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Covering Kids & Families[®] Evaluation

*Case Study of Oregon: Exploring
Medicaid and SCHIP Enrollment Trends
and their Links to Policy and Practice*

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About the Covering Kids & Families Evaluation

Since August 2002, Mathematica Policy Research, Inc., and its partners, the Urban Institute and Health Management Associates, have undertaken an evaluation to determine the impact of RWJF's investment in the Covering Kids & Families (CKF) program, as well as to study factors that may have contributed to, or impaired, CKF's efforts. The evaluation will continue through April 2008.

The evaluation focuses on these key issues:

- Documenting and assessing the strategies and actions of CKF grantees and their coalitions aimed at increasing enrollment of children and families and the barriers to their implementation.
- Assessing the effectiveness of CKF grantees and their coalitions in conducting outreach; simplifying the application and renewal process; and coordinating efforts by existing health insurance programs to expand coverage measuring progress on CKF's central goal—expanding enrollment and retention of all eligible individuals into Medicaid and State Children's Health Insurance Program (SCHIP).
- Assessing the sustainability of CKF after RWJF funding ends.

Findings from the evaluation, presented in a series of short highlight memos and issue briefs and in more detailed case study and synthesis reports, can be found at <http://www.rwjf.org/newsroom/featureDetail.jsp?featureID=1031&type=3>.

Background

The *Covering Kids & Families*® (CKF) initiative of the Robert Wood Johnson Foundation (RWJF) had two goals: to reduce the number of children and adults eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) who remain uninsured, and to build the knowledge, experience and capacity necessary to sustain the enrollment and retention of children and adults in those programs after the CKF program ends. RWJF issued four-year CKF grants to 46 states, beginning in 2002. CKF expanded on its predecessor, the RWJF *Covering Kids Initiative* (CKI), which operated from 1999 to 2002.

CKF worked through state and local coalitions to maximize enrollment in public health insurance programs for uninsured, low-income children and adults. CKF grantees employed three strategies to increase enrollment and retention of eligible uninsured children and families:

- *Outreach* to encourage enrollment in SCHIP and Medicaid;
- *Simplification* of SCHIP and Medicaid policies and procedures to make it easier for families to enroll their children and keep them covered; and
- *Coordination* between SCHIP and Medicaid to ensure the easy transition of families between programs if they apply for the wrong program or their eligibility changes subsequently.

This is one of 10 case studies that examine the link between enrollment trends and policy and practice at the state and local levels. The case studies look particularly at the role of outreach, simplification and coordination in changing levels of new enrollment over time. The case studies are the work of Mathematica Policy Research, Inc., and its subcontractors, the Urban Institute and Health Management Associates, the team entrusted with evaluating the CKF program.

Introduction

This case study examines the trends in new Medicaid and SCHIP enrollment in Oregon from 1999 through 2004. In particular, we are interested in exploring the potential links between new enrollment trends and major outreach strategies or policy changes that took place in Oregon at the state and local levels, especially those associated with the CKF grant. Ideally, we would examine such links through a formal impacts analysis that estimates the effect of individual policy changes or outreach efforts on the number of children enrolling in Medicaid or SCHIP. This type of analysis is not possible, however, because many of the outreach efforts and policy changes occurred at the same time. In addition, no state or other geographic area is a defensible comparison group for a more rigorous analysis. The case study approach however, combines exploratory data analysis with in-depth key informant interviews, and allows us to assess the potential influence that major outreach efforts or policy changes have had on new enrollment.

The main source of information for the study is child-level enrollment data from the Medicaid Statistical Information System, which we obtained from the Centers for Medicare & Medicaid Services. Using these data, we developed a measure indicating the number of new entries in Medicaid or SCHIP during each month of the period 1999 through 2004. Our definition of a new entry is any child who is newly enrolling in one of these programs and who has not been enrolled in either of them in the past 12 months. Thus, it excludes any child who is transferring between these programs or reentering one of them after a short disenrollment period. We focus on this measure rather than on a count of all new enrollees or of overall enrollees because we expect new entries to be more sensitive to major outreach efforts or policy changes associated with new enrollment.¹

With these data, the evaluation team assembled a timeline showing the number of new entries in Medicaid and SCHIP for Oregon from October 1999 through June 2004. This period covers nearly the entire period of RWJF's original CKI grant to the state (awarded in mid-1999) and the first 19 months of the subsequent CKF grant (awarded in December 2002). We also assembled a similar timeline for each local program and for each county the projects served.

In June 2006, we discussed these data in detailed interviews conducted with the state CKF grantee, state officials and selected local projects. During these interviews, we asked informants to identify the key changes taking place in state and local policies and outreach practices and whether and how these might account for the trends seen in new entries. In some instances, the evaluation team conducted follow-up interviews with informants by telephone. Other sources provided additional insights, including the CKF Online Reporting System, program documents and demographic and economic data from the Bureau of Census and from the Bureau of Labor Statistics.

State Policy Context

The last 15 years of Oregon health policy can be roughly divided into two very different periods: the 1990's, when the state played a leadership role, nationally, in adopting innovative expansions of public health coverage to address the problem of the uninsured; and the 2000's when the state (until very recently) enacted a series of program restrictions and experienced an erosion of coverage. Through both eras, policy makers focused the bulk of their attention on programs for families, including adults, rather than programs for children alone. But both the expansions and cuts to Oregon's programs had important spillover effects on children, as described below.

Throughout the 1990's, the State of Oregon adopted several health policy initiatives that resulted in significant expansions of public health insurance coverage for tens of thousands of uninsured or underinsured Oregonians, both adults and children. Specifically, in 1994, the state implemented a Medicaid demonstration called the Oregon Health Plan (OHP), which expanded Medicaid to nearly all individuals under 100 percent of the Federal Poverty Level (FPL) who were not previously eligible for Medicaid through existing regulations. A premise of the plan was that the state could not afford to cover all health services for everybody, but that access to a full range of primary and preventive health care services for a larger pool of residents would reduce long-term costs. Thus, after considerable research and negotiation with stakeholders, the program implemented a prioritized list of benefits that allowed the state to provide health care coverage to more people. For pregnant women and children under age six, the eligibility limit for OHP was set at 133 percent of the FPL, and a more comprehensive package was provided. At the time, the OHP expansion was unique among states because it made Medicaid available to most people living in poverty regardless of age, disability or family status and because it utilized the aforementioned priority list of health care conditions and treatments (Oregon Department of Human Services, 2004).

Four years later, in 1998, Oregon adopted its State Children's Health Insurance Program (SCHIP). Oregon's SCHIP, which expanded health insurance coverage to children up to 170 percent of the FPL,² functions as a separate 'Medicaid look-alike' program, and is administered in exactly the same way as children's Medicaid (through the OHP). In conjunction with SCHIP, the state also expanded Poverty Level Medicaid (Medicaid poverty expansion) coverage to pregnant women and infants in families with incomes between 133 percent and 170 percent of the FPL.

The state legislature continued with its efforts to expand coverage for working families, and also established the Family Health Insurance Assistance Program (FHIAP) in 1998. FHIAP provides sliding scale premium subsidies for uninsured residents with family incomes up to 170 percent of the FPL that can be used to buy private individual coverage, or group health insurance coverage offered under an employer's plan. Although the eligibility requirements for the program are identical to those for SCHIP, the FHIAP benefit package is typically more limited (lacking dental benefits, for example) because it is a commercial insurance product. The premium payment required of FHIAP enrollees is determined by family income. Like SCHIP, FHIAP is not an entitlement program and funding is allocated by the state legislature; the program is currently funded through the state's tobacco tax. In the overall context of Oregon state coverage programs, FHIAP is small: the program reported an average monthly enrollment of 15,085 for fiscal year 2006 (children ages 0 to 18 account for less than a third of total FHIAP enrollment) (Oregon Department of Human Services, 2006).³

Oregon's trend toward more restrictive coverage policies began in 2003 when the state implemented its 'OHP2' expansion using the new Health Insurance Flexibility and Accountability (HIFA) demonstration waiver authority. The state initially sought to expand the original Oregon Health Plan coverage to individuals with incomes up to 185 percent FPL, by separating the program into two groups: 1) OHP Plus, which includes categorically eligible adults, children and disabled persons, who receive a comprehensive benefit package similar to that offered under the original OHP; and 2) OHP Standard, which includes the state's expansion population (adults up to 100 percent of the FPL), who receive a leaner benefits package and are subject to significant cost-sharing and more restrictive policies surrounding premium payment.

Just as OHP2 was being implemented, however, state budget difficulties mounted as the nation entered an economic recession. Beginning in 2000, Oregon was particularly hard hit by increasing rates of unemployment, dwindling state tax revenues,⁴ and increasing expenditures. In response, the state legislature adopted a series of measures to contain costs in various public programs, and a popular target for these cuts was the budget of the Office of Medical Assistance Programs (OMAP), which was growing at a rate legislators felt could not be sustained.

Nearly all of the OMAP budget restrictions were directed at programs that only served adult populations. The state's unfolding budget crisis, as it coincided with the launch of OHP2, had major implications for implementation of that initiative. While the division of OHP into Plus and Standard populations proceeded as planned in February 2003, the second phase of the demonstration, (whereby the state would increase enrollment in OHP with savings realized from the split) was never implemented. Instead, the OHP Standard population (adults eligible through poverty-level expansion) was the target of several subsequent programmatic restrictions in 2003 and early 2004. These included increased cost-sharing, strict penalties for premium nonpayment, and a reduced scope of covered benefits. The cost-containment measures culminated in the placement of a cap on the program's enrollment beginning in July 2004; the cap was set at 25,000 covered adults. During this period, Standard enrollment fell drastically, from roughly 102,000 adult beneficiaries in 2002, to approximately 51,000 by late 2003 (OHREC 2004). Even before the enrollment cap was imposed, the number of covered individuals fell as persons were either disenrolled for premium nonpayment or because they failed to renew their coverage under the incorrect assumption that this piece of OHP was 'closed' or no longer active. (Various stakeholders reported that the rapid series of program restrictions supported this perception among many Standard enrollees.)

Notably, in contrast to the numerous cost-containment strategies aimed at the OHP adult population, there were relatively few policy changes that directly targeted children's programs during the period from 1999-2004. In fact, there were some enhancements to Medicaid for children, SCHIP and FHIAP during this time. Specifically, as part of the 1115 waiver implemented in February 2003, eligibility was expanded from 170 percent to 185 percent of the FPL for children and pregnant women enrolled in the three programs.⁵ In late 2004, a SCHIP plan amendment increased the assets limit for that program to \$10,000 (from \$5,000), making the limit identical to that of FHIAP. Though technically outside of the period for which we have data in this report, another notable enhancement to children's programs was implemented in July 2006, when the continuous eligibility period for children under SCHIP was increased from six months to 12 months.⁶

While the series of restrictions targeted at adults covered under OHP Standard were the most publicized cost-containment measures during this study's data period, several other events bear mentioning here for their potential effect on children's program enrollment:

- The state eliminated its Medically Needy program in early 2003;
- With the exception of FHIAP, the state eliminated funding for outreach for public health insurance programs during this period;
- Program enrollment and renewal processes were essentially maintained as-is, with little support for simplification or coordination efforts⁷ (as had been occurring in most states across the nation after implementation of SCHIP);
- Key informants noted a change in the way that OHP applications were processed during our data period. In the late 1990's, over 70 percent of all applications were mailed in for processing at a central state eligibility office, but by the end of our data period about the same percentage of OHP applications were processed in face-to-face interviews at local eligibility offices;
- There was high turnover in administrative leadership at the Office of Medical Assistance Programs (OMAP), though the staffing remained relatively stable; and
- Problems with access to health care for those enrolled in OHP, which were already a concern among health care program officials in the state, were exacerbated when managed care organizations in several areas dropped OHP Standard coverage after OHP2 was implemented.

Additionally, the state lost a potential source of funds that could have alleviated some of the pressure caused by burgeoning state deficits when, in early 2004, voters rejected a ballot measure to implement a combination of new taxes, including an income tax surcharge and a cigarette tax increase. That vote resulted in a loss of \$780 million of general fund revenue plus an additional \$23 million in revenue from cigarette taxes dedicated to the Oregon Health Plan for the legislative biennium (National Conference of State Legislatures, 2004). A list of policy changes made to Oregon health coverage programs appears in Table 1.

TABLE 1

Key Recent Events in Child Health Coverage in Oregon (1999–2006)

1994

Oregon implements an 1115 Medicaid demonstration waiver, called the Oregon Health Plan (OHP). The OHP covers children ages 0 to 5 and pregnant women in families with incomes up to 133% of the Federal Poverty Level (FPL), and covers children ages 6 to 18 in families with incomes up to 100% of the FPL. The program also covers adults not traditionally eligible in families with incomes of up to 100% of the FPL, using a prioritized list of benefits.

1998

Launching of the Family Health Insurance Assistance Program (FHIAP), a program providing private individual- or employer-sponsored group premium subsidies for uninsured residents with family incomes of up to 170 percent of the FPL.

Poverty-level Medicaid coverage expanded to include pregnant women and infants between 133% and 170% of the FPL.

Oregon's SCHIP implemented as a separate, 'Medicaid look-alike' program. The program expands coverage for children through age 18, in families with incomes of up to 170% of the FPL.

1999–2001

Robert Wood Johnson Foundation's (RWJF's) Covering Kids Initiative.

2002–2006

December 2002–December 2006:

RWJF's Covering Kids & Families (CKF) Initiative.

Oregon Health Access Project is the lead agency for the state coalition.

Four local pilot projects are located in Multnomah, Jackson/Klamath, Lincoln and Union/Baker/Wallowa counties.

2003

February:

Oregon Health Plan 2 is implemented through a HIFA waiver. OHP enrollees now fall into two distinct categories: 'OHP Plus' enrollees include categorically eligible adults, children and disabled persons, who receive a comprehensive benefit package and 'OHP Standard' enrollees include the state's expansion population who receive a leaner benefits package.

Expanded SCHIP and FHIAP coverage for pregnant women and children 0 to 18 from 170% to 185% of the FPL.

TABLE 1 (CONTINUED)

2004

July: Closed OHP Standard program to new enrollment.

October: SCHIP Plan Amendment #5: Increased assets limit from \$5,000 to \$10,000.

2004–2005

“KidCare”, a state-sponsored outreach initiative, is piloted in two counties and does not result in any significant increase in enrollment activity.

2006

July: Eligibility period extended for SCHIP population, from six months to 12 months of continuous coverage.

History of Covering Kids and Families Programs in Oregon

The Health Division of the Oregon Department of Human Services (formerly the Department of Human Resources) led the Covering Kids (CKI) grant from 1999-2001. Though the CKI project adopted a series of strategies to reduce the number of uninsured children in the state (e.g., developing simplified application forms for OHP, and staffing traditional and nontraditional “information-distribution” sites), efforts related to the grant were severely curtailed by the state budget crisis that coincided with the grant period. Project staff reported that the Oregon CKI initiative could not realize its full potential due to several factors, including funding cuts to its lead agency, departmental reorganization that redirected the focus of a key coordinating council that was created by the project, and declining provider participation in OHP (Robert Wood Johnson Foundation 2005).

It is not surprising, then, that a different agency was selected to lead the subsequent CKF grant in Oregon. With support from state officials involved in the original CK effort, the Oregon Health Access Project (OHAP) applied for and received funding to lead the CKF grant. OHAP is the research and education arm of the Oregon Health Action Campaign, a coalition of organizations and individuals operating statewide and in select local communities to organize consumers and groups to advocate for expanded access to quality health care at an affordable price. OHAP’s CKF activities are accomplished primarily through its statewide coalition, the Expanded Access Coalition (EAC). A subcommittee of that coalition, called the Committee on Outreach, Enrollment and Retention (COER) serves as the CKF Steering committee.

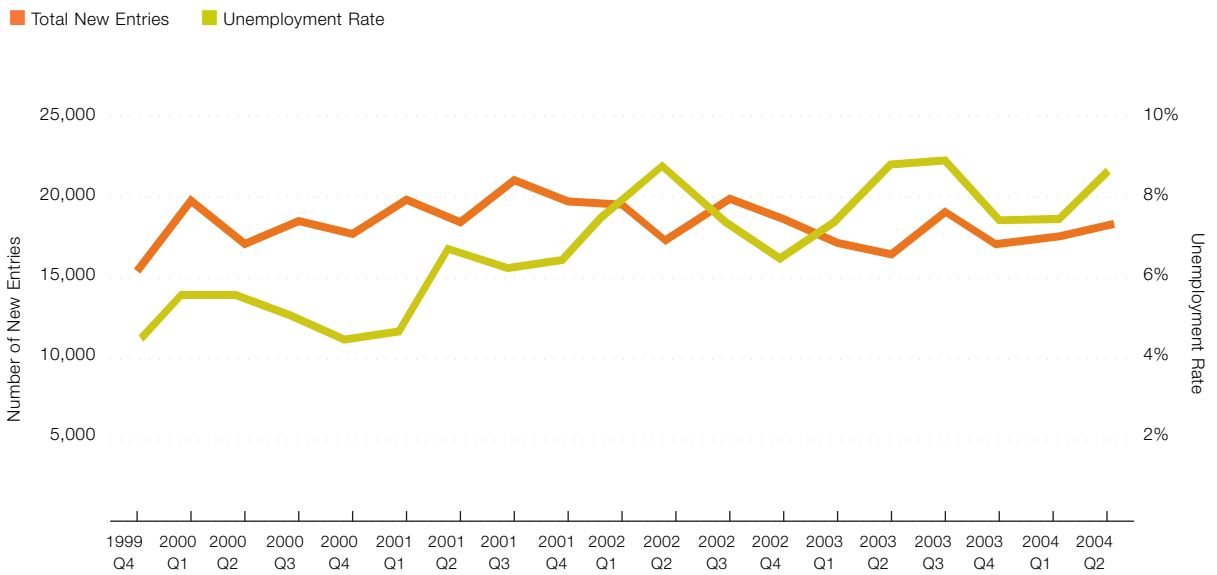
In December 2002, OHAP received a four-year CKF grant of \$999,968. As state grantee, the agency has focused on goals such as simplifying public health coverage applications, establishing formal links between public health insurance programs (namely, OHP and FHIAP), reducing delays in the processing of applications marked ‘pending’ by state eligibility workers, and making certain program policies—such as asset test limits and period of continuous eligibility—synchronized across public programs.

The lead grantee also oversaw the activities of four local CKF programs (combined, these pilot sites received half of the grant funds). Three of those programs are discussed in this case study:

- 1. Health Network for Rural Schools (HNRS)** serves a primarily rural, tri-county region in the northeastern area of the state. Under the Covering Kids grant, the project placed outreach workers within school health programs in Union County. When the HNRS was awarded the CKF grant, it expanded in scope to include school districts in Wallowa and Baker Counties as well. The project conducted very intensive, one-on-one outreach to uninsured families identified by trained outreach workers.
- 2. Oregon Health Access Project—Lincoln County Coalition** is located in a small coastal county that is primarily rural, with significant populations of Hispanic and Native American residents. Lincoln County has one of the highest uninsurance rates in the state, and unemployment rates are higher than the state average. The tourist and fishing industries are major employers, but only provide seasonal employment. In a region with limited resources to increase enrollment and retention in public coverage programs, the CKF grant allowed the coalition to raise awareness and engage the community in mobilizing resources to address problems faced by low-income people.
- 3. Portland Enrollment Project (PEP!) for Homeless and Uninsured Youth and Families**, is a collaborative of homeless youth-serving agencies under the leadership of Outside In, a non-profit Federally-Qualified Health Center (FQHC). Under the CKF grant funding, PEP! worked to advocate for and enroll homeless youth, adults and families into public health insurance programs through direct application assistance and health education.

FIGURE 1

Total New Entries to Children’s Public Health Coverage and Unemployment Rate, Oregon, October 1999–June 2004



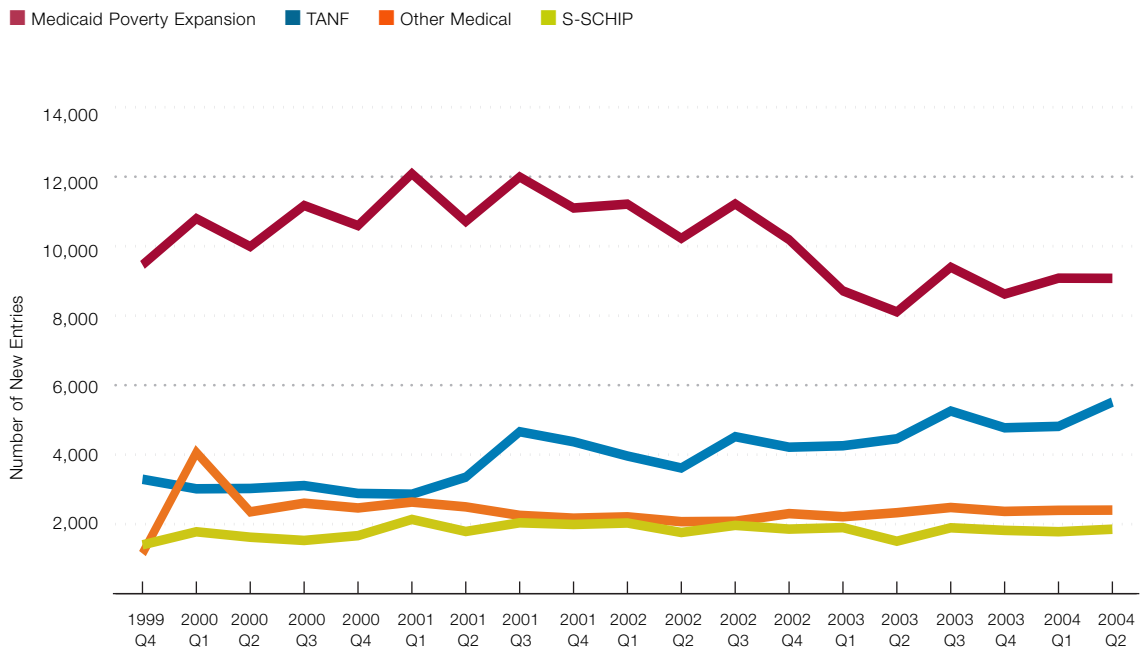
Source: New entries: Mathematica, Inc. tabulations from Medicaid Statistical Information System. Unemployment rate: Bureau of Labor Statistics

State-level Findings

Economic Trends. As discussed in Section II of this report, beginning in late 1999, Oregon entered into a state budget crisis that was among the worst in the country. By the end of 2001, the state had the highest unemployment rate in the nation (at 7.5 percent); the unemployment rate continued to rank among the nation’s highest until 2005. One would think a downturn in a state’s economy might be accompanied by increased enrollment in public programs for low-income children, as an increasing number of unemployed families seek assistance. However, Figure 1 indicates that there is no clear link between Oregon’s rising unemployment rate and total new entries of children into the state’s public health insurance programs. While the period 1998 through 2004 witnessed a steady increase in unemployment from below 5 percent to nearly 9 percent, child enrollment in OHP remained steady at roughly 18,000 children. This finding implies that restrictive state policies enacted during this period may indeed have had a balancing effect on overall children’s enrollment, whereby the potential for a large enrollment boost due to an increase in those eligible (related to unemployment and decreases in family income) was offset by restrictions on program enrollment.

FIGURE 2

New Entries to Children’s Public Health Coverage, by Program Type, Oregon, October 1999–June 2004



Source: Mathematica, Inc. tabulations from Medicaid Statistical Information System.

While children’s overall enrollment doesn’t appear to be positively correlated with the unemployment rate, enrollment by at least one group of eligible children appears to be linked. Figure 2 displays new enrollment trends for selected children’s eligibility groups, and here there is a slight indication of a link between economic conditions and new enrollment for the Temporary Assistance for Needy Families/1931(b) group, which one would expect to be most sensitive to economic conditions. As the figure illustrates, the number of new TANF entries rose steadily over time from 3,292 in the fourth quarter of 1999 to 5,513 in the second quarter of 2004. In contrast, the other three groups experience either an overall decrease in new enrollment or essentially no change in new enrollment.

Links between Enrollment and Major Policy Changes.

It appears that implementation of OHP2 had a significant, negative effect on at least one group of children. Specifically, the most striking change in the number of new entries displayed in Figure 2 (which shows enrollment trends for selected children’s eligibility

groups) is the significant drop in new enrollment among the Medicaid poverty expansion group beginning in the third quarter of 2002. A much smaller dip can also be identified in SCHIP enrollment at that period. In the subsequent three quarters, Medicaid poverty expansion enrollment declined by 28 percent, or over 3,000 children.

The timing of this drop corresponds to the implementation of OHP2, and the ensuing changes to the OHP Standard program; even though OHP2 was not fully rolled out until the first quarter of 2003, key informants agreed that information about the new OHP Standard group and related benefit restrictions would have been communicated to families in the second half of 2002. According to these informants, Medicaid poverty expansion-eligible children are probably most sensitive to changes made to coverage programs for poverty-expansion eligible adults, since the eligibility levels of these programs are similar. Because the majority of the OHP program restrictions targeted the Standard population—mainly adults eligible through poverty-level expansions—it is logical that the new enrollment of Medicaid poverty expansion-eligible children was affected when those restrictions were implemented. For instance, key informants unanimously agreed that confusion was widespread when the state began enacting changes to the OHP Standard program policies, and they described situations where families mistakenly believed that when the Standard program enrollment was capped, the entire Oregon Health Plan was closed, including the components that only covered children. Though the program restrictions directly affected policies related to adults only, children's programs experienced decreases in new enrollment in the period leading up to and during the changes.

It is also notable that, in Figure 2, the point at which the rapid Medicaid poverty expansion enrollment decline ceases (in the second quarter of 2003) corresponds to the period when children's eligibility was expanded as part of the 1115 waiver, from 170 percent to 185 percent of the FPL. There is a slight upsurge in entries during that period for every program except 'Other Medicaid'.⁸ This eligibility expansion appears to have offset some of the negative effects on enrollment related to changes in OHP2.

Besides the changes to OHP Standard, several other program changes have implications for the number of new entries into public coverage programs. The enrollment application used to determine eligibility for all OHP programs became more complex during the data period and application processing also changed. Specifically, as mentioned above, by the end of our data period informants reported that about 70 percent of OHP applications were processed in face-to-face interviews at local eligibility offices. In contrast, during the late 1990's, over 70 percent of all applications were mailed in for processing at a central, state eligibility office. Mail-in applications typically ease the application process for individuals who have transportation or geographic barriers or who fear being stigmatized by seeking assistance through a

local social service office; it is reasonable then, that an increase in applications processed through face-to-face interviews (and concurrent decrease in mail-in applications) might be associated with declining enrollment.

Key informants noted that Figure 2 illustrates that new enrollment in SCHIP was essentially unchanged during the data period. This could reflect the fact that the state did not conduct, in the early years of SCHIP, any targeted outreach to families with higher incomes in order to ‘grow’ the SCHIP program.

Finally, despite its small size, the FHIAP program was described as very popular among legislators, and we heard from key informants that outreach for this program continued even during the state’s fiscal crisis. The average number of new child entries in FHIAP increased considerably over the data period from a monthly average of 33 new entries in Q4 of 1999, to a monthly average of 127 new entries in Q2 of 2004 (data not shown).⁹

Links between Enrollment and CKF State Activities

The Oregon Covering Kids & Families funding period coincided with the statewide fiscal crisis as well as the significant restructuring of adult Medicaid coverage in the state, described above. In a state budget environment in which public programs across the board were targets of cost containment, dedicated resources and state support for children’s outreach were predictably absent in Oregon during our study period. State officials attended CKF coalition meetings and sat on the CKF steering committee; the relationship between state and CKF officials, however, was strained during this period, due at least in part to the difficult budget situations of state agencies. One way in which state program and CKF officials collaborated to improve enrollment processes was through participation in the Covering Kids & Families Process Improvement Collaborative (PIC) during 2004 and 2005. All of the individuals who participated in that effort, which attempted to reduce the “pending” application rate in a pilot county through a client tracking system and internal eligibility staff training, spoke very highly of their experience with PIC.

CKF officials played a key role in disseminating timely and accurate information to the families affected by changes to the OHP Standard program. In bimonthly statewide coalition meetings, the state grantee provided state partners with updates on program changes; more frequently, CKF officials used listservs, newsletters, mailings and press releases to communicate with state and local partners who served affected families directly.

Additionally, CKF served as another type of information channel—from the “front lines” to the legislature. Armed with the experiences of local projects and partners, CKF state leaders were able to, as one informant remarked, “put a human face on [issues of public health insurance coverage] during the budget crisis.”

Local-level Findings

This case study focused on three of the four communities served by local CKF projects—the Health Network for Rural Schools project, the Lincoln County project and the Portland Enrollment Project (PEP!).

Links between Enrollment and Local Project Activity

To explore the possibility that local outreach activities by the CKF projects may have had an effect on the number of children enrolling in public coverage, we compared the trend in new entries in each local area with the trends we would have expected based on those in other parts of the state.¹⁰ If the actual trend in the area exceeded our expectations, it suggests that local outreach activities were relatively more successful than outreach activities elsewhere in the state; likewise, if the actual trend in the area was less than our expectations, it suggests that local outreach activities were relatively less successful than outreach activities in other parts of the state.

Our analysis suggests that for one of the three local projects, actual new entries consistently exceeded expectations throughout the data period. For the other two projects, actual entries in each local area held close to what was expected based on trends in other parts of the state, suggesting that the presence of the CKF local project in those areas did not result in a measurable increase in enrollment during the project period. As was the case at the state level, the most noticeable change in the new enrollment for these two projects is a rapid drop in the last half of 2002 through the first half of 2003—a period that roughly corresponds with the implementation of OHP2 and the OHP Standard program restrictions.

FIGURE 3

Total New Entries to Children’s Public Health Coverage (Actual vs. Predicted) Health Network for Rural Schools, Union, Baker and Wallowa Counties, October 1999–June 2004



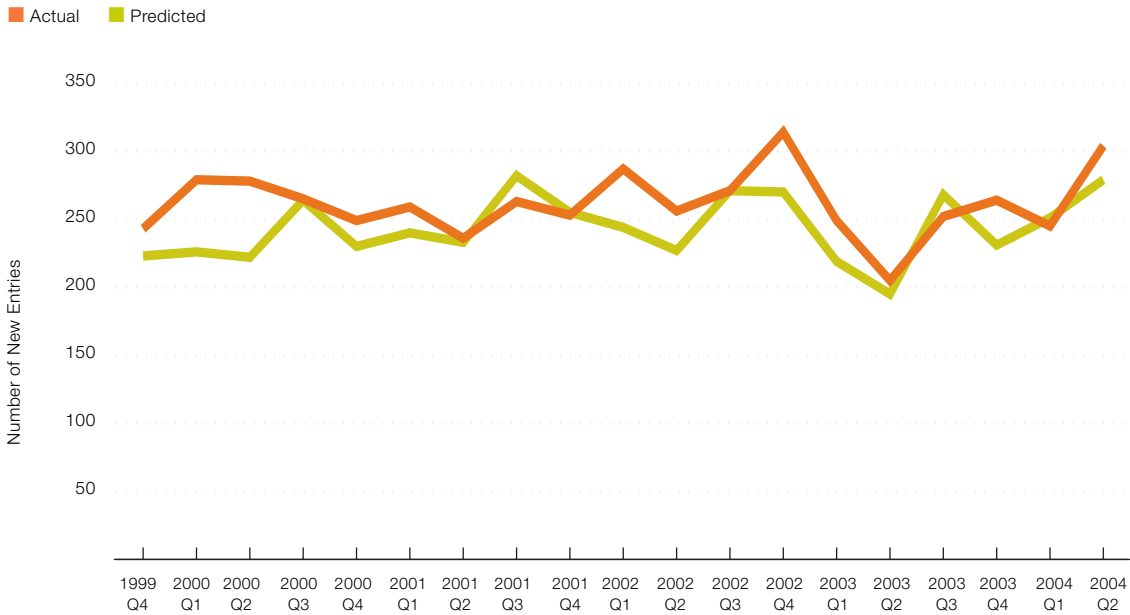
Source: Mathematica, Inc. tabulations and estimates from Medicaid Statistical Information System.

Findings from the Health Network for Rural Schools (HNRS) indicate that outreach activities in the project’s tri-county target area were more successful than in other areas of the state. As Figure 3 illustrates, the actual number of new entries consistently exceeds the expected number during the data period. The HNRS project conducted outreach to students from families without health insurance through a time-intensive and personalized approach. Their primary outreach strategy involved visiting virtually every uninsured family in their service area; outreach workers traveled throughout the rural tri-county area with all the tools needed to assist with completing program applications (e.g., portable printers and copy machines). While potentially very successful in a rural area, these methods may not be feasible or easily applied to other, nonrural projects.

Key informants attributed the project’s success to several factors: good working relationships with school leadership in districts throughout the three counties; the ability to address transportation barriers by traveling to families; outreach workers’ possession of the ‘date stamp’ that is necessary for application processing, and; training local,

FIGURE 4

Total New Entries to Children’s Public Health Coverage (Actual vs. Predicted) Oregon Health Access Project, Lincoln County, October 1999–June 2004



Source: Mathematica, Inc. tabulations and estimates from Medicaid Statistical Information System.

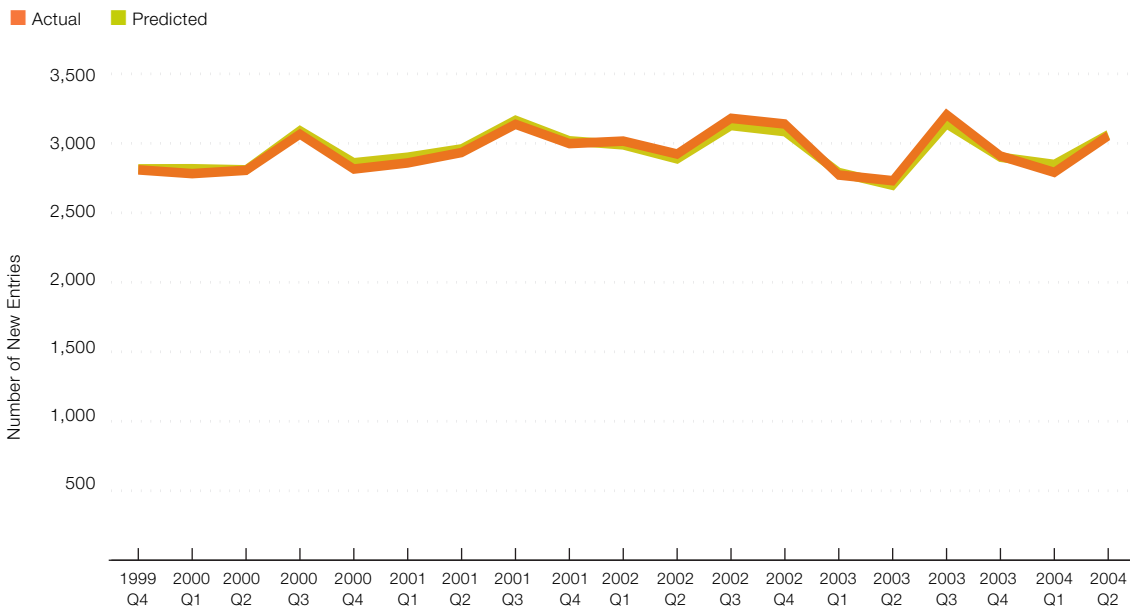
trusted individuals from within the community as outreach workers. Project staff also reported that the biggest challenge to conducting their activities was keeping outreach staff up-to-date on the many changes to OHP programs during the grant period, but the trend in new entries for HNRS indicates that the project was able to overcome this challenge.

Findings from Lincoln County (Figure 4) show that for most of the data period, the number of actual new entries just exceeded the number expected. As in the state-wide Figure 2, an increase at the point when children’s eligibility was expanded from 170 percent to 185 percent of the FPL (in February 2003) is evident in this locality.

One noteworthy non-CKF outreach effort bears mention here, because it targeted children in Lincoln County. In 2004, Oregon’s Governor Kulongoski launched an initiative to increase the number of children with health coverage in the state. The state-sponsored KidCare initiative was piloted during 2004-2005 in two counties—Lincoln and Hood River. KidCare activities included larger-scale media campaigns as well as local, grassroots outreach involving not only the Department of Human Services but

FIGURE 5

Total New Entries to Children’s Public Health Coverage (Actual vs. Predicted) Portland Enrollment Project for Homeless and Uninsured Youth & Families, Multnomah County, October 1999–June 2004



Source: Mathematica, Inc. tabulations and estimates from Medicaid Statistical Information System.

also schools, county health departments, safety-net clinics, physicians and hospitals, pharmacists, faith communities, child-care centers, food banks and others. In this instance, the outreach mainly consisted of information sharing and promotion of coverage; it did not involve direct application assistance. The initiative was considered a failure by most, because there was not any significant change in enrollment as a result of KidCare outreach activities. CKF officials in the county surmised that barriers related to health care access may have played a role in KidCare’s lack of success—county residents may not have applied for the program because ‘the card may not be very useful’ to them if it is difficult to identify a participating provider. KidCare was piloted at a time when there was a lot of confusion about OHP Standard—that program was closed just months before the outreach efforts began—and that could have offset outreach efforts in a major way (Oregon Department of Human Services, 2005).

Findings from PEP! of Multnomah County are difficult to interpret because the PEP! targets a relatively small subgroup of the county's population (homeless youth and families within the city of Portland) and, at the same time, there is a large, strong network of community health centers in the county that conduct public health insurance outreach and enrollment activities. Bearing this in mind nonetheless, the findings for Multnomah County suggest that, throughout the data period, the number of new entries was nearly the same as the number expected (Figure 5).

In contrast to the Lincoln County figure, there is only a slight rise in enrollment at the time when children's eligibility was expanded in early 2003; considering that PEP! targets homeless youth and families—a population unlikely to have incomes at a level high enough to be affected by that change—this is not surprising. On the other hand, it is surprising that the new entries for this most-populous county do not decrease more significantly around the time of the OHP2 implementation and Standard population.¹¹ The PEP! target population for the CKF grant (homeless youth 18 and under) is typically eligible for OHP Plus and was not directly affected by the changes made to OHP Standard. Staff indicated, however, that homeless youth would be sensitive to the OHP Standard cost-containment policy changes because many of their older peers are enrolled in that program. The lack of any significant change in program enrollment at that time might reflect the efforts of PEP! coalition members and other outreach entities in Multnomah County to: 1) promote early enrollment and retention in OHP Standard (which included sponsoring an individual's premium payments); and 2) publicize that the OHP Plus program was still open to new enrollment.

Conclusions

This case study suggests that changes in state policies that restrict adult coverage in public programs had important spillover effects on children, suppressing new entries into children's public health insurance programs. During essentially the entire CKF grant period, state policy-makers placed a high priority on controlling public program costs—especially those related to the burgeoning Medicaid budget—and meeting the state's balanced budget requirement during difficult economic times. While children's programs were not directly targeted by state cost containment measures, children's enrollment appears to have been affected and dwindled during this period. Program enhancements, such as the eligibility expansion enacted in early 2003, were largely overshadowed by the concurrent restructuring of the Oregon Health Plan, numerous new restrictions in adult coverage, and an eventual enrollment cap on the OHP Standard program. During this time, these significant program changes reportedly caused considerable confusion among residents about the state of public coverage in Oregon.

No amount of effort by a relatively small grant program like CKF, or a state pilot initiative like KidCare, could offset the effects of the large statewide policy shifts that limited adult enrollment in OHP and had ripple effects on children's new entries into coverage programs. Several informants reasoned, however, that the state would have experienced even steeper declines in enrollment if not for the diligent work of CKF and its partners.

Although outside of our formal data period, recent policy actions and directives targeted at children's coverage programs signal that the state has experienced some improvement in its economy and that policy-makers may be open to enhancing children's coverage. Echoing a move that several other states have already taken, in March 2006 Oregon's governor announced plans for a universal children's coverage initiative, called 'Healthy Kids', that would cover all children in the state through age 18, through existing programs. Oregon's CKF experience has informed many of the proposal components, such as a streamlined application that would be available online, a 12-month continuous eligibility period, and a grant program to provide local communities with funds for outreach and application assistance. Early plans called for the Healthy Kids initiative to cover all children in families through 300 percent of the FPL with a federal match, and then up to 350 percent with state-only subsidies. A complete buy-in component, open to any family regardless of income, is also part of the Healthy Kids plan. The state administration hopes to fund the universal coverage initiative with a new tobacco tax, which has been referred to voters for a November 2007 ballot measure.

Additionally, just after our case study interviews, child health advocates celebrated the implementation of 12-month continuous eligibility for SCHIP enrollees (in July 2006) and anticipated a similar eligibility period extension for the children's Medicaid poverty expansion group by January 2008. This shift to a longer period of guaranteed coverage eligibility will likely have a positive effect on children's retention rates in the state-improving health insurance retention is just as critical to the workings of an effective state health insurance program, in that stable health insurance coverage can improve access to health care and continuity of care. A future evaluation synthesis study will set out to measure retention among publicly insured children during the CKF grant period, for Oregon and several other states.

Endnotes

1. In addition, within the Medicaid program, we focus on new-entry children whose program eligibility is based on income (either in the poverty expansion group or one of the eligible groups related to Temporary Assistance for Need Families [TANF]). Outreach efforts and enrollment simplification policies are more likely to affect these children than those enrolled for other reasons, such as disability or foster care status.
2. The lower threshold for SCHIP-eligible children is 100 percent FPL for children age 6 to 18 and 133 percent FPL for those age 0 to 5.
3. By comparison, average OHP Plus enrollment for the same period was 355,908 and average SCHIP enrollment was 29,248.
4. Oregon does not have a state sales tax and relies on income taxes (which are particularly vulnerable to economic recession) as a main revenue stream.
5. The state has federal approval to extend eligibility beyond this—to 200 percent FPL—but in light of the ongoing budget constraints, Oregon has yet to implement this expansion.
6. The state plans to roll this change out to the Medicaid children's population by 2008.
7. In 2003-04, the state worked with the Covering Kids and Families Expanded Access Coalition to redesign the OHP application, but many who worked on the effort indicated that the final product remained long and complex. Also, the state participated in the Robert Wood Johnson Foundation-sponsored CKF Process Improvement Collaborative in the period 2004-05.
8. "Other Medicaid" includes all those children enrolled in Medicaid who are not included under the TANF or Poverty-related Medicaid eligibility categories (such as children in the state's foster care system).
9. Data obtained from staff of the Family Health Insurance Assistance Program (February 2007).
10. Expected enrollment is based on a forecasting model that predicts, for each county and city in the state, the number of children enrolling in Medicaid or SCHIP in that quarter. Inputs to the model include: (1) the number of children below 200 percent of the FPL; (2) the population that has just moved into the county from out of state; and (3) the local unemployment rate.
11. According to key informants, Multnomah County is unique in that it has both dedicated outreach and enrollment staff as well as access to "state screens" that allow the staff to view progress on each application. This coordination between local outreach workers and the state screens has been "vital to Multnomah County's success."

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