

**CHIPRA Express Lane Eligibility
Evaluation**

**Case Study of Maryland's Express
Lane Eligibility**

Final Report

October 25, 2013

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Margaret Wilkinson



HEALTH MANAGEMENT ASSOCIATES

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EXECUTIVE SUMMARY

Maryland's experience with Express Lane Eligibility (ELE) predates the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA), the legislation that officially provided states with the option to adopt ELE. Prior to CHIPRA's enactment in 2009, and consistent with the state's longstanding commitment to providing health coverage to its lowest income citizens, Maryland implemented a process similar to ELE that used information from individual income tax return filings to identify and target outreach efforts to children without health insurance who might be eligible for Medicaid or CHIP (called the Maryland Children's Health Program, or MCHP). Over time, this process has evolved so that the Department of Health and Mental Hygiene (DHMH)—which administers Maryland's public coverage programs—can use tax return information on residency, household size, and income to establish Medicaid and MCHP eligibility, provided that taxpayers consent to share their information for this purpose. As a result of this evolution, Maryland received federal approval of its ELE process, helping the state obtain a CHIPRA performance bonus.

Maryland currently operates two distinct ELE processes, which have been implemented in phases. Under the first process, the Comptroller sends an outreach mailing (including a blank application and cover letter) to all taxpayers who report on their state tax return (1) federal adjusted gross incomes up to 300 percent of the federal poverty level (the upper income limit for MCHP) and (2) one or more uninsured dependent child(ren). The state uses information from tax returns to establish in-state residency when determining Medicaid/MCHP eligibility for children in families that apply in response to the mailing. The second ELE process targets families who meet both of the above criteria but who have also consented—via a checkbox on their tax return—to share their information with DHMH for the purpose of determining medical assistance program eligibility, and whose children are not currently enrolled in Medicaid/MCHP (as determined by a data match). Like the first ELE process, the second process includes a blank application and a cover letter, but there are some key differences between the two in how information from the tax returns is used, the instructions on the cover letter, and where applications are processed. In short, the second ELE process allows for more targeted mailings and permits families to apply for Medicaid/MCHP using the income and household size reported on their tax return, provided that nothing has changed.

Maryland's ELE approach stemmed from the state's 2008 Kids First Act, which authorized the initial tax-based outreach strategy. In addition to support from a key legislator in the General Assembly, child and health advocates played a critical role in championing the Kids First Act and the ELE processes that evolved from it. ELE in Maryland involved a lengthy development period due in part to unique challenges of partnering with the Comptroller's

Office and using information from income tax returns. For instance, the state spent a significant amount of time researching and subsequently modifying state law to permit data-sharing between DHMH and the Comptroller. Revising income tax forms—a key part of Maryland’s ELE approach—also proved to be a complex and time-consuming process that needed to be initiated far in advance of the ELE outreach mailings.

Table ES.1. Key Facts about Maryland’s Express Lane Eligibility

Policy simplification adopted?	ELE
Policy adopted in Medicaid, CHIP, or both?	Medicaid and CHIP
Processes affected?	Enrollment only
What eligibility factors are addressed by ELE?	Phase 1: State Residence, Citizenship Phase 2: State Residence, Citizenship, Income, Household size
Implementation date?	Phase 1: September 2008 Phase 2: December 2012
Partner Agencies	Office of the Comptroller (taxation agency)
Is the simplified process different from the perspective of the enrollee/applicant?	Yes. Families in both phases are sent an application, rather than having to locate one. Additionally, the application is shorter because families in Phase 2 do not have to report their income and household size if nothing has changed.
Faster time to coverage for applicants?	No, although Phase Two applications are shorter, eligibility workers process ELE applications in the same way as traditional applications.
Any time savings for the state?	No, application processing takes the same amount of time for ELE and traditional applications.
Estimated cost to implement?	Approximately \$5,000 for programming required for Phase 2 data sharing, other costs are unknown
Estimated ongoing net administrative costs or savings?	Phase 1 ongoing net administrative costs: \$98,000 for mailings Phase 2 ongoing net administrative costs: \$11,000 for mailings and processing

While enrollment in Medicaid/MCHP increased during the time that ELE was implemented (an 18 percent increase between 2008 and 2011), it is not possible to estimate the full impact of the ELE outreach mailings on enrollment, since the state did not implement a tracking mechanism for applications associated with the vast majority of the mailings and several other improvements to outreach, eligibility, and enrollment processes occurred during the same time

frame. Enrollment outcomes for the second ELE process (the more-targeted approach, which allows the state to track applications and subsequent enrollment) have been lower than expected. Only 9,000 of 2.7 million residents who filed taxes in 2010 agreed to share data; 4,000 of those residents reported having uninsured dependent children who met the income guideline. After a data match was performed to remove families with children already enrolled in Medicaid/MCHP from the mailing list, 3,600 families were identified as having children potentially eligible for Medicaid or MCHP and were sent a more-targeted mailing. Only 113 children have been enrolled via ELE as a result of that mailing. Key informants attribute this low return rate to hesitancy and fear of sharing data with the government, as well as the requirement that families opt-in to data sharing, rather than opt out, which often leads to lower participation. Moreover, though information about ELE-related revisions to Maryland's income tax forms was incorporated into existing tax preparer education events (i.e., annual events to educate tax preparers and software vendors on tax form changes) neither DHMH nor the Office of the Comptroller targeted these entities with ELE-specific education efforts. While measurable ELE enrollment outcomes are modest so far, stakeholders are hopeful that the number of ELE-enrolled children will increase as taxpayers grow familiar with the data-sharing question on the tax form and as the state becomes more experienced with the process and continues to improve on the tax

Maryland is one of only a handful of states that have taken the innovative approach of using ELE and specifically the state income tax system to reach eligible but unenrolled children, and the state's experience provides several lessons for other states as they consider new ways to facilitate eligibility and enrollment processes for public health coverage. One of the most important lessons learned by state officials is that establishing a process for data-sharing with a state tax agency—an organization with different missions and priorities than a health and human service agency—can be challenging and can require legislative authorization given the strict nature of tax confidentiality laws. Second, Maryland's approach to ELE—which requires households to complete a full application that is submitted through traditional pathways—might limit the success of ELE in terms of increased enrollment and administrative efficiency. Nevertheless, Maryland's outreach-based approach is a relatively inexpensive way to communicate with hundreds of thousands of households with children potentially eligible for coverage, particularly those families near the upper-income thresholds for Medicaid/MCHP who may have little or no experience with public benefit programs and otherwise be difficult to reach. Moreover, Maryland's experience with ELE has reportedly increased agency and program administrators' comfort level with interagency data sharing, and this familiarity can be advantageous moving forward, given the Affordable Care Act's emphasis on electronic data sharing and verification.

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 Maryland’s Express Lane Eligibility program. Before CHIPRA’s passage in 2009, Maryland implemented a process similar to ELE that used family income—collected by the Office of the Comptroller as part of annual income tax return filings—to identify and target outreach efforts to uninsured children who might be

eligible for Medicaid or CHIP. Over time, this process has evolved so that the Department of Health and Mental Hygiene (DHMH)—which administers Maryland’s public coverage programs—can use the tax return information on residency, household size, and income to establish Medicaid and CHIP eligibility, provided that taxpayers consent to share their tax return information for this purpose.

To learn about Maryland’s ELE program, staff from the Urban Institute conducted a site visit in May 2013, interviewing 16 key informants over a two-day visit to the state (see Appendix A). The research team also conducted one focus group with parents whose children were enrolled in Medicaid or CHIP via ELE. Parents shared their experiences with ELE and traditional enrollment for Medicaid or CHIP, as well as their experiences obtaining health care services for their children.

2. State Context

Maryland’s Medicaid and CHIP eligibility levels are among the most generous in the country—it is one of only a handful of states that offers any coverage to adults without dependents, for instance, and few states exceed Maryland’s current eligibility level for children (300 percent of the federal poverty level) (Kaiser, 2013). Since the inception of the Maryland Children’s Health Program (MCHP)—the name of the state’s CHIP program—in 1998, Maryland has made great strides in extending public coverage to children in Maryland.¹ However, a study in 2008 by the Maryland Health Care Commission found that approximately 140,000 Maryland children were uninsured in 2006 and 2007, and about 70% (or 100,000) of those children were eligible for but not enrolled in Medicaid or MCHP (Hilltop Institute, 2009). Additionally, an estimated 16% of adults were uninsured in the state (Wikler and Bailey, 2008).

In an effort to increase participation in Medicaid and MCHP, Maryland has taken several steps to make it easier for families to apply for and retain coverage. For example, Maryland currently uses a 4-page application that allows both parents and children to apply for Medicaid and MCHP at the same time. In 2008, the state eliminated the asset test and face-to-face interview for all beneficiaries and permitted self-declaration of income. Eligibility workers at local health departments responsible for application processing are now able to access various databases—such as the state labor department, the Social Security Administration, and state vital records—to verify income, citizenship, and identity, often eliminating the need for clients to submit paper documentation with their application.

¹ MCHP was initially a combination CHIP program, with a Medicaid expansion component and a separate program called MCHP Premium. In July 2012, however, Maryland converted its combination program to a full Medicaid expansion program (with no separate program component).

In 2007, the state also turned its attention to covering uninsured adults, expanding Medicaid eligibility for both parents and adults without dependent children to 116 percent of the FPL. Parents receive a full Medicaid benefit package while adults without dependents are enrolled in the limited-benefit Primary Adult Care (PAC) program.² Throughout this period of simplification and expansion, DHMH also provided intensive training to eligibility workers at local offices to ensure that they were prepared for the “culture change” associated with simplified and expanded eligibility policies. (See Table 1 for more key facts about Maryland’s public coverage programs.)

Table 1. Key Facts About Maryland’s Medicaid Program

Medicaid/CHIP Program Type and Name	Medicaid and Medicaid Expansion CHIP program (MCHP)		
Upper income limits for Medicaid/CHIP		Medicaid	MCHP
	Infants	185%	200%
	1-5	133%	200%
	6-18	100%	200%
12 months Continuous Eligibility?	No		
Presumptive Eligibility for Children?	No		
In-Person Interview Required?	No		
Asset Test?	No		
Joint Medicaid and CHIP Forms for Application and Renewal?	Yes		
Premium Assistance Subsidies?	Yes, MCHP Premium for children up to 300% FPL (there are two premium levels, based on income)		
Adult Coverage	Parents of dependent children with incomes below 116% FPL are eligible for Medicaid. Other non-disabled adults with incomes below 116% FPL are eligible for primary care services under the Primary Adult Care (PAC) waiver program.		
Renewal Processes	A pre-populated form is mailed out 90 days prior to coverage ending. Families are required to sign and mail back the form, even if there are no changes.		
Delivery system	Risk-based managed care		

Sources: Site visit interviews, Heberlein et al. 2013, Kaiser State Health Facts.
 FPL=Federal poverty level; MCHP=Maryland Children’s Health Program.

While Maryland’s adult-focused coverage expansions were being implemented, policymakers continued to look for innovative strategies to reach children who were eligible for but not enrolled in Medicaid/MCHP. In particular, Delegate Heather Mizeur, a member of the

² Prior to the 2007 legislation expanding Medicaid (the Working Families and Small Business Health Coverage Act of 2007), eligibility limits for parents were at 46 percent of the FPL and adults without dependents were not eligible. The legislation authorized a phased-in expansion of full Medicaid benefits to adults without dependents, but the provision was not fully implemented due to budget constraints.

state's General Assembly, sponsored the Kids First Act (House Bill 1391), a legislative package designed to identify and enroll 100,000 of the estimated 140,000 uninsured children in Maryland. The Act created a state tax-based Medicaid/MCHP outreach initiative and directed DHMH to study and make recommendations for improving eligibility and enrollment processes for Medicaid and MCHP, including the feasibility of facilitating outreach or auto-enrollment through linkages with electronic data sources.³ Signed into law by Governor Martin O'Malley in May 2008, almost a year before CHIPRA's passage, the Kids First Act was the genesis of Maryland's ELE program, which—as detailed in the following sections—evolved over the course of several years and involved additional legislation.

3. Planning and Design: What Was Needed to Develop the Policy?

Kids First Act of 2008. The Kids First Act directed DHMH to use the state's individual income tax system to target outreach efforts via mailings to children who might be eligible for Medicaid or MCHP. Key informants credited Delegate Mizeur with introducing the concept of using the state's tax system for Medicaid/MCHP outreach and enrollment. She had worked on John Kerry's 2004 presidential campaign and helped to create his health care platform, which included a similar concept. There was also precedent in Maryland for using tax-based outreach for a county-funded health program, Healthy Howard.⁴ In 2007, the Howard County Health Officer, Peter Beilensen, requested that the Office of the Comptroller mail letters to individuals in Howard County who, according to tax records, could be eligible for the program. The Comptroller identified 2,000 individuals for this mailing, 1,800 of whom were eligible for Medicaid or MCHP.

Certain features of Maryland's tax system support the concept of tax-based outreach for public programs. For example, Maryland has an Earned Income Tax Credit (EITC) that supplements the federal, refundable EITC; some counties in Maryland also offer a local EITC. (Nationally, fewer than half of all states (23) have an EITC [Center on Budget and Policy Priorities, 2012] and several states lack an income tax altogether [Internal Revenue Service, 2013]). No doubt because of available EITCs, numerous low-income Maryland households—the Medicaid and MCHP target population—file state income tax returns even though they are not legally obligated to do so. In 2011, 284,703 Maryland families received an Earned Income Tax Credit, representing 10.7% of taxpayers in the state (Maryland State Comptroller, 2011).

³ Earlier versions of the Kids First Act also included a mandate for children's coverage that would be enforced through the state tax system, but this provision was eliminated during the legislative process.

⁴ Healthy Howard is a county-based health initiative that (among other things) provides subsidized health coverage for low-income individuals who aren't eligible for Medicare, Medicaid, or MCHP. For more information see: <http://www.healthyhowardmd.org/>.

Child and health advocates played a critical role in garnering support for the Kids First Act and the ELE processes that the initiative spawned. In particular, champions within the Advocates for Children and Youth organization and the Maryland Women’s Coalition for Health Reform launched a campaign supporting the Kids First Act, raising awareness about the legislation’s key provisions and encouraging residents to contact their legislator about supporting the initiative. According to key informants, supporting efforts to increase children’s coverage was a strategy for health advocates to achieve broader goals of universal coverage for all Marylanders including adults.

Kids First Express Lane Eligibility Act of 2010. Though the Kids First Act of 2008 created a process for tax-based outreach mailings for children’s coverage and forged a new partnership between DHMH and the Comptroller, it stopped short of authorizing interagency data-sharing. Relying on new rules passed in CHIPRA and recognizing that this feature would allow for more targeted—and potentially more effective—outreach mailings, the primary supporters of the Kids First initiative (including Delegate Mizeur and child and health advocates) began working to establish a process for data-sharing between the Comptroller and DHMH. There was some resistance from the Comptroller with regard to sharing tax information, which had not been a typical function of the agency. As one key informant explained, “Taxpayer privacy is of paramount importance, which is why the Comptroller’s Office first balked at divulging information to DHMH without the taxpayer giving upfront permission...The Comptroller’s Office takes confidentiality very seriously.”

Accordingly, Kids First Act supporters devoted considerable efforts during the planning phase to researching state and federal laws pertinent to sharing tax information, and both Delegate Mizeur and the Comptroller’s office sought legal opinions—which were not in agreement—on the permissibility of this type of data-sharing. Ultimately, it was determined that DHMH could obtain income tax return data from the Comptroller, but only from taxpayers who consented to the data-sharing. A second piece of legislation—the Kids First Express Lane Eligibility Act, or House Bill 1375—was signed into law in July 2010. In addition to authorizing the income tax return consent procedure, this legislation extended the tax-based outreach activities established by the 2008 Kids First Act for several more years.

A key issue when this 2010 legislation was being considered was whether taxpayer consent to data-sharing would be obtained through an opt-in or opt-out method. The legislation’s supporters pushed for an opt-out provision (i.e., the Comptroller would share taxpayer information with DHMH unless the taxpayer actively chose to opt out by checking a box) reasoning that the ELE mechanism would be more effective and reach more eligible individuals this way. But others argued for an opt-in provision out of concern for taxpayer privacy. In short, opt-in supporters were uncomfortable with the idea of sharing information without

explicit, active approval from the taxpayer. Ultimately, confidentiality concerns prevailed, and the opt-in approach was adopted. Revenue collection depends on taxpayers being able to trust the confidentiality of tax returns. Key informants considered this compromise instrumental to achieving broader consensus on the legislation. Others noted that since federal ELE rules require active consent before Medicaid/CHIP programs can use partner agency findings to automatically enroll a child, electing the opt-in approach for data-sharing would better position Maryland to pursue an ELE approach that uses auto-enrollment in the future. Another important factor in the passage of the 2010 law was a 2009 letter from Maryland's Attorney General—the aforementioned legal opinion sought by Delegate Mizeur—which stated that data sharing between the Comptroller and DHMH is allowable; this letter was described as a “linchpin” in garnering broader legislative support and moving the effort forward.

Key informants also noted that it was very important to the Comptroller's Office that it incurred no new costs related to the Kids First effort. The initial legislation provided up to \$300,000 for two years from the Maryland Health Care Provider Rate Stabilization Fund,⁵ to cover the costs of the mailings, requisite changes to income tax forms, and computer programming. No funding source was provided in the second piece of legislation that enhanced and extended the initiative; rather, ongoing costs are included in DHMH's budget. The agencies set up an annual invoicing process, so that the Comptroller's Office could bill DHMH on an ongoing basis to cover all costs, an arrangement that was essential for obtaining Comptroller support for the initiative.

CMS-Approved Express Lane Eligibility. The processes authorized by the 2008 and 2010 Kids First Acts served an outreach function—that is, taxpayer information was used to identify children potentially eligible for Medicaid/MCHP but not to actually help determine those children as eligible for the program. This distinction is important, since CHIPRA explicitly defines ELE as when a state's Medicaid and/or CHIP program relies on another agency's eligibility findings to *qualify* children for public health coverage. In other words, the Kids First effort did not initially meet the definition of ELE that was established in 2009 as part of CHIPRA. In September 2010, however, DHMH began using information from tax returns to establish in-state residency for Medicaid/MCHP eligibility determinations, which was recognized by CMS as ELE. According to state officials, the process of obtaining federal approval for their ELE plan was easy and was facilitated by the hands-on technical assistance they received from CMS staff, a number of whom were familiar with Maryland's Medicaid and MCHP programs. With a federally approved ELE process and four other simplifications in place, the state could qualify for the CHIPRA performance bonus. As one state official noted, “We were already going that way, but the performance bonus was a nice icing on the cake.”

⁵ This Fund is administered by the Maryland Insurance Commissioner and consists primarily of revenues generated by an annual premium tax imposed on health maintenance organizations and managed care organizations.

Maryland's approved ELE process involved a lengthy development period. This was due in part to the time spent researching and then modifying state law so that tax information could be shared between state agencies, and in part to the complexity and time involved in changing the state's income tax return form—a key part of the ELE effort. One key informant explained, "I learned that it's not easy to change a tax return form. Adding a new page to the tax return form is a big deal, so we did have to work on spacing and the length of the question. [The Comptroller's Office] had legitimate concerns about adding a question." ELE-related changes were handled like all other changes—through the Comptroller's existing, formal process for revising the income tax return form each year. It involves weekly meetings of a "Forms Committee" starting each summer (once the legislature is out of session and any tax law changes have been decided) and lasting several months.

Alternative Approaches Considered. DHMH considered other, non-tax based approaches to ELE. To comply with the 2008 Kids First Act's charge to study and make recommendations for additional improvements to Medicaid/MCHP outreach, eligibility and enrollment, DHMH asked the Hilltop Institute—an organization that provides analytical support to DHMH and is responsible for storing Maryland's Medicaid and MCHP enrollment data—to examine the potential for linkages with programs such as SNAP, the Women Infants and Children's (WIC) program, and the National School Lunch Program (NSLP) for the purposes of streamlining Medicaid/MCHP eligibility determinations. The resulting study described the challenges related to establishing such linkages, including technological capacity and differences in both program eligibility rules and requirements related to citizenship and immigration status (Hilltop, 2009). Notably, Hilltop's study was conducted prior to CHIPRA's passage and to the creation of the federal ELE option, which addresses some of these concerns.⁶ Ultimately, DHMH's recommendation to the legislature was to continue with the Comptroller initiative as authorized under the Kids First Act, but to take no action on the other options studied.

Also in 2009, a pilot outreach initiative similar to ELE was authorized during the legislative session (HB 500) requiring collaboration between the Baltimore City Public School System's Free and Reduced Meals (FARM) program and DHMH. The two-year initiative allowed the school system to share information about families applying for FARM with DHMH, for the purpose of identifying children eligible for but not enrolled in Medicaid/MCHP. Specifically, unless a parent opted out via a checkbox on the FARM application, the school system was obligated to share with DHMH the name/address/eligibility information of each student in

⁶ CHIPRA's ELE option allows Medicaid and CHIP programs to rely on another agency's program eligibility findings to qualify children for public health coverage even when programs use different methods to assess income or otherwise determine eligibility. Prior to CHIPRA (and when Maryland's study of potential ELE-type linkages with other public programs was conducted), federal law limited states' use of information from other agencies by requiring such information to be cross-walked with Medicaid and CHIP eligibility methodologies.

Baltimore City who enrolls in FARM. DHMH then conducted a data match to identify children who are not already enrolled in Medicaid/MCHP, and mailed a cover letter and blank application to their families.⁷ The legislation authorizing the pilot expired in 2011 and has not been renewed, though state officials suggested that they might consider replicating the effort in the future, once the intensive work of implementing the Affordable Care Act is complete.

Unlike some other states with ELE programs, Maryland officials did not consider using ELE for Medicaid/MCHP renewal. In large part this is because Maryland's ELE initiative stemmed from the Kids First legislation which had an explicit goal of enrolling previously uninsured children into coverage, and was not focused on retention. It is also notable that Maryland already uses a streamlined renewal process for Medicaid/MCHP—the state sends enrollees a prepopulated renewal form that must be signed and returned (and any changes noted) for coverage to continue.

4. Implementation

Implementation of the 2008 Kids First Act (ELE Phase One). In the first year of the Kids First initiative, the Comptroller's Office used 2007 income tax returns to identify taxpayers who had dependent children and whose reported federal adjusted gross income did not exceed 300 percent of the FPL (the highest income eligibility standard for Medicaid/MCHP) and sent those taxpayers a mailing that included a cover letter and a blank Medicaid/MCHP application.⁸ DHMH provided a template for the letter, which was developed with assistance from a communications firm (GMMB) and tested to ensure appropriate length and literacy level. The letter, sent by the Comptroller, informs the taxpayer that his or her dependent children may be eligible for health coverage through the Maryland's Children's Health Program, and encourages them to fill out the application and either drop it off or mail it to their local health department. DHMH created two different versions of the letter—the one sent to taxpayers with incomes up to 116 percent of FPL mentions "free" health coverage, whereas the letter sent to taxpayers with incomes between 116 and 300 percent of FPL mentions "free or low-cost" health coverage, since families in MCHP's upper income band pay nominal premiums.

⁷ Subsequent analysis by Hilltop found that 16.3 percent of children who received the mailing were enrolled in Medicaid/MCHP by the end of that calendar year. However, this rate does not reflect the true effectiveness of this outreach method, because it does not take into account the number of applications that were submitted but found ineligible and it is not able to determine whether enrollment of a child who received the mailing is actually due to the mailing and not some other, unknown factor (Hilltop, 2011).

⁸ Though Maryland has an online application available through a website called SAIL (www.marylandsail.org), most applicants submit paper application forms by mail or in person.

While this initial mailing targeted the population within the Medicaid/MCHP income range, it did not consider whether children were already covered under these programs or another type of health insurance. That issue was addressed in the second year of the initiative, when the Comptroller revised the Maryland 2008 income tax return form to include a question about whether dependents listed on the form had “health care.” The intent of this additional question was to better target those taxpayers with children eligible for but not enrolled in Medicaid/MCHP. However, DHMH and stakeholders were concerned that the new question was confusing, so it was subsequently revised for the 2009 tax return form. Specifically, the term “health care” was replaced with “health insurance” and a time frame for coverage (“does child have health insurance *now*”) was specified.

With the additional information on the health coverage status of taxpayers’ dependent children, the Comptroller’s Office has been able to create a more targeted data file for the outreach mailings—beginning with the mailings based on findings from 2008 tax returns, the target population for these mailings has included taxpayers who reported (1) federal adjusted gross income of up to 300 percent of the FPL and (2) one or more dependent children without coverage. As Table 2 demonstrates, the evolution to a more targeted approach significantly decreased the number of mailings sent to families each year.

The applications included in the ELE mailings are virtually the same as those submitted through other pathways, with the only distinction being that the ELE applications have a shortened section on immigration questions.⁹ Importantly, there is no indicator

Focus Group Findings: Questions on the tax return

Focus group participants recalled checking a box on their tax form about health insurance, but were unaware what checking the box might do for them.

“I do remember being asked [whether] my son enrolled in an insurance program.”

“I thought it was just more like a [survey] to see how many people were enrolled in the program and if it was doing well.”

Parents did not recall a question about data sharing, and some admitted that they might feel uncomfortable sharing their income data with another agency.

“I don’t remember any [questions] about data.”

“It’s like what would this benefit [but] the guy who does [my taxes] from H&R Block [is] very dependable. So I’m sure that’s something he would have just checked because he thought I wouldn’t mind.”

“I would check it because when you’re doing [taxes with] H&R Block, they don’t give out [data].”

⁹ This distinction has not allowed the state to track applications submitted through Phase One of ELE, however, as the state did not develop an electronic tracking system or provide training to eligibility workers to identify ELE-generated applications.

identifying the applications as associated with the ELE outreach mailings (either on the paper form or in the eligibility processing system) and families are required to submit the applications in the same manner as any other applicant—by either mailing or submitting in-person at their local health department. Because of these factors, it is not possible for DHMH to determine the number of enrollments that have resulted from ELE Phase One mailings.

Implementation of the Kids First Express Lane Eligibility Act (ELE Phase Two). Maryland’s second phase of ELE involves data sharing between the Comptroller’s Office and DHMH, which required Memoranda of Understanding (MOUs) between DHMH and the Comptroller. Key informants at the Comptroller’s agency described the MOU process as time-consuming because it required “a lot of back and forth” between the agencies and their attorneys and was slightly delayed by staff turnover at the Comptroller’s Office. The negotiations themselves, however, were not challenging.

To comply with legal requirements for active consent, a checkbox was added to the 2010 tax return form, with instructions for taxpayers to mark the box if they are willing to share their income information with DHMH for the purposes of determining Medical Assistance Program eligibility. The Comptroller creates a data file of taxpayers who (1) had one or more uninsured dependent children, (2) consented to share their information with DHMH, and (3) whose federal adjusted gross income did not exceed 300 percent of FPL. This file is transferred to DHMH’s contractor, the Hilltop Institute, where a data match is conducted with monthly Medicaid/CHIP enrollment files to identify (and remove from the list) families with children who are already enrolled in Medicaid or MCHP. Hilltop then transfers the updated file back to the Comptroller’s Office, and the Comptroller sends each family on the list a mailing that—like the ELE Phase One mailings—includes a letter and a blank application. The letter that is sent to these families, however, includes information from their income tax return—specifically their reported federal adjusted gross income and household size. It instructs a family who wishes to apply for Medicaid or MCHP: “If this information has not changed since your [Tax Year] filing, please sign the bottom of this letter and do not fill out Sections C and F on the enclosed application.”

Though the application provided in the mailings for the second phase of ELE is the same as the one included in the mailings established under the first phase, the submission process is different. The

applications generated from ELE Phase One are sent to the appropriate local health department eligibility office for processing, but applications submitted under the second phase are all routed to a single contractor for processing—Health Care Access Maryland (HCAM) in Baltimore City to reduce the need for statewide

Focus Group Findings: Steps taken to apply for Medicaid/MCHP

Families received a letter in the mail asking if they wanted health insurance for their children. However, none of the focus group participants remembered having an application included with the letter. Instead, they called a number where someone helped them complete an application.

“The letter...was just to inform me that Maryland had a program that you could put your child into...even though the parents ...couldn’t afford insurance for the children, that your child can receive free healthcare.”

“The letter seemed like it was, he was eligible”

“When I received the letter, there wasn’t an application included. You had to call the number.”

“I just told them I received a letter about children’s healthcare, so they started asking me questions...I felt a little weird, because they talked about, do you work...I didn’t like that part...[then] they sent me some papers...for me to sign.”

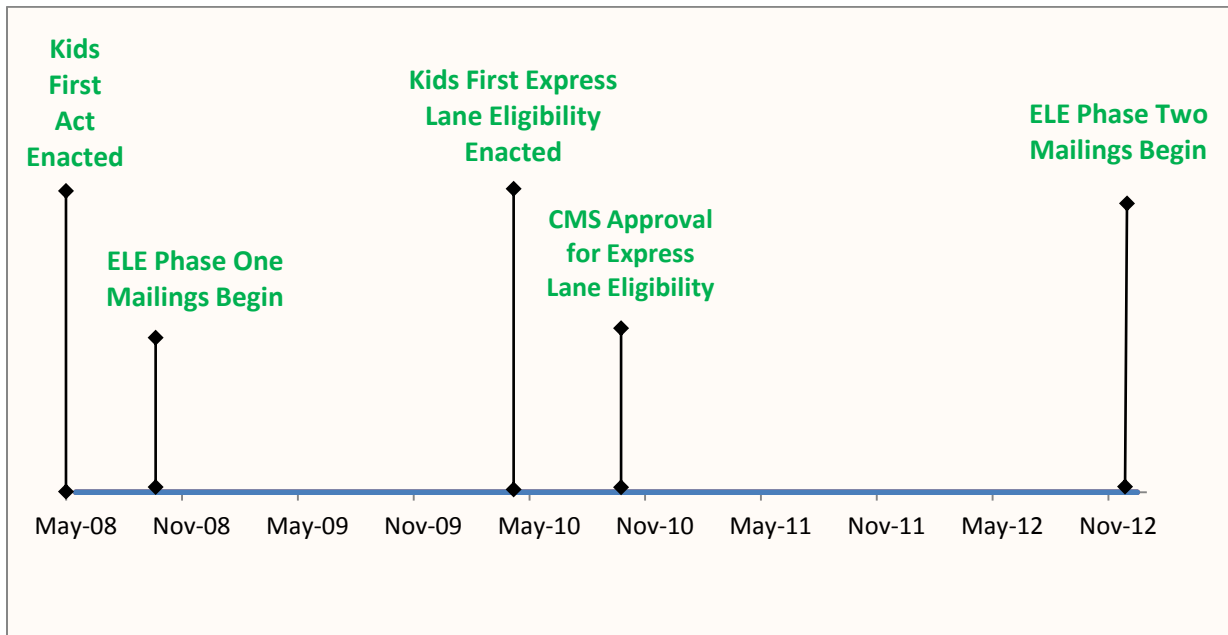
“Sometimes they go overboard asking just different questions about how your income is, which they already know because they always check it anyways.”

training and ensure quality.¹⁰ The applications are also color-coded, so they stand out from the other applications for Medicaid and MCHP that are submitted to HCAM through traditional routes. HCAM’s computer system for entering application data includes a flag for ELE-submitted applications, which caseworkers refer to as “Kids First applications.” This makes it possible to identify and track applications submitted through the second phase of ELE.

Under the second phase of ELE, residency, income and household size information obtained from the income tax returns is meant to be used to qualify children for Medicaid/MCHP, with no further documentation or verification of these eligibility factors required by the state. However, based on discussions with eligibility caseworkers responsible for processing ELE applications, this might not be how ELE works in practice. These workers suggested that ELE application processing is no different from the traditional process, and indicated that they still verify eligibility by accessing the applicant’s income information via electronic databases, and follow up with applicants if there is a discrepancy.

¹⁰ DHMH has a separate contract with Health Care Access Maryland for processing ELE applications, and the contractor bills DHMH monthly for this work.

Exhibit 1: ELE Implementation in Maryland



At the time of this writing, there had only been one round of mailings (in December 2012) associated with Maryland’s ELE Phase Two. The ELE Phase One mailings have continued in conjunction with those mailed under the second phase. That is, the Comptroller’s Office still sends letters and applications to those families who indicate that they have an uninsured dependent child but who did not actively consent to information sharing. Exhibit 1 details the timeline of Maryland’s ELE implementation.

ELE-Related Trainings and Education: DHMH officials reported that they incorporated information about the ELE mailings into their standard trainings for eligibility caseworkers and call center staff at local health departments, so that these individuals would be prepared to answer questions that families might present about the mailings.

In Maryland, tax preparers are another audience for ELE-related training and education, given the state’s approach of using individual income tax return forms as a vehicle for both collecting information on children’s coverage status and obtaining active consent to sharing information with DHMH. Nationally, roughly 60 percent of taxpayers use a tax preparer to help file individual income tax returns, and another 29 percent purchase tax preparation software (Economist, 2012). The Comptroller’s Office incorporated some ELE-related information into presentations at events held by Certified Public Accountant (CPA) and Volunteer Income Tax Assistance (VITA) groups as well as by software vendors with tax preparation products. ELE-related questions on income tax returns may be part of the discussion at these events—which are typically focused on preparing for the coming tax season and reviewing revisions to the forms—but they are not an explicit focus. DHMH officials acknowledged that educating tax

preparers was not part of their ELE strategy, noting that “it wasn’t even on the radar” that the Medicaid and MCHP-eligible population might use tax preparers. Findings from parent focus groups highlight the potential importance of this group, as the parents participating in the group had used the services of a tax preparer (see Focus Group Findings on page 12).

5. Outcomes

Key informants involved in Maryland ELE had mixed opinions of whether and how well the initiative had achieved its desired outcomes. On the one hand, gains in enrollment and administrative efficiency have been limited, likely due to the approach the state has taken with ELE (i.e., using findings to help qualify children for coverage only after a taxpayer opts in to data-sharing and completes a full application). On the other hand, many state officials expressed satisfaction with the approach and felt it was working as designed by helping DHMH reach and enroll uninsured children in the state. Maryland’s ELE outcomes are described in more detail below.

Enrollment: Enrollment in Medicaid/MCHP has increased over the period that the Kids First initiative and subsequent CMS-approved ELE was implemented. From 2008 to 2011, children’s enrollment grew from 493,969 to 585,315, representing an 18 percent increase (CMS, 2011). The proportion of this increase that can be attributed to ELE, however, is unclear. Several other outreach, eligibility, and simplification efforts related to Medicaid/MCHP were implemented during the same time period, including but not limited to an adult coverage expansion, elimination of the asset test, and self-declaration of income. This period also encompasses the Great Recession, when enrollment in public benefit programs increased across the country as more families experienced job loss and reductions in household income. Given the inability to track applications associated with ELE’s first phase—and the fact that the second phase, which does involve a tracking mechanism, was only recently implemented—it is difficult to assess ELE’s individual impact on enrollment, apart from all these other factors.

Though applications (and subsequent enrollment) associated with ELE Phase One cannot be determined, DHMH officials reported the number of mailings that have been sent to target populations so far. Specifically, 446,590 mailings were sent in 2008 to households reporting a federal adjusted gross income below 300 percent of the FPL on their 2007 tax return. In 2009 and 2010, an additional 152,565 and 145,977 (respectively) mailings were sent to households in this income range who indicated on their 2008 and 2009 (respectively) tax returns that they had one or more uninsured dependent children. In 2011, the Comptroller sent 137,577 mailings based on findings from the 2010 tax returns (this figure does not include the more targeted ELE Phase Two mailings sent to families who consented to data-sharing, described in the next paragraph). Key informants attributed the large reduction in the number of mailings between

2008 and subsequent years to the aforementioned revisions to the ELE-related questions on the tax returns (i.e., specifying an age range for dependents and a timeframe, and replacing “health care” with “health insurance”), which allowed the state to better target the mailings. Some also noted that the reduction in mailings might reflect a lower population of uninsured children over time. Table 2 shows the ELE-related tax return questions used in each year of the initiative as well as the number of outreach mailings.

Table 2: Total Number of Mailings Sent to Taxpayers, by Tax Return Year

Tax Return Questions	Total Number of Mailings Sent to Taxpayers		
	<116% FPL	117-300% FPL	Total
2007 Tax Return ✓ Relationship to dependent	154,709	291,881	446,590
2008 Tax Return ✓ Check if dependent is a child ✓ Does child have health care? Yes or no?	62,566	89,999	152,565
2009 Tax Return ✓ Check if dependent under age 19 ✓ Does child have health insurance now? Yes or no?	61,869	84,108	145,977
2010 Tax Return ✓ Check if dependent under age 19 ✓ Does child have health insurance now? Yes or no? ✓ Check here if you authorize us to share your information with the Medical Assistance Program for help finding health insurance	60,549	77,028	137,577

Adapted from: The Hilltop Institute, “Lessons from the Implementation of the Maryland Kids First Act”, October 2012.

Key informants interviewed for this case study were universally disappointed by the number of children who enrolled through the more targeted phase two ELE pathway. Of the 2.7 million families filing taxes in 2010, only 1.4 percent, or 9,000 households, agreed to share data with DHMH (Robert Wood Johnson, 2013). Of those households, approximately 3,600 had children who were potentially eligible for (and not already enrolled in) Medicaid/MCHP based on their federal adjusted gross income level and household size. By the end of February 2013, just 113 children had been enrolled via the more targeted ELE approach (Swinburn and Colby, 2013). Key informants attributed the low return rate to the small number of taxpayers who agreed to share their tax information with DHMH, which they thought was related to hesitancy and fear of sharing data, and are hopeful that these numbers will increase as taxpayers become more accustomed to the data sharing question.

Program Costs: As noted earlier, DHMH has funded all costs incurred for the design and implementation of all ELE processes, and receives regular invoices from the Comptroller for ELE-related costs. Programming needs for the first phase of ELE were limited to the Comptroller’s Office (since there was, at that stage, no interagency data-sharing), and these initial programming and staffing costs are not available to the evaluation team. It is estimated, however, that the programming costs associated with the implementation of interagency data sharing during ELE Phase Two cost the state approximately \$5,000. Furthermore, DHMH spends approximately \$98,000 annually for the mailings and processing associated with Phase One and another \$11,000 for Phase Two. In total, Maryland has spent more on mailings than the savings estimated from administrative efficiencies (Hoag et al., 2012). This is likely due to the way in which ELE applications are processed in comparison to traditional MCHP applications.

Administrative Efficiencies: ELE applications generated from the first phase of the initiative must be completed and processed in the same manner as traditional applications, while applications related to the second phase already have residency and income established and verified through the Office of the Comptroller. However, as described above, it appears that eligibility workers responsible for processing ELE Phase Two applications still verify these eligibility factors through other data systems in the same way they do for traditional applications. Thus, there is essentially no time saved in processing ELE applications.

Additionally, while selecting a single site for ELE application processing had advantages—mainly the ability to track more

easily ELE-generated enrollment and fewer staff to train—one disadvantage to this approach involves applicants with a prior history on Medicaid or MCHP. Specifically, if a case already exists for an applicant, HCAM must have the case transferred from the relevant local office, which results in a short delay in processing time for both eligibility staff and the client.

Focus Group Findings: Benefits and Cost Sharing in Medicaid/MCHP

With the exception of coverage for dental services and some prescription medications, families were overall satisfied with the services covered under Medicaid.

“[Access is] very good, especially the pediatrician and the dentist.”

“It was okay starting out, but actually when you go to the doctor and then you find out certain [services] you can’t receive...that’s when this becomes a problem...My son, his teeth are turned out, and he’s always biting himself...and that isn’t going to get him braces, because he’s supposed to be in some type of category. And all his doctors are always saying why, because he actually needs it, but they won’t give it to him.”

“When I first went, I had to [pay] a copay. I was shocked. I went to pick up a prescription...and they told me, okay you have to pay. I was like what are you talking about? I was so confused. And at that time...I did not have the money, so I had to come back like two days later and then pay.”

To lessen the potential initial impact of ELE on eligibility workers, the state decided to stagger the outreach mailings over a period of several weeks, so as not to overwhelm eligibility and call center systems with applications and calls. Accordingly, local health and social service offices have not experienced a noticeable increase in applications that can be associated with the mailings. Similarly, application processing associated with the more targeted ELE Phase Two mailings has not visibly increased the workload at HCAM due to the small number of ELE applications returned so far. The help hotline, however, has reported a small increase in call volume after each mailing occurs.

The Office of the Comptroller noted that ELE has resulted in only a “slight additional burden” for agency staff. Like all Maryland state agencies, the Comptroller’s office experienced hiring freezes during the recession. And although staffing is reportedly sufficient, the new responsibilities and roles associated with the ELE initiative (e.g., making changes to the tax return forms, creating new computer programs, and preparing/sending annual outreach mailings) did mean that some staff at the Comptroller’s Office had less time to devote to other responsibilities.

Client perspective: From the client perspective, the ELE application process is not much different from the traditional enrollment pathway. Clients do, however, experience a somewhat shorter application process. In particular, they receive a mailing with a streamlined application—with one fewer page and no questions on immigration status—rather than having to locate an application themselves. Moreover, income and household size are printed on the letter sent to individuals in the second phase of ELE. If nothing has changed, applicants do not have to complete questions regarding income or household size on the application. Parents who participated in focus groups, however, described a different ELE process despite the fact that they were verified by DHMH as having been enrolled through the second phase of ELE. In particular, these parents reported receiving a letter—without an application—that required them to call a number to complete an application. Once they had called, a partially pre-printed application was mailed to them, which they had to sign and return before their child was enrolled in coverage. In addition, parents did not recall answering a question permitting data sharing, and admitted that they might feel

Focus Group Findings: Access to care

Focus group participants felt that it was easy to find a primary care physician, but had struggled to find specialists who accept Medicaid.

“It’s pretty easy [to find a primary care physician].”

“The only thing that I have a problem with [is]...looking for specialists...we had to... go to two different ones to make sure that they accepted the insurance.”

“It’s like certain doctors don’t take that type of insurance...it was kind of hard at first [to find a doctor] because...my granddaughter has a bone disorder, so it’s like going to find the right doctor that would accept that.”

uncomfortable doing so (see Focus Group Findings on page 12). Despite this, parents expressed their gratitude for the ELE process, as it allowed their children to enroll in Medicaid/MCHP (see Focus Group Findings on page 23).

6. Looking Forward: Future Prospects for Using ELE Policy

It is not yet clear whether and how Maryland’s ELE approach might change in the coming years. Many key informants readily acknowledged that Maryland’s approach to ELE “is not as innovative as it could be” but also suggested that DHMH often takes a more conservative approach to new initiatives, primarily out of concern for the impacts on the agency budget and staffing resources, which were described as very lean. ELE modifications are unlikely in Maryland’s very near future, reflecting both the view that ELE is working as designed—hence no need for adjustment—and the fact that DHMH officials are extraordinarily busy with implementation for the Affordable Care Act and, therefore, unable to pursue a different or expanded approach to ELE right now.

At the same time, the state legislation that authorized ELE in Maryland placed time limits on the initiative (as does federal legislation, which only authorizes ELE through September 2014). The 2010 Kids First legislation stipulates that the ELE Phase One outreach mailings be sent to taxpayers based on findings from filings only through tax year 2012 and—although no specific end date is provided for Phase Two mailings in the legislation—also states that the Kids First initiative will remain effective through June 2014. At the very least, legislative action will be necessary to reauthorize

Maryland’s current ELE activities. Most key informants supported an indefinite extension of ELE activities and saw no reason to discontinue the ELE process. They reasoned that it was a relatively inexpensive way to reach eligible but unenrolled children, and also suggested

Focus Group Findings: Health Reform

None of the parents believed that health reform would help them due to negative advertising.

“A couple people at my job are always talking about it, and...it’s not going to take care of us.”

“At the beginning...I heard of ways that it was going to help. But then with the legislation from Maryland...they were against certain things...that I don’t see how it’s going to help us now.”

“What we’re seeing is more...negative, so it will make us feel apprehensive...and so I’m just really unsure of why we’re just receiving all the negative aspects of it. I haven’t received any positive”

that, while ELE outcomes are modest so far, the number of ELE-enrolled children may increase as the state becomes more experienced with the process and continues to improve on the tax form questions, data-sharing arrangement, and outreach materials.

As part of Affordable Care Act implementation, Maryland is developing a new, Affordable Care Act-compliant, integrated eligibility and enrollment system that will serve Medicaid, MCHP, and the Maryland Health Connection—the name of the state’s new health insurance marketplace, where residents can shop for private coverage and apply for federal health insurance subsidies. Though it will initially focus just on health coverage programs in order to meet the Affordable Care Act’s aggressive deadlines, eventually the system will determine eligibility for other non-health programs (such as SNAP and TANF) as they are migrated over in future phases. Some key informants reasoned that, once these programs have been phased into the new streamlined eligibility and enrollment system, it will be much easier to adopt an ELE approach that involves sharing data between Medicaid/MCHP and SNAP or TANF.

There have been preliminary discussions between officials at DHMH, Maryland Health Connection, and the Office of the Comptroller about the potential for using information from the state’s income tax return forms to identify and target outreach efforts to uninsured individuals—primarily adults—who will be newly eligible for either Medicaid or subsidized marketplace coverage beginning in 2014. This would require updating tax forms to include questions about coverage status for the entire household, not just minor dependents. Anticipating a development process that could be as lengthy as what was required for ELE, one informant said of the idea, “We knew we couldn’t accomplish it in the past legislative session, but it might be something [Maryland Health Connection] will look to next session.”

Though policymakers will continue to assess the potential for adult-focused tax-based outreach methods related to the ACA coverage expansions, DHMH officials have already decided to use an ELE-like mechanism for adults without dependents who are currently enrolled in the limited-benefit Primary Adult Care program. Specifically, these enrollees will be automatically deemed eligible for Medicaid expansion coverage beginning in 2014.¹¹ Key informants shared other examples of how an ELE-like approach could be applied in the future to facilitate eligibility and enrollment processes for other populations. For instance, parents whose children are already enrolled in Medicaid/MCHP could be deemed eligible for Medicaid expansion or Maryland Health Connection-based coverage.

Regardless of whether and how ELE continues, Maryland’s experience with the initiative has increased agency and program administrators’ comfort level with interagency data sharing, and this familiarity should serve the state well moving forward, given the ACA’s emphasis on electronic data sharing and verification. One key informant noted, “I think we’ve moved beyond reluctance to share data. The state can’t wait to use the federal hub [authorized under

¹¹ A similar approach was used when Maryland expanded full Medicaid benefits to parents up to 116 percent of the FPL in 2008; many parents eligible for this expansion were already enrolled in the Primary Adult Care program, and the state used an automatic, ELE-like process to enroll them into the more comprehensive Medicaid program.

the ACA to facilitate eligibility and enrollment in Medicaid and the new marketplaces]. Another simply concluded, “The Comptroller had never released that data to another state agency and now it is okay for them to do it.”

7. Lessons Learned

Maryland’s ELE experience yields a number of key lessons for policymakers. These include:

Simple messages can help promote a complex policy idea like ELE. Maryland’s ELE champions found that a simple message focused on the goal of ELE worked well in selling ELE to legislators and the administration. As one key informant explained, “ELE is a confusing policy topic.” ELE supporters in Maryland developed several messages that even those without a health policy background could understand, namely that 100,000 children in Maryland were eligible for but not enrolled in Medicaid or MCHP, and that ELE could help these children obtain health coverage.

Advocates and others external to state agencies can play an important role in ELE implementation. Though the state administration was supportive of ELE, key informants pointed to those outside state agencies as “the driving force” behind Maryland’s initiative—particularly supporters in the state legislature and child and health advocates. These stakeholders were reportedly among the first to realize ELE’s potential benefit for children in Maryland, and elevated the option to the attention of DHMH and the Comptroller. Additionally, advocates can serve as a catalyst for new legislative options and a third party to facilitate collaboration between agencies.

A tax-based ELE approach can take a long time to develop. Maryland’s ELE process took several years to develop, in large part because it relied on the income tax system and there was not an existing infrastructure for collaboration between DHMH and the Office of the Comptroller. This infrastructure was created as part of ELE design, which involved in-depth research on federal and state laws pertaining to the sharing of taxpayer information, passage of a new state law to permit data-sharing, MOUs between DHMH and the Comptroller, and a series of revisions to the state income tax form (a lengthy process in itself). As one key informant concluded, “I think the tax information is the most ideal information to use...if you can get through the state and federal rules about sharing data.”

An opt-in approach to interagency data sharing can limit the effectiveness of ELE. Though the second phase of ELE has only been implemented recently, early outcomes show that a very small proportion of taxpayers gave active consent to data sharing. Key informants attributed this low response to suspicion and hesitancy to share data with the government, and confusion about how their information would be used. In addition, one official noted that “the more

things you put on [the tax return] asking people for information that is not required, the greater the tendency for them not to fill it out.” Several informants suggested that the wording of the question about information sharing could be improved and that over time taxpayers might become more accustomed to seeing the question in the future, making them more likely to opt-in.

The timing of tax-based outreach mailings is important and, if not timed strategically, could lead to confusion. The contractor responsible for conducting the data match for Maryland’s second phase of ELE received 2011 taxpayer data in spring 2013, around the time that taxpayers are filing 2012 taxes. Accordingly, key informants

raised concerns that sending a mailing that references 2011 tax return filings within months of the date when most taxpayers have filed 2012 taxes could be very confusing. Moreover, the greater the time between tax return filing, data sharing, and receipt of the mailings (and thus when applications are potentially submitted), the greater the likelihood that taxpayers’ income, insurance status, and address could have changed—in other words, some eligible filers might not have received the mailing, and others who were eligible at the time of tax return filing may no longer be. One key informant suggested that more frequent and timely transfers of tax return filing data from the Comptroller to DHMH—such as monthly transfers starting in January, with data from taxpayers who filed during that month and consented to information-sharing—would considerably shorten the amount of time between tax return filing and the receipt of mailings.

Targeting tax preparers with ELE-specific trainings or education events may increase the success of ELE approaches that rely on the state income tax system, particularly if taxpayers must opt-in to data-sharing. Though information about ELE-related revisions to Maryland’s income tax forms was incorporated into existing tax preparer education events (i.e., annual events to educate tax preparers and software vendors on tax form changes) neither DHMH nor the Office of the Comptroller targeted these entities with ELE-specific education efforts. If tax preparers had been more engaged during ELE implementation—via ELE-specific information sessions, for instance—they may have been more proactive in educating the taxpayers they assist on the benefit of sharing information with DHMH and addressing any concerns about the risk of such data-sharing. This may have led to a higher proportion of taxpayers opting to share their data with DHMH under the second phase of ELE.

Focus Group Findings #6: Implications of having Medicaid and MCHP

Families felt thankful that their children had health insurance.

“When you’ve got children, you need help, whichever way it comes. No matter how it comes, as long as it’s coming, you’re able to get your children taken care of.”

“I feel happy.”

“Relieved.”

Requiring a multi-step process for ELE may limit its success in enrolling eligible children and achieving administrative savings. Though Maryland has made adjustments to its ELE-related approach over the years so that outreach mailings are more targeted and ELE-related questions are clearer, the state has maintained its multi-step approach (i.e., reporting an uninsured child and consenting to data sharing on the tax return and then subsequently filling out an application for coverage) which is more burdensome from the consumer perspective when compared to other, more automated ELE approaches. As one key informant frankly stated, “Although we are calling it *Express Lane Eligibility*, people aren’t really getting enrolled immediately. The people who are diligent will get enrolled, but if the parents aren’t diligent, they will likely not enroll.”

Tracking ELE-generated applications and subsequent enrollment is critical to understanding whether ELE processes are successful. It is a positive development that the more targeted, ELE Phase Two mailings can be tracked. However, there is no way to know what effect the hundreds of thousands of outreach mailings that were sent in earlier phases may have had on enrollment, or if—compared to other methods—tax-based methods are an effective way to reach and educate parents about their child’s potential eligibility for public health coverage.

8. Conclusion

Maryland is one of just a handful of states that has taken the innovative approach of using the state income tax system to reach children eligible but unenrolled for public health coverage, and—through its subsequent CMS-approved ELE process—sharing taxpayer information between state agencies for the purpose of qualifying children for coverage. Maryland’s ELE initiative has involved some challenges, particularly with regard to establishing a system for data-sharing between two agencies (DHMH and the Office of the Comptroller) with very different missions and priorities. Maryland’s approach is also conservative when compared to other states with ELE, in that it requires ELE-targeted households to complete a full application that is submitted through traditional pathways. Though these design features have limited the effectiveness of the state’s ELE initiative as measured through increased enrollment and administrative efficiency, Maryland is on the cutting edge of data sharing between tax and health agencies. With intensive outreach to tax preparers and more thorough use of tax data to qualify children for health coverage, the state could become a national leader in ELE implementation.

Works Cited

- Centers for Medicare and Medicaid Services. CHIP Statistical Enrollment Data System (SEDS). Rockville, MD: Centers for Medicare and Medicaid Services, February 2011.
- Center on Budget and Policy Priorities. "Policy Basics: State Earned Income Tax Credits." December 2012. Available at: <http://www.cbpp.org/cms/?fa=view&id=2506>
- Children's Health Insurance Program Reauthorization Act of 2009, Public Law No. 111-3, Section 104. Available at: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr2enr/pdf/BILLS-111hr2enr.pdf>
- Families USA. "Issue Brief: Express Lane Eligibility: What Is It, and How Does It Work?" Washington, DC: Families USA, October 2010. Available at: <http://www.familiesusa.org/assets/pdfs/Express-Lane-Eligibility.pdf>
- Heberlein, M., T. Brooks, J. Alker, S. Artiga, and J. Stephens. "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013." Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, January 2013. Available at: <http://www.kff.org/medicaid/upload/8401.pdf>
- Hilltop Institute. "House Bill 1391: Maryland's Kids First Act." Baltimore, MD: University of Maryland Baltimore City. January 2009. <http://www.hilltopinstitute.org/publications/KidsFirstActStudy-EligibilityImprovements-January2009.pdf>
- Hilltop Institute. "Revised Update to Medicaid Enrollment as a Result of the School Lunch Program," February 14, 2011
- Hoag, Sheila, Sean Orzol, Margaret Colby, Adam Swinburn, Frederic Blavin, Genevieve M. Kenney, Michael Huntress. "CHIPRA Mandated Evaluation of Express Lane Eligibility: First Year Findings." December 2012. Available at: <http://aspe.hhs.gov/health/reports/2013/ChipraExpressLaneYear1/rpt.cfm>
- Internal Revenue Service. "States without an Income Tax." April 2013. Available at: <http://www.irs.gov/uac/States-Without-a-State-Income-Tax>
- Kaiser Family Foundation. "Maryland State Health Facts." 2013. Available at: <http://kff.org/state-category/medicaid-chip/?state=MD>
- Kenney, G.V., V. Lynch, M. Huntress, J. Haley, and N. Anderson. "Medicaid/CHIP Participation Among Children and Parents." Washington DC: The Urban Institute, December 2012. Available at: <http://www.urban.org/UploadedPDF/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.pdf>
- Office of the Comptroller. "Income Tax Summary Report, Tax Year 2011." 2011. Available at: http://finances.marylandtaxes.com/static_files/revenue/incometaxsummary/summary11.pdf
- Robert Wood Johnson Foundation. "How Well Did Maryland Identify and Enroll Uninsured Children Who Are Potentially Eligible for Medicaid or CHIP?" March 25, 2013. Available at: http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf405138

Spicer, Laura, David Idala, Jamie John, and Tricia Roddy. "Lessons from the Implementation of the Maryland Kids First Act." October 2012. Available at:

<http://www.hilltopinstitute.org/publications/LessonsFromImplementation-KidsFirst-October2012.pdf>

Swinburn, Adam and Maggie Colby. "Administrative Costs Associated with ELE and Non-ELE Enrollment Simplification Strategies." April 26, 2013.

The Children's Partnership. "Archive of Past Federal Express Lane Legislation." Washington, DC: The Children's Partnership, n.d. Available at:

http://www.childrenspartnership.org/Content/NavigationMenu/Programs/EHealthAgendaforChildren/ExpressLaneEligibility/LawandGuidance/Archive_of_Past_Legi.htm

The Economist. "Guides through the swamp." March 24, 2012. Available at:

<http://www.economist.com/node/21551052>

Wilker, Beth and Kim Bailey. "Dying for Coverage in Maryland." Washington, DC: Families USA. April 2008. Available at: <http://familiesusa2.org/assets/pdfs/dying-for-coverage/maryland.pdf>

Appendix A: Site Visitors and Key Informants

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Site Visitors

The Urban Institute

Brigette Courtot

Margaret Wilkinson

Key Informants

Department of Hygiene and Mental Health

Tricia Roddy

Alice Middleton

Betsy Wieand

Office of the Comptroller

George Freyman

Office of Delegate Heather Mizeur

Jeremy Crandall

HealthCare Access Maryland

Vanessa Daniels

Ramona Giles

Hilltop Institute

David Idala

Laura Spicer

Jayne Miller

Advocates for Family and Youth

Leigh Cobb

Anne Arundel County Department of Social Services

Kim Wheldon-Randall

Nancy Tucker

Christine Boswell

Shonda DeSheilds

Katrina Hopkins

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