Express Lane Eligibility and Beyond:
How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP

A CATALOG OF STATE POLICY OPTIONS

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Executive Summary

Automated enrollment strategies have achieved remarkable results with a range of public and private benefit programs, dramatically increasing program participation while lowering ongoing operating costs and reducing erroneous eligibility determinations. The recently passed Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) should make such steps much easier for states to take in helping eligible but uninsured children obtain and retain health coverage. After describing relevant provisions in CHIPRA, this paper explores the potential use of automated strategies to achieve four goals:

- Identifying uninsured children;

- Determining their eligibility for Medicaid and the Children's Health Insurance Program, or CHIP (formerly called "the State Children's Health Insurance Program," or SCHIP);

- Enrolling eligible children into coverage; and

- Retaining eligible children.

The paper catalogs options that states could consider. No state would do everything described here.

Identifying uninsured children

Uninsured children can be identified in two ways. First, parents can be given the opportunity to indicate that their children are uninsured. At the same time, they can authorize use of otherwise confidential personal data to determine such children's eligibility for health coverage. To do this without completing formal applications, parents can simply check a box when they file state income tax forms, apply for unemployment benefits, seek care for their children from a hospital or health center, complete health forms as their children start school, etc.

Among uninsured children who qualify for Medicaid or CHIP, nearly nine in ten (89.4 percent) live in families who file federal income tax forms. In a state that offers an Earned Income Tax Credit that supplements the federal credit, a similar percentage may file state income tax forms. A slightly smaller but still sizable proportion is likely to do so in other states as well. If parents can ask for help covering their uninsured children by checking a box on the state income tax return, numerous uninsured children will be identified, and the process of determining their eligibility and enrolling them into coverage will begin.

Second, state officials can identify potentially uninsured children by comparing a list of children who may be income-eligible for Medicaid and CHIP (such as children receiving other need-based assistance) with a list of children who have health coverage. More than 70 percent of uninsured, low-income children live in families who participate in Food Stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), suggesting that public benefit program records may be a good place in which to locate potentially eligible children. To ascertain children's insurance status, data from these public program records can be matched against lists of children with health coverage, derived from Medicaid and CHIP case files as well information about privately insured children that insurers are required to share with states under Section 6035 of the Deficit Reduction Act of 2005.

Determining eligibility

CHIPRA gives states the option to provide children with "Express Lane Eligibility," through which eligibility requirements for Medicaid and CHIP can be satisfied based on findings by other government agencies. Such "deemed" eligibility allows a state to disregard technical differences between how government departments evaluate income or other aspects of eligibility. For example:

- A state can automatically find a child income-eligible for Medicaid or CHIP based on gross income or adjusted gross income shown on the family's state income tax form.

- Children who receive Food Stamps* can automatically meet Medicaid requirements related to income and immigration status. Even under current program rules, only one-tenth of one percent of uninsured children who receive Food Stamps have earnings that, based on different basic methods for evaluating income, are too high to qualify for Medicaid or CHIP.

- Children who receive free school lunches can automatically be found income-eligible for Medicaid. While eligibility errors are more frequent for the National School Lunch Program (NSLP) than for Food Stamps, 96 percent of children receiving free lunches have incomes that qualify them for Medicaid or CHIP under current program rules, even after taking into account NSLP mistakes.

The only eligibility requirement that cannot be satisfied through Express Lane Eligibility is U.S. citizenship, to which standard documentation methods apply. As of January 2010, states have a new option of documenting citizenship and identity by presenting the Social Security Administration (SSA) with a child's name and Social Security Number (SSN). Citizenship is established when SSA confirms that its files contain no information inconsistent with citizenship. Children receive coverage pending such SSA responses, and families need not submit paper documents unless the SSA process runs into problems.

In addition to Express Lane Eligibility, states can use other methods to help determine children's eligibility for health coverage without requiring parents to complete standard application forms:

- States can use available data to "pre-populate" application forms. Parents can confirm the accuracy and completeness of such forms by calling a toll-free number and entering a numeric identifier (such as the final digits of an SSN). Similarly, a taxpayer filing a state income tax form electronically could be prompted to authorize an automatic transfer of information from the tax form to an on-line application for Medicaid and CHIP.

- States can use data about income and other factors to identify children who probably qualify for Medicaid and CHIP. Such a "target list" can make it efficient for states to pay community agencies to help parents complete health coverage application forms.

- State agencies (such as income tax agencies) can use income data to identify families whose children appear income-eligible for Medicaid or CHIP. The agencies can send these families notice that, if the children are uninsured, they may qualify for health coverage. Such notices would encourage parents to call toll-free numbers to apply by phone.

- A state can use income data to provide children with short-term "presumptive eligibility." Community-based organizations can then follow-up by phone or in person to help such children transition to ongoing coverage.

To encourage school district participation in data-matching and enrollment efforts, children's Medicaid and CHIP enrollment can be one factor used to determine the allocation of poverty-related school aid, as happens in Illinois.

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*Food Stamps was recently renamed the "Supplemental Nutrition Assistance Program," or SNAP. Because the older term is more likely to be familiar to readers, this paper continues to use it.

Enrollment of eligible children

Suppose a state uses some of the above-described mechanisms to identify uninsured children and qualify them for Medicaid or CHIP, without the submission of a full, standard application form. How would the state enroll such children into health coverage while satisfying applicable procedural requirements (like signing applications under penalty of perjury)? Following are several possible approaches:

- Families could be encouraged to go on-line to take the final steps needed for enrollment. Such steps may involve nothing more than providing an electronic signature, which CHIPRA explicitly allows. At the same time, in a state that uses managed care, families would be asked to select a managed care plan.

- If a family fails to respond, Managed Care Organizations (MCOs) can play a carefully crafted role to fulfill applicable procedural requirements without opening the door to conflicts of interest or abusive marketing. If a family does not select a plan, the child could be auto-assigned to an MCO, but the MCO's capitated payments would not begin until the plan obtains the required paperwork during an initial orientation visit from MCO staff.

- Whether or not the state uses MCOs to deliver care, it can pay community organizations to reach out to families and help them complete the paperwork required for coverage to begin.

In a managed care state, the following strategies can prevent the steps described above from increasing the proportion of MCOs that receive capitated payments without providing care:

- MCOs can be given incentives to provide care to auto-enrolled children. For example, each MCO's share of such children can be based, in large part, on the MCO's prior provision of preventive care to auto-enrolled children, as documented by encounter data. Alternatively, some or all of an MCO's capitated payments for an auto-enrolled child could be withheld until the MCO documents the provision of at least one health care service.

- MCO contracts could require an initial visit within a certain period of time following enrollment, with immediate provision of notice to the state. The presence or absence of such notices would allow the state to efficiently track in "real time" auto-enrolled children's access to care.

- Parents could be mailed health insurance cards for their children with a strip of tape across the signature line stating that the card cannot be used until it is "activated" by calling a toll-free number (and perhaps punching in a numeric identifier, such as the final digits of an SSN). This would confirm both that the state sent the card to the proper address and that the parent understood the child had health coverage.

Retention of eligible children

States interested in keeping eligible children enrolled in health coverage can follow Louisiana's example. That state reduced the percentage of children losing coverage at the end of their eligibility periods from 28 percent in 2001 to 8 percent in 2005. More recently, the proportion of procedural denials at renewal fell below 1 percent. Louisiana reached these results by taking steps that include the following, which other states can replicate:

- Children's eligibility is renewed without requesting information from the parents when eligibility appears reasonably certain based on third-party data from public programs and other sources.

- If available data do not permit automated renewals, parents are encouraged to provide the missing information by calling toll-free phone numbers. Automated systems record the parents' information if state workers are unavailable. Parents who provide information by phone need not complete paper forms. As a result, fewer than 15 percent of children whose eligibility periods are coming to a close require the completion of renewal forms.

Introduction

For several years, the majority of uninsured children have been eligible for, but not enrolled in, Medicaid and the Children's Health Insurance Program, or CHIP (formerly called "the State Children's Health Insurance Program," or SCHIP). This paper explores how states can identify and enroll eligible but uninsured children by borrowing automated strategies that have proven effective with other public and private benefits. By "automated strategies," this paper refers to procedures that use data matches or other methods that substantially reduce or even eliminate the need for families to complete traditional application forms.

After briefly discussing the background of automated enrollment, the paper explores how the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gives states new financial incentives to maximize the enrollment of eligible children as well as new tools to use data to help eligible children participate, including an option for so-called "Express Lane Eligibility." Finally, it explains how Express Lane Eligibility and other automated enrollment approaches could help achieve four goals essential to covering the greatest possible number of eligible children: namely, identifying uninsured children; determining their eligibility; enrolling them into coverage; and keeping them covered.

Following the body of the paper are appendices that address the following topics:

- How a range of public and private benefit programs have used automated enrollment strategies in the past;

- Basic perspectives on automated enrollment;

- Samples of state income tax forms that ask parents about their children's health coverage;

- Operational details about implementing some strategies described in this report;

- The statistical methods used to obtain some of the findings of this report; and

- Using data matches with the Social Security Administration to establish children's satisfactory immigration status.

Although auto-enrollment methods have an impressive track-record with other benefit programs, they are just beginning to be applied to children's health coverage.[1] Nevertheless, particularly after recent changes in federal law, automated enrollment strategies deserve serious consideration by policymakers willing to innovate in reaching bold coverage goals for children's health care.

Two final preliminary comments are important. First this paper catalogs examples of how states could move in this direction. No single state could or would want to implement all of the policy options explored here.

Second, interpreting a new and groundbreaking statute like CHIPRA is necessarily a tentative enterprise without guidance from the Centers for Medicare and Medicaid Services (CMS). Some states may hesitate to move forward until CMS has announced its view. On the other hand, as noted below, Congress forbade CMS from denying federal matching funds if a state implements a good-faith reading of CHIPRA with which CMS subsequently disagrees. For many states, this statutory protection may allow them to act quickly and decisively in using CHIPRA's new tools to reach and enroll as many eligible, uninsured children as possible.

Background

As Appendix A discusses in some detail, many public and private benefit programs have used automated enrollment strategies with great success. These approaches involve an unusually proactive role for administrative agencies, which use available data to qualify eligible individuals and provide them with benefits. Means-tested Medicare subsidies, Massachusetts' health care reform initiative, Louisiana's renewal of children's eligibility, and default enrollment methods for 401(k) accounts have all achieved extraordinary results enrolling and retaining eligible individuals. Rapid increases in participation levels have been accompanied by significant administrative savings as agencies shifted from traditional paper-based applications, manually verified and processed by public employees, to eligibility determination driven by data matches. At the same time, errors have proven to be less likely when eligibility is based on reliable, third-party data, rather than the inherently fallible memories and paper files of applicants, reviewed and evaluated by state and local staff.

These new approaches have risks, of course. It takes time and patience to implement significant changes to eligibility determination procedures. Interagency relationships are critical to the success of many of the strategies discussed in this paper, and such relationships do not mature overnight. A state venturing into this area will be forced to break new ground. And of course, enrolling more eligible children necessarily means increased state costs.

Medicaid and CHIP now cover 79 percent of eligible children.[2] It may not be easy for states to reach the remaining uninsured children who qualify for help. In many states, the "lowest-hanging fruit" have long since been harvested, and innovative methods may be needed to achieve significant further gains. Newly enacted federal legislation gives states both increased financial incentives for reaching these children and new tools for doing so.

CHIPRA's new options for using data to reach and enroll eligible children

Section 203 of CHIPRA gives states new authority in two areas directly relevant to automated enrollment. First, the legislation creates an option for state Medicaid and CHIP programs to provide children with Express Lane Eligibility (ELE). ELE qualifies children for health coverage based on the findings of other government agencies, even if such agencies' eligibility methodologies differ from those ordinarily used by Medicaid and CHIP. Second, CHIPRA gives states new tools to access and use data relevant to eligibility determination. This paper's discussion of these provisions is not a comprehensive legal analysis; rather, it seeks to provide general information that may help state officials, advocates, and stakeholders understand the new automated enrollment opportunities that became available when CHIPRA took effect on April 1, 2009.

This part of the paper begins by describing several broad changes made by CHIPRA.[3]

General changes made by CHIPRA

Following is a list of CHIPRA's general modifications to federal law that may be relevant to automated enrollment, with some comments about the implications of certain changes:

- Future state allocations of CHIP dollars are based in part on CHIP enrollment levels. States with more CHIP children will receive larger allocations in subsequent years.

- In addition to normal Medicaid and CHIP matching payments, states receive "performance bonuses" if they (a) increase the enrollment of children who would have qualified for Medicaid under state law in effect as of July 1, 2008 and (b) implement at least five of eight specified policies, which include three policies discussed in this paper (Express Lane eligibility, presumptive eligibility, and automatic renewal through use of "pre-populated forms" or data matching).

  > **Implication:** *States have strong, new financial incentives to maximize the enrollment of eligible children.*

- Most of CHIPRA's provisions became effective on April 1, 2009, despite the absence of regulations promulgated by CMS. If a state changes its child health program based on a good-faith understanding of the federal statute, it may not be denied federal financial participation for the resulting costs based on subsequently announced final regulations or administrative guidance.

  > **Implication:** *HHS and CMS are now in transition. It is not clear when CHIPRA will receive authoritative interpretation. In the meantime, a state that proceeds aggressively to enroll eligible children, based on a good-faith reading of the statute, has a statutory guarantee of federal matching funds, even if CMS eventually decides that the state acted incorrectly.[4]*

- States have the option to provide Medicaid and CHIP, with federal matching funds, to legal immigrant children who have lived in the U.S. for less than five years.

- States have the option to provide federally-matched Medicaid and CHIP to immigrant children without taking into account the income and assets of people who sponsored their immigration into the United States.

- States must document citizenship when American children seek either Medicaid or CHIP. However, as of January 1, 2010, states have a new option to meet this requirement (including proof of identity) by obtaining confirmation from the Social Security Administration (SSA) that, based on a child's Social Security Number (SSN) and name, the information in SSA files is consistent with that child's U.S. citizenship. While a request for confirmation is pending with SSA, otherwise eligible children are enrolled in coverage, and federal funding is available, regardless of the outcome of the SSA query. When states establish and operate eligibility determination systems to interface with SSA, they receive 90 percent federal matching funds for information technology infrastructure development and 75 percent matching funds for operating costs.

  > **Implication:** *As states use these enhanced federal matching funds to improve their eligibility systems so they can automatically receive and input data from SSA, such improvements could lower the additional cost of subsequently improving those systems to do similar things with other sources of data. This is particularly likely if the initial investment in SSA-related eligibility system improvement is designed with later expansions in mind.*

- When a child receives presumptive eligibility for Medicaid, the resulting costs no longer count against a state's CHIP allocation.

- For federal fiscal years 2009 through 2013, CHIPRA appropriates $100 million in outreach and enrollment grants, $10 million of which are reserved for efforts targeting American Indians and $10 million of which are for a nationwide enrollment campaign. The latter effort includes integrating Medicaid and CHIP eligibility and enrollment systems with those for programs run by the Departments of Agriculture (such as Food Stamps[*] and the National School Lunch Program) and Education.

  > **Implication:** *Some of these grant funds might be used to expedite automated enrollment strategies by, for example, improving Medicaid and CHIP eligibility systems to incorporate data provided by other government agencies.*

- Enhanced matching funds are available for translation and interpretation services related to enrollment, retention, or service use. The Medicaid matching rate for these services is 75 percent. For CHIP, the rate is either 75 percent or 5 percentage points above the state's usual CHIP matching rate, whichever is higher.

  > **Implication:** *It is now more affordable for states to fund intensive, community-based application assistance that targets immigrant children.*

Express Lane Eligibility (ELE)

A state implementing the ELE option can grant eligibility based on the findings of other public agencies, which CHIPRA terms, "Express Lane agencies." Such "deemed eligibility" applies despite differences between the methodologies used by health coverage programs and Express Lane agencies (ELAs). For example, without asking a family for information about income, a state Medicaid or CHIP program could find a child income-eligible based on:

- gross income or adjusted gross income shown on the family's state income tax form;

- the child's receipt of Food Stamps; or

- the child's receipt of free lunches under the National School Lunch Program.

Other examples of programs that can be used to establish ELE include the School Breakfast Program, Head Start, the Child Care and Development Block Grant, housing programs, the Low-Income Heating Assistance Program (LIHEAP), etc.[5] However, only government entities can serve as ELAs, so Express Lane Eligibility cannot be based on the findings of private contractors that help administer public benefit programs (unless those findings are preliminary and subsequently finalized by government agencies).[6]

ELE can be used for both initial eligibility determinations and subsequent redeterminations. It can establish any element of eligibility for health coverage except citizenship, for which a state must use normal Medicaid and CHIP methods to confirm eligibility (as modified by CHIPRA to include data matches with SSA). ELE applies to children age 18 and younger. At state option, it may also apply to young people age 19 or 20.

ELA findings can establish eligibility for health coverage only within a "reasonable period of time" after the ELA makes its findings, but states can define what constitutes such a period.

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[*] Food Stamps was recently renamed the "Supplemental Nutrition Assistance Program," or SNAP. Because the older term is more likely to be familiar to readers, this paper continues to use it.

A state may not use ELE to **deny** eligibility for health coverage. Rather, a state must see whether standard methods could qualify for Medicaid or CHIP a child for whom findings from other agencies did not establish eligibility via ELE. In addition, if ELE leads to a child's enrollment in a plan for which premiums are charged, the state must notify the family that the child might qualify for a less costly form of coverage if standard methods are used to reevaluate the child's eligibility.

The following requirements apply to a state that wishes to use anything but state income tax data to establish ELE:[7]

- The ELA must notify the family of the information to be disclosed to the child health agency, explaining that (a) the information will be used solely to determine eligibility for health coverage and (b) the family has the option to prevent disclosure.

- The ELA must be subject to an interagency agreement limiting the disclosure and use of information it provides to the child health agency.

Before children receive CHIP based on ELE, the state must meet "screen and enroll" requirements. Ordinarily this means that each child must be screened for possible Medicaid eligibility. This would force the family to complete the standard Medicaid application process, thus preventing ELE from accomplishing its goals. To avoid that result, the legislation gives states that implement ELE two new options for meeting "screen and enroll" requirements:

- A state may set an income threshold that is at least 30 percentage points above the normal Medicaid income eligibility threshold, stated in terms of the federal poverty level (FPL). If the ELA finds that a child has income at or below that elevated threshold, the child can receive Medicaid. Children above it can receive CHIP, with no need for further screening.

- A state may temporarily enroll children in CHIP when, based on an ELA's income finding, children seem likely to ultimately qualify for CHIP. During that temporary enrollment period, for which enhanced CHIP federal matching funds are available, the state determines whether the children qualify for Medicaid, using simplified procedures that minimize the burden on parents. In this context, states may not require parents to furnish information that has already been presented to the state (unless the state has reason to believe that the information was erroneous). CHIPRA does not place a specific limit on the duration of temporary eligibility, although it requires states to act promptly.

ELE can ease transitions between Medicaid and CHIP when family income changes. That is because Medicaid and CHIP programs are listed as Express Lane agencies. As a result, even if these two programs in a state use different income methodologies, when one terminates a child's eligibility based on a finding that the family's income is within the range covered by the other program, the latter program can enroll the child without any further analysis of income.

In each state implementing ELE, a statistically valid sample of ELE-recipient children will be evaluated to identify the proportion who were erroneously granted health coverage. If the proportion exceeds 3 percent, the state must submit a corrective action plan to the Secretary, and the state may not claim federal matching funds for children *in the sample* who exceeded the 3 percent threshold. However, errors determined through this process do not reduce federal matching funds available for children outside the sample. Accordingly, they do not count against a state for purposes of Medicaid Eligibility Quality Control (MEQC) review or payment error rate measurement (PERM).

Like the CHIP program as a whole, Congress must reauthorize the option to use ELE in federal fiscal year 2014 and later years.

Other new tools for states to obtain and use data

Most of the new tools described below can be used for adults as well as children.

General data access. To supplement existing statutory authority for data-sharing, CHIPRA authorizes every federal, state, and private agency with data relevant to eligibility for Medicaid or CHIP to provide that data to state Medicaid and CHIP programs, so long as the following conditions are met:[8]

- The person described in the data (or that person's parent, guardian, or authorized representative) either (a) has affirmatively consented to disclosure or (b) has not objected after receiving advance notice and a reasonable opportunity to object.

- The data are used exclusively to identify individuals who are eligible or potentially eligible for Medicaid or CHIP, to enroll or attempt to enroll them into health coverage, or to verify eligibility for coverage.

- An interagency agreement, consistent with standards promulgated by HHS, prevents the unauthorized use, disclosure, or modification of data and otherwise complies with federal requirements for privacy and data security. The agreement must also commit the Medicaid or CHIP program to use the data to attempt to enroll eligible individuals.

Unauthorized disclosure of such information is punishable with civil and criminal penalties.

Specific data access. The statute gives state Medicaid and CHIP programs access to the following:

- *The national New Hires Data Base (NHDB)* maintained by child support enforcement officials inside the U.S Department of Health and Human Services. NHDB is the only source of data about, in all states and the federal government, all workers' quarterly wages and all new hires. Depending on how CMS interprets CHIPRA, access to NHDB may be limited to states that implement ELE.

- *Data about enrollees in private health insurance* that health plans (including self-insured, employer-based plans) must provide to states for purposes of Medicaid third-party liability enforcement. Under CHIPRA, states can access this data to identify potentially eligible children not yet enrolled in coverage. As with NHDB, such access may require ELE implementation, depending on how CHIPRA is interpreted.

- *Vital records data* from any state may be disclosed, so long as the above-described requirements for general data access are satisfied.

Federal statutory changes that make it easier to provide coverage include the following:

- *Electronic signatures* may be used, for example, to meet federal requirements that Medicaid applications and declarations of citizenship must be signed under penalty of perjury. In the past, CMS's approach to electronic signatures has sometimes been inconsistent.

- *State-initiated enrollment.* A state may initiate and determine children's eligibility based on data rather than a formal application from the family. However, children may not be enrolled until their parents have consented in writing, by phone, orally, through electronic signature, or through other methods approved by HHS. In such cases, the state must provide notice of certain key facts (covered services, cost-sharing amounts, medical support obligations, etc.).

- *Requirements for signatures under penalty of perjury* do not apply to elements of eligibility that are determined based on data from public agencies rather than information from an applicant.

- *Immigrant applicants* are no longer required to present paper documentation of satisfactory immigration status. Instead, a state can rely on evidence provided in digital or electronic form.[9]

Identifying uninsured children

Using these new tools available under federal law as well as preexisting state options, two auto-enrollment mechanisms can help identify uninsured children without requiring parents to complete full-blown application forms.

Parental check boxes

The first mechanism lets parents quickly identify their uninsured children by checking a single box that does three things:

- Indicates that a particular child is uninsured;
- Asks for help providing the child with subsidized health coverage; and
- Authorizes the disclosure of any otherwise confidential information needed to determine eligibility. As part of such authorization, parents could be given the opportunity to provide their social security numbers (SSNs), thereby helping government agencies conduct data matches needed to expedite eligibility determinations.

> **Parental SSNs**
>
> With many of the strategies discussed in this paper, states facilitate data-matching by asking parents for their SSNs. This critically important step needs to be handled carefully. Under federal law, states must obtain an SSN for the individual seeking Medicaid or CHIP but may not require it from other members of the family. From a policy perspective, some immigrant parents of eligible children can be deterred from applying if they believe they must furnish their SSNs. Accordingly, states need to make clear that, while providing a parental SSN may greatly simplify and speed the application process, parents can seek coverage for their children without furnishing this information.

Parents can receive such an opportunity at many junctures, including:

- When parents file state income tax forms;
- When uninsured children seek health care at hospitals or community health centers;[10]
- When children begin the school year;[11]
- When parents are laid off and file for unemployment insurance;[12] etc.

In 2004, 90.7 percent of all uninsured children and 89.4 percent of those who qualified for Medicaid or CHIP lived in families who filed federal income tax forms, according to recent research.[13] Legally required to file were 84.6 percent of all uninsured children and 79.4 percent of those who qualified for Medicaid or CHIP. Most of the remainder qualified for federal Earned Income Tax Credits (EITC) and so had strong incentives to file tax returns, even if they owed no tax.

Similar proportions of uninsured families are likely to live in households that file *state* income tax forms in the 20 states that offer fully refundable EITCs to supplement the federal credit.[14] A somewhat smaller but still sizable percentage of eligible, uninsured children may have their parents file returns in states without such EITCs, for several reasons. If the state follows the federal government's lead in setting the gross income thresholds above which filing is mandatory, many poor and near-poor families will be legally required to file.[15] Nationally, among uninsured children who qualify for Medicaid and CHIP, 71.1 and 98.7 percent, respectively, live in families for whom federal law requires the filing of a tax return.[16]

Even workers with incomes below legal filing requirements may have good reasons to file in a state without an EITC. Some such workers have had earnings withheld to pay state income taxes, and filing a state return lets them claim a refund. Also, some states may offer refundable credits (other than an EITC) for which low-income families qualify. In short, whether or not a state offers its own EITC, a strategy deserving serious consideration would permit parents, on state income tax returns, to identify their uninsured children and to authorize sharing their tax information with health officials to help determine such children's eligibility for free or reduced-cost health coverage.

For this approach to be most effective, officials need to consider modifying both electronic and paper income tax forms. A surprisingly large percentage of low-income families have their income tax forms filed electronically.[17] It may also be important to conduct outreach to tax preparers, alerting them to the service they can provide to their clients by facilitating children's enrollment into health coverage.[18]

State tax agencies may object to adding new questions to tax forms, arguing that compliance falls when more items are added; that existing forms are already crowded; and that adding a new item to the tax form may require another to be removed. Notwithstanding such objections, Iowa, Maryland, and New Jersey successfully changed their 2008 income tax forms to ask parents to identify their uninsured children, and Massachusetts does the same with adults.[19] Appendix C includes examples of these forms.

State data-matching

The second strategy to identify uninsured children involves data matching. The basic concept is straightforward: records listing children are compared to records of children with health coverage. Children on the former but not the latter list may be uninsured.

For example, a file listing children who receive other need-based public benefits could be matched against a file listing children who receive Medicaid or CHIP. Such other benefits can include Food Stamps, a state EITC, the National School Lunch Program (NSLP), child care subsidies, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Low Income Home Energy Assistance Program (LIHEAP), etc.[20]

FIGURE 1 **Insurance status of children receiving Food Stamps but neither Medicaid nor CHIP: 2004**
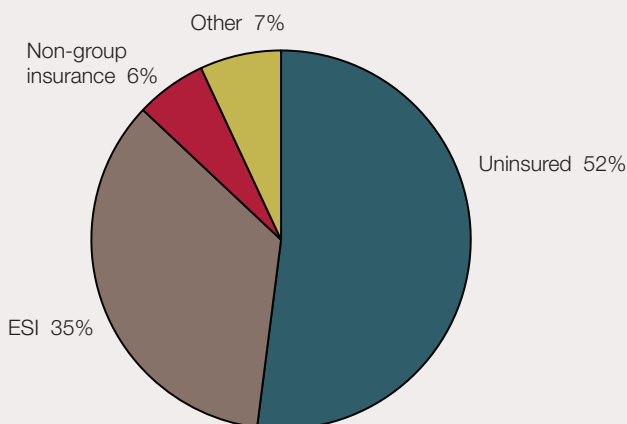
Source: Urban Institute Health Policy Center analysis based on the 2005 CPS-ASEC.
Notes: (1) Estimates exclude children enrolled in Medicaid or CHIP. (2) "ESI" means employer-sponsored insurance. "Other" refers to other federal coverage, including coverage the federal government provides to dependents of active-duty military. (3) Estimates reflect an adjustment for the underreporting of public coverage on the CPS.

Using the records of other need-based programs to identify potentially eligible children and qualify them for Medicaid or CHIP may be a promising strategy. In terms of nutrition assistance alone, more than 70 percent of low-income, uninsured children live in families whose members receive NSLP, WIC, or Food Stamps.[21]

To identify uninsured children by using these data-driven approaches, further effort may be needed to screen out children with private coverage. Even with Food Stamps, a program limited to the poor, a surprisingly large percentage of enrollees have private insurance. Among Food Stamp children who were not enrolled in Medicaid or CHIP in 2004, 35 percent received health coverage through a parent's employer (Figure 1).

Identifying children with private coverage is essential to determining CHIP eligibility, since children with employer-sponsored insurance (ESI) are generally ineligible. It is also important to establishing the parameters of Medicaid coverage, since Medicaid becomes the secondary payor when a child receives private coverage.

Increasingly, states can identify privately insured children through contracts with consultants that help with Medicaid Third-Party Liability (TPL) collection. This information should grow even more complete under Section 6035 of the Deficit Reduction Act of 2005, which requires each state to pass legislation mandating all health plans, including self-insured employers, to provide state Medicaid agencies with information identifying all privately insured state residents. The goal of this legislation was to help states with TPL collection. As noted above, CHIPRA now allows this information to be used for additional purposes as well—namely, to identify children who may qualify for Medicaid or CHIP and to help determine their eligibility.

Determining eligibility

More parents will pursue the application process to a successful conclusion if they do not need to complete full, traditional forms before their children's eligibility is determined. Three approaches can help achieve this goal:

- Through Express Lane Eligibility, external data can directly establish key elements of eligibility, greatly limiting the information that parents must provide and that states must process before determining children's qualification for health coverage.

- Parents can ask states to complete application forms based on available data. Once parents certify those forms as correct, a state could grant eligibility accordingly.

- Public employees or community groups can help families complete application forms. However, the cost of such application assistance may be hard to justify unless the "target" list consists of children who are highly likely to qualify for health coverage.[22] Income data can help narrow the list to such good prospects.

Using Express Lane Eligibility to establish eligibility based on data

This section of the paper describes how states could use ELE to grant children's eligibility based on state income tax information, Food Stamp files, and eligibility records maintained by the National School Lunch Program (NSLP). Other programs can also establish ELE, but these three examples both illustrate more general issues and are important to consider on their own. After discussing these three specific programs, this section explores how states can establish satisfactory immigration status in the context of ELE and common challenges that may arise with ELE, regardless of which non-health program is used.

1. State income tax records

As noted above, nearly 9 in 10 (89.4 percent) uninsured children who qualify for Medicaid or CHIP live in families who file federal income tax forms, and a large proportion may also be reachable through state income tax forms. Under CHIPRA, a state can grant income eligibility based on gross income or adjusted gross income shown on state income tax forms or records, notwithstanding differences between how tax law and health programs count income and define households. To illustrate such differences, tax data do not identify step-parents whose income ordinarily must be disregarded in determining Medicaid eligibility and may not show whether particular income disregards apply to a given family. ELE permits a state to ignore these differences. Based purely on tax data, without conducting any further analysis, a state may find that a child has sufficiently low income to qualify for health coverage.[23]

This approach raises questions that involve potential objections from state revenue departments; what happens when tax data do *not* establish eligibility; privacy of tax data; and timeliness of tax data.

Possible concerns of state revenue departments. The states that have begun exploring the interface between tax data and health coverage have frequently found that revenue officials have many concerns that can slow or derail initiatives in this area. Above is a discussion of possible unwillingness to modify state income tax forms, but tax officials may be equally reluctant to share tax data. Privacy is a core issue for income tax agencies, which depend on voluntary reporting. People's willingness to include all relevant information on their tax forms hinges on their confidence that such information will generally remain confidential.

Several approaches are possible. First, the Medicaid or CHIP office might access income tax data only when a parent taxpayer uses the state income tax form to request disclosure to the state's health agency for the purpose of determining the taxpayer's uninsured children's potential eligibility for Medicaid and CHIP. This approach would build on the longstanding principle in income tax law that a taxpayer has the power to authorize income tax agencies to share the taxpayer's return information with other individuals or entities for specified purposes.[24]

Second, income data could simply be disclosed to the state's health agency, without giving the taxpayers the ability to prevent that disclosure. To preserve the credibility of the state income tax system, taxpayers would need to be informed that this information is being shared, just as they are informed about other disclosures of tax information. This could be done, for example, through a Privacy Act notice contained in the instructions for the state income tax form.

Such compulsory disclosure could make sense in states that, like New Jersey, mandate coverage for every child.[25] But in other states, it is hard to see an argument for this approach. Further, depending on how CMS interprets the ELE provisions in CHIPRA, ELE may be unavailable unless the taxpayers can prevent disclosure.

This suggests a third approach. Taxpayers who report an uninsured child on their state income tax form could be told that, unless they object to disclosure, their tax return data will be shared with the state's health agency to see if such a child qualifies for free or low-cost health insurance.

Fourth, a state could obtain income tax data based on an applicant's consent given on a greatly simplified application for health coverage. To verify income, many Medicaid and CHIP agencies already conduct data-matching with state income tax information. Authorization to share this information is typically included on the standard Medicaid/CHIP application form. To build on this existing mechanism, a state could allow families to apply for coverage by doing no more than stating the names and SSNs of the uninsured children and all adults living in the household; stating whether the uninsured children for whom coverage is sought are U.S. citizens; and signing the form under penalty of perjury. So long as that form includes the "boilerplate" authorization to access state income tax records, a state can view the family's tax records to see whether the children are income-eligible, based on ELE.[26] This approach has the advantage of using an existing mechanism for data-sharing, without any need for state legislation or new interagency agreements with state tax agencies. It has the disadvantage of requiring the family to complete an additional form, however minimal, rather than simply check a box on a tax return that the family is already filing.

Tax data that do not show eligibility. As with other ELE options, if tax records do not establish income-eligibility, the state must evaluate eligibility using standard procedures. Presumably, this can be done by sending a regular application form to the family, along with instructions about how to apply for coverage and where to go for assistance.[27]

Timeliness of tax data. By definition, tax data show income during the prior calendar year. Low-income households' economic circumstances change in ways that affect eligibility for Medicaid or CHIP. Families whose children now qualify because incomes have dropped since the prior year must be given an opportunity to submit a standard application—but what happens if a family's income increased? Possible approaches are analyzed at some length in Appendix D. Briefly, they include the following:

- A state could wait until the following year before adjusting eligibility based on the recent increase in family income.

- After a certain date (such as April 15), a state could stop using prior-year income tax forms to establish eligibility.

- A state could use more recent sources of income data to update the information on tax forms.

- A state could limit the length of the child's coverage, requiring redetermination by a fixed date that limits the gap between the tax year on which eligibility is based and the time during which the child receives coverage.

- A state could start a regular cycle of redetermining eligibility whenever third-party income data covering the prior calendar year first reaches the state revenue agency via the state-level equivalents of W-2 and 1099 reports.

- For parents who authorize the use of tax return data to establish their children's eligibility for health coverage, the return could ask such parents to describe any major income increases since the applicable tax year. If no such increases are reported, the tax data alone would establish eligibility. If increases are reported, the state may need to use administrative verification to confirm the accuracy of the taxpayer's updated income estimates.

2. Food Stamps

Express Lane Eligibility could be granted based on a child's receipt of Food Stamps, which reaches at least 12.4 percent of uninsured children who qualify for Medicaid and CHIP.[28]

This nutrition assistance is generally limited to children whose "net income" (as determined by the Food Stamp program) is no more than 100 percent of FPL and whose "gross income" (without any income disregards) is at or below 130 percent of FPL. As a general rule, if a Medicaid program determined income based on the net income levels found by the Food Stamps program, every child receiving Food Stamps would automatically qualify as income-eligible for Medicaid.[29]

Income is not the only Medicaid eligibility issue that could be resolved, using Express Lane Eligibility, based on a child's receipt of Food Stamps. For example, satisfactory immigration status for non-citizens and state residence (for immigrants and citizens alike) could both be based on Food Stamp receipt, since those eligibility requirements apply to Food Stamps and to health coverage. However, as noted above, a state would need to apply Medicaid's citizenship documentation rules before granting a U.S.-citizen child health coverage based on Food Stamp receipt.

In analyzing this application of Express Lane Eligibility, it is useful to estimate how many additional children would qualify for health coverage based on Food Stamp income eligibility determinations. Even if Food Stamps finds that a child has "net income" below 100 percent of FPL and "gross income" below 130 percent of FPL, ordinary Medicaid methodologies could find the child has income above 100 percent of FPL, because the two programs use different income disregards and different definitions of the household members whose needs and earnings count in deciding a child's income.

FIGURE 2   **Uninsured children who received Food Stamps during the average month in 2005, by eligibility for Medicaid and SCHIP**

Ineligible for immigration-related reasons 3.7%

Ineligible because of excess income 0.1%

Eligible for SCHIP 7.0%

Eligible for Medicaid 89.2%
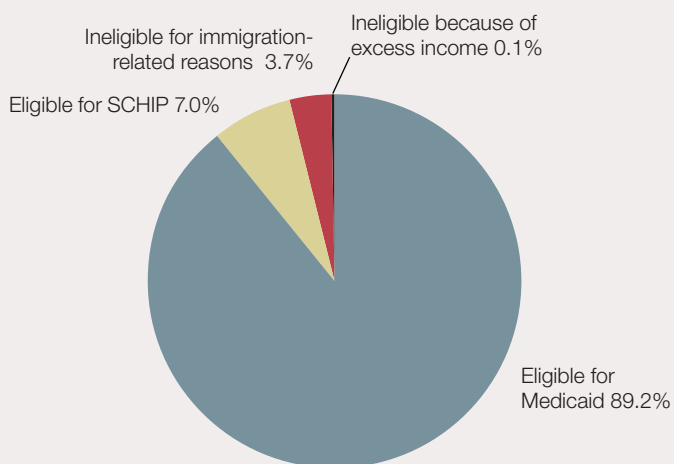
Source: TRIM3 microsimulation model based on calendar year 2005 data from the March 2006 CPS. See Appendix E for more information about methodology.

Note: In 2005, children were ineligible for federally-matched Medicaid and CHIP if they were legal immigrants who lived in the U.S. for less than five years. In addition, the income of their immigration sponsors was taken into account in determining their eligibility. Such restrictions were not permitted for Food Stamps. CHIPRA now allows federal matching funds, at state option, when legal immigrant children receive health coverage despite their recent arrival in the U.S. and notwithstanding income of immigration sponsors.

In addition, non-citizen children's eligibility is more generous for Food Stamps than for Medicaid and CHIP in states that do not take advantage of new options provided under CHIPRA. Legal immigrant children during their first five years of residence in the United States can qualify for Food Stamps, but at state option they may be denied Medicaid and CHIP. Along similar lines, states may consider an immigration sponsor's income in determining eligibility for health coverage, but Food Stamps does not count such income.

No previous research has analyzed eligibility for health coverage among uninsured children who receive Food Stamps. To fill this gap, Urban Institute researchers examined children whom the Census Bureau classifies as uninsured throughout 2005. Using methods described in Appendix E, researchers found that, among such uninsured children who received Food Stamps during the average month in 2005, 96 percent qualified for federally-funded Medicaid or CHIP. Almost all of the children ineligible for health coverage under 2005 rules were non-citizens affected by the differences that then distinguished program rules about immigrant eligibility. Only one-tenth of one percent of uninsured, Food-Stamp-recipient children were ineligible for health coverage based on excess income, without regard to immigration issues (Figure 2).

As of 2004, 22 states used their own funds to provide Medicaid and CHIP to non-citizen children who were ineligible for federal matching funds because of immigration status or sponsor deeming.[30] In those states as well as others that implement the newly available options under CHIPRA for covering legal-immigrant children, almost all uninsured children receiving Food Stamps would qualify for health coverage, without any adjustment of eligibility methodologies.[31] ELE would thus relieve states of a largely pointless administrative burden that they must assume, absent ELE, if they wish to "cross walk" data in Food Stamp files to measure them against the slightly different income methodologies used by Medicaid and CHIP.

In states that do not take advantage of these new options to receive federal match for previously ineligible immigrant children, ELE can apply to citizens, achieving similar results. Almost no uninsured, U.S.-citizen children who receive Food Stamps have incomes too high to qualify for Medicaid or CHIP, under the latter programs' current eligibility rules. Examining such U.S.-citizen children to see whether they qualify for health coverage would not be an efficient use of resources, compared to simply granting them ELE.

3. The National School Lunch Program (NSLP)

NSLP reaches numerous uninsured children who qualify for Medicaid or CHIP. Nearly three out of five (59 percent) uninsured children with incomes below 200 percent of the FPL live in families who participate in NSLP.[32]

Free meals under NSLP are offered to children with gross family incomes at or below 130 percent of FPL. (Eligibility for reduced-price meals extends to 185 percent of FPL, measured in gross income).

Accordingly, using the "threshold" option for "screen and enroll" created by CHIPRA, a state could find every child who receives free school lunches to be income-eligible for Medicaid, since every such child would have income, as found by NSLP, no more than 30 FPL percentage points above the applicable income threshold for Medicaid. A state could realize substantial increases in coverage by taking this approach, since 83 percent of NSLP participants receive free rather than reduced-price meals.[33]

In assessing the usefulness of this strategy, it is important to note several possible limitations.

NSLP can establish only income-eligibility. Immigration status and citizenship are irrelevant to eligibility for NSLP. Children could receive presumptive eligibility (PE) for health coverage based on their participation in NSLP, since income is the only factor relevant to PE, but for children to move from presumptive to ongoing eligibility, a state would need to find that the children are U.S. citizens or have satisfactory immigration status. This might require providing the families with intensive application assistance.

Obtaining cooperation from the schools can be challenging and time-consuming. Education agencies have much on their plates. Helping children qualify for health coverage can be seen as a distraction from more fundamental missions, even if Medicaid and CHIP dollars are used to fund necessary administrative costs. And in many states, cooperation must be secured from each individual district, slowing statewide implementation.

This task is made even more difficult by the state of eligibility data in many NSLP programs. Some include neither SSNs nor home addresses in their lists of participating students, making the process of matching to other records quite difficult. Some schools maintain eligibility records on paper, rather than digitally. In a number of states, reliable current data are in the hands of local districts only.

For health officials and advocates to assess the potential offered by this strategy in their state, they need to analyze the information technology used by NSLP programs. If a statewide source of participation data includes identifiers that can facilitate matching, this could be a fruitful strategy. Otherwise, it could be very challenging.

One policy intervention worth considering would change schools' incentives by using Medicaid and CHIP participation rates as one factor that determines the distribution of school aid that targets districts serving disproportionate numbers of poor children. Illinois law takes this approach. As a result, the Chicago public schools devote significant resources to helping eligible children enroll in health coverage, matching NSLP and Medicaid/CHIP case files to target outreach resources at children who may qualify for health coverage but are not yet enrolled.[34]

Eligibility errors. Mistaken eligibility determinations are more common with NSLP than Food Stamps. According to the Government Accountability Office, 98 percent of Food Stamp recipients met all eligibility requirements in 2003.[35] By contrast, a recent study by Mathematica, Inc., found that, among children participating in NSLP during school year 2005-2006, 9 percent were ineligible for any assistance, and an additional 6 percent received free school lunches even though they qualified only for reduced-price meals.[36]

TABLE 1 **Recipients of free and reduced-price school lunches, by income-eligibility for health coverage in the average state**

	Children receiving free school lunches	Children receiving reduced-price school lunches
Income-eligible for Medicaid	81%	49%
Income-eligible for CHIP	14%	38%
Income too high for both programs	4%	13%
Total:	**100%**	**100%**

Source: Author's calculations, based on data from Mathematica, Inc., and Urban Institute Health Policy Center estimates of eligibility for Medicaid and CHIP, derived from the 2005 CPS-ASEC. See Appendix E for more information.

Despite such errors, NSLP eligibility information, correctly applied, remains viable as a basis for income-eligibility determinations for health coverage. Many children who erroneously receive excess NSLP benefits nevertheless qualify for Medicaid or CHIP, because eligibility for health coverage typically exceeds maximum income eligibility for NSLP. As noted above, free and reduced-price meals go to families with gross incomes at or below 130 percent FPL and 185 percent FPL, respectively. Many states extend CHIP to families with net incomes up to 200 percent of FPL or higher levels, calculated after making various deductions. So children who are incorrectly classified as eligible for free rather than reduced-price lunches, for example, are typically income-eligible for Medicaid or CHIP.

The above-described Mathematica study allows us, for the first time, to approximate the proportion of NSLP-recipient children who, despite NSLP errors, are income-eligible for health coverage. Based on the *actual* income levels of children who receive free and reduced-price school lunches—not the levels found by NSLP—only 4 percent of free-school-lunch recipients had too much income to qualify for Medicaid and CHIP in 2004. However, roughly 13 percent of reduced-price-lunch recipients had such excess income (Table 1).

While children receiving reduced-price meals could reasonably be the target of intensive outreach, using ELE to provide automatic income-eligibility for health coverage could be problematic for some policymakers, since many children receiving reduced-price meals have too much income to qualify for Medicaid and CHIP under standard methods. By contrast, because the income eligibility threshold for free school lunches is so far below maximum income eligibility for Medicaid and CHIP in most states, the vast majority of children receiving free school lunches are, notwithstanding some erroneous NSLP eligibility determinations, income-eligible for health coverage under current law. This contributes to the case for expediting their enrollment via ELE, rather than requiring families and public officials to evaluate whether children already found eligible for free school lunches qualify under Medicaid and CHIP income-eligibility methods.

4. Establishing satisfactory immigration status

A state could grant income-eligibility based on a child's receipt of free school lunches or a family's income as shown on income tax forms, and that would be sufficient to provide presumptive eligibility, but for a child to receive ongoing coverage, the state would need to document citizenship or satisfactory immigration status (SIS).

As a practical matter, a state may be able to confirm, through systems operated by the Social Security Administration (SSA), that a child has a valid Social Security Number (SSN) matching the child's name. If so, the child is very likely to be a U.S. citizen or an immigrant who is authorized to stay in the United States.

A successful match between a child's SSN and SSA records is not enough to claim federal matching funds. Further documentation is required. But once it becomes clear that the child is highly likely to qualify for health coverage, documentation needed to maximize federal funds can be gathered when enrolling the child, using the methods explored in the enrollment section of this report.[37]

Appendix F describes several alternative methods of establishing satisfactory immigration status that are bolder than the approach discussed here.

5. Overcoming challenges that arise with ELE

a. Meeting "screen and enroll" requirements. In deciding which children receive Medicaid and which are placed in CHIP, new CHIPRA options for "screen and enroll" deserve serious consideration. The approach that promises to enroll the largest number of children while minimizing application burdens on parents and reducing state administrative costs involves "percentage of FPL" thresholds. For example:

- If a state uses ELE to grant eligibility based on tax records, a child whose gross income or adjusted gross income[38] for all members of the tax filing unit is within 30 FPL percentage points of the applicable Medicaid income threshold could conclusively be found income-eligible for Medicaid. A child would be income-eligible for CHIP if the family's tax income was above that threshold but below a level consistent with CHIP eligibility.

- In using ELE with nutrition programs, children receiving free school lunches and Food Stamps could be found income-eligible for Medicaid, since they all have gross incomes at or below 130 percent of FPL. (The latter figure is 30 FPL percentage points above the lowest nationally mandated eligibility threshold for children—namely, 100 percent of FPL for children ages 6-18.)

- Whether children who receive reduced price school lunches or WIC qualify for Medicaid or for CHIP depends on the child's age and the state's eligibility thresholds. Both of these programs help families with gross incomes at or below 185 percent of FPL. In some cases, determining the right health coverage program for a child will require knowing, not just whether the child received particular benefits, but the household income level found by the Express Lane agency.[39]

b. Maximizing federal matching funds. A state using the approach to screen-and-enroll described in the previous section may need to develop a strategy for accessing enhanced CHIP federal matching funds for the children who receive Medicaid through ELE. Such funding is available for children who qualify for Medicaid as "optional targeted low-income children," because they "would not [have been] eligible for Medicaid under the policies of the State [Medicaid] plan in effect on March 31, 1997."[40]

Some states may prefer to use Medicaid matching funds for these children, rather than deplete a limited store of CHIP dollars. Under CHIPRA, a state can make that choice. But most states would presumably seek to maximize their receipt of CHIP dollars at the higher matching rate. And in any case, to qualify for performance bonuses under CHIPRA, a state would need to document how many ELE-recipient children would have qualified for Medicaid under rules in effect on July 1, 2008.

To maximize its receipt of both enhanced-match CHIP dollars and performance bonuses, a state could require, before a child enrolls, that the family must provide all information needed to see whether the child would have qualified for Medicaid under the state's rules that were in effect in 1997 and 2008. This would prevent Express Lane Eligibility from achieving its objectives, since children would remain uninsured if parents failed to take these steps, and states would not achieve administrative savings if they applied these two sets of former Medicaid rules to each ELE-covered child. Alternatively, after enrolling each child, the state could ask the family to provide all information needed to see whether the child would have qualified for Medicaid during the applicable time periods. This would not prevent children from enrolling, but it would impose state administrative costs. Moreover, some parents may not accede to the state's information requests, which would limit the state's receipt of federal funds for which the state should properly qualify.

Perhaps the least problematic approach would base state claims on a statistically valid sample of children who receive health coverage through ELE. That sample would show, among all ELE enrollees in Medicaid and in CHIP, the percentage who would have been ineligible for Medicaid under 1997 rules and the proportion who would have qualified based on 2008 rules. This approach allows a state to achieve the enrollment and efficiency advantages of ELE without foregoing available federal dollars. A long line of cases at the HHS Departmental Appeals Board holds that states may use such sampling to claim federal financial participation (FFP).[41]

In the past, CMS has maintained that sampling can be used to establish state error rates and thus to *deny* FFP, but sampling may not be used to *claim* FFP. No one knows how the Obama Administration will analyze this issue, but a good argument can be made that, regardless of whether sampling can ordinarily be used to claim FFP, in this situation, where alternatives to sampling would prevent the success of a Congressionally-approved mechanism for finding and enrolling eligible children, sampling should be permitted.[42] Such an approach is consistent with the longstanding federal statutory requirement that Medicaid eligibility must be determined "in a manner consistent with simplicity of administration and the best interests of the recipients."[43]

Using data to pre-populate initial application forms

To let parents seek health coverage for their children without compiling and presenting all relevant information about income, a state could create an alternative to the standard application process. Through that alternative, a parent could ask the state to determine the family's income based on the family's tax data and other available information.[44] The federal income tax system offers a similar option today, through which an EITC claimant can ask IRS to calculate the amount of his or her credit.[45]

Under one form of this approach, the state would respond to the parent's request by "pre-populating" an application form with the family's income information, based on available data. The state would provide the form to the parent, who would be asked to make necessary corrections or to confirm the information's accuracy by calling a toll-free number and "punching in" a numeric identifier (such as the final digits of an SSN). Alternatively, a state could make clear that the parent is legally obliged (upon penalty of sanctions) to make necessary corrections if errors exceed a specified, minimum dollar threshold. If the state receives no corrections, information on the "pre-populated" form determines the child's eligibility. Similar approaches are used by some Medicaid and CHIP programs when they renew children's coverage[46] and by the California state income tax system.[47]

FIGURE 3 Percentage of federal income tax returns filed electronically, by adjusted gross income: Tax Year 2006

64%

63%

54%

60%

Under $15,000 | $15,000–$29,999 | $30,000–$49,999 | $50,000–$99,999
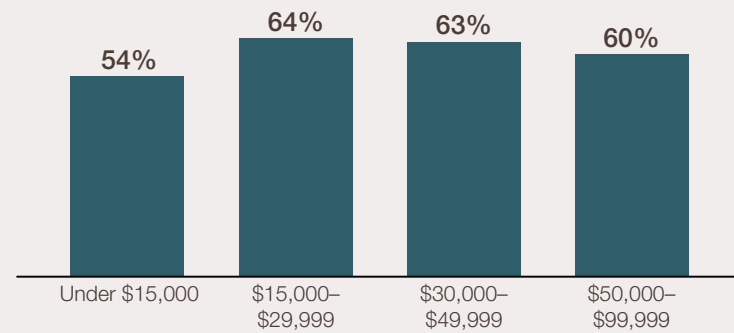
Source: IRS, Statistics of Income Division, January 2008, preliminary data for Tax Year 2006.

One promising approach along these general lines involves taxpayers who complete the electronic filing of state income tax forms in a state that also permits on-line applications for health coverage. Each such taxpayer could receive an automatic internet prompt inviting the taxpayer, if he or she has uninsured, minor children, to begin an application for such children's health coverage by pre-populating the state's on-line application form with information contained in the electronically filed tax return. As noted above, a surprisingly large proportion of low-income tax filers use electronic filing—presumably because of the widespread use of either volunteer or paid tax preparers (Figure 3).

Helping parents complete application forms

Without asking parents to complete traditional application forms, states can provide application assistance to obtain the information needed to determine children's eligibility for health coverage. Such assistance can be provided by public employees or by community-based organizations that contract with the state or receive a per capita payment for each child who successfully enrolls in Medicaid or CHIP. This approach has considerable evidence of effectiveness.[48] Although CHIPRA's enhanced federal matching percentage for translation services will reduce the cost to states of using this approach in immigrant communities, some states may continue to believe that this strategy cannot be pursued with sufficient efficiency unless data are used to narrow the list of "target" children to exclude those who appear to be ineligible, either because of excess income, health coverage, or other factors.[49] When parents request help, but the data suggest that their children are probably ineligible, application forms surely need to be mailed, but a state could reasonably decide against using scarce administrative dollars to provide those families with hands-on assistance.

As a second approach to helping parents complete forms, states could give children presumptive eligibility when available data show that they are uninsured and appear to qualify as income eligible.[50] In such cases, intensive application assistance would be reserved for when additional information is needed to help children transition from temporary to ongoing health coverage.

Under a third variant, state officials can send low-income families notice of potential eligibility for child health coverage, asking parents to call a toll-free line if their children are uninsured and want health coverage. Eligibility staff can take applications over the phone, or families can provide information in response to automated voice prompts. In either case, families would not need to complete paper forms.

Enrolling eligible children into health coverage

Once children have been identified as uninsured and eligible for coverage, they can be enrolled. But how does this happen if parents have not filed formal application forms but simply requested coverage for their children and consented to disclosure of otherwise confidential data? How can states meet the Medicaid statutory requirement that parents must sign application forms under penalty of perjury?[51] And how can states with managed care avoid providing monthly payments to managed care organizations (MCOs) for children who do not receive care because their parents do not understand that they are enrolled (or for other reasons, such as a state's possession of incorrect address information that caused a Medicaid or CHIP card to be mailed to the wrong place)?

A state could begin by letting the parents know that their uninsured children appear to qualify for health coverage. Parents could be directed to a toll-free number or to a website where they could provide their electronic signatures and any remaining items of information needed to complete the enrollment process. At the same time, in a state with mandatory managed care, the parents would be asked to select a health plan by a specific date.

If the family fails to respond to this outreach and does not choose a health plan after several notices, the child could be auto-assigned to a particular MCO. The MCO would then be told that capitated payments will begin once the MCO (a) obtains the family's signature on the application form and other necessary paperwork (such as documentation of citizenship or satisfactory immigration status) and (b) provides the family with information about how to use the MCO's health coverage. Many MCOs may be interested in enrolling these children because they are healthier, on average, than children whose parents affirmatively file Medicaid/CHIP application forms.[52] It may be necessary to include the cost of these outreach and enrollment efforts in the capitated fees paid to MCOs.

A critically important feature of this approach is that, to avoid the kind of marketing abuses and conflicts of interest that have sometimes harmed beneficiaries, an MCO would not undertake any of these steps until *after* the parents selected a plan or the child was auto-assigned. As a result, MCOs could not use these procedures to market themselves to families. Alternatively, a state could go farther to avoid potential conflicts of interest by paying community-based application assisters, rather than MCOs, to complete the enrollment process for these children.

States could take additional steps, through managed care contracts, to ensure that auto-enrolled children receive necessary services. Such steps would require MCOs, as a condition of payment, to take the initiative in providing state officials with pertinent information, thereby reducing the administrative burden that otherwise might fall on states in monitoring MCO performance. For example:

- MCOs could be given financial incentives to provide auto-enrolled children with preventive care. An MCO's share of auto-assigned children could be based, in significant part, on the evidence it gives the state showing, based on encounter data and HEDIS measures, prior performance providing preventive care to such children. This would encourage both good service to auto-enrolled children and the collection of relevant encounter data. As an alternative incentive, capitated fees for each auto-enrolled child could be withheld, in whole or in part, until the MCO reports that it has provided a single covered service.

- MCO contracts could require an initial visit within a certain period of time following enrollment. Many states have Medicaid contracts that already contain such requirements, which could be strengthened by, in the case of auto-enrolled children, requiring the MCO to notify the state promptly after the initial visit. That would allow the state to efficiently track, in "real time," auto-enrolled children's access to care.

A slightly different approach to expedited enrollment has been suggested in other contexts.[53] Once children have been found eligible for Medicaid or CHIP, their parents could be sent an insurance card that is activated by calling a toll free number (and perhaps by also "punching in" a personal identifier, such as an SSN's final digits). Before coverage begins, the parent would need to take this simple step acknowledging coverage, and the state would confirm that the Medicaid or CHIP card reached its intended recipient.

Retaining eligible children

As noted above, Louisiana's LaCHIP program has achieved remarkable results preventing eligible children from losing health coverage when their enrollment periods end; the percentage of children losing coverage at renewal fell from 28 percent in 2001 to 8 percent in 2005, and fewer than 1 percent of children now see their coverage terminated for procedural reasons, such as failure to complete forms or provide verification.[54]

Capable of replication in many other states, Louisiana's key strategies include the following:

- Caseworkers use external data sources, whenever possible, to renew eligibility when in the workers' judgment such data show a "reasonable certainty" that the children continue to qualify. Data sources include records from agencies that administer Food Stamps, TANF, and child support enforcement. They also include income and wage records maintained by the state workforce agency. Such third-party data matches renew eligibility for 53 percent of Medicaid and 34 percent of CHIP children.

- When third-party data do not establish eligibility, state officials encourage parents to call the state to provide the missing information by phone, through either conversations with staff or Automated Voice Response systems. Telephone calls renew eligibility for 22 percent of Medicaid and 45 percent of CHIP children.

- Renewal forms must be completed only if data matches and telephone contacts, including vigorous follow-up, fail to obtain necessary information. As a result, *renewal forms are needed for only 10 percent of Medicaid children and 16 percent of CHIP children.*

Conclusion

States face difficult challenges significantly increasing enrollment of their eligible, uninsured children. In the wake of CHIPRA, powerful financial incentives now reinforce many states' longstanding desires to surmount these challenges and provide the greatest possible number of eligible children with health coverage. Fortunately, that same legislation puts new tools in states' hands with which they can accomplish this goal, allowing states to use automation and more effectively fulfill four key functions: namely, identifying uninsured children, determining their eligibility, enrolling eligible children into coverage, and keeping eligible children insured.

Appendix A. Past examples of automated enrollment strategies

Many programs have used automated enrollment strategies with great success. Some examples involve children or health coverage; others do not. But they all provide benefits without delay when individuals are known to qualify. For example:

- In its first year of operation, Massachusetts' health reform law reduced the number of uninsured in the Commonwealth by roughly 50 percent.[55] Receiving very little attention is the central role played by automatic enrollment. Newly eligible adults with incomes below 100 percent of the federal poverty level (FPL) were enrolled automatically into premium-free coverage based on data matches with eligibility files maintained by the state's previous program for subsidizing hospital uncompensated care. Within eight months of the new program's launch, the auto-enrolled group exceeded the Commonwealth's initial estimates of the eligible population.[56] By contrast, in other eligibility categories, enrollment reached 32 percent of the estimated eligible population.[57]

- In the first six months of the Medicare Part D program, low-income subsidies (LIS) for prescription drug coverage reached nearly three out of four (74 percent) eligible seniors.[58] Unless they opted out, beneficiaries who received Medicaid or Supplemental Security Income (SSI) the previous year were automatically enrolled into LIS based on data matches with state Medicaid agencies and the Social Security Administration (SSA). Application forms were needed only for people not included in those data matches.

  Compared to LIS, other programs without automated enrollment achieved significantly lower participation rates after much longer periods of implementation. For example, Food Stamps reached just 31 percent of eligible families after two years of program operation;[59] and without access to automated enrollment mechanisms, SCHIP covered 60 percent of eligible children after five years, despite dramatic program simplification and intensive outreach initiatives to find and enroll eligible children.[60]

- For decades, Medicare Part B has enrolled seniors automatically when they turn 65, withholding premiums from their social security checks unless beneficiaries complete forms "opting out" of coverage. As a result, 96 percent of eligible seniors have participated.[61] By contrast, Medicare Savings Programs (MSPs), which pay premiums and out-of-pocket costs for poor and near-poor Medicare beneficiaries, reach less than one-third of eligible seniors,[62] in large part because, to obtain MSP, people must apply through their state's Medicaid agency.

- Every year, data matching between Medicare and the Internal Revenue Service (IRS) automatically gives each Medicare Part B enrollee an interim income determination and corresponding premium subsidy without having to file application forms.[63] Starting in 2007, Medicare Part B premiums have been means-tested, with income determined based on federal tax data with a two–year lag. For example, 2006 federal income tax data determine a senior's 2008 income for purposes of establishing the applicable Part B premium subsidy. Increases in income since the base year do not reduce an individual's subsidy amount; however, beneficiaries can augment subsidy levels by submitting applications to SSA that show decreased income since the base year.

- In some states, data matching and other steps to relieve families of the need to fill out forms have been effective in renewing children's health coverage under Medicaid and CHIP. The example of renewals in Louisiana is described in the body of the report. Briefly, children whose coverage is about to expire are automatically renewed if income eligibility is shown by data matches with records from external sources (Food Stamp files, child support enforcement records, state workforce agency databases, etc.). When such data do not prove sufficient, families are encouraged to provide the necessary information by phone. Only if these steps fail must families complete paper renewal forms. After Louisiana implemented these measures, the percentage of children losing coverage at the end of their eligibility periods dropped from 28 percent in 2001 to 8 percent in 2005.[64] More recently, the proportion of procedural denials at renewal fell below 1 percent.[65]

- Automated enrollment strategies are not limited to health coverage or to low-income people. One well-known example involves retirement savings. When an employer arranges a 401(k) account and enrolls new workers who complete forms, 33 percent participate. By contrast, when new employees are enrolled unless they complete forms opting out, enrollment reaches 90 percent.[66]

Appendix B. Basic perspectives on automated enrollment

The previous appendix lists just a few examples from a longer list,[67] but the basic structure is clear. By basing eligibility on third-party data and arranging "defaults" so that inaction leads to enrollment, automated strategies can dramatically increase take-up. Potential benefits of this approach may also include:

- lower ongoing administrative costs when eligibility is determined by data matches rather than the manual processing of application forms;[68]
- fewer errors when eligibility is based on reliable, third-party data rather than applicants' inherently limited memories and paper records;[69]
- fewer paperwork requirements imposed on applicants; and
- less likelihood of federal sanctions, since automated eligibility procedures are less likely to depart from program rules.[70]

On the other hand, this approach has disadvantages that can involve the following:

- the time needed to develop productive interagency relationships, which can require overcoming initial reluctance to share data;
- the cost of investing in needed information technology and the general absence of enhanced federal matching funds for IT improvements related to eligibility;[71]
- the need, in many states, to define the respective roles of state and county agencies in applying these new methods for determining and renewing eligibility;
- the need to retrain staff to function effectively in a different environment for eligibility determination; and
- the reduced ability of program administrators to limit caseloads by imposing procedural requirements that interfere with enrollment and retention.[72]

Automated enrollment strategies implicitly apply a vision of human decision-making in which inertia is recognized as a powerful force. As a result, the administrative agency takes an unusually active role ensuring that eligible families receive benefits. In the words of Louisiana Congressman Rodney Alexander at the 1998 launch event for that state's SCHIP program, "Children will not be helped if we don't intervene."[73]

As suggested by behavioral economics research, inertia has a powerful effect among people at all income levels. For example, one study found that 49 percent of older employees at seven private companies failed to file the forms required to obtain their employers' matching contributions to 401(k) accounts, even though it would have cost such workers nothing to do so. The average amount "left on the table" equaled 1.3 percent of annual income. Financial education directed at these workers had almost no effect, raising participation rates by just one-tenth of one percent.[74]

Compared to these workers, low-income parents are much more likely to provide their children with health coverage. Among eligible children who lack private insurance, 79 percent have been enrolled in Medicaid or SCHIP. [75] Nevertheless, the take-home lesson is clear: whether it involves low-income parents and child health coverage or middle-income employees and retirement savings, enrollment procedures are much more likely to succeed if they take into account inertia as a key determinant of behavior.

Two final comments are important. First, the mechanisms described in the body of the paper seek to extend health coverage to children whose families are connected to other public or private systems, such as state-administered public benefit programs, public schools, state income tax records, hospital emergency rooms, or prior receipt of health coverage. Other methods are needed to reach uninsured children whose families fall outside these systems.

Second, the key feature of many automated enrollment strategies is that they adjust eligibility criteria to fit available data. Such adjustments can produce enormous gains in terms of administrative efficiency and program participation by eligible individuals, but they trade off some precision in fitting eligibility rules to policymakers' ideal vision of who most deserves assistance.

Eligibility for means-tested, federal-funded grants and loans for higher education illustrates this trade-off:[76]

- If a student's family includes one person who received certain need-based benefits (SSI, Food Stamps, NSLP, TANF, or WIC) at any point during 2008, the student automatically qualifies for aid during the 2009-2010 school year.

- If the student's family does not include anyone who received such benefits, then:

    — If the family's adjusted gross income (AGI) shown on federal income tax records for 2008 was below $50,000, eligibility for student aid during 2009–2010 is based entirely on income during 2008, as shown by tax records.

    — If AGI in 2008 was $50,000 or more, eligibility during 2009–2010 is based on income shown on tax forms for 2008 and documentation of the value of current assets (real property, bank accounts, etc.) at the time the application for student aid is filed.

Suppose parents who were indigent in 2008 won the lottery in 2009. Such income would not affect the children's eligibility for student aid until 2010–2011. But if a family's income declined substantially after the end of 2008, the family can explain its changed circumstances to the college financial aid office, which can immediately increase the amount of federally-subsidized financial assistance.

Despite these simplifications, many families find it challenging to complete application forms for student aid.[77] As a result, the Bush Administration proposed basing student aid entirely on prior-year AGI, and others suggested replacing paper applications forms with data matches.

Policymakers could instead move in the opposite direction, increasing the alignment between eligibility rules for federally-funded student aid and an abstract definition of which students most need assistance. In that case, all applicants would need to document current income and assets, with periodic recertifications throughout the school year. As a result, with the 27.1 percent of undergraduates who receive such assistance,[78] parents would periodically provide pay stubs and other documentation of income on an ongoing basis, which college administrators or federal officials would need to verify. It is not obvious that the gains in aligning eligibility criteria with abstract notions of who most deserves assistance would outweigh the resulting widespread inconvenience and increased administrative costs as well as the many fully eligible students who would lose financial aid because of their families' failure to meet the increased procedural requirements for retaining assistance.

Defining eligibility based on available data is not an issue of program integrity. Program integrity involves ineligible people receiving benefits. In fact, erroneous grants of eligibility are less likely when eligibility rules can be applied based entirely on third-party data, rather than the manual presentation and verification of paper documents.

Many of the strategies discussed here change how eligibility is defined. The precise issue facing policymakers is how to evaluate the trade-off between (a) eligibility criteria fitted to an ideal definition of need, on the one hand, and (b) lower taxpayer-funded administrative costs, less red tape for applicants, and higher participation by eligible individuals, on the other.

Appendix C. Examples of state income tax forms and instructions

Iowa Individual Income Tax Short Form   **IA 1040A 2008**

For full-year Iowa residents only.

Reset Form
Print Form

STEP 1: Fill in all spaces. You MUST fill in your Social Security Number.

Your last name

Your first name/middle initial

Spouse's last name

Spouse's first name/middle initial

Current mailing address (number and street, apartment, lot or suite number) or PO Box

City, State, ZIP

☐ Check this box if you or your spouse were 65 or older as of 12/31/08.

Your Social Security Number ● _ _ Spouse Social Security Number ● _ _

Are your name, your spouse's name, if applicable, and your address the same as on last year's return? ☐ YES ☐ NO

Residence on 12/31/08
County No. ● SchoolDistrict No. ●

Dependent children for whom an exemption is claimed in Step 3
How many have health care coverage? _____ ●
How many do not have health care coverage? _____ ●

STEP 2: Filing Status: Mark one box only.

1 ☒ Single: Were you claimed as a dependent on another person's Iowa return? ☐ YES ☐ NO ▲
2 ☐ Married filing a joint return.
5 ☐ Head of household with qualifying person. If qualifying person is not claimed as a dependent on this return, enter the person's name and
6 ☐ Qualifying widow(er) with dependent child. | SSN here. Name: _____ SSN: _____

STEP 3

Exemption Credits

YOU (and spouse if filing jointly)

a. **Personal Credit:** Enter 1 (Enter 2 if filing joint or head of household) ....▲_____ X $ 40 = $ _____
b. Enter 1 for each person who is **65 or older** and/or 1 for each person who is **blind** ...▲_____ X $ 20 = $ _____
c. **Dependents:** Enter 1 for each dependent ....▲_____ X $ 40 = $ _____
d. Enter first names of dependents here: _____ e. TOTAL $ _____

STEP 4

Figure your income

1. Total wages, salaries, tips and unemployment compensation. .... 1. _____ .00
2. Taxable interest. If more than $1,500, complete Schedule B. .... 2. _____ .00
3. Taxable dividends. If more than $1,500, complete Schedule B. .... 3. _____ .00
4. Net income. Add lines 1, 2, and 3. .... 4. ▲ _____ .00
5. Federal income tax refund received in 2008. .... 5. ▲ _____ .00
6. TOTAL. Add lines 4 and 5. .... 6. _____ .00
7. Federal tax payment information. (a) Federal tax withheld .... a. ▲ _____ .00
   (b) Additional paid in 2008 for 2007 and any prior year. b. ▲ _____ .00 7. _____ .00
8. Income subject to tax. Subtract line 7 from line 6. If greater than $100,000 you must use IA 1040 long form.. 8. _____ .00

STEP 5

Figure your tax, credits and checkoff contri- butions

9. Tax from tables. See IA 1040A tax tables at www.state.ia.us/tax. .... 9. ▲ _____ .00
10. Total exemption credits from Step 3. .... 10. _____ .00
11. BALANCE. Subtract line 10 from line 9. If less than zero, enter zero. .... 11. ▲ _____ .00
12. Multiply line 11 by your School District Surtax Rate. See 2008 School District Surtax List. .... 12. ▲ _____ .00
13. Fish and Wildlife Fund Contribution. $1 or more supports the Wildlife Diversity Program. .... 13. ▲ _____ .00
14. State Fairgrounds Renovation Contribution. $1 or more helps renovate the fairgrounds. .... 14. ▲ _____ .00
15. Volunteer Firefighters/Veterans Trust Fund. $1 or more shared by two organizations. .... 15. ▲ _____ .00
16. Child Abuse Prevention. $1 or more. .... 16. ▲ _____ .00
17. Total Tax and Contributions. Add lines 11 through 16 . ... 17. _____ .00
18. Iowa income tax withheld from Box 17 of your W-2 form(s). .... 18. ▲ _____ .00
19. Iowa Earned Income Credit. (Federal EIC credit $_____ X .07) .... 19. ▲ _____ .00
20. Total credits. Add lines 18 and 19. .... 20. _____ .00

STEP 6

Figure your refund or amount due

21. If line 20 is more than line 17, subtract line 17 from line 20. This is your REFUND. .... 21. ▲ _____ .00
    Mail to Iowa Income Tax Refund Processing, Hoover State Office Bldg, Des Moines IA 50319-0120
22. If line 20 is less than line 17, subtract line 20 from line 17. This is the AMOUNT OF TAX YOU OWE. ...... 22. ▲ _____ .00
23. Penalty. See back of the IA 1040V payment voucher. .... 23. ▲ _____ .00
24. Interest. See back of the IA 1040V payment voucher. .... 24. ▲ _____ .00
25. TOTAL AMOUNT DUE. Add lines 22, 23, and 24 and enter here. .... 25. ▲ _____ .00
    ePay at www.state.ia.us/tax or write check to Treasurer, State of Iowa / **Mail to Iowa Income Tax Processing, PO Box 9187, Des Moines IA 50306-9187**

↑Staple W-2s, payment, and voucher here.→

POLITICAL CHECKOFF.
This checkoff does not increase the amount of tax you owe or decrease your refund.

SPOUSE ▲ YOU
$1.50 to Republican Party ☐ ☐ $1.50 to Republican Party
$1.50 to Democratic Party ☐ ☐ $1.50 to Democratic Party
$1.50 to Campaign Fund ☐ ☐ $1.50 to Campaign Fund

Next year, (check one): Would you like to receive an IA 1040 booklet?
This option is not available to electronic filers. 0. ☐ Yes ▲ 1. ☐ No

PLEASE

SIGN HERE ►

SIGN HERE ►

• Verify your Social Security Number(s)
• Recheck your math
• Attach all W-2s

I (We), the undersigned, declare under penalty of perjury that I (we) have examined this return, including all accompanying schedules and statements, and, to the best of my (our) knowledge and belief, it is a true, correct, and complete return. Declaration of preparer (other than taxpayer) is based on all information of which the preparer has any knowledge.

Your Signature _____ Date
Spouse's Signature _____ Date
Daytime Telephone Number

Preparer's Signature _____ Date
Address
Daytime Telephone Number
Identification Number
41-080 (9/2/08) **S08**

This return is due April 30, 2009.   Mailing Addresses: See lines 21 and 25 above.

NJ-1040
2008
5R

STATE OF NEW JERSEY
INCOME TAX-RESIDENT RETURN

WEB

For Tax Year Jan.-Dec. 31, 2008, Or Other Tax Year Beginning _____, 2008, Month Ending _____, 20_____

↓ IMPORTANT! YOU MUST ENTER YOUR SSN (s). ↓   Fill in ☐ if application for Federal extension is enclosed or enter confirmation #_____

Your Social Security Number

Last Name, First Name and Initial (Joint filers enter first name and initial of each. Enter spouse/CU partner last name ONLY if different)

Place label on form if all preprinted information is correct. Otherwise, print or type your name and address.

Spouse's/CU Partner's Social Security Number

Home Address (Number and Street, including apartment number or rural route)

County/Municipality Code (See Table p. 51)

City, Town, Post Office   State   Zip Code

For Privacy Act Notification, See Instructions

NJ RESIDENCY STATUS   If you were a New Jersey resident for ONLY part of the taxable year, give the period of New Jersey residency.

From M M / D D / Y Y To M M / D D / Y Y

FILING STATUS

(Fill in only one)

1. ☐ Single

2. ☐ Married/CU Couple, filing joint return

3. ☐ Married/CU Partner, filing separate return. Enter Spouse's/ CU Partner's Social Security Number in the boxes above

4. ☐ Head of household

5. ☐ Qualifying widow(er)/ Surviving CU Partner

EXEMPTIONS

6. Regular ● Yourself ☐ Spouse/ CU Partner ☐ Domestic Partner

7. Age 65 or Over ☐ Yourself ☐ Spouse/CU Partner

8. Blind or Disabled ☐ Yourself ☐ Spouse/CU Partner

9. Number of your qualified dependent children ....

10. Number of other dependents ....

11. Dependents attending colleges ....

12. Totals (For Line 12a - Add Lines 6, 7, 8, and 11)
(For Line 12b - Add Lines 9 and 10) ....

ENTER NUMBERS HERE

6
7
8
9
10
11
12a   12b

DEPENDENTS

13. Dependent's Last Name, First Name, Middle Initial

Dependent's Social Security Number   Birth Year

Does dependent have health insurance? (see instr.)   Yes   No

a _____

b _____

c _____

d _____

GUBERNATORIAL ELECTIONS FUND ➤

Do you wish to designate $1 of your taxes for this fund? ☐ Yes ☐ No

If joint return, does your spouse/CU partner wish to designate $1? ☐ Yes ☐ No

Note: if you fill in the Yes oval(s), it will not increase your tax or reduce your refund.

Under the penalties of perjury, I declare that I have examined this income tax return and rebate application, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete and that I occupied the rental property for which I am applying for the tenant homestead rebate as my principal residence on October 1, 2008. If prepared by a person other than taxpayer, this declaration is based on all information of which the preparer has any knowledge.

Pay amount on Line 54 in full. Write Social Security number(s) on check or money order and make payable to:

STATE OF NEW JERSEY TGI

◆ Your Signature   Date

Mail your check or money order with your NJ 1040-V payment voucher and your return to:
NJ Division of Taxation
Revenue Processing Center
PO Box 111
Trenton, NJ 08645-0111

◆ Spouse's/CU Partner's Signature (if filing jointly, BOTH must sign)   Date

IF REFUND:
NJ Division of Taxation
Revenue Processing Center
PO Box 555
Trenton, NJ 08647-0555

If you do not need forms mailed to you next year, fill in (See instruction page 15) .... ☐

I authorize the Division of Taxation to discuss my return and enclosures with my preparer (below) .... ☐

Paid Preparer's Signature   Federal Identification Number

You may also pay by e-check or credit card. For more information go to:
www.state.nj.us/treasury/taxation

Firm's Name   Federal Employer Identification Number

Division Use   1 2 _____ 3 _____ 4 5 6 _____ 7 _____

Excerpt from page 9 of the instructions for the 2008 NJ-1040 form:

Privacy Act Notification

The Federal Privacy Act of 1974 requires an agency requesting information from individuals to inform them why the request is being made and how the information is being used.

Your social security number is used primarily to account for and give credit for tax payments. The Division of Taxation also uses social security numbers in the administration and enforcement of all tax laws for which it is responsible. In addition, the Division of Taxation is required by law to forward an annual list to the Administrative Office of the Courts containing the names, addresses, and social security numbers of individuals who file a New Jersey resident tax return or tenant homestead rebate application. This list will be used to avoid duplication of names on jury lists. The Division of Taxation is also required to transmit to the Department of Human Services (DHS) annually information from New Jersey resident tax returns that will permit DHS to identify individuals who do not have health insurance and who may be eligible for Medicaid or the NJ FamilyCare Program.

Appendix D. Approaches to addressing the timeliness of income tax data

Income tax data show family income during the prior tax year, which usually means the previous calendar year. If income has fallen since then, and a child qualifies for additional assistance, the family can submit an application that is processed using normal procedures. But what happens if income has risen since then?

A state could decide that such changes do not affect Medicaid or CHIP eligibility until the following calendar year. This approach has ample precedent. For example, increased income does not reduce Medicare Part B premium subsidies for two years. Low-Income Subsidies for Medicare Part D are not reduced until the year after income rises. Federally-funded grants and loans for college are not adjusted to reflect increased income until the start of the school year following the year in which family earnings rose (e.g., income increases in 2009 first affect financial aid in the 2010-2011 school year, which typically begins 8 or 9 months after the end of 2009). And of course, the Medicaid/CHIP option for 12 months of continuous eligibility—one of the 8 best practices that can help qualify a state for performance bonuses under CHIPRA—ignores increased income during those 12 months. That same approach to continuous eligibility is mandatory for NSLP, as a result of policy changes made during the Bush administration.

Despite these precedents, a state may try to shorten the delay between improvement in household circumstances and reduced subsidies. To move towards that goal while simultaneously retaining many advantages of ELE in securing broad participation and lowering state administrative costs, following are five possible approaches:

1. *Limit the period during which tax data may be used to begin eligibility.* For example, a state could decide that prior-year tax data can establish Express Lane Eligibility only if a family requests health coverage by no later than April 15. (This would apply ELE when parents file timely state income tax returns that identify uninsured children and request disclosure of tax data to their state's health agency.) This approach is authorized by CHIPRA, which requires that the state select a "reasonable period of time" for granting ELE. Moreover, some state Medicaid agencies already base income determinations on prior-year tax data during the first three months of the year. In such states, permitting the use of such prior-year data through April 15 would represent just a two-week extension of current policy.

2. *Adjust tax data based on more recent information.* A state could adjust the income shown on tax forms to take into account more recent income information in the files of other government benefit programs as well as quarterly earnings and new hires data since the end of the prior calendar year. The latter information is maintained by state workforce agencies (SWAs) and incorporated into the Income Eligibility and Verification System, which is used to verify applications for Medicaid and other public benefits. This supplementation would eliminate many gaps between prior-year tax data and more recent household circumstances, since changes in hours and wages of employment are by far the most significant components of income volatility among low-income families.[79] As noted in the body of the paper, CHIPRA gives Medicaid and CHIP programs access to the NHDB, which provides that same information about employment in all states and the federal government—a particularly important step in states where many residents work at jobs across state borders.

Of course, this supplementation would be imperfect. Some states have relatively weak SWA information technology, which can delay electronic access to quarterly earnings records; slightly longer delays apply to NHDB, which compiles information reported by all SWAs. These delays are likely to shorten—but not disappear—under the American Recovery and Reinvestment Act of 2009, which gives states strong incentives to change their unemployment insurance programs in ways that require more rapid access to quarterly earnings records.[80]

A more fundamental problem is that unearned and self-employment income is not reported to SWAs or to the NHDB. However, a similar limitation already affects standard enrollment procedures, which typically rely on prior-year tax forms to document self-employment income.

This second approach to dealing with data lags is analogous to methods already approved by CMS (while operating under its former name, "the Health Care Financing Administration"). An April 7, 2000 State Medicaid Director (SMD) Letter explains that, in renewing coverage, a Medicaid program can grant eligibility based on a determination made by another public benefit program that terminated eligibility, so long as the determination was made "within the time period established by the State for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate." The following example illustrates how this framework could apply to ELE. Suppose a state generally certifies children's eligibility for 9-month periods. In that case, tax data could establish eligibility for any application made during the first 9 months of the year—so long as the state has no reason to believe, after checking quarterly earnings, new hires, Food Stamp case files, and other available records, that the prior-year tax data is no longer accurate. If such checks show a material change, the prior-year tax data would be adjusted accordingly before determining a child's eligibility for Medicaid or CHIP.

3. *Base the redetermination date on the age of the tax data.* This approach ensures that time lags between data used to establish eligibility and the period in which a child receives coverage never exceed a specified period. For example, if a state ordinarily covers children for 12-month periods, eligibility based on tax data could last through the end of the calendar year. Whether a child applies using standard procedures in January 2010, documenting income through December 2009, or applies in April 2010 using tax data through December 2009, eligibility would be granted through December 2010 based on income information through December 2009.

New Jersey is taking a similar approach in implementing a recent increase of parents' income-eligibility levels for Medicaid. That state is finding parents eligible based on earlier applications the parents filed seeking health coverage for their children. The parents' eligibility periods last until 12 months following *the date of such earlier applications*, not 12 months following *the new grant of eligibility*.[81]

Like the previous approach to addressing time lags, this one is consistent with the above-described SMD letter. That letter explains that, when eligibility is renewed based on the findings of another program, the state can begin counting the new Medicaid eligibility period starting either with the date of the renewal or "the date when the last review of eligibility was conducted in the other program."

This is only one example of how the redetermination date could be based on the age of the tax data, rather than the date of application. In another example, the eligibility conferred by tax data could last no longer than if the family had requested coverage on a state income tax form filed by April 15. For example, in a state with 12-month continuous eligibility periods, coverage based on 2009 tax data would end, at the latest, on April 30, 2011, even if the family sought express lane coverage in the closing months of 2010.

Of course, if a state shortens a child's eligibility period based on the age of tax data when parents apply using express lane procedures, parents need to be informed that, by supplementing tax data with more recent information about income, or by filing a standard application form, their children's eligibility could last for a longer period.

4. *Begin a regular renewal cycle based on annual availability of tax data.* Under this approach, income-eligibility would be renewed each year based on the state income tax agency's receipt of third-party income data covering the calendar year. The national deadlines for W-2 and 1099 reports are February and March for paper and electronic transmissions, respectively.[82] Whatever deadlines apply at the state level could become a basis for automatically renewing children's income eligibility each year. One advantage of this approach is the accuracy of such third-party income reports,[83] which exceeds many individual applicants' ability to accurately answer a state's questions about income.

5. *Request confirmation or updating.* If a parent uses a state income tax form to identify an uninsured child and to authorize disclosure of tax data to determine that child's eligibility for free or reduced-cost health coverage, the form could also require the parent to indicate whether household income has risen, since the year covered by the return, by more than a specified, minimum amount. Any such indication of additional income might be subject to administrative verification.

    Under another version of this approach, the state would provide the family with a "pre-populated" form showing the family's income, based on available tax data, perhaps supplemented by the above-described sources of more recent income information. The parent would be asked to correct errors (perhaps limited to those that exceed a certain minimum dollar threshold) or to confirm the information's accuracy by calling a toll-free number and "punching in" a numeric identifier (such as the final digits of a Social Security Number). Only after receiving such confirmation would the child be found income-eligible. Alternatively, a state could make clear that the parent is legally obliged to make necessary corrections of errors on the pre-populated form that exceed a specified amount, and that if none are forthcoming, information on the form will determine the child's eligibility. As noted in the body of the paper, similar approaches are used by some Medicaid and CHIP programs when they renew children's coverage[84] and by the California state income tax system.[85]

Appendix E. Statistical methodology

This appendix describes how the body of the report reached its conclusions about children's health coverage and two need-based nutrition programs: Food Stamps and NSLP.

Food Stamps

Urban Institute (UI) researchers used the Transfer Income Model, Version 3 (TRIM3), to analyze the characteristics of uninsured children receiving Food Stamps. Maintained and developed at the Urban Institute under primary funding from the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, TRIM3 incorporates data from the March Current Population Survey—Annual Social and Economic Supplement (CPS-ASEC or CPS) and applies state and national program rules to each CPS-ASEC person, determining monthly eligibility for Medicaid, SCHIP, Food Stamps, and other benefits. More information on TRIM3 is available from the public-use website, http://trim.urban.org/T3Welcome.php. Researchers estimated Medicaid and SCHIP eligibility, during the average month in 2005, among children whom CPS-ASEC classified as uninsured throughout the year and whom TRIM3 classified as receiving food stamps. TRIM estimates were compared to estimates of eligibility derived from an alternate model and were found to be similar.

One key feature of the TRIM3 model is that it imputes monthly characteristics to CPS-participant households. This overcomes important timing problems. Using CPS data without TRIM3's monthly imputations, one could estimate, based on each household's *annual income*, Medicaid and SCHIP eligibility among uninsured children who, according to CPS, received Food Stamps *at any point during the prior calendar year*. This would overestimate the number of uninsured, Food-Stamp-recipient children whose incomes make them ineligible for health coverage because this alternative approach does not adjust for income fluctuations throughout the calendar year. Uninsured children who qualified for Medicaid or SCHIP when they received Food Stamps during some months can experience increased income in other months that would make them appear ineligible for health coverage based on annual income data recorded by CPS.

While the imputation of monthly characteristics overcomes the timing problem created by CPS' annualized time frame, such imputation necessarily departs from the CPS data themselves, introducing some uncertainty into the results. A further limitation of the TRIM3-based estimates presented in the text is that they do not adjust CPS-reported insurance status to compensate for differences between CPS-reported Medicaid enrollment totals and state administrative data. Considerable controversy surrounds methodological choices about how best to align CPS health coverage data with administrative benchmarks.

NSLP

Based on data from Mathematica, Inc., about the actual household income of children participating in NSLP, the body of the report estimated the percentage of NSLP-recipient children who are income-eligible for Medicaid and SCHIP.

Table A-1 shows the results of Mathematica's research.

TABLE A-1 **NSLP participants, distribution by level of NSLP**
assistance and actual household income: 2005–2006

FPL	Free school lunch participants	Reduced-price school lunch participants
Less than 50	26.9%	4.7%
50 to 99	37.0%	13.5%
100 to 129	16.5%	14.8%
130 to 184	12.6%	41.6%
185 to 199	1.9%	8.0%
200 to 224	1.6%	5.8%
225 to 249	1.4%	4.4%
250 to 399	1.5%	6.6%
400+	0.6%	0.5%
Total:	100%	100%

Source: Ponza, et al., 2007, unpublished data.

Table A-2 shows the proportion of all children, at each income level, who are income-eligible for Medicaid and SCHIP, based on the model of each state's eligibility rules maintained by UI's Health Policy Center.

TABLE A-2 **Children of various income levels, by income-eligibility for Medicaid and SCHIP: 2004**

FPL	Income-eligible for Medicaid	Income-eligible for SCHIP	Income too high for both programs	Total
Less than 50	100%	0%	0%	100%
50 to 99	99%	1%	0%	100%
100 to 129	73%	25%	1%	100%
130 to 184	38%	59%	3%	100%
185 to 199	26%	62%	13%	100%
200 to 224	18%	44%	39%	100%
225 to 249	13%	32%	55%	100%
250 to 399	8%	10%	82%	100%
400+	3%	1%	96%	100%

Source: Urban Institute Health Policy Center Eligibility Simulation Model, derived from the 2005 CPS-ASEC.

Notes: (1) FPL was determined by using Census family units, which include all related individuals living in a single household. That is the same way the Mathematica researchers analyzed income eligibility for NSLP, based on NSLP's eligibility rules, which determine income by combining all members of a single household who buy and prepare food together. (2) Income-eligibility for Medicaid and SCHIP was analyzed by examining Health Insurance Units, which are limited to spouses and dependent children living together, consistent with the eligibility methods used by health coverage programs. (3) Citizenship status was not considered in determining income-eligibility. (4) Children may appear eligible despite relatively high family income because Census family units were used to determine income as a percent of poverty for this table, as indicated in Note 1, while income eligibility is determined using a more restrictive family unit that includes only the members of the nuclear family, as indicated in Note 2. For example, a child's Medicaid eligibility is not affected by the income of step-parents, grandparents, and siblings, who are included in Census family units. Thus a child's income eligibility for health coverage may be determined based on a lower family income value than would be calculated if the income of all related members of the household was taken into account.

TABLE A-3 Children receiving free school lunches under NSLP, by income level and income-eligibility
for Medicaid and SCHIP

FPL	Income-eligible for Medicaid	Income-eligible for SCHIP	Income too high for both programs	Total
Less than 50	26.9%	0.0%	0.0%	26.9%
50 to 99	36.6%	0.4%	0.0%	37.0%
100 to 129	12.0%	4.1%	0.2%	16.3%
130 to 184	4.8%	7.4%	0.4%	12.6%
185 to 199	0.5%	1.2%	0.2%	1.9%
200 to 224	0.3%	0.7%	0.6%	1.6%
225 to 249	0.2%	0.4%	0.8%	1.4%
250 to 399	0.1%	0.2%	1.2%	1.5%
400+	0.0%	0.0%	0.6%	0.6%
Total	81.5%	14.4%	4.0%	100.0%

Source: Calculations based on Ponza, et al., 2007 and HPC model of 2005 CPS-ASEC, Tables A-1 and A-2.

Note: Totals may not add because of rounding.

TABLE A-4 Children receiving reduced-price school lunches under NSLP, by income level
and income-eligibility for Medicaid and SCHIP

FPL	Income-eligible for Medicaid	Income-eligible for SCHIP	Income too high for both programs	Total
Less than 50	4.7%	0.0%	0.0%	4.7%
50 to 99	13.4%	0.1%	0.0%	13.5%
100 to 129	10.8%	3.7%	0.1%	14.7%
130 to 184	15.8%	24.5%	1.2%	41.6%
185 to 199	2.1%	5.0%	1.0%	8.1%
200 to 224	1.0%	2.6%	2.3%	5.9%
225 to 249	0.6%	1.4%	2.4%	4.4%
250 to 399	0.5%	0.7%	5.4%	6.6%
400+	0.0%	0.0%	0.5%	0.5%
Total	48.9%	38.0%	13.0%	100.0%

Source: Calculations based on Ponza, et al., 2007 and HPC model of 2005 CPS-ASEC, Tables A-1 and A-2.

Note: Totals may not add because of rounding.

To obtain the totals in the body of the paper, UI researchers multiplied each cell in Table A-1 by the corresponding cell in Table A-2 and summed the results. The calculations are shown in Tables A-3 and A-4 for free and reduced-price school lunch recipients, respectively.

This analysis of NSLP, Medicaid, and SCHIP has several limitations. First, it is national in scope. States vary in terms of Medicaid and SCHIP eligibility standards; the income distribution of children; and presumably the error rate of NSLP eligibility determination. In effect, Table 1 in the body of the report shows Medicaid and SCHIP income-eligibility of NSLP participants in a hypothetical state that is at the national average in each of these dimensions. Fewer NSLP participants will be ineligible in a state that has unusually generous Medicaid and SCHIP eligibility; unusually accurate NSLP eligibility determination; or an unusually high proportion of very low-income children. More will be ineligible in states that depart from the average in opposite directions.

Second, the analysis combines NSLP income distributions from the 2005-2006 school year with Medicaid/SCHIP income eligibility findings from 2004. This may overstate the percentage of children with too much income to qualify for health coverage. If Medicaid/SCHIP eligibility rules from 2005 and 2006 were applied, the proportion of ineligible children might decline, because eligibility for health coverage grew more generous in 2005 and 2006.[86]

Third, in showing the income distribution of NSLP recipients, the data from Mathematica, Inc., do not distinguish among children based on their citizenship and immigration status. It is possible that the income distribution of children who meet Medicaid and CHIP requirements for citizenship and immigration status may differ from the distribution for NSLP-recipient children as a whole.

Appendix F. Alternative approaches to establishing satisfactory immigration status (SIS)

Develop data-sharing agreements with the Social Security Administration that allow the state to grant SIS when SSA has found a child to be a legal permanent resident

As mentioned in the text of the paper, ELE cannot be used to establish citizenship, but it can be used to show satisfactory immigration status. Before it provides a Social Security Number (SSN) to a non-citizen, the Social Security Administration (SSA) must obtain documentation from U.S. Citizenship and Immigration Services that the non-citizen "has been lawfully admitted to the United States, either for permanent residence or under authority of law permitting him or her to work in the United States."[87] Under SSA administrative guidelines, the same evidence must be presented to document legal permanent residence as is required to show status as a qualified alien to establish Medicaid eligibility.[88] If SSA has determined, for purposes of issuing SSNs, that a child is a legal permanent resident, a state may be able to use that finding, via ELE, to conclude, without any need for further inquiry, that the child has satisfactory immigration status for purposes of Medicaid or CHIP eligibility.[89]

This approach has several limitations:

- It may not work in a state that retains the five-year residency requirement for immigrant children, since SSN data do not include the date on which lawful permanent residence began.

- For SSA to serve as an Express Lane agency, it could not provide a state with information about a child's status as a legal permanent resident until it gave the family notice and an opportunity to prevent the information disclosure.

- Although SSA's database for storing information about SSNs contains a field indicating whether someone is a "Permanent Resident Alien," SSA's current systems for digitally verifying SSNs to states do not provide routine access to that field.[90] In the future, federal officials could develop a system of digital verification that provides states with this information.

Use SSN matches as initial evidence of SIS

The underlying federal statutes about documenting immigration status for purposes of several public benefit programs (including Medicaid) make clear that acceptable documentation, sufficient to grant interim coverage while awaiting verification from the Department of Homeland Security, can consist of "such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status."[91] This provision may give a state the legal authority to determine that electronic confirmation of a child's valid SSN constitutes reasonable evidence of SIS.

To increase the likelihood of CMS approval, a state taking this approach could propose a Medicaid Eligibility Quality Control (MEQC) pilot that would sample the case files of children who are found to have SIS based on confirmation of SSN validity. The state would then determine the percentage of such children who received health coverage in error, perhaps going so far as to eschew federal matching funds to the extent that more than 3 percent of children found to have SIS based on SSN matches were in fact ineligible. This would be much more restrictive than the approach usually taken under MEQC and Payment Error Rate Measurement (PERM) procedures, which deny federal matching funds for erroneous expenditures that exceed 3 percent of total spending for all beneficiaries. Since children are the least expensive group of Medicaid beneficiaries, federal sanctions, without the kind of MEQC pilot suggested here, are unlikely to be triggered by the small number of erroneous grants of health coverage that might result from finding non-citizen children to have SIS based on SSN matches.

Notes

1   For examples of recent state and local explorations of using external data to facilitate enrollment of the uninsured into Medicaid and CHIP, see Stan Dorn, *Using 21st-Century Information Technology to Help Eligible People Receive Health Coverage: State and Local Case Studies*, prepared by the Urban Institute for the State Coverage Initiatives Program of AcademyHealth, October 2008.

2   Stan Dorn, *Eligible but Not Enrolled: How CHIP Reauthorization Can Help*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, September 2007.

3   For a good summary of all of CHIPRA's provisions, see Dawn Horner, *The Children's Health Insurance Program Reauthorization Act of 2009*, Georgetown University Center for Children and Families, February 2009.

4   Such a state might invest in carefully tracking the results of innovative policies. If the results are positive, they can be used to advocate for a continuation of such innovation.

5   The statute identifies particular agencies that can serve as Express Lane agencies and then articulates several "catch all" categories for agencies that are not specifically listed. Such categories include: (a) public agencies that have fiscal liability or legal responsibility for the accuracy of the findings used to establish ELE; and (b) public agencies that are subject to an interagency agreement limiting the disclosure and use of information to the purpose of determining eligibility for health coverage.

6   Agencies that determine eligibility for programs established with Title XX Social Services Block Grants may not qualify as Express Lane agencies.

7   Whether these requirements apply to state income tax agencies depends on how CMS interprets CHIPRA's language, which is not completely clear on this issue.

8   These conditions do not apply to data-sharing authority in place before the enactment of CHIPRA.

9   It is not immediately obvious how to reconcile this provision with another section of the legislation that addresses renewals of eligibility in a state that exercises the option to provide Medicaid to newly arrived immigrant children (or to disregard the income of immigration sponsors in determining eligibility). The latter section provides that, "a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.'' Newly added Social Security Act Section Section 1903(v)(4)(C) [42 U.S.C. 1396b(v)(4)(C)]. An interpretation favorable to the strategies discussed in this report would construe "the documentation presented to the State by the individual" to include the "evidence in digital and electronic form" that newly added Social Security Act Section 1902(dd) [42 U.S.C. 1396a(dd)] permits in satisfying the documentation requirements for non-citizens specified in Social Security Act Section 1137(d)(2) [42 U.S.C. 1320b–7(d)(2)]. Consistent with this interpretation is the language of the latter section, which requires only that "there must be presented" certain documents, not that the applicant must be the one providing the documents.

10   Such providers often try to help uninsured patients qualify for health coverage today, but the approach described in the text would introduce three innovations: first, it would establish a secure, internet connection or other data transmission method through which the consent to disclosure and request for help described in the text are conveyed to state health agencies; second, providers could be required (perhaps as a condition of receiving reimbursement from Medicaid and insurance that covers public employees and retirees) to give parents of uninsured children an opportunity to request coverage whenever they seek care; and third, families would not be required to complete full-blown applications to obtain health coverage for their children. By contrast, providers now may decide not to invest the effort needed to qualify children for Medicaid and CHIP if the amount of the bill is small; and parents or staff must complete paper application forms before children's eligibility is evaluated.

11   Despite its intuitive appeal, this approach may be efficient only if parental requests for coverage can be digitized with individual child identifiers that allow matches to Medicaid and CHIP enrollment data as well as third-party information pertinent to eligibility. The data infrastructure maintained by state and local education agencies varies considerably.

12   This may best be done, not just when initial Unemployment Insurance (UI) forms are filed, but also when UI recipients file subsequent reports showing that they still qualify for UI because they are searching for work. That timing provides information about available child health coverage after the initial period following job loss, which can be a difficult time in which to absorb new information. Cassie Sauer, personal communication, December 19, 2007.

13   Stan Dorn, Bowen Garrett, Cynthia Perry, Lisa Clemans-Cope, and Aaron Lucas, *Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and CHIP*, prepared by the Urban Institute for First Focus, February 2009.

14   These states were D.C., Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Vermont, Washington, and Wisconsin. A "refundable" credit goes to eligible people at all income levels, including those who owe no income tax, so the states that offer only a non-refundable EITC (Delaware, Maine, and Virginia) provide no incentive for low-income families to file returns when they owe no tax and are not legally required to file. Rhode Island's credit was partially refundable. See Urban Institute/Brookings Institution Tax Policy Center, "State EITC Based on the Federal EITC," *Tax Facts*, October 3, 2008; Internal Revenue Service, States and Local Governments with Earned Income Tax Credit, Page Last Reviewed or Updated: February 04, 2009, downloaded on 2/20/2009 from http://www.irs.gov/individuals/article/0,,id=177866,00.html.

15   At the federal level, if gross income is above $11,500, a head of household under age 65 must file a tax return. For a non-elderly married couple filing jointly, the threshold is $17,900. IRS, *1040 Instructions 2008*, Chart A. With a 3-person household, those dollar figures translate into 63 percent and 98 percent of FPL, respectively. For a 4-person household, they amount to 52 percent and 81 percent of FPL—and these are *gross* income numbers.

16   Dorn, et al., 2009, op cit.

17   According to IRS data for January through August 2007, 59 percent of all federal income tax returns for tax year 2006 were filed electronically; but the proportion rose to 79 percent among returns claiming the Earned Income Tax Credit. Author's calculations from IRS, Statistics of Income Division, *Tax Year 2006 Taxpayer Usage Study*, data for returns received January 1 through August 24, 2007, Report No. 1.

18   To reduce the need to cajole tax preparers, a state could simply require taxpayers to provide the requested information, as New Jersey has done in requesting the identification of uninsured children. If neither mandates nor encouragement sufficed, tax preparers could be given modest financial incentives to help uninsured children enroll. Other states have used "per head" payments to for-profit entities and others who successfully help children enroll in coverage. During much of the time since adoption of CHIP, California has paid "certified application assisters" $50 whenever they completed an application form for a child who was ultimately found eligible and enrolled in Medicaid or CHIP; such assisters include tax preparers and others. Beginning in 2005, that fee was increased to $60. Mireille Jacobson and Thomas C. Buchmueller, "Can Private Companies Contribute To Public Programs' Outreach Efforts? Evidence From California," *Health Affairs*, March/April 2007; 26(2): 538–548. Obviously, a lower payment would be appropriate here, since the tax preparer is asked to do very little in addition to standard income tax preparation.

19   To place some of these tax forms in context, New Jersey and Massachusetts have enacted individual mandates for covering children and adults, respectively. In Massachusetts, tax forms are a central method used to detect violation of the individual mandate. In New Jersey, the mandate is not yet being enforced; the existing statute makes clear that the purpose of sharing tax data with the health agency is to facilitate outreach and enrollment, but policymakers may envision using the tax data for enforcement purposes as well. In Iowa and Maryland, no individual mandate has been enacted.

20   A state can take two routes to such data matching. First, under CHIPRA, any of these data sources can be accessed so long as the statutory requirements of new Social Security Act 1942 are met. Such requirements include advance notice to the family and a reasonable chance to opt-out of disclosure. Second, matching is permitted, independent of CHIPRA, if it is allowed by other laws. For example, the Food Stamp statute permits information disclosure to "persons directly connected with the administration or enforcement of … federally assisted State programs," 7 U.S.C. 2020(e)(8). Food Stamp regulations explain the latter term to mean "federally-assisted State programs providing assistance on a means-tested basis to low income individuals." 7 C.F.R. 272.1(c)(1)(i). This allows disclosure to Medicaid and CHIP agencies, without requiring prior notice to Food Stamp recipients.

21   Stan Dorn and Genevieve Kenney, *Automatically Enrolling Eligible Children and Families Into Medicaid and CHIP: Opportunities, Obstacles, and Options For Federal Policymakers*, prepared by the Economic and Social Research Institute and the Urban Institute for The Commonwealth Fund, June 2006.

22   Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes*, 2005. Washington, DC: National Council on Aging.

23   Some state officials may be concerned that self-employment income is treated too generously under income tax rules, permitting deductions for depreciation, meals and entertainment costs, etc. If so, the amount of gross or adjusted gross income shown on state income tax forms could be increased, to add back some of these deductions.

24   See, e.g., Federal Internal Revenue Code Section 6103(c).

25   Even in such states, policymakers could require disclosure of a child's *insurance status* without also mandating disclosure of a family's *income information and social security numbers*. In that way, the income tax form would be used to detect violations of the state mandate, but the taxpayer would retain the ability to decide whether to share other information on the return for the distinct purpose of qualifying uninsured children for free or reduced-cost health coverage.

26   Depending on how CMS interprets CHIPRA, additional steps may need to be taken to ensure that tax data can establish ELE. For example, the state may need to provide a notice from the state's tax agency that describes the information to be disclosed, the purposes of such disclosure, and how the taxpayer can prevent disclosure (in this case, by simply not signing the Express Lane application form). In addition, there may need to be an interagency agreement between the tax and health agencies that limits the latter's use and disclosure of tax information. In many states, such agreements may already be in place.

27   This analysis assumes that the family has not submitted a formal application for health coverage, which, in the case of Medicaid, would trigger a legal obligation to process that application within specific timeframes.

28   Urban Institute Health Policy Center analysis based on the 2005 CPS-ASEC. Estimates reflect an adjustment for the underreporting of public coverage on the CPS.

29   One exception involves so-called "categorical eligibility," through which states provide Food Stamps automatically to families who already receive TANF, SSI, General Assistance, or certain non-cash components of TANF, such as child care and transportation assistance. In theory, the latter non-cash benefits could confer eligibility on many families who otherwise would be ineligible for Food Stamps, since income-eligibility standards for non-cash TANF benefits are relatively high in many states. However, only 280,000 out of 25 million food stamp recipients are categorically eligible and would otherwise not qualify for food stamps. Government Accountability Office, *Food Stamp Program: FNS Could Improve Guidance and Monitoring to Help Ensure Appropriate Use of Noncash Categorical Eligibility*, March 2007, GAO-07-465.

30   Shawn Fremstad and Laura Cox, *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance*, prepared by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, November 2004.

31 For each of these children to receive health coverage, Medicaid and CHIP would need to cover legal immigrant children without regard to either length of residence in the U.S. or the income of immigration sponsors who are not the children's parents or guardians.

32 Dorn and Kenney, op cit.

33 Author's calculation, based on preliminary data for the average month in FY 2007. USDA, *National School Lunch Program: Participation And Lunches Served*, data as of July 29, 2008. Downloaded on 8/29/2008 from http://www.fns.usda.gov/pd/slsummar.htm.

34 Dorn 2008, op cit.

35 GAO, *Food Stamp Program: States Have Made Progress Reducing Payment Errors, and Further Challenges Remain* (GAO-05-245) May 2005.

36 M. Ponza, P. Gleason, L. Hulsey, and Q. Moore, *NSLP/SBP Access, Participation, Eligibility, and Certification Study – Erroneous Payments in the NSLP and SBP*, "Vol. I: Study Findings," prepared by Mathematica, Inc., for the U.S. Department of Agriculture, Food and Nutrition Service, Office of Research, Nutrition and Analysis, USDA, 2007.

37 A warning here is important. A small percentage of children will not qualify for federal matching funds despite valid SSNs. For example, their families may have only temporary authorization to work in the U.S.

38 As explained above, a state could increase the amount of such income for self-employed individuals.

39 For example, in a state that denied Medicaid to school-age children with incomes above 100 percent of FPL, recipients of reduced-price school lunches could all be found income-eligible for CHIP rather than Medicaid, since their incomes, as determined by NSLP, would be more than 30 FPL percentage points above the Medicaid threshold. But in a state that extended Medicaid to income levels above 100 percent of FPL, a child's receipt of reduced-price meals, by itself, would not determine whether that child qualified for Medicaid or for CHIP. To apply this screen-and-enroll method in such cases, the state Medicaid and CHIP agency would need to learn, not just whether a child received benefits, but the household income amount found by the Express Lane agency.

40 42 C.F.R. § 435.4.

41 *New York State Dept. of Social Services*, DAB No. 1134 (1990), cited with approval in *Connecticut Department of Social Services*, DAB No. 1982 (2005). See also *llinois Department of Public Aid,* DAB No. 1320 (1992); *New York State Department of Social Services*, DAB No. 1216 (1991); *Ohio Department of Human Services*, DAB No. 900 (1987).

42 ELE is one of 8 "best practices," at least 5 of which must be implemented by a state to claim performance bonuses. It would thus be ironic if, to claim a performance bonus, a state needed to implement ELE in a fashion that prevented it from accomplishing its objectives.

43 Social Security Act Section 1902(a)(19) [42 USC 1396a(a)(19)].

44 Such a parent would need to consent to disclosure of the family's otherwise confidential personal data while providing social security numbers and other identifying information needed for data matching.

45 After the taxpayer concludes that he or she qualifies for EITC, the taxpayer asks IRS to determine the credit amount. Internal Revenue Service, Publication 596, Cat. No. 15173A, *Earned Income Credit (EIC): For use in preparing 2007 Returns*.

46 A. Cohen, M. Dutton, K. Griffin, and G. Woods. *Streamlining Renewal in Medicaid and CHIP: Strategies from Other States and Lessons for New York*, prepared by Manatt Health Solutions for the United Hospital Fund, 2008.

47 The latter approach is used only with taxpayers whose tax situation is simple and straightforward. W. Gale and B. Harris, "Return-Free Filing: What is it and how would it work?" in *The Tax Policy Briefing Book* (Urban Institute and Brookings Institution Tax Policy Center, Washington, DC) (Last Updated: December 14, 2007).

48 See, e.g., G. Flores, M.A. Abreu, C.E. Chaisson, A. Meyers, R. C. Sachdeva, H. Fernandez, P. Francisco, B. Diaz, A. Milena Diaz, and I. Santos-Guerrero, "Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." *Pediatrics*, December 2005, Vol. 116, No. 6, pp. 1433–41; Jacobson and Buchmueller 2007, op cit.; A. Aizer, "Public Health Insurance, Program Take-Up, And Child Health," *The Review of Economics and Statistics*, August 2007, Vol. 89, No. 3, pp 400–415.

49 Access to Benefits Coalition, op cit.

50 As noted elsewhere in the text, a state may extend presumptive eligibility to any child who appears income eligible, without regard to other elements of eligibility, including immigration status and citizenship.

51 An important unresolved question is whether, for some children, CHIPRA lets eligibility be determined based entirely on external data matches. If so, signed applications may be unnecessary, since CHIPRA provides that signatures are not required for elements of eligibility that are determined based on data rather than representations from applicants.

52 Parents are more likely to complete the full, traditional application process for health coverage when they know their children have significant health problems. One study examined children with special health care needs (CSHCN), defined as having a chronic physical, developmental, behavioral, or emotional condition that requires health and related services of a type or amount beyond that needed by children generally. Among CSHCN who qualified for Medicaid and CHIP, 80.6 percent enrolled in coverage, compared to 65.6 percent of healthier children. Amy J. Davidoff, Alshadye Yemane, and Ian Hill, "Public Insurance Eligibility and Enrollment for Special Health Care Needs Children," *Health Care Financing Review*, Fall 2004, 26(1): 119-135. Along similar lines, another study found that, among CHIP-eligible children, 98.2 percent of those whose parents reported them to have poor health were enrolled in coverage, compared to 45 to 46 percent among eligible children in better health. The study did not find a statistically significant relationship between health status and probability of enrollment for Medicaid-eligibility children. Lisa Dubay, Genevieve Kenney, and Jennifer Haley, "Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era," *New Federalism, National Survey of America's Families,* Series B, No. B-40, March 2002, Urban Institute. However, another study focused specifically on Medicaid

enrollment in 1994 and 1995 found that impaired health status increased eligible children's likelihood of receiving coverage. For example, 15.4 percent of eligible children enrolled in Medicaid had one or more chronic illnesses, compared to 10.7 percent of eligible children not enrolled. Amy J. Davidoff, A. Bowen Garrett, Diane M. Makuc, and Matthew Schirmer, "Medicaid-Eligible Children Who Don't Enroll: Health Status, Access to Care, and Implications for Medicaid Enrollment," *Inquiry*, Summer 2000, 37(2): 203-218.

53   J.R. Kennedy, "Enrollment, Marketing & Outreach for Coverage Expansions: The Louisiana Experience," *State Coverage Initiatives National Workshop*, New Orleans, LA, January 25, 2007.

54   For a fuller account of how Louisiana achieved these results, see T. Brooks, *The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and CHIP*, Georgetown University Center for Children and Families, Feb. 2009. In addition to the Brooks paper, the information in this section of the report comes from R. Kennedy, *Transforming the Medicaid Eligibility Process in Louisiana: How We Reduced Uninsured Kids by 19 Percentage Points in 9 Years, Louisiana Dept of Health & Hospitals*, December 19, 2007, available at http://www.dhh. louisiana.gov/offices/publications/pubs-119/San%20Jose%20Retention%20Presentaton%2012%2007%20Update%20[Compatibility%20 Mode].pdf.

55   S. Long, "On The Road To Universal Coverage: Impacts Of Reform In Massachusetts At One Year," *Health Affairs* Web Exclusive June 3, 2008.

56   The Long study, cited above, found that uninsurance in this group fell by more than two-thirds, suggesting that the state had originally underestimated the number of uninsured.

57   Dorn August 2007, op cit.

58   Dorn August 2007, op cit.

59   Government Accountability Office (GAO), *Medicare Part D Low-Income Subsidy: Progress Made in Approving Applications, but Ability to Identify Remaining Individuals is Limited*. May 8, 2007. GAO-07-858T.

60   J.L. Hudson and T.M. Selden, "Children's Eligibility And Coverage: Recent Trends And A Look Ahead," *Health Affairs*, Web Exclusive, August 16, 2007.

61   D.K. Remler and S.A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health*, January 2003, Vol. 93, No. 1, pp. 67-74. The take-up rate for Part B may decline now that Social Security enrollment has been delayed until age 66 for many people. This requires them to submit applications before enrolling in Medicare Part B at age 65. It also means that, for younger seniors, premiums will increasingly be paid by check, rather than withholding from Social Security checks.

62   A.D. Federman, et al. "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs,* January/February 2005, Vol. 24, No. 1, pp. 263-270.

63   Dorn August 2007, op cit.

64   L. Summer and C. Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*, June 2006, prepared by the Georgetown University Health Policy Institute for The Commonwealth Fund.

65   T. Brooks, *The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP*, Georgetown University Center for Children and Families, Feb. 2009; J. R. Kennedy, "Kid's Health Coverage in LA: Reaching the Finish Line," 2007 LaCHIP Conference, Baton Rouge, Louisiana, November 4, 2007, available at http://www.dhh.state.la.us/offices/publications/pubs-119/LaCHIP%20Outreach%20 Conference.pdf.

66   D. Laibson, "Impatience and Savings," *National Bureau of Economic Research Reporter*, Fall 2005, pp. 6-8.

67   Other examples include direct certification of eligibility in NSLP, through which receipt of Food Stamps, Temporary Assistance to Needy Families (TANF) and other benefits establishes automatic eligibility for free school lunches; adjunctive eligibility in WIC, through which receipt of Medicaid and other benefits automatically establishes eligibility for WIC; "categorical eligibility" for Food Stamps, through which receipt of SSI, TANF, General Assistance, or other state-specified benefits establishes automatic eligibility for Food Stamps; etc. See Dorn August 2007, op cit.

68   J. R. Kennedy, "LaCHIP Outreach, Enrollment, & Retention," paper prepared for the *Winter Medicaid Administrative Management Conference* (New Orleans, LA) January 17, 2007; P. Gleason, et al., *Direct Certification in the National School Lunch Program—Impacts on Program Access and Integrity*, prepared by Mathematica Policy Research, Inc., for the U.S. Department of Agriculture (USDA), 2003, Report E-FAN-03-009; N. Cole, Data Matching in the National School Lunch Program: 2005, "Volume 1: Final Report," prepared by Abt Associates, Inc., for *USDA, 2007, Report CN-06-DM; Food and Nutrition Service of the Minnesota Department of Children, Families and Learning, Free and Reduced Price Meal Eligibility Cost Study*, March 2002.

69   M. Ponza, P. Gleason, L. Hulsey, and Q. Moore, *NSLP/SBP Access, Participation, Eligibility, and Certification Study: Erroneous Payments in the NSLP and SB*, "Volume I: Findings, Final Report," prepared by Mathematica Policy Research, Inc., for USDA. October 2007. See also the discussion of WIC adjunctive eligibility and program integrity in Government Accountability Office, *Means-Tested Programs: Information on Program Access Can Be an Important Management Tool*, GAO-05-221, March 2005.

70   Such an effect was observed when NSLP shifted to 12 months of continuous eligibility, based on income at the time of application. Income variation throughout the year no longer created a risk that children would erroneously continue receiving benefits. Similar results followed when NSLP incorporated Direct Certification of eligibility, through which children are found eligible for NSLP based on their receipt of Food Stamps, TANF, or certain other benefits.

71   Federal law provides enhanced payment for Medicaid Management Information Systems (MMIS), furnishing 90 percent matching funds for information technology infrastructure development and paying 75 percent of operating costs. 24 U.S.C. Section 1396b(a)(3). However, under federal regulations that date from the 1970s, MMIS payments are generally not available for eligibility determination systems. 42 CFR 433.112(c) and 42 CFR 433.111(b)(3). CHIPRA creates an important exception, allowing MMIS-level payments for changes to state information systems

that permit implementation of the new option for documenting citizenship through data exchange with SSA. As noted in the body of the report, some of the development of information systems to accomplish that goal may also facilitate the state options described here. Further, under contemporary approaches to MMIS that include the development of Electronic Health Records, IT development that is needed to automatically incorporate information about the receipt of other public benefits into Medicaid EHRs may qualify for MMIS reimbursement. Dorn August 2007, op cit.

72   Perspectives may differ on whether this is an advantage or disadvantage.

73   Kennedy January 2007, op cit.

74   The workers in this study were all age 59½ or older. It cost such workers nothing to make contributions required to obtain matching contributions from their employers since, after age 59½, employee contributions can be withdrawn immediately without financial penalty. The money "left on the table" averaged 1.3 percent of annual income. J. Choi, D. Laibson, B.C. Madrian, *$100 Bills on the Sidewalk: Suboptimal Saving in 401(k) Plans*, National Bureau of Economic Research Working Paper 11554, August 2005.

75   Dorn Sept. 2007, op cit.

76   U.S. Department of Education, *2008–2009 Federal Student Aid Handbook*, downloaded on 2/20/2009 from http://www.ifap.ed.gov/fsahandbook/0809FSAIndexedHBook.html.

77   Tamar Lewin, "The Big Test Before College? The Financial Aid Form," *New York Times* February 21, 2009.

78   Lutz Berkner, Christina Chang Wei, Shirley He, Stephen Lew, Melissa Cominole, Peter Siegel, and James Griffith, *2003–04 National Postsecondary Student Aid Study (NPSAS:04)*, "Undergraduate Financial Aid Estimates for 2003–04 by Type of Institution," prepared for the U.S. Department of Education by MPR Associates, Inc., RTI International, and the National Center for Education Statistics, NCES 2005–163, June 2005.

79   C. Newman, "Income Volatility Complicates Food Assistance," *Amber Waves*, USDA Economic Research Service, September 2006, Volume 4, No. 4, pp. 16-21.

80   This legislation provides financial incentives for states to take the most recently completed quarter's earnings into account in granting eligibility for Unemployment Insurance. That is not possible unless states can rapidly access quarterly earnings data.

81   Dorn October 2008, op cit.

82   Internal Revenue Service (IRS), *Employer's Tax Guide for Use in 2008,* (Circular E), Publication 15, Department of the Treasury, 2008.

83   Janet Holzblatt, "The Challenges of Implementing Health Reform through the Tax System," in *Using Taxes to Reform Health Insurance*, eds. Henry J. Aaron and Leonard E. Burman (Brookings Institution Press: Washington, DC) 2008.

84   Cohen, et al., op cit.

85   As noted above, the latter approach is used only with taxpayers whose tax situation is simple and straightforward. Gale and Harris, op cit.

86   D. Cohen Ross, L. Cox, and C. Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*, Kaiser Commission on Medicaid and the Uninsured and the Center for Budget and Policy Priorities, January 2007.

87   20 C.F.R. 422.107(e)(1).

88   *POMS Manual,* Sections RM 00203.410, "Evidence of Alien Status for an SSN Card for an Alien Lawfully Admitted for Permanent Residence;" RM 00202.230, "Form SS-5 - Evidence Blocks (PBC, EVI, EVA, EVC, and PRA);" RM 00203.600, "List of Documents Establishing Lawful Alien Status for an SSN Card." Almost all immigrants who, according to SSA's database, are "Permanent Resident Aliens," or PRAs, are qualified aliens under Medicaid and CHIP. The only exception involves citizens of countries with which the United States has entered into a Compact of Free Association (CFA) – namely, the Marshall Islands, Micronesia, and Palau. Under the CFA, citizens of these nations have a right to work in the U.S., but they are not qualified aliens for purposes of Medicaid and CHIP. Collectively, these nations have fewer than 200,000 citizens of all ages, including both those who live in the United States and who remain in their countries of origin. Gwen N. Ouye-Nakama, *Impacts of the Compact of Free Association on Hawaii's Health Care*, Hawaii Institute for Public Affairs, the Hawaii Uninsured Project, Policy Brief No. 04-02, July 2004. Aside from this tiny group, SSA and Medicaid use the identical documents to verify status as a PRA and a qualified alien, respectively. Compare State Medicaid Manual Section 3212.4 A with the above-cited POMS Manual Sections. Overall, SSA is more restrictive in that it denies PRA status to immigration parolees and to Cuban/Haitian entrants, groups that fit within the Medicaid and CHIP definition of "qualified alien."

89   A legal permanent resident is a "qualified alien" eligible for Medicaid and CHIP. 8 U.S.C. 1641(b)(1). Beth Morrow of The Children's Partnership suggested this general application of ELE.

90   Social Security Administration, Office of Systems, Office of Earnings, Enumeration, and Administrative Systems, Division of Technology Services and Exchanges, Data Exchange Branch, *The State Verification and Exchange System (SVES) and State Online Query (SOLQ) Manual*, Revised March 2005.

91   Social Security Act Section 1137(d)(2)(B) [42 U.S.C. 1320b–7(d)(2)(B)].