share
State Health Access Reform Evaluation
Robert Wood Johnson Foundation
shadac
State Health Access Data Assistance Center

August 2010

Reaching Uninsured Children: Iowa's Income Tax Return and CHIP Project

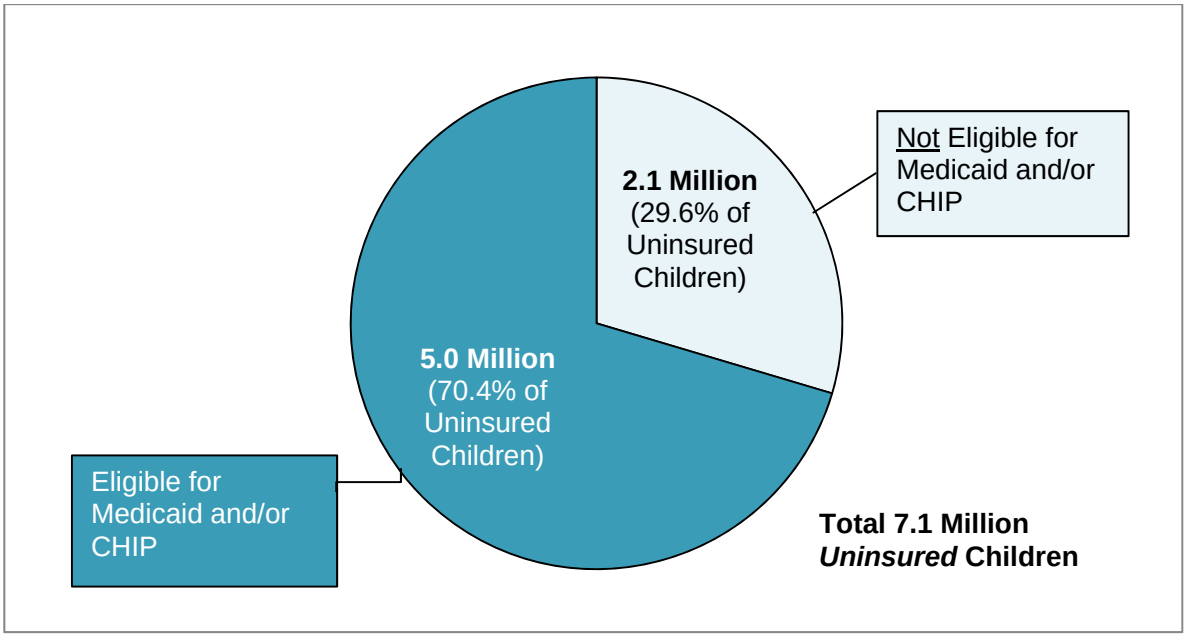
— *Brenda Freshour-Johnston*

Iowa Department of Human Services

INTRODUCTION

Despite rigorous outreach efforts by states, five million children who are eligible for Medicaid or the Children's Health Insurance Program (CHIP) remain uninsured (Figure 1). This represents roughly 70 percent of all uninsured children in the U.S. (Dubay, Cook, & Garret, 2009) 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. Despite these incentives to boost enrollment, there is concern that states may have maximized the potential for enrollment through traditional outreach methods, irrespective of spending on these activities (Dorn, 2009a).

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.

BACKGROUND: HEALTH REFORM IN IOWA

In 2008 the Iowa General Assembly passed House File 2539 ("HF 2539"), the state's comprehensive health reform legislation. HF 2539 establishes the use of several innovative strategies to reduce the number of uninsured in the state. One such strategy involves the collaboration of the Iowa Department of Revenue (IDR) and the Department of Human Services (DHS). HF 2539 requires these agencies to work together to facilitate enrollment in Iowa's CHIP ("***hawk-i***") and Medicaid programs through the collection of tax information. The following responsibilities are components of this mandate:

- state tax forms must be modified to include a question about health care coverage for dependents;
- the definition of "health care coverage" must be determined;
- ***hawk-i*** information must be sent to residents who are determined to be potentially eligible based on tax data; and
- IDR and DHS must report annually to the Governor and the General Assembly.

IMPLEMENTATION

A Memorandum of Agreement outlining responsibilities for the ***hawk-i*** outreach project was created by DHS and IDR. According to the terms of the memorandum, DHS was responsible for: determining the definition of health care coverage; creating mechanisms to track which ***hawk-i*** and Medicaid enrollments occurred through the HF 2539 initiative; collaborating with IDR to create new materials for distribution to potential enrollees; and paying for 40 percent of the postage costs. DHS was also responsible for assisting IDR with a legislative report for submission to the governor and general assembly.

IDR's responsibilities included adapting the tax forms to facilitate the initiative by adding the health care coverage question and writing instructions for completion of the new question. IDR was charged with determining which families met the income requirements and sending those families the application materials for ***hawk-i***. IDR was also responsible for providing DHS with the number of brochures sent out by zip code, school district or county. DHS wanted to know approximate locations where brochures were being sent in order to better identify pockets of uninsured people and more effectively target outreach to counties with higher uninsurance rates and other areas where interventions would be most effective. DHS is still acquiring this data for 2008 but has high expectations for its applicability in the future.

TAX FORM CHANGES

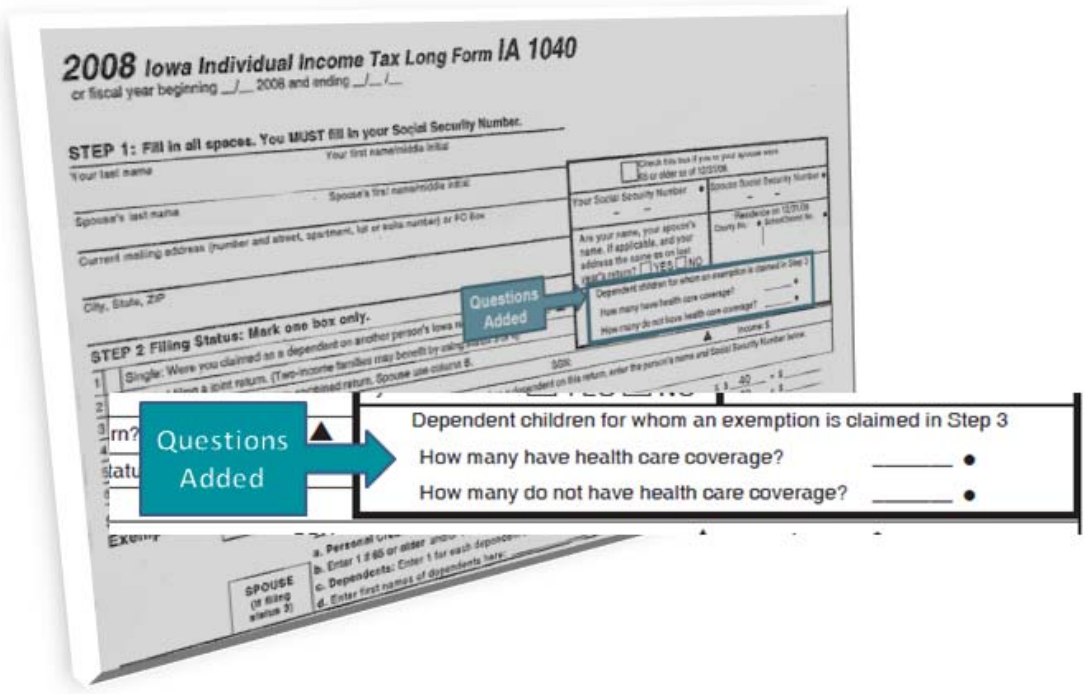
HF 2539 included language that changed the reporting of family-level information to the reporting of child-specific information. The legislation required that IDR collect information on each dependent child, with the capability of assessing individual-level health care coverage status, instead of simply asking if a taxpayer had dependents. In the past, Iowa had collected virtually no information on individual children and had relied on federal rolls to cross-check and verify dependents. Data matches with federal rolls were possible for the tax form initiative but would have created a six-to ten-month delay, significantly postponing the mailing of brochures. Altering the question on the tax form was determined to be preferable to waiting for federal data-matching, as it was hoped that a faster turnaround time for mailing brochures would help achieve higher mail return rates.

The design of the health care coverage question to be added to the Iowa tax form was influenced by the need to identify dependents. The result was a two-part question about the dependent children for whom an exemption was being claimed (Figure 2). Of these children, the question asked,

1. *How many have health care coverage?*
2. *How many do not have health care coverage?*

By using a question that asked for the number of dependents with AND without coverage, IDR could identify the exact number of children to whom the answer applied and also which respondents chose not to answer. The goal of this specificity was to facilitate more accurate outreach to children who were ***hawk-i*** eligible but not enrolled.

Figure 2: Iowa Individual Income Tax Long Form – Addition of Dependent Question for 2008



CHALLENGES: INTER-AGENCY COLLABORATION

Because responsibility for implementing the requirements of HF 2539 ultimately fell to IDR, this agency retained final authority over the implementation and was granted the "last word" in decision-making processes, with DHS acting in an advisory capacity. This, however, posed several implementation challenges. One such challenge occurred when the definition of health care coverage (which DHS obtained from the U.S. Census and which stated that coverage could be private—i.e., non-government—or publicly-sponsored) was omitted from the 2008 tax form. This created the possibility that respondents would fail to identify public coverage as insurance, thus incorrectly indicating that their dependents were uninsured. To resolve this issue, IDR and DHS agreed to specifically indicate on the 2009 tax form that ***hawk-i*** and Medicaid are considered health care coverage.

The calculation of income presented another significant hurdle in correctly identifying potentially eligible ***hawk-i*** and Medicaid enrollees, since DHS and IDR each calculate income differently. In 2008, DHS used a 20 percent earned income disregard for ***hawk-i*** while also counting some income that IDR did not include. Additionally, the various ways in which families can file taxes (i.e., single, married, or married-filing-as-single) complicated the identification of eligible households. These variations made it difficult to determine household size and to identify dependents in the household who were listed on another household's tax form (such as the household of an ex-spousal parent). Together, IDR and DHS tried to include as many households as possible, taking into consideration many different family situations. Ultimately, to account for discrepancies in household size and income, an application brochure was sent to any household stating that at least one dependent child lacked health care coverage and falling within the ***hawk-i*** income guidelines for a family of eight.

Another implementation issue arose from the mismatch between the definition of dependent children used by IDR and DHS's eligibility criteria for ***hawk-i***. That is, IDR includes college-aged children as dependents, but a child must be under the age of 19 to qualify for ***hawk-i***. DHS wanted to add a note about this discrepancy on the tax form; however,

IDR did not want to confuse tax payers by defining dependent children differently on different areas of the form out of concern that this would lead people to file incorrectly.

RESULTS

Most families responded to the health care coverage question that was added to Iowa's tax forms: 62.7 percent of families reported the presence of health care coverage, and 13.7 percent reported the absence of coverage. In all, 25.3 percent of families did not report health care coverage one way or the other. A total of 57,450 ***hawk-i*** brochures were sent as a result of Iowa's tax form change (IDR, 2009).

As stipulated by HF 2539, DHS needed to be able to clearly identify which applications had been sent by IDR, and DHS hoped to computerize a tracking method. Ultimately, however, the first 29,000 brochures had to be hand-marked by DHS staff, while the remaining brochures were printed with a "how you heard about us" section requiring the applicant to indicate the manner in which they had been informed of the program (e.g., tax return). The first solution was labor-intensive, and the second was subject to the possibility of recall bias and the possibility that respondents might not answer the question at all.

Of the 57,450 ***hawk-i*** brochures sent as a part of the 2008 tax initiative, 475 were returned (IDR, 2009). DHS did err on the side of over-inclusion, and they estimate that 20 percent of the mailings went to people who didn't qualify. Given this assumption, the response rate among qualifying households was approximately one percent, with the response rate for the hand-marked brochures almost double the response rate for the brochures asking respondents to name a referral source. This discrepancy indicates that for the latter group of brochures many people either chose not to respond or did not identify the correct referral mechanism. The online ***hawk-i*** application—which accounts for approximately 32 percent of all applications—further complicated tracking efforts since the "How you heard about us" inquiry is not a required field.

Of the 475 ***hawk-i*** applications returned as a result of the tax form change, DHS approved 140 and referred 191 to Medicaid.[1] The remaining 143 applications were denied for the following reasons:

- Insufficient information to determine eligibility (30%)
- Income beyond eligibility limits (20%)
- Prior noncompliance with Medicaid (i.e., failure to provide verification paperwork as requested) (33%)
- Applicant outside age guidelines (5%)
- Applicant covered by other health insurance (4%)
- Respondent did not reside with applicant child (3%)
- Applicant did not meet Iowa residency requirement (1.5%)
- Immigration status not verified or invalid (5%)

In all, 471 previously uninsured children obtained health coverage as a result of Iowa's 2008 tax outreach: 239 of these were approved for the ***hawk-i*** program and 232 were approved for Medicaid coverage.[2] Material costs for the project came to $0.68 for each household that received a brochure in 2008 (including envelope, brochure, postage and handling), which translates to $83.16 per enrollee (IDR, 2009).

[1] One application was still pending action by DHS at the time of IDR's 2009 report to the Iowa Governor and General Assembly.
[2] More than one child can apply for coverage on the same application, which accounts for the discrepancy between the number of applications and the number of insured children (140 and 239, respectively, for ***hawk-i***, and 191 and 232, respectively, for Medicaid).

LESSONS LEARNED FROM IOWA'S TAX-BASED OUTREACH

1. **Establish an inter-agency data-sharing agreement if possible.**

   For 2008, IDR was responsible for all mailings. Since DHS simply provided application materials and did not deal with mailing and personal addresses, the two agencies did not enter into a data-sharing agreement during the first year.

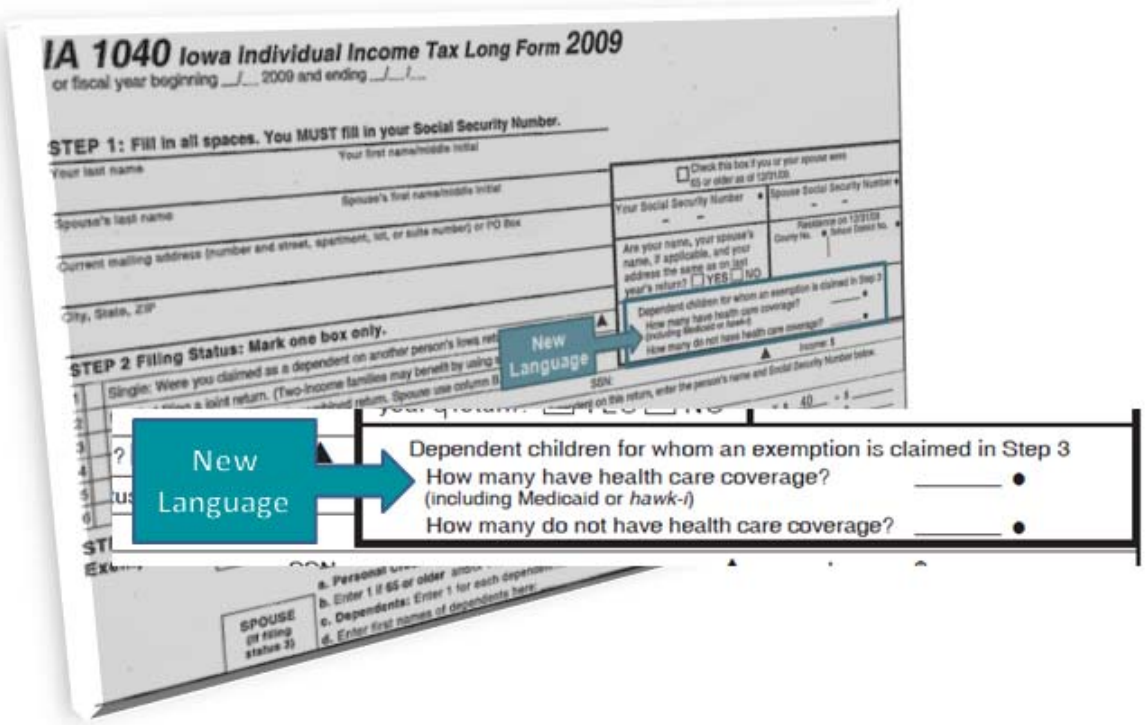
   Data-sharing would offer several advantages: Information matching ***hawk-i*** and Medicaid enrollees back to the tax form initiative would eliminate the need for a separate tracking mechanism. Additionally, data-sharing between DHS and IDR could facilitate enrollment procedures by removing the burden of income verification from the applicant. Easier income verification procedures would also likely reduce churning (Dorn, 2009b). Finally, data-sharing could facilitate targeted outreach by allowing DHS to more accurately identify areas of the state with higher rates of children lacking health care coverage.

   For 2009, DHS is beginning to collect social security numbers, with which they could perhaps conduct a data match with IDR in the future. DHS also asked IDR for additional changes to the tax form to collect more information on dependents—for example, adding a separate page. However, IDR worried that people either would not provide the information or would be charged by tax preparers for completion of a separate form. As the targeted group for the dependent coverage question is low-income families, this posed a significant concern.

2. **Ensure that the wording of health insurance questions on the tax form is as clear as possible.**

   If the question is not clear and over-inclusion is the default, this could result in unnecessary expenditures on materials and postage to households that are ineligible. In 2009, Iowa's dependent coverage question was changed to clarify that ***hawk-i*** and Medicaid are considered coverage (See Figure 3).

Figure 3: Iowa Individual Income Tax Long Form – Change to Dependent Question for 2009



3. **To make outreach as targeted as possible, consider criteria for automatic exclusion.**

   For example, exclude individuals who live out of state but owe taxes to your state. Individuals who do not reside in your state likely do not qualify for public program coverage.

4. **Notify professional tax preparers of changes to the tax form.**

   This includes both the vendors of electronic tax preparation programs (TurboTax, TaxSlayer, etc.) and conventional tax preparers.

   Vendors of electronic programs need advance notification of any changes in order to be able to test their systems before the tax year begins. In 2008, 37.6 percent of electronic filers with dependents did not respond to the health care coverage questions. In an attempt to improve this response rate, the electronic vendors were made aware of Iowa's 2009 changes by August 2008 so they could prepare their software for the upcoming tax year.

   Conventional tax preparers need to be trained about how to treat tax form modifications. In 2008, 28.8 percent of people who had their taxes prepared by firms with over 100 clients did not respond to the health coverage question. As a result, for the 2009 tax year IDR did training with tax preparers to help them understand the purpose of the question and to get them on board with the process.

5. **Consider administrative complexities ahead of time in order to minimize the administrative and cost burden where possible.**

   Addressing administrative issues on the back end can place a strain on staff resources. The development of a computerized tracking mechanism, for example, would be more efficient than relying on a manual one (i.e., hand-marking). Additionally, consider sending a postcard with contact information with the ***hawk-i*** phone number and website instead of mailing an entire application. Iowa plans to use this second approach for the 2010 tax year.

6. **Track your results as precisely as possible and automate the tracking mechanism.**

   Iowa has seen enrollment increases in its CHIP and Medicaid programs—as have numerous other states—but outside factors such as the economy, media campaigns, and new web platforms are influencing this trend. Without a tracking mechanism in place, it is difficult to identify the impact of tax-based outreach separate from the impact of other influencing factors. It is important that this mechanism cover all application methods, including web-based applications (i.e., make "How did you hear about us?" a required field). Additionally, automating the tracking mechanism where possible eliminates the problem of potential recall and non-response bias.

REFERENCES

Dorn, S. (2009a). "Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP. A Catalog of State Policy Options." Urban Institute. Retrieved from www.urban.org/UploadedPDF/411549_schip_reauthorization.pdf

Dorn, S. (2009b). "The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage. State Health Access Reform Evaluation." Retrieved from http://www.rwjf.org/files/research/51368fullreport.pdf

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

Iowa Department of Revenue (IDR) (2009). "Dependent Health Care Coverage in Iowa: Tracking Coverage through Tax Year 2008 Returns." Report to the Governor and General Assembly. Prepared by Amy Rehder Harris, Tax Research and Program Analysis Section.

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.

State Health Access Data Assistance Center
2221 University Avenue, Suite 345
Minneapolis, MN 55414
Phone (612) 624-4802