

Improving Public Coverage for Children: Lessons from CKF in New Jersey

EXECUTIVE SUMMARY

Health insurance coverage in New Jersey is threatened seemingly on all sides: private insurance coverage is eroding; the number of uninsured individuals is growing; and state budget pressure, combined with federal policy pressure, could lead to public insurance coverage cutbacks. Thus, the need for advocates for health insurance coverage is greater than ever. An historical review of the Robert Wood Johnson Foundation's *Covering Kids & Families* grant in New Jersey reveals that advocates for insurance coverage, working in concert with state officials, can positively impact public insurance policy and procedures, and can sustain this work even after its funding ends.

INTRODUCTION

Congress created the State Children's Health Insurance Program (SCHIP) in 1997 to provide health insurance coverage to children whose families earned too much to qualify for Medicaid but who did not have private insurance coverage (P.L. 105-33; Rosenbach 2007). To capitalize on the new opportunities that SCHIP afforded states, the Robert Wood Johnson Foundation (RWJF) introduced the *Covering Kids Initiative* (CKI) program in 1999 to increase Medicaid and SCHIP enrollment (Wooldridge 2007). In 2002, RWJF expanded the program to include parents, renaming it *Covering Kids & Families* (CKF).¹

CKF grantees used three strategies to increase enrollment and retention in Medicaid and SCHIP:

1. Outreach, to encourage enrollment;
2. Simplification, to make it easy to enroll and stay enrolled in Medicaid and SCHIP; and
3. Coordination, to ensure that families can easily move between Medicaid and SCHIP when required (if their income changes, for example), and that public insurance coverage is coordinated with other public programs and private coverage.

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This issue brief was written by Mathematica Policy Research, Inc. Support for this publication was provided by the Robert Wood Johnson Foundation in Princeton, New Jersey.

In this brief, we draw from a variety of qualitative and quantitative data sources, including the Centers for Medicare & Medicaid Services (CMS); the U.S. Census Bureau; the Covering Kids Online Reporting System (a system for CKF grantees to report on policy changes affecting coverage from 2002 to 2006); other reports on CKF grantees and on New Jersey from RWJF's CKF evaluation; surveys administered as part of the CKF evaluation to Medicaid and SCHIP officials and state grantees; and, finally, personal communication with Medicaid and SCHIP officials and state grantees. Unless otherwise cited, it is from these data that we review how the relationship between the New Jersey state CKF grantee organization and state government supported New Jersey's Medicaid and SCHIP outreach, simplification and coordination activities. We then examine the extent to which CKF's mission is continuing in the post-RWJF grant period. Finally, we review the trends in children's coverage in New Jersey, and discuss lessons learned from the efforts of the CKF project in New Jersey, as well as look at the future of grassroots coverage initiatives in New Jersey.

CONTEXT: THE RELATIONSHIP BETWEEN THE STATE CKF GRANTEE AND STATE OFFICIALS IN NEW JERSEY

New Jersey was one of only nine CKF states to receive a \$1,000,000 CKF children's grant because of its large population of uninsured children. The Health Research and Educational Trust (HRET) of New Jersey, an affiliate of the New Jersey Hospital Association, had served as the state CKI grantee from 1999 to 2001 and also was selected as the state CKF grantee in 2002.²

To improve grantees' chances of success, RWJF required CKF grant recipients to engage state officials in the work of CKF. The grant program required grantees to form a statewide coalition that included Medicaid and SCHIP officials as well as representatives from other government agencies, advocacy groups, community-based organizations, health plans, providers, businesses, schools, and others. In other locations, such a stipulation might have created a forced relationship, but in New Jersey, the two parties had what some sources called an "extraordinary" working relationship. A variety of factors contributed to this, but probably most important was that individuals in both parties identified themselves not as "state official" or as "CKF grantee" but as "advocate for kids and families." In other words, they shared the same priorities, and had mutual respect for each other's efforts to cover more uninsured children and families. Another advantage was the ability to build upon the working relationship between the grantee and the state that was forged during the previous three years under CKI, CKF's predecessor program.

Throughout the CKF program, there was consistency in the state agency staff, the CKF grantee staff, and in coalition membership, which promoted strong working relationships over time.

Other factors contributed to this close relationship as well. Political leaders strongly supported efforts to expand coverage of the uninsured, which aided efforts to improve Medicaid and SCHIP. In addition, state officials and the state CKF grantee did not have a one-sided relationship, as sometimes happens when a group advocates for a cause with the state. Although the grantee clearly needed state officials to make change happen, New Jersey officials recognized that they needed CKF to provide an external voice and validation of problem issues. As evidence of the state's support, in 2004 state Medicaid and SCHIP officials challenged New Jersey hospitals to contribute to CKF and the state agency matched donated funds to help meet the grant program's requirement to raise matching funds.³

In short, the relationship between state officials and the New Jersey CKF state grantee was pivotal to efforts to find and enroll children in state health insurance programs, and CKF's coalition structure provided a regular forum for all interested parties to work together to achieve changes in Medicaid and SCHIP policies and procedures.

OUTREACH

Beginning in 2000 (before CKF was implemented), New Jersey's Department of Human Services conducted aggressive outreach for its SCHIP expansion program, including a \$2 million statewide media campaign. However, in 2001 the state was faced with a budget shortfall that required it to cut back outreach severely. Building on efforts begun under CKI, CKF stepped up its outreach, working with the state through the coalition to market SCHIP and Medicaid. Outreach events mounted by CKF included:

- A Back-to-School campaign, spearheaded by CKF annually each August. Coalition members distributed thousands of pieces of marketing materials at local health departments during their back-to-school immunization drives.
- Back-to-School media events, featuring state legislators and policy-makers.
- Marketing outreach through newsletters to the 500 public school districts in the state, and working with school nurses' associations and principals to generate support.

In addition, CKF supported outreach conducted by the state. For example, local CKF projects regularly staffed state-sponsored outreach activities, such as helping families complete SCHIP applications at state-sponsored health fairs and at NJ FamilyCare Awareness Days at minor league ballparks around the state, so that the state could focus its resources on regions that were not served by a local CKF grant; in effect, the local projects have served the entire state. These events continued through the end of the grant in early 2007. During the last year of the grant alone, the state and local grantees staffed 88 application assistance events.

CKF's focus was not limited to outreach events, however. It also sought to educate health professionals and community agency staff about program eligibility requirements and application procedures. For example, it sponsored (and continues to sponsor) a yearly conference during Cover the Uninsured Week to educate hospital administrators and community agency workers about coverage issues and relevant state and federal policy developments. It also initiated training sessions for outreach staff who work with immigrant populations, including those at hospitals and clinics, about how to enroll immigrants. In addition, in the first three years of the grant, each of the three local New Jersey grantees held 12 application assistance training sessions (that is, a total of 36 sessions throughout the state) aimed at improving application assistance in community organizations. These training sessions continued in the last year of the grant, during which the state and local grantees trained 402 people at 30 training sessions. Over the life of the grant, CKF provided application assistance training to approximately 1,400 outreach workers.

SIMPLIFICATION

The proportion of children eligible for Medicaid or SCHIP who enroll and remain enrolled depends in part on the ease of the application and renewal process. New Jersey, like most other states, sought to simplify the enrollment and re-enrollment process.

As shown in Table 1, state officials report that the New Jersey CKF grantee and its coalition members directly influenced enrollment simplification policies and procedures in the state.⁴ For example, the state CKF grantee pushed for a simplified, one-page application, having heard from local grantees that application length was a barrier to enrollment. The CKF grantee also helped design the new application form, pilot-tested its use, and provided feedback to the state to help it implement the one-page application in July 2005. State officials said that, on a scale of 1 to 10, with 10 indicating that the change had a critical effect on the number of children and parents enrolled in

public programs, they would rate the impact of this change as an “11.” As of January 2007, New Jersey state Medicaid and SCHIP officials reported that this simplification was still completely in effect, and they were “very confident” that this change would remain in effect at least two more years; they believed this change was not at risk of reversal.

TABLE 1

Key Simplification Policy or Procedural Changes Promoted by CKF and Adopted by New Jersey

| Simplification Improvement | Change would not have occurred without CKF, as reported by: | Change was accelerated by CKF, as reported by: |
|---|---|--|
| Implementation of a one-page application, July 1, 2005. Local CKF projects identified the application length as a barrier to enrollment. The CKF state grantee then helped develop, pretest and implement a one-page, simplified application. | State officials and State CKF grantee | |
| Simplified presumptive eligibility, by using the regular application for presumptively eligible individuals. | State officials | |
| CKF helped reduce the number of income documents needed to prove eligibility, from three months’ worth of documentation to either one pay stub or alternate verification (such as state tax records). | State CKF grantee | State officials |
| CKF encouraged, and the state adopted, self-declared disregards: as of 2005, a resident could self-declare full-time student status or care of an elderly relative and qualify for the disregards without proof. | | State officials |
| CKF identified a stigma associated with applying for health insurance and welfare services at the same location. CKF helped the state successfully pilot a change in Monmouth County to send applications directly to the state’s vendor; this change was then implemented statewide. | State CKF grantee | |

Source: Survey of CKF State Grantees and State Medicaid and SCHIP Officials, July 2005.

State officials also agreed that CKF played a vital role in securing the simplifications made to the presumptive eligibility application.⁵ CKF demonstrated that parents of children who qualified for presumptive eligibility often would not follow up with the regular application that was required to get insurance coverage, even though the children were eligible. Since the presumptive eligibility application contained all the same information as the regular Medicaid/SCHIP application, the state agreed that the regular application should be used for presumptive eligibility and that no further application would be required. CKF thus helped eliminate a problem that led to coverage gaps in New Jersey, and this improvement remains in effect. In January 2007, New Jersey Medicaid and SCHIP officials reported that they were “very confident” that this change would remain in effect at least two more years, and they likewise believed this change was not at risk of reversal.

In other instances, the state grantee believed that CKF accelerated a change that might have occurred without the CKF grantee, but would have happened at a slower pace. For example, CKF sought changes in how families could apply for health insurance coverage by making it possible to apply by mail, rather than through welfare offices (see Table 1). CKF also played a role in improving retention policies, both through its push for pre-populated renewal forms and by helping to secure 12-month continuous eligibility in New Jersey (data not shown). Both changes are still in effect, and each policy change reduced enrollment and/or retention complications for applicants and made for an easier, less burdensome entry to obtaining and maintaining public health insurance coverage.

COORDINATION

Enhanced coordination was essential to achieving a seamless program. Before CKF, New Jersey counties employed their own standards for Medicaid and SCHIP application processes. CKF pursued improved coordination by working with the state to analyze processing gaps; they also convened county boards of social services that agreed to follow common policies and procedures, thereby creating uniformity in the application process across counties. Both state officials and grantee staff agreed CKF was vital to making this change. Another coordination improvement encouraged by CKF was improved communication and information sharing between the county boards and the state vendor that processed Medicaid and SCHIP applications. This eliminated the need for families to reapply for another program when their eligibility status changed and created an easier transition for families moving between Medicaid and SCHIP.

CKF's work also had spillover effects with the state's food stamp program. When CKF determined that the food stamp and health insurance applications requested the same information, the state agreed to allow the food stamp application to serve as the health insurance application if families indicated that they also wanted health insurance coverage.

SUSTAINABILITY

RWJF required each CKF grantee to plan for sustainability after the grant ended, including identifying funders who might support CKF activities and the coalition in the post-grant period, as well as soliciting organizations that might adopt and institutionalize CKF activities, such as outreach. Before the grant ended, interviews with the New Jersey CKF grantee staff indicated that they were having an extremely difficult time meeting the matching requirements of the CKF grant, and that they had not identified other sources of funding to support CKF work when the grant ended. The CKF project director anticipated that because the sponsoring organization, HRET, was committed to CKF issues, it would regard the work of CKF as important enough to continue supporting it; the project staff also hoped that coalition members would institutionalize many CKF activities. Coalition members who participated in an online survey in 2005 said that, although the grantee had not secured resources to continue work, they too, expected CKF's activities and the coalition to continue based on the coalition's diverse membership and its commitment to the issues. Moreover, even towards the end of the New Jersey grant, the coalition continued to expand its membership.

As of this writing, HRET supports CKF, albeit in a scaled back manner compared to when the work was funded by RWJF. The staff who worked on CKF now spend "...a nominal amount of time, all provided in-kind..." so that activities can continue in some fashion. Key ongoing activities include:

- The coalition continues to meet and collaborate as it did during the CKF grant period, although in-person meetings have been reduced from four times a year to two times a year. The members have added more conference calls since the grant ended and share more information by e-mail, so that the group stays abreast of the latest issues concerning coverage in New Jersey.
- The CKF grantee has continued to host a statewide conference during Cover the Uninsured Week, which it has been able to support using unspent grant-matching funds.

- The CKF grantee has continued to distribute outreach and educational materials developed during CKF; mailing costs are covered either by remaining grant-matching funds or by the host organization, HRET.
- The CKF grantee continues to serve as an information clearinghouse on state programs, state policy changes, new policy developments and national policy changes that have implications for New Jersey FamilyCare or New Jersey’s uninsured population.
- The CKF grantee continues to serve as a conduit for organizing meetings between the state and agencies that participate in the coalition. Because of the long-standing relationship with state officials, grantee staff remain key players in pushing for policy change in the state.

TRENDS IN CHILDREN’S HEALTH COVERAGE

The New Jersey CKF grantee, working with state officials and its coalition, helped improve New Jersey Medicaid and SCHIP policies and procedures in each of CKF’s target areas—outreach, simplification and coordination. However, trends in health insurance coverage paint a clear picture of the need for these efforts to continue. As Table 2 shows, the percentage of uninsured children in New Jersey rose from 7.5 percent in 1999 to 13.3 percent in 2006. At the same time, private insurance eroded at a rate twice as fast as government coverage increased. Taken together, the data indicate

TABLE 2

New Jersey Health Insurance Coverage Trends Among Children Under Age 18

| Year | Percentage not covered by private or government health insurance | Percentage covered by government health insurance | Percentage covered by private health insurance |
|------|--|---|--|
| 2006 | 13.3 | 19.0 | 70.9 |
| 2005 | 10.5 | 17.8 | 75.3 |
| 2004 | 10.0 | 16.7 | 77.2 |
| 2003 | 10.6 | 17.1 | 75.8 |
| 2002 | 9.7 | 19.2 | 76.0 |
| 2001 | 11.3 | 16.1 | 78.1 |
| 2000 | 8.5 | 16.7 | 79.6 |
| 1999 | 7.5 | 15.3 | 80.9 |

Source: U.S. Census Bureau, 2008a.

that the need for outreach, simplification and coordination remains; in fact, the need, as evidenced by the 13.3 percent of children who are uninsured, is the highest it has been in at least eight years.

LESSONS LEARNED

The experience of CKF in New Jersey offers three lessons about advocacy. First, CKF's experiences in New Jersey demonstrate that advocates for children's coverage can make substantial contributions to policies and procedures, increasing the number of people insured by working closely with state officials. State officials said CKF was vital to many of the policy changes the state made, and the combined state and CKF outreach efforts resulted in an increased percentage of children covered by Medicaid or SCHIP. For advocates to be able to make such an impact, the effort must be two-sided: CKF and state staff had the same goals, valued each other as collaborators and respected each other's contributions.

A second lesson is that advocates' contributions to the goals of children's health coverage can be sustained even when funding ends. For example, a year after the end of RWJF funding, HRET continues to sponsor an annual statewide "Cover the Uninsured" conference, distribute outreach materials promoting state coverage of uninsured residents and organize coalition meetings. Although efforts are scaled back compared to efforts when RWJF funding supported it, many key CKF activities continue. This is not to suggest that all grantees will be able to sustain activities after grant funding ends. In New Jersey, the grantee and its coalition members were committed to the goals of CKF; the grantee organization is dedicated to enhancing health care delivery and, well before the grant ended, New Jersey CKF staffers reported that they would find a way to sustain the work "because it had to be done."

Finally, coverage in New Jersey is threatened seemingly on all sides: private health insurance coverage is eroding; the number of uninsured individuals is growing; and with the current pressure to balance the New Jersey state budget, as well as federal pressure to cut SCHIP income eligibility to 250 percent of the federal poverty level (New Jersey's income eligibility level is 350 percent of the federal poverty level), publicly funded insurance could face cutbacks in some form. The need for advocacy programs for health insurance coverage is greater than ever. Although CKF's impact is difficult to measure, the evidence indicates that CKF made a valuable, positive and lasting contribution to state health policy and procedures in New Jersey.

While CKF outreach and education activities are continuing after RWJF funding came to an end, they are doing so on a much smaller scale because it has not been possible to replace all of the grant funds with financial support at the same level from other sources. In a time of economic insecurity, CKF's work is still needed to help children and families secure health coverage for which they qualify, but an infusion of new funds and energy, as well as a change in federal and state policies, may be needed to maintain the outreach and other efforts that are necessary to reduce the number of uninsured children and adults in New Jersey.

AFTER CKF: ACHIEVING COMPREHENSIVE INSURANCE COVERAGE IN NEW JERSEY

In February 2008, the Robert Wood Johnson Foundation awarded the New Jersey Citizen Action Education Fund a three-year *Consumer Voices for Coverage: Strengthening State Advocacy Networks to Expand Health Coverage* (CVC) grant. This grant is to implement a coalition of organizations representing consumer groups, develop a health care coverage campaign, and create influential grassroots advocacy that results in comprehensive health insurance coverage in New Jersey. The New Jersey CVC grantee was selected partly because of the high levels of uninsured people in New Jersey, and partly because the economic and political environment in New Jersey lent itself to an opportunity to influence policy and achieve comprehensive coverage. Nevertheless, the challenges CVC faces are great: it must develop relationships among varied organizations that have not worked together before, while at the same time respond to legislative activity to expand insurance coverage, in the face of a sharp downturn in the New Jersey economy.

The findings from CKF show that effective coalitions that influence policy and procedures can be developed. CKF's coalition resulted in close working relationships and alignment of interests among grantee staff, state officials, and other coalition members that improved the existing SCHIP and Medicaid programs. However, the CVC grantee's mandate goes beyond improving existing programs—to influencing policy-making to achieve comprehensive coverage for *all* New Jerseyans. This represents a broader challenge than the one the CKF grantee faced, as it requires developing public support for the idea of covering all New Jerseyans, and not just low-income children and their parents, and allocating the resources to do so.

Although CVC began just as the New Jersey economy turned down sharply and many existing programs are facing cuts, this was also the situation the CKF grantee faced at the start of the CKF program. State outreach funds fell sharply in 2001 and the CKF grantee supported outreach itself as well as focusing attention on other activities such as program simplification. In other words, CKF's history suggests that the current economic downturn does not predestine the CVC program in New Jersey to failure. An evaluation of the CVC program will examine CVC's success with these goals over the next three years.

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Endnotes

1. RWJF invested nearly \$150 million in the two programs, through funds and technical assistance to community-based grantees in every state (RWJF 2008). RWJF funded 46 state CKF grantees in 45 states and the District of Columbia; grantees included community-based organizations, service agencies, government agencies, academic institutions and health care providers (Wooldridge 2007). (RWJF also funded smaller liaison grants in the other five states.) In turn, these state grantees funded 152 local grantees—at least two in each state—using half of their grants (the average state grant was \$828,215) (Wooldridge 2007). Local grantees were intended to be local laboratories for innovation that could report to state grantees on barriers to enrollment and the most effective types of outreach (Wooldridge 2007).

2. The New Jersey CKI grant amount was \$999,994. Under CKI, there were five local grantees; under CKF, there were three local grantees.
3. As a condition of RWJF funding, CKF grantees had to raise matching funds equal to 50 percent of their grant amount.
4. In 2005, staff from Mathematica Policy Research, Inc. and Health Management Associates interviewed the state CKF grantee and Medicaid and SCHIP officials. Each respondent was asked to name the three most important policy or procedural changes that CKF affected through their work, and then to indicate for each policy change mentioned, whether it: (1) would have occurred without CKF; (2) would have occurred with CKF, but more slowly; or (3) would not have occurred without CKF—CKF was vital to securing changes.
5. Presumptive eligibility is a process to establish short-term eligibility for Medicaid or SCHIP based on family income or pregnancy status (Agency for Healthcare Research and Quality 2008). Establishing presumptive eligibility allows immediate coverage of covered services and guarantees payment to providers. However, coverage under presumptive eligibility rules traditionally is short-term, and families must follow up with a formal application (Agency for Healthcare Research and Quality 2008).

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