Branch 5503, representing 8,678 children, for a response rate of slightly more than 5 percent. About two-thirds of households returned the application by mail and one-third completed applications with telephone bank staff. Eligibility workers have approved coverage for 76 percent (6,636) of ELE children and denied coverage for 22 percent (1,924).[9] The most common reasons cited for denial were existing enrollment in Medicaid/CHIP or, if CHIP-eligible, enrollment in third-party major medical insurance.[10] In about 30 percent of ELE cases, the client already has private insurance. Because most ELE applications can be processed without additional verification, and because they are prioritized over standard applications, the overall time from application receipt to enrollment averages three days for ELE enrollments, relative to about nine days for standard enrollments.

Focus Group Findings:
How did you first hear about Healthy Kids?

We asked focus group members how they first heard about Healthy Kids.

I saw it on a billboard that offered health insurance for all children, regardless of income. That was a new idea for me to have insurance without a cap, a group that was pro-insuring kids.… I had applied before, but the application was long, so I started it and then didn't finish it. Then SNAP sent me one sheet, which was easier. It went from a thing I started but couldn't finish (because I couldn't do it on a Mac at home) to a thing I could fill out easily.

I have no idea. I just got a letter in the mail, filled it out, and sent it in. I didn't know what [Healthy Kids] stood for before you said it.

My manager at my job told me about it.

I worked in the county clinic and heard about it awhile ago.

Although implementation did not involve any public outreach efforts specifically related to ELE, intensive advertising and outreach associated with the Oregon Healthy Kids initiative—which launched about one year before ELE—likely reduced the number of remaining uninsured children. Healthy Kids included a large-scale marketing campaign, featuring billboards and advertisements on public buses. A school-based campaign included a dedicated Healthy Kids coordinator who liaised with district leaders across the state; more than 500,000 fliers were sent home with school children; and outreach was conducted to student athletes through partnerships with their coaches. A Communities of Color outreach campaign with population-specific materials was designed to reach seven different ethnic

[9] The remaining cases represented duplicates (87) or were still pending (31).

[10] Denials for existing enrollment in public insurance may occur when a child's enrollment in Medicaid or CHIP is completed in between the time that SNAP conducts its monthly data run and the family returns an ELE form.

groups, including African Americans, African refugees, Latinos, Native American tribes, and South Asian populations; a targeted outreach grant program has ongoing contracts with 27 partner organizations to meet enrollment and outreach goals; and an additional 18 outreach grants have been made to safety net providers and public health departments with funding through a CHIPRA outreach grant. Finally, approximately 100 application assisters, most of whom are insurance agents, continue to work to sign up children for Healthy Kids. These assisters are paid $75 per application that results in enrollment.

Pilot ELE Partnership with the NSLP

OHA piloted an ELE partnership with NSLP in 2010, modeled after the SNAP-ELE program. OHA planned to gather data on children receiving NSLP who were not already enrolled in public insurance or receiving SNAP benefits and to mail them a shortened application, using NSLP-reported income to determine Medicaid and CHIP eligibility. Although OHA believed that NSLP was a promising partner given its contact with low-income children, it is administered by 200 separate school districts in Oregon and does not maintain a centralized database of information on enrolled children. Operational challenges in compiling data from individual school districts have led the state to discontinue this program. Participating districts also cited concerns about data quality and a lack of communication from OHA. Given that many other states have expressed interest in pursuing ELE partnerships with NSLP, Oregon's experience—described in more detail below—might provide valuable lessons.

Beginning in September 2010 (the 2010–2011 school year), the state included two additional statements on the application for free and reduced-price school meals in four pilot school districts: Portland Public School District, Eugene School District, David Douglas School District, and South Lane School District. School employees and volunteers then recorded responses along with other data collected on the NLSP applications. The two statements were as follows:

1. I do not want my information shared with State children's health insurance programs. Sign here: _____
2. I have a child (or children) who does not have any kind of health coverage—neither private health insurance nor Oregon Health Plan/Healthy Kids. I am interested in free or reduced cost health coverage for at least one of my children. ❒Yes ❒No

School district officials believed that the new items were likely to confuse applicants and generate unreliable data. First, the new items were placed after an optional question on the student's racial or ethnic group, which one official suggested might have led parents to believe the items were not required. In addition, the opt-out structure of the first statement is atypical for school forms. Parents are accustomed to opting in to school programs. As evidence of this confusion, many applicants signed the first statement (opted out of information sharing) but checked "yes" on the second statement (indicating they wanted more information). School officials predicted that confusion about the opt-out language would be particularly high among non-native English speakers. Though school officials expressed these concerns to the program manager of School Nutrition Programs at the Oregon Department of Education, they were not aware of any attempts to revise the wording. The districts that we interviewed had not taken steps to inform students of the ELE enrollment option or to explain the two statements to applicants.

Data challenges were the most significant hurdle for the NSLP-ELE effort. One district encountered particular difficulties recording data using MealTime software, which is widely used and reflects federal guidelines for NSLP. To capture data on the two new ELE questions, the district had to enter separate responses manually for each child; MealTime software could not be modified to add a household-level question. This extra data entry occurred during a compressed time frame at the beginning of the school year, when staff are primarily focused on ensuring timely access to NLSP benefits. In addition, extracting data from MealTime in a format that OHA could use proved difficult; the district has since discontinued data collection. Another school district that uses proprietary software to manage its NSLP enrollments and has a dedicated staff member for data analysis did not perceive challenges in extracting and submitting data to OHA.

OHA has also struggled to use NSLP data in a timely way, and few children have enrolled through NSLP-ELE. Though data were first collected in the fall of 2010, OHA did not make its first data request from school districts until March 2011. Data that had been collected in September 2010 were deemed "too old" by that time, because income and other information could have changed since the forms were originally completed, so applications were never mailed to potentially eligible children. Data collected in September 2011 were used to generate mailings in early 2012. From these mailings, 144 applications—including 250 children—were returned, and 186 children have been enrolled. Districts again collected data in September 2012, but OHA has not requested these data and has no plans to do so.

Limited outreach by OHA staff to NSLP partners also resulted in waning enthusiasm and increasing confusion. School district representatives with whom we spoke did not know how their data were used or how many children were enrolled in Healthy Kids as a result. Some found it difficult to maintain enthusiasm about the work's value and the large cost of manually entering data without such feedback. In addition, some district officials did not believe that OHA adequately addressed their concerns about ELE-specific questions on the NSLP form. Though OHA had decided to discontinue NSLP-ELE, school district staff with whom we spoke did not know the status of the program or whether they would be asked to pull data for the 2012-2013 school year.

5. Outcomes: What are the observed outcomes?

OHA policy staff thought of ELE in the context of broader concurrent simplification efforts and found it difficult to pinpoint the relative influence of ELE on observed outcomes since 2010, versus these other strategies. Similarly, respondents we interviewed outside of the OHA and DHS offices were largely unfamiliar with ELE as a specific program, but they were aware of the package of policy changes that supported streamlined enrollment. For example, some external stakeholders were familiar with 12-month continuous eligibility, alignment of renewal dates for SNAP and medical insurance, and reduced income documentation requirements, but they incorrectly applied the Express Lane label to this whole package of activities and did not know that the shortened Healthy Kids application that some families received was a result of ELE information-sharing with SNAP. Oregon has not studied ELE applicants' demographic or utilization characteristics, so we cannot comment on whether there are systematic differences between those who accessed Healthy Kids via ELE versus traditional routes. With these caveats in mind, the following outcomes might be attributed to ELE:

- **Steady, but lower than expected, flow of ELE applications and enrollments.** During the first year, an average of 400 children applied via ELE each month, a rate that has since declined to roughly 150 to 200 children per month, with significant month-to-month fluctuations that reflect the seasonality in SNAP enrollments. Respondents were

disappointed with the low overall response rate (5 percent). To date, only 6,636 children have been enrolled via ELE; officials initially anticipated that 34,000 children would enroll. Although current numbers are well below originally projected targets, most respondents were satisfied with the program's performance. They attributed the lower application volume to the smaller pool of uninsured children, given the success of Healthy Kids marketing and outreach campaigns that occurred around the same time ELE began.

Focus Group Findings:
What happened after you applied?

We asked focus group members if they remembered getting a card confirming their enrollment in Healthy Kids after replying to the ELE letter.

I remember [getting] a card. It took about a month between the letter and the card. (Two people remembered this.)

I was shocked by how fast it was.

I remember that there was a phone call because I had to choose between a list of providers, Care Oregon or other providers, so first I checked with my doctor to see which one they took. Then I checked with the dentist.

- **Decreased uninsurance rates in Oregon.** Oregon youth uninsurance rates decreased from 11.3 percent in 2009 to 5.6 percent in September 2011, according to OHA analyses.[11] Because ELE was in effect for only half of this period, and because the number of ELE enrollments is so small, it cannot be credited with this substantial decrease. However, ELE is noteworthy as part of the overall package of simplification and outreach strategies that contributed to this achievement.

- **Administrative cost neutrality, but loss of federal matching funds.** Mathematica analyses from the first year of the ELE evaluation indicate that the volume of ELE enrollments, although modest, yields sufficient administrative efficiencies to offset the agency's costs to obtain SNAP data and mail shortened applications on a monthly basis (Hoag et al. 2012). However, children from households with incomes from 133 to 163 percent of the FPL, who would otherwise be enrolled in CHIP, but are enrolled in Medicaid according to ELE's disregard rules, represent a loss of federal matching funds to OHA. Several staff expressed concern about these placements.

- **Eased application experience for families.** Focus group participants universally expressed an appreciation for enrollment through the new ELE process, which they perceived as very easy to complete. They liked not having to fill out a complex form and not having to submit as much (if any) additional verification material. Reflecting on ELE versus the traditional enrollment process, one participant described ELE as "like a flight from here to Vegas compared to a flight from here to London … coach. And with no peanuts." Another respondent described ELE "like the carpool lane in traffic." One participant highlighted how easy it was to receive the letter and be reminded of the program because "someone is literally putting it in your hands." They were also relieved to have their children enrolled in coverage. As one member put it, "For families, it's a sense of security, knowing you can sleep well at night."

[11] The reported decrease in uninsurance rates reflects comparisons from two different surveys. Baseline estimates for 2009 reflect data from the American Community Survey (ACS), whereas the September 2011 estimate is from a state-funded survey with some methodological differences. Data from the 2010 ACS indicated a 9.2 percent youth uninsurance rate, a 2.1 percent point drop from the baseline year (Budnick 2012).

- **Staff satisfaction and increased productivity at Branch 5503.** Despite initial concerns about how their time would be counted and whether the shortened application would be accurate, eligibility staff at Branch 5503 were highly satisfied with the ELE process and recommended its expansion. As one case worker summarized: "Looking at SNAP [income] is so much easier as a worker in the field. Just having that ready to go … if ELE was opened as a normal program, it would be beneficial for our clients as well as us."

Focus Group Findings:
What happened when you tried to see a doctor?

We asked focus group members where they went to get health care for their children.

I take them to a doctor. It's the same doctor they had before, so I could choose coverage to keep that.

My daughter has a doctor, but when we did the new application, they changed the provider. I have to change it back, so that's irritating. She's been going to the same place since she was born, then all of a sudden they said they didn't take the insurance any more. I have to see if I can switch that back.

I do wish Kaiser was more on board. I've been working for government since '98, and everything's been through Kaiser. My son had great insurance through them. When I lost my job, it would have been great to get on OHP and then go to the same providers. But we couldn't.

My son does not have a doctor. But knock on wood, he's only had one visit since we moved here. But that was an ER trip for stitches.

- **Strong, continued partnership with SNAP.** SNAP and OHA initially undertook ELE as part of the agencies' broader work to streamline enrollment and ease the process for clients. They continue to meet regularly and discuss different ways to improve both ELE and other reform initiatives. As the state prepares to implement the ACA, respondents believed this partnership laid the groundwork for further cooperation: "I think it has us open to the ease of things and what could be easier or work better."

6. Looking Forward: Future Prospects for ELE Policy

Staff in OHA and DHS offices felt that ELE was a successful policy that aligned well with Oregon's culture of facilitating access to health insurance and the goal of reducing administrative burdens that unnecessarily deter qualified applicants. Given the smooth implementation experience for children, and positive (though modest) outcomes, OHA and DHS officials currently plan to expand ELE to include adults receiving SNAP, a policy option that they are discussing with CMS as part of their 1115 waiver renewal negotiations.

SNAP-ELE for adults would play a particularly critical role should Oregon move forward with a Medicaid expansion under the ACA. Although Oregon has not formally committed as of April 2013, Governor John Kitzhaber has publicly stated that he is confident that the legislature will approve an expansion (Cooper 2012). OHA analyses completed in July 2012 indicated more than 254,000 SNAP recipients younger than 65 with incomes below 138 percent of the FPL are not enrolled in medical assistance programs or OHP Standard. Given high SNAP coverage rates for eligible households, most adults who would be newly eligible are already part of the SNAP caseload.[12]

[12] Analyses by the Urban Institute using data from the 2010 ACS estimated that 252,000 adults ages 19 to 64 would become newly eligible in Oregon under a Medicaid expansion to 138 percent of the FPL, a figure nearly identical to what OHA estimated using actual SNAP caseload data (Kenney, Zuckerman, et al. 2012).

Though the state would like to move forward with SNAP-ELE for adults, concerns persist about the federal requirement to add 30 percentage points to Medicaid eligibility levels when using SNAP income to complete ELE enrollments. OHA analysts reviewed a random sample of 296 combined SNAP/Medical Assistance cases, comparing household income using the current SNAP methodology with the new modified adjusted gross income (MAGI) methodology that will be used for Medicaid eligibility determinations in 2014.[13] The analysis found that "[n]o individuals became eligible using SNAP information who would not have been eligible using MAGI", and that "SNAP income was nearly always higher than MAGI would have been." The report concluded that the state should pursue eliminating the added percentage points because they are unwarranted, given the close alignment between income calculations.

OHA did not indicate plans to expand ELE beyond the SNAP partnership because officials were not aware of other potentially viable partners, though they remain open to learning about other states' experiences. From a procedural perspective, some respondents indicated an interest in exploring ELE for renewals and in moving ELE determinations to the Self-Sufficiency Offices. There are efficiencies to central processing of ELE applications (for example, only six staff completed detailed training), and the arrangement was necessary to meet current CMS requirements for separate eligibility determinations, but some staff wondered whether more children could be enrolled if DHS eligibility workers in Self-Sufficiency Offices were allowed to process Medicaid and CHIP enrollments immediately following SNAP determinations.

Most families seeking SNAP benefits would also like to obtain medical benefits, but some could be dissuaded by the longer application. Self-Sufficiency Office staff already process full medical benefit determinations; allowing them to use SNAP income calculations would accelerate the medical benefit assessment and eliminate the need for families to respond to a mailed ELE application before receiving health insurance benefits. As one worker summarized, "It would be huge for branch offices [to be able to enroll families in medical based on eligibility for SNAP] as well because often people apply for foods stamps and medical, so if you could get them enrolled at the same time and be on the same time frame, that would be great. They would love you."

7. Lessons Learned

Several important lessons for both ELE and ACA implementation can be drawn from Oregon's experiences. First, an ELE program that relies on mailing applications to the parents of SNAP children without public insurance, to which families must then respond, might have limited success in reaching the target population. Although respondents attributed lower-than-expected ELE enrollments partially to the success of other OHA initiatives that reduced the pool of uninsured children, the low response rate (5 percent) suggests that the need to respond to a mailed application was a significant procedural hurdle that limited the effectiveness of ELE. Oregon might consider using more automated processes or, with CMS's permission, explore enabling DHS eligibility workers in Self-Sufficiency Offices to use SNAP income findings to determine Medicaid/CHIP eligibility in real time. Given the time savings that Branch 5503 workers reported in processing ELE applications—about 15 minutes less than a standard application—increasing the volume of

[13] There are key differences in the methodologies. For example, MAGI defines household composition in terms of tax dependency, whereas SNAP household size is based on those who prepare and purchase food together; MAGI excludes child support, whereas SNAP includes it as unearned income (CMS 2012).

applications that can be routed through ELE could significantly improve productivity and enhance the enrollment experience for clients.

Second, Oregon's analyses of the alignment of SNAP income calculation methods and the new MAGI approach suggest the need to revisit ELE's requirement to use a 30 percentage point disregard when establishing Medicaid and CHIP eligibility using SNAP income. CMS could consider whether smaller disregards are appropriate following ACA implementation. This would also help to allay state concerns about enrolling households that would not otherwise be eligible for Medicaid, or enrolling CHIP-eligible children in Medicaid at a financial disadvantage to the state. It also could encourage more states to take up the ELE policy option or to broaden its application to include adults. States like Oregon, with high SNAP penetration rates, might be particularly well positioned to use SNAP-ELE partnerships to smooth the enrollment experience of newly eligible adults, and CMS might wish to incentivize these policy choices.

Finally, although data-sharing between OHA and DHS occurred smoothly, OHA found that obtaining NSLP data from school districts was prohibitively complex, ultimately leading the agency to discontinue the NSLP-ELE pilot. ELE partnerships could be more successful when they build on existing data infrastructure or, at a minimum, can draw on centrally stored and uniformly formatted data. As one respondent summarized, Oregon learned that to start a new ELE partnership, the data must be in a format that can be processed quickly before the information becomes unusable because families move and incomes change. Significant delays in program implementation while data formatting issues are resolved could result in lost momentum and enthusiasm from ELE partners, particularly if active communication lines are not maintained. Oregon's experience also highlights the need to tailor the wording and placement of ELE statements on the NSLP application so that parents are more likely to respond and provide clear information. For example, school officials believed that data quality would have improved if ELE statements featured "opt-in" rather than "opt-out" language and did not appear after optional questions.

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APPENDIX A

SITE VISITORS AND KEY INFORMANTS

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