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Using Information from Income Tax Forms to Target Medicaid and CHIP Outreach: Preliminary Results of the Maryland Kids First Act

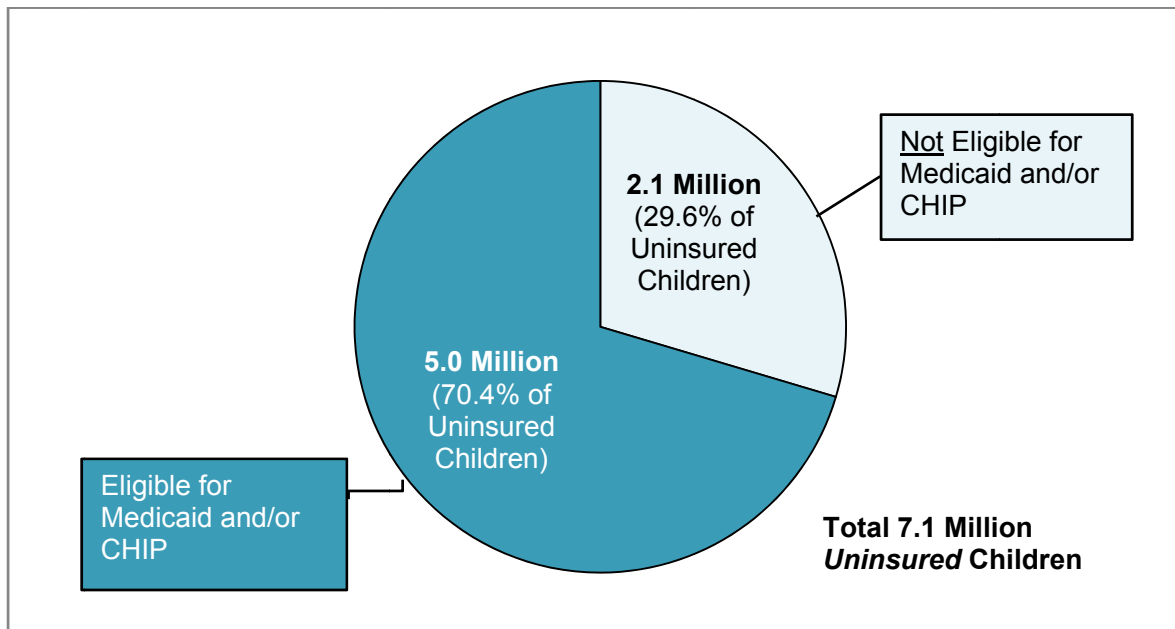
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INTRODUCTION

Despite rigorous outreach efforts by states, 5 million children who are eligible for Medicaid or the Children’s Health Insurance Program (CHIP) remain uninsured (Figure 1). This represents roughly 70% of all uninsured children in the U.S.ⁱ The passage of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) underscores the importance of enrolling uninsured eligible children, as the 2008 legislation includes financial incentives for states to maximize enrollment in these programs. Specifically, future CHIP

funding allocations from the federal government will be based on a state’s net enrollment change relative to current CHIP enrollment. Increased CHIP enrollment will bring about a larger allocation; lower enrollment will mean a reduced allocation. In addition, increased Medicaid enrollment can help states qualify for performance bonuses.ⁱⁱ Despite these incentives to boost enrollment, there are concerns that states may have maximized the potential for enrollment through traditional outreach methods, irrespective of spending on these activities.ⁱⁱⁱ

Figure 1: All Uninsured U.S. Children by Medicaid/CHIP Eligibility*



Source: Dubay, L., Cook, A., and Garret, B. How Will Uninsured Children Be Affected by Health Reform? Urban Institute, August 2009. Retrieved from http://www.urban.org/uploadedpdf/411950_uninsured_children.pdf.

*These numbers exclude unauthorized immigrant children.

Facing limited outreach funding and having exhausted conventional outreach methods, states are searching for new, more efficient ways to identify and enroll uninsured children who are eligible for Medicaid/CHIP. Several pioneer states—Iowa, New Jersey, and Maryland—have begun to use adjusted gross income (AGI) and other data from tax forms as an innovative way to build upon more traditional outreach efforts. All three of these states enacted legislation in 2008 asking parents to identify uninsured children on state income tax forms and required Medicaid and CHIP outreach accordingly.^{iv} The extent to which these states succeed in linking tax information to increase participation of eligible children in public health insurance programs will determine whether—and how—other states seeking to enroll more uninsured children should adopt this practice in either its original or modified form. This issue brief highlights Maryland’s early efforts to use income tax returns to identify potentially eligible—but unenrolled—children. It examines the benefits and drawbacks of this strategy as well as mechanisms for maximizing its effectiveness.

USING TAX INFORMATION TO IDENTIFY ELIGIBLE CHILDREN

Because Maryland provides a state Earned Income Tax Credit (EITC) that supplements the federal EITC, numerous low-income Maryland households that are not legally obligated to do so choose to file state income tax returns. In 2006, more than 250,000 Maryland households with incomes below \$40,000 filed returns claiming the state EITC, representing 19.1% of all returns filed in Maryland that year.^v Nationally, low-income families with children receive the EITC more than any other means-tested benefit.^{vi} Linking Medicaid/CHIP outreach to EITC may prove to be an inexpensive and efficient method of identifying and reaching most low-income families with children who are eligible but unenrolled.

National research has shown that 89.4% of uninsured children who qualify for Medicaid or CHIP live in households that file federal income tax returns.^{vii} The high rate of tax filers could be partly attributed to the national EITC. However, even in states without an EITC to supplement the federal credit, a very large proportion of uninsured children who qualify for Medicaid or CHIP may have parents who are legally required to file state income tax returns. The above-described national research has also shown that 79.4% of eligible, uninsured children lived in families who are legally

required to file a federal income tax return; if a state’s legal filing thresholds resemble federal standards, state income tax returns could be a useful strategy for identifying uninsured children, even in places without a state EITC.

It should be duly noted that the use of annual income tax information may fail to capture monthly or seasonal income fluctuation. Also, the income reported on state income tax forms may not properly identify the financial status of some individuals. For example, children of self-employed individuals whose tax deductions and disregards suggest that they might be low-income may not be eligible according to Medicaid/CHIP income rules.

MARYLAND’S KIDS FIRST ACT

Governor Martin O’Malley signed the Maryland Kids First Act in May 2008, following legislative approval earlier in the year.^{viii} The Act directed the Maryland Department of Health and Mental Hygiene (DHMH) to use the state’s personal income tax system to target outreach efforts to children who might be eligible for Medicaid or CHIP (in Maryland, the latter program is known as the Maryland Children’s Health Program, or MCHP).

Maryland’s Kids First legislation was implemented in two phases: the first using information from tax year 2007, and the second using information from tax year 2008. Phase I required the Comptroller to send a notice to any taxpayer with a dependent child if the taxpayer’s 2007 reported income did not exceed the highest income eligibility standard for Medicaid/CHIP (300% of the federal poverty level [FPL]). The notice was to be developed by DHMH and would indicate that the taxpayer’s dependent(s) might be eligible for these programs. The notices also included information on how to enroll. However, no information on health care coverage status of dependents was collected from the 2007 tax return.

In Phase II, the 2008 Maryland income tax forms 502 and 503 (filed in 2009) were modified to ask taxpayers to report the health care (*coverage*^{ix}) status for each dependent child. The Comptroller was then required to send Medicaid/CHIP applications and enrollment instructions to families who presumably met income eligibility standards and who indicated that one or more of their children was uninsured. Taxpayers would not be penalized if they chose not to report dependent health insurance status.

PRELIMINARY EFFORTS

Although DHMH developed the notice to families who were within the state’s income eligibility guidelines for Medicaid and CHIP based on tax year 2007 state income returns, the notice was mailed by the Comptroller’s office due to data privacy regulations that prohibited DHMH from accessing the non-aggregate income tax data maintained by the Comptroller. Approximately 450,000 families received the eligibility letter—180,000 families under 116% of the FPL and the rest between 116 and 300% of the FPL.^x The mailings were staggered to avoid overwhelming the eligibility system’s capacity to process applications.

In 2008, the Comptroller’s office added a question pertaining to health care coverage for dependent children. Due to space limitation on the tax form, the statutory reference to the “presence or absence of health care coverage” was converted to this question: “If Dependent Child is checked, does child have *health care?*” (Figure 2). This modification of the tax form allowed a more targeted outreach than that which was based on tax year 2007 returns. The Comptroller will be responsible for sending a Medicaid/CHIP application and enrollment instructions to income-eligible taxpayers who indicate the presence of uninsured dependent children and, once again, will handle this mailing due to data privacy regulations.

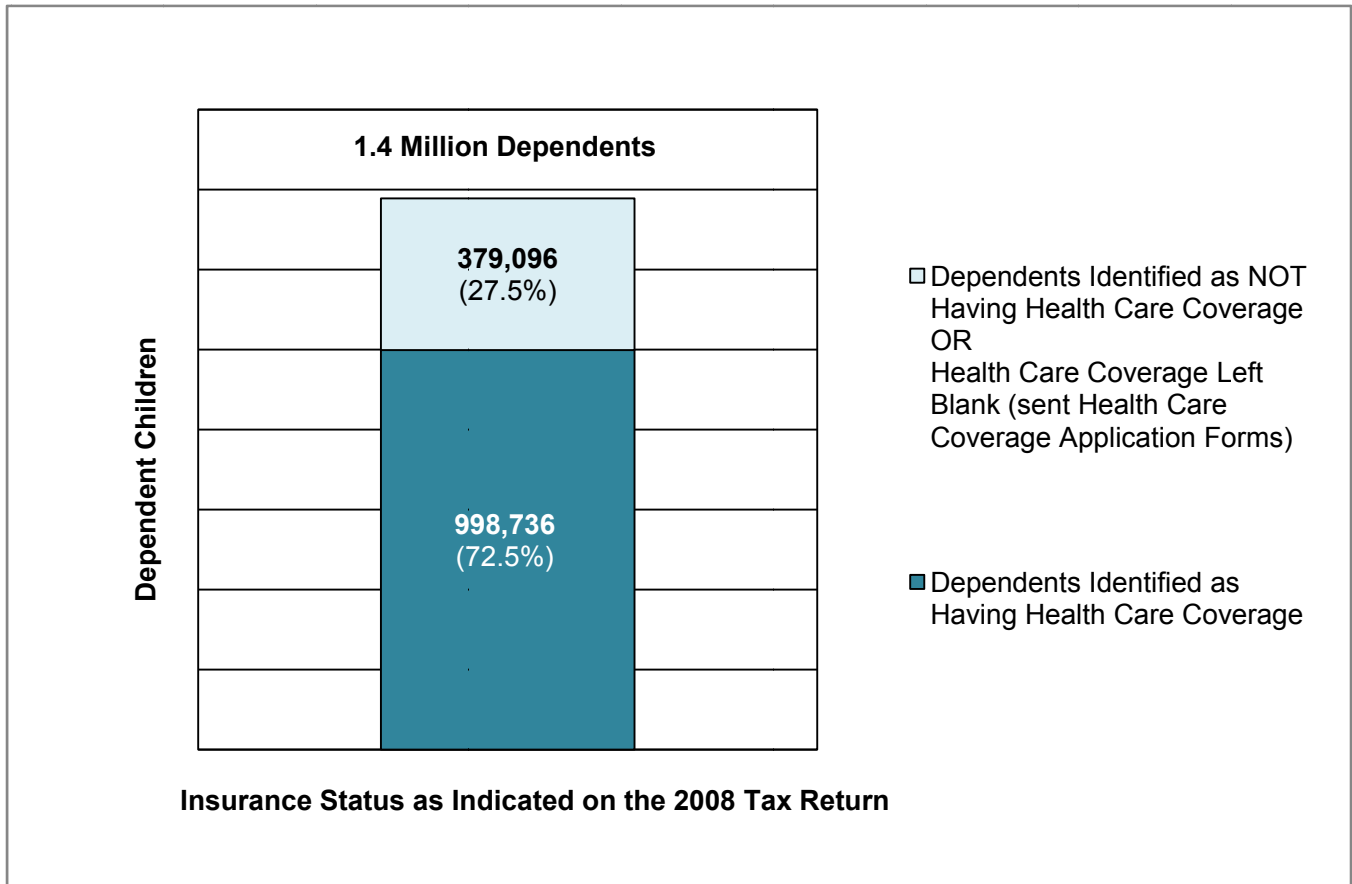
Figure 2: Dependent Health Care – Maryland Individual Income Tax Forms 502/503

(1) First Name Last Name		(C) Dependents:		(4) Check if Dep. ▶ Child	(5) If Dependent Child is checked, does child have health care?		(6) Regular	(7) 65 or Over
		(2) Social Security number	(3) Relationship		▶ Yes	▶ No		
		▶						
		▶						
		▶						
		▶						
		▶						

Using preliminary statistics derived from the 2008 tax returns (as of September 1, 2009), the Comptroller’s office concluded that 998,736 dependent children were identified on returns as having health care coverage; tax returns identified 379,096 dependent children (representing 234,303 households) as either *not* having health care coverage OR being members of households

where the tax filer left the question blank. For the purpose of determining whether to send a mailing, the Comptroller classified the latter group as not having health care coverage (Figure 3). The inclusion in the mailing list of households that left the question on health care coverage blank could mean that many households with insured children are captured on the list.

Figure 3: Maryland Dependent Insurance Status as Indicated on the 2008 Tax Form



DATA-SHARING ISSUES

Maryland, like most states, has a statute that prohibits the sharing of tax data due to privacy concerns. The Kids First Act did not specifically override the earlier statute because law makers envisioned the Comptroller as the appropriate authority to implement the statewide outreach effort (as they previously had done for Howard County, Maryland).^{xi}

Data-sharing provides two advantages not foreseen by law makers. First, it may increase the efficiency and reduce the cost of the mailings by allowing the Medicaid/CHIP agency to identify children already enrolled in the programs. This is an important step to take because there is no empirical research on how parents interpret a question about health care on a tax return. Parents may report their Medicaid-enrolled child as “not having *health care*” if they want to ensure access to this benefit. They may also misread the question to

refer to medical services, not health care coverage; or interpret the question to refer only to private health insurance. Furthermore, there is no indication of the timeframe to which parents are responding. They could be reporting the health care coverage status of their child in the 2008 calendar year and not the status at the time of filing. Importantly, since there is a lag time between the filing and the outreach mailing, some uninsured children may have obtained insurance since the filing. Additionally, the inclusion in the mailing list of households that left the question on health care blank could mean that many households with insured children receive a mailing.

The second advantage of data-sharing is that it provides a means for the state to better evaluate the impact of the outreach initiative. By sharing identifiers of the dependent children and households that were included in the mailing, those targeted by the outreach could be tracked in Medicaid/CHIP applications and enrollment

files. A tracking mechanism would assist in measuring the success of the outreach initiative. The state would be able to quantify how many children receiving the mailing apply for coverage, are determined eligible, and then enroll in a public insurance program. Measuring all of these outcomes would help policy makers determine whether continued investment in the outreach is warranted, and assist in projecting the cost to state insurance programs.

Because of these data-sharing complications, the Comptroller's Office plays a pivotal role in implementing the Kids First Act, and its willingness to collaborate was crucial in getting the Act passed.

KIDS FIRST AND FEDERAL ACTION

CHIPRA aims to encourage CHIP and Medicaid enrollment by providing financial incentives for states to increase enrollment numbers. However, CHIPRA also aims to facilitate the enrollment process itself by permitting federal privacy laws and data-sharing across federal means-tested programs, such as free or reduced school lunch, food stamps, and Women, Infants, and Children (WIC). In addition, the new option for "Express Lane Eligibility" permits states to deem the financial eligibility determinations from these programs or from state tax forms as acceptable to Medicaid and CHIP, regardless of technical differences between program financial eligibility rules. This does not, however, eliminate the need to verify other components of Medicaid eligibility such as immigration and citizenship status. In addition, CHIPRA does not eliminate the need for state health programs and state tax collectors to address data privacy issues that emanate from state law. These must be resolved before state health and tax agencies can share income tax records or Medicaid enrollment information for purposes of outreach targeting. Non-legislative options may include the agencies' execution of a data-sharing agreement.

Either through state legislation or administration action, state income tax forms could go beyond asking parents to identify their uninsured children and give parents an opportunity to request disclosure of their tax data to the state's health agency for purposes of a health insurance eligibility determination for their uninsured children. Indeed, CHIPRA expressly authorizes state agencies with data relevant to Medicaid and CHIP eligibility to share these data with state Medicaid and CHIP programs, so long as various procedural requirements are observed. These include an opportunity for parents to consent or

opt-out actively before the data are shared.^{xii} Whether these steps are legally sufficient at the state level depends on state-by-state legal interpretation of state law. Maryland's experience with the Kids First Act speaks to the importance of collaboration between state revenue and health agencies if either option is to be feasible. Even if parents are given the option to permit inter-agency data sharing, the tax agency must modify the tax forms to include the appropriate language, which—as indicated by Maryland's experience—may be done best with input from the state health agency.

To bypass the need for agencies to coordinate incongruent regulations and procedures at the state level, CHIPRA could be changed at the federal level to allow states to determine Medicaid/CHIP eligibility based on federal tax records. In this case, state-level data privacy issues would be avoided and all states would have access to a universal, readily-available, and well-populated data source. For now, however, tax-based Medicaid/CHIP outreach relies on state-level tax data, which requires establishing formal inter-agency and data sharing agreements as well as building trusting, cooperative relationships between staff at tax and health agencies.

LESSONS LEARNED

The Kids First Act is an example of what a state can do to identify and enroll uninsured, eligible children in a Medicaid/CHIP program. Maryland's experience with the Kids First Act outreach initiative can be used as a guide for other states seeking to develop their own outreach strategies for this population. Key lessons learned to date include:

- (1) Involve the major stakeholders in the development phase of the initiative. Early stakeholder participation is critical to the initiative's success. It may be useful to address issues such as inter-agency collaboration and changes to the tax form during this phase.
- (2) Determine whether data can be shared across state agencies. Legislative action, if practicable, may be useful for eliminating data-sharing barriers. Data-sharing will lessen the chances of unnecessary mailings to people already enrolled in a program, thereby alleviating enrollment confusion and reducing the overall cost of the outreach initiative.

- (3) Ensure that the design of the health care coverage question is informed by current relevant research literature. Consulting health literacy experts and seeking public input on the wording of notices/letters or the health care coverage question on the tax form helps ensure that the target population clearly understands the information provided. For example, the statutory reference to the “presence or absence of health care coverage” was converted into this question: “If Dependent Child is checked, does child have *health care*?” By deleting the word “coverage” due to lack of adequate space on the tax form, the intent of the question became ambiguous; a taxpayer could understand “health care” to mean either health insurance coverage or direct access to medical services. Because of this ambiguity, the extent to which the question accurately measures what it is supposed to measure is unclear. Additionally, the age of the child was not specified, which could also affect the accuracy of the responses.
- (4) Consider not including households that left the health care coverage question blank, as the inclusion of this population could mean that many households with insured children receive a mailing.
- (5) Indicate the time period of interest on the health care coverage question. Preferably, the question should inquire about the health care coverage status of the dependent child at the time of filing. Since there is a lag time between the income tax filing and the outreach mailing, some uninsured children may have obtained insurance since the filing.
- (6) Mail the letters/notices in small batches to ensure that the eligibility system’s capacity to process applications is not overwhelmed.
- (7) Design a mechanism to track Medicaid/CHIP applications and inquiries that result from the mailing. A tracking mechanism is essential for accurate measurement of the outreach strategy’s effectiveness.
- (8) Because the adjusted gross income reported on the state tax form may not properly identify the financial status of some individuals (for example, self-employed taxpayers), states should consider expanding the self-employment section on the tax form so that applicable deductions and disregard rules can be considered in the initial review of whether an individual meets the program’s income eligibility standards.
- (9) It should also be noted that annual income reported on income tax forms may fail to capture monthly or seasonal income fluctuation that may affect eligibility for public insurance programs.
- (10) Finally, bear in mind that not all initiatives of this type require legislation. However, legislation may be necessary if states want to modify the state tax form, use state-appropriated funds for the initiative, or require the Comptroller to send out information packets containing Medicaid/CHIP applications.

The outcome of Maryland’s Kids First Act is highly relevant to the exploration of innovative Medicaid and CHIP outreach methods: Success of this outreach initiative would provide evidence that tax-based outreach is an effective method of reaching uninsured but eligible children, and worth pursuing further.

NOTES

ⁱ Dubai, L., Cook, A., & Garret, B. (2009, August). How Will Uninsured Children Be Affected by Health Reform? Urban Institute. Retrieved from http://www.urban.org/uploadedpdf/411950_uninsured_children.pdf

ⁱⁱ Dorn, S. Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP. A Catalog of State Policy Options. Retrieved from http://www.urban.org/uploadedPDF/411879_eligible_children.pdf

ⁱⁱⁱ Dorn, S. (2007, September). Eligible but Not Enrolled: How SCHIP Reauthorization Can Help. Urban Institute. Retrieved from www.urban.org/UploadedPDF/411549_schip_reauthorization.pdf

^{iv} National Conference of State Legislatures. (2009). Children's Health Reform: A Snapshot of State Action. Retrieved from <http://www.NCSL.org/IssuesResearch/Health/CHildrensHealthReformLaws/tabid/14477/default.aspx>

^v Maryland State Comptroller, Revenue Administration Division, Income Tax Summary Report: Tax Year 2006. Retrieved from <http://www.marylandtaxes.com/finances/revenue/reports/incometaxsummary/summary06.pdf>

^{vi} Zedlewski, S., Adams, G., Dubai, L., & Kenney, G. (2006, February). Is There a System Supporting Low-Income Working Families? Urban Institute; Leonard E. Burman & Deborah I. Kobes. (2003, March 17). "EITC Reaches More Eligible Families Than TANF, Food Stamps," Tax Notes. Urban Institute and Brookings Institute Tax Policy Center.

^{vii} Dorn, S., Garrett, B., Perry, C., Clemans-Cope, L., & Lucas, A. (2009, February). Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and CHIP, prepared by the Urban Institute for First Focus.

^{viii} Maryland 2008 House Bill 1391. Retrieved from <http://mlis.state.md.us/2008rs/billfile/hb1391.htm>

^{ix} The Comptroller rewrote the statutory language (questioning the "presence or absence of health care coverage") as follows: "If Dependent Child is checked, does child have health care?" Deletion of the word "coverage" (which the Comptroller regarded as necessary to accommodate space limitations) made the question ambiguous. A taxpayer might understand "health care" to mean either "health insurance coverage" OR "access to medical care" (i.e., direct medical services). Because of this ambiguity, the extent to which the question accurately measures what it is intended to measure is unclear.

^x<http://www.dhmf.state.md.us/mma/docs/MMACMIN08JUN.doc>

^{xi} The Comptroller had prior experience with a similar outreach initiative for the Healthy Howard Health Plan, a community-supported health plan for uninsured residents of Howard County.

^{xii} Dorn, S. <http://www.maxenroll.org/resource/new-chipra-opportunity-express-lane-eligibility>. See CHIPRA Section 203(d), which requires (a) either advance consent to disclosure or a failure to opt-out of disclosure after receiving a notice and a reasonable opportunity to object; (b) using the disclosed data solely (1) to identify eligible or potentially individuals and to enroll or attempt to enroll them into coverage and (2) to verify eligibility for Medicaid and CHIP; and (c) an interagency agreement meets privacy/data security requirements and commits to Medicaid or CHIP agency to use the disclosed data to attempt to enroll eligible individuals into health coverage.

ABOUT THE SHARE INITIATIVE

SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

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

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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