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Improving Public Coverage for Children: Lessons From CKF in Washington

SUMMARY

Only a handful of states have achieved near-universal health insurance coverage for children. Washington is among those states, in part because private insurance coverage has remained high in the state, but also due to strong political will and the presence of many advocates endorsing the expansion of public coverage to those still uninsured.

Even with supportive policies in place, the need for advocacy remains, as Washington faces the fiscal impacts of a weakening economy, which can have repercussions for coverage policies. An historical review of the Robert Wood Johnson Foundation's *Covering Kids & Families*® (CKF) grant in Washington reveals that advocates for insurance coverage, working in concert with state officials, can positively impact public insurance policy and procedures. Washington's CKF experience also validates the usefulness of the coalition model. Although the CKF project could not afford to maintain its staff after its grant ended, CKF coalition members have maintained the focus on coverage issues in the state by merging their efforts into a similarly focused coalition.

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 SCHIP afforded states, the Robert Wood Johnson Foundation (RWJF) introduced the *Covering Kids Initiative* (CKI) program in 1999 to increase low-income children's enrollment into the Medicaid and SCHIP programs (Wooldridge 2007). In 2002 RWJF expanded the program to include parents, renaming it *Covering Kids & Families*.¹

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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.

This brief examines CKF's work in Washington State in the three key CKF strategy areas: outreach, simplification and coordination. It also examines the extent to which CKF initiatives are continuing since the CKF grant period ended. It concludes with trends in children's coverage in Washington and discusses lessons learned from the efforts of the CKF project in Washington.

The brief draws information from a variety of qualitative and quantitative data sources, including: Medicaid and SCHIP data from the Centers for Medicare & Medicaid Services (CMS); the U.S. Census Bureau; the Covering Kids Online Reporting System (in which CKF grantees reported on policy changes affecting coverage during the grant period); reports on CKF grantees from RWJF's CKF evaluation; surveys administered to Medicaid and SCHIP officials and state grantees as part of the CKF evaluation; and, finally, personal communication with Medicaid and SCHIP officials and state grantees. Using these data, we review health reform in Washington, and examine how the relationship between the CKF grantee organization and the state government supported Medicaid and SCHIP outreach, simplification and coordination activities in the state.

BACKGROUND: THE HISTORY OF PUBLIC INSURANCE COVERAGE IN WASHINGTON

Washington was an early and progressive leader in state health reform. (See Appendix A for a summary of the history of children's health insurance coverage in the state.) Currently, Washington operates the following public health insurance programs in addition to Medicaid and SCHIP:

- The *Basic Health Plan* (BHP) is one of the nation's first state-based health coverage programs for low-income uninsured individuals. Begun in 1987 as a pilot program, it expanded statewide in 1993 and covers two population groups: families and childless adults with incomes up to 200 percent of the federal poverty level (FPL) who are eligible for premium subsidies; and individuals with income above 200 percent of the FPL who are not eligible for premium subsidies. The state contracts with private insurers who provide insurance through HMO plans. Benefits cover inpatient and outpatient care, but there are limits on prescription drugs and mental health services. BHP enrollees share costs for premiums, which are based on income, age, family size and choice of health plan.
- The *Children's Health Plan* (CHP), established in 1990, uses state funds to cover noncitizen children who were not eligible for Medicaid. In 2002 the program was discontinued due to lack of funds and CHP-eligible children were encouraged to enroll in BHP. CHP was reinstated in January 2006.

Washington also was an early reformer in Medicaid. In the early 1990s the state began expanding its Medicaid program to cover pregnant women and infants up to 185 percent of the FPL and children below age 19 up to 200 percent of the FPL. Since 1993 its Medicaid program has operated under a managed care model, using the same HMOs that serve the other public coverage programs.

In 1999 Washington implemented its SCHIP program, offering coverage to children up to age 19 with incomes between 200 and 250 percent of the FPL. The program mirrors Medicaid, using the same health plans and offering the same benefits; families contribute to program costs through monthly premiums.

In the mid-1990s, an economic downturn in Washington led to a decline in state revenues. However, the state was able to avoid cutting its public health insurance programs because the governor, the legislature and advocates for children in the state considered coverage a high priority and the state was able to find other revenues to support the programs.² Beginning in 2001, budget shortfalls forced program cuts such as the termination of CHP in 2002 and a retraction of Medicaid and SCHIP eligibility from 12 to six months in 2003. Tobacco settlement monies subsequently allowed Washington to close its budget gap so it could continue covering Medicaid-eligible children up to 200 percent of the FPL and children in the SCHIP expansion.

CKF IN WASHINGTON

Washington Health Foundation (WHF) served as the state CKI grantee from 1999 to 2001 and was selected as the state CKF grantee in 2002. Founded in 1992, WHF's mission is to improve the health of the people of Washington through public affairs, policy development, grantmaking and direct service provision (Washington Health Foundation 2008).³ WHF received a \$900,000 CKF children's grant and was one of 16 states to receive an additional \$150,000 CKF grant to focus on adult enrollment in public insurance programs. As required by RWJF, half of the grant money went to support local CKF grantees in the state, who worked on outreach in their communities.⁴

To improve grantees' ability to influence state policy, RWJF required all state CKF grant recipients to engage state Medicaid and SCHIP officials in a statewide coalition. Washington's coalition also included representatives from other government agencies, advocacy groups, community-based organizations, health plans, providers, businesses and schools. Washington is home to many organizations and coalitions that focus on health, children and health insurance coverage, and this likely made it easy for WHF to assemble a working coalition.

By all reports, staff at WHF built a strong CKF coalition, engaging relevant stakeholders, including state officials, and developing close relationships with them. State Medicaid and SCHIP officials said that they shared a close partnership with CKF staff, easily building on the relationship that the two parties had established under the predecessor CKI program. State officials said that the CKF staff from WHF were "great coalition builders...bringing agencies together" and improving the way state policies were implemented. As a respected advocate for children and families, CKF "continually nudged [the state] forward" to improve the way the Medicaid and SCHIP programs worked.

State officials cited two areas in which CKF played a key role in supporting coverage for children and families:

1. identifying ways to mitigate the effects of policy changes that otherwise might have reduced enrollment and retention; and
2. improving coordination among public insurance programs to help Washingtonians maintain coverage.

OUTREACH

Between 2000 and 2002 Washington State sponsored three large outreach efforts to find and enroll eligible children and families:

1. the *Healthy Kids Now* campaign, which publicized the availability of and promoted enrollment in Medicaid and SCHIP through media buys, rack cards and a brochure with a joint application for both programs;
2. the *Medicaid Outreach Project*, a community-based outreach endeavor that helped families learn about and get help enrolling in Medicaid or SCHIP; and
3. the *Help for Working Families Campaign*, a media campaign and call center designed to make low-income families aware of Medicaid and SCHIP benefits and enable them to enroll by phone.⁵

However, in 2002 the state's budget was cut due to revenue shortfalls, and Washington eliminated funding for outreach. According to the state SCHIP director, "CKF took on the outreach role." CKF supported outreach in the following ways:

- Funding an outreach program, through a contract with the Health Improvement Partnership, a nonprofit organization that engages in enhancing community well-being.⁶ CKF hoped to maintain outreach until the state could resume supporting it.
- Training workers at local eligibility offices to conduct outreach and to complete the Medicaid and SCHIP applications. This was needed because the state had switched responsibility for these tasks from its dedicated public health insurance staff to state welfare office workers, who were unfamiliar with public health coverage programs and overburdened by TANF, child care and food stamp applicants.

- Conducting training for “outreach audiences,” such as school nurses, public health workers, community health center staff and businesses. Over the four-year grant, CKF conducted seven sessions throughout the state, training 103 individuals. With the help of the local grantee sites, the state CKF grantee also provided outreach information at 29 presentations attended by more than 10,000 individuals.
- Providing application assistance at 1,095 outreach sites during the four-year grant period.
- Developing and distributing a “Child Profile” brochure. The brochure described the Medicaid and SCHIP programs in both English and Spanish, and explained who was eligible, where to call or go for assistance, and so on. Between 2002 and 2005, this brochure was included in 911,000 mailings from the state (such as mailings for school and immunization registries and other public programs).

SIMPLIFICATION

With the help of CKF, Washington was able to implement several changes that simplified enrollment. State officials reported that CKF had considerable influence on reinstating 12-month eligibility. Washington had 12-month continuous eligibility (continuous meaning that enrollees remain enrolled for 12 months even if their circumstances change) until 2003, when the state restricted eligibility to six months in an effort to lower costs.

According to state officials, CKF staff issued a report written with other children’s advocates in the state, showing that the switch to six-month continuous eligibility led 35,000 eligible children to lose Medicaid and SCHIP coverage. CKF’s report also showed how the need to re-enroll after six months was a barrier to maintaining enrollment and that enrollment churning—enrolling, being dropped from coverage, and later re-enrolling—was costing more than offering 12-month continuous eligibility. This report convinced the legislature of the need to reinstate 12-month eligibility in 2005. The state SCHIP director rated this policy change highly (at “10” on a scale of 1 to 10), which indicated the change had a critical effect on the number of children and parents enrolled in public health insurance programs. While state officials said the change might have happened without CKF working on the issue, they believed that CKF had accelerated it.

CKF staff estimated that the churning rate for Medicaid and SCHIP was around 20 percent, so they encouraged the state to simplify the renewal process. For example, CKF alerted the state to a common barrier to re-enrollment—the fact that, although many enrollees sent their renewal forms on time, state and local eligibility staff did not process the renewals quickly enough to avoid wrongful terminations. CKF staff and the state determined that 47 percent of those who failed to re-enroll at the renewal time were wrongly terminated for this reason.

Although these individuals were eventually reinstated, the wrongful terminations caused problems on two fronts:

1. enrollees who were terminated were confused about their status and had trouble getting health care during that period of time; and
2. state workers had to deal with the additional burden of issuing and withdrawing the terminations.

CKF encouraged, and the state adopted, the use of an electronic interface with the state computer system for renewal processing, which eliminated the problem. State officials rated this change an “8” on a scale of 1 to 10 in improving enrollment in public health insurance programs in Washington, and they expected this change to be permanent.

To identify and test additional strategies for simplifying renewal procedures, the CKF grantee participated in a “process improvement collaborative.” State officials, the CKF grantee and others formed a team that participated in training sessions supported by RWJF on the rapid cycle Plan-Do-Study-Act (PDSA) model of testing changes (Institute for Healthcare Improvement 2003). After training, the team selected process changes to test and studied the results to decide whether the changes were worth implementing. In Washington, the team tested eight process changes focused on simplifying retention processes. Two of the changes showed improved results:

1. offering phone renewals, which was later implemented statewide; and
2. implementing a new intake process to align the renewal dates for health insurance with those of other public programs when enrollees have a change of circumstance (such as a change in income).

The latter change later expanded nearly statewide. Participating in the process improvement collaborative gave team members skills they could use to simplify the programs in other ways. For example, CKF staff influenced the adoption of a simplified phone application, accelerated the creation of

a pre-populated renewal form and encouraged the state to discontinue the signature requirement on applications (the signature requirement was reinstated in 2003 after state auditors deemed its elimination improper).

COORDINATION

According to CKF grantee staff, the greatest coordination improvement they helped bring about was bridging the “coordination void” between two state agencies, one that set eligibility policy and procedures (the Health and Recovery Services Administration) and another that determined eligibility (the Economic Services Administration). CKF staff reported working hard to help these two parties understand each other’s goals and the practical implications of their actions.

CKF also helped implement a system that electronically assessed potential Medicaid eligibility for children enrolled in the free and reduced-price lunch program. CKF then targeted outreach directly to children deemed likely to be Medicaid-eligible. The state CKF grantee called this program a “tremendous success.”

CKF staff also reported that they tried to coordinate BHP and Medicaid/SCHIP applications, to make transferring between these programs easier. Coordination had been “one-way” in these programs—applicants to BHP could check a box to be screened for Medicaid/SCHIP eligibility; however, if people applied to Medicaid/SCHIP and were found ineligible, there was no referral to be screened for BHP. Despite efforts to foster screening and referrals in both directions, the CKF staff said that bureaucratic barriers prevented the various state agencies involved in administering these programs from reaching agreement on this issue. According to state officials interviewed in mid-2008, no progress has been made to resolve the situation.

The CKF grantee also helped secure reinstatement of the CHP, the state-only public insurance program serving immigrant children, which had been terminated in 2002. According to the CKF grantee, the state expected those children who lost CHP coverage to enroll in other programs, such as Medicaid or BHP. But very few did so, because there was little coordination to help them transfer to other programs, or they were ineligible for Medicaid (which restricts eligibility to legal immigrants in the United States for at least five years), or they could not afford BHP premiums. CKF worked closely with state officials and other advocates to demonstrate the need for this coverage in the state, and for it to be coordinated with other coverage programs. According to the state CKF grantee, their advocacy helped revive CHP. Although enrollment was capped at 8,000 children, it reached this level the first day the program reopened, according to CKF staff.

SUSTAINABILITY

RWJF required CKF grantees to match 50 percent of the CKF grant amount by the third year of the four-year grant.⁷ The Foundation included this requirement to help grantees gain fundraising experience, so that they would be able to financially support CKF activities when the grant ended. The requirement was intended to induce each CKF grantee to lay a foundation for sustainability by identifying funders who would support CKF activities and the coalition in the post-grant period, and/or by soliciting other organizations to adopt and continue CKF activities.

State CKF grantee staff in Washington indicated that they had a 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. CKF staff believed they had likely used up most private matching funds during the grant period. In addition, state Medicaid and SCHIP officials indicated that they were operating on a tight budget and did not expect to be able to financially support CKF activities when the grant ended, but could provide in-kind support in the form of meeting space. State officials clearly hoped CKF would find funds to continue; just as CKF had funded outreach, the state was hoping CKF might find more money "...to fund some of the important projects that we both want, like electronic applications and a single application for the Basic Health Plan and Medicaid/SCHIP."

The CKF project did not continue under WHF auspices when the RWJF grant ended in December 2005.⁸ However, some CKF activities previously done by the grantee were assumed by CKF coalition members. For example, the Spokane Public Schools Project took over the Healthy Kids Now mailings, and some school district employees were trained to work one or two hours per week on Medicaid outreach enrollment in the schools.

The state CKF coalition was able to continue by merging with another state coalition—the Health Coalition for Children and Youth (HCCY)—which is staffed by the Children’s Alliance, the children’s advocacy organization in the state. The Children’s Alliance had been one of the CKF grantee’s key partners. Alliance staff had participated in the CKF coalition, and many CKF coalition members already participated in HCCY. Thus, HCCY was a natural partner to turn to when the CKF coalition could not survive on its own. Like the state CKF coalition, HCCY also focuses on outreach, (although other community groups conduct outreach), simplification and coordination in children’s health coverage programs. (HCCY has a primary focus on the implementation of Washington’s Cover All Kids Law, which was enacted in 2007 and is discussed below in the “After CKF” section.)⁹ According to staff at the Children’s

Alliance, although the formal CKF project did not survive, CKF’s work is continuing at the same level of activity through the work of HCCY.

TRENDS IN CHILDREN’S HEALTH COVERAGE

Washington has one of the lowest rates of uninsured children in the nation (6.8 percent); in 2007 it had the tenth lowest rate in the United States.

Four factors explain the low rates of uninsured children in Washington:

1. the large number of public insurance programs;
2. the number of large employers (such as Boeing, Costco, Microsoft and Starbucks, among others) that offer private coverage;
3. strong support for children’s health insurance coverage from the legislature and from the current governor (elected in late 2004); and
4. the presence of many groups and coalitions that have advocated for more public coverage, especially for children, since the 1980s.

As Table 1 shows, the percentage of uninsured children in Washington decreased from 10.3 percent in 1999 to 6.8 percent in 2007.¹⁰ The percentage of children covered by government health insurance increased nearly 6 percent in the same period; however, public coverage does not appear to be substituting for private coverage, which decreased by 0.5 percentage points in this period.

TABLE 1

Washington Health Insurance Coverage Trends Among Children Under Age 18

| Year | Percentage uninsured | Percentage covered by government health insurance | Percentage covered by private health insurance |
|------|----------------------|---|--|
| 2007 | 6.8 | 29.7 | 70.7 |
| 2006 | 6.9 | 31.6 | 69.2 |
| 2005 | 8.7 | 31.8 | 67.9 |
| 2004 | 6.6 | 36.0 | 67.4 |
| 2003 | 8.4 | 37.0 | 63.9 |
| 2002 | 9.0 | 30.4 | 67.3 |
| 2001 | 11.1 | 27.0 | 70.4 |
| 2000 | 9.2 | 31.3 | 68.0 |
| 1999 | 10.3 | 24.0 | 71.2 |

Source: U.S. Census Bureau 2008

Note: Rows total more than 100 percent; some children reported both public and private coverage and were counted in both categories.

LESSONS LEARNED

Washington's state CKF grantee served an important role during its four-year period of operation. It continued Medicaid and SCHIP outreach when the state could not. It played a key role in moving forward many simplifications to eligibility policies and the determination and renewal processes, such as 12-month eligibility and simplified renewal policies; and it worked to improve coordination among the agencies that run the state's public insurance programs. State officials credited the grantee with creating a coalition that worked well and included the right people at the table to make change happen. While state officials reported that many of the changes CKF helped achieve would have happened without CKF, they might have taken longer to accomplish without CKF.

The Washington CKF grantee's experience offers lessons about advocacy. First, as a similar study on New Jersey's CKF program found, Washington's CKF experiences demonstrate that advocates for children's coverage can make substantial contributions to Medicaid and SCHIP policies and procedures, leading to increased enrollment of children (Uzoigwe, Hoag and Wooldridge 2008). As in New Jersey, the effort in Washington worked in large part because CKF and state staff shared the same goals and valued each other as collaborators.

Washington's experience also validates the usefulness of the coalition model, demonstrating that advocates who work collaboratively and agree on policy goals and priorities can maintain progress towards common goals, even if one (or even the key) coalition member loses an important source of funding. Interviews conducted with state CKF grantees in 2003 indicated that most expected their collaborators to somehow continue the work of CKF, even if the grantees no longer existed when RWJF funding ended (Hoag and Stevens 2005). However, it also is documented that coalitions can sometimes hinder grantees' work, and that "forced" collaborations—those required by funders—sometimes are partnerships on paper only (Lasker and Weiss 2003; Weiner and Alexander 1998; Lasker, et al. 2001; Lewin Group 2000).

In Washington, the partnerships that the CKF grantee formed with other advocates led to the continuation of CKF activities, even though the CKF grantee staff was reassigned to other nonrelated positions (and later left WHF) and the CKF grantee's lead agency has shifted its attention to other public health issues. The partnership between the CKF project and the Children's Alliance was already strong at the inception of CKF; in a 2003 interview, staff from the CKF project named the Children's Alliance as the organization most helpful to them as they worked to increase enrollment of children in Medicaid and SCHIP. The Children's Alliance plays a key role today in continuing CKF activities by staffing the HCCY coalition and taking the lead in advocating for universal coverage for children. Since the Children's Alliance was already conducting these activities, it did not have to raise additional funds to be able to continue CKF's work. Just as RWJF anticipated when it required CKF projects to form coalitions, coalition members continue to make progress toward CKF goals in Washington.

AFTER CKF: ACHIEVING COMPREHENSIVE INSURANCE COVERAGE IN WASHINGTON

Washington has made substantial progress in reducing the rate of uninsured children, due to its relatively high rate of private insurance coverage, strong political will and advocacy by consumer groups and others to expand public coverage to those who do not have access to, or cannot afford, private coverage.

In 2007 broad support for reducing uninsurance among children led the state to enact the Cover All Kids Law, which aims to achieve universal coverage of all children by 2010. Coverage under this law is being phased in over three years; by 2009 the state plans to expand coverage to children in families earning up to 300 percent of the FPL, with a buy-in program for children whose families earn more than that amount. There are also efforts to consider expansions of coverage for adults. With the re-election in 2008 of Governor Christine Gregoire, a strong supporter of coverage issues in her first term, advocates are hoping that universal coverage can be achieved.

However, CKF's experience from 2002 to 2005 shows that Washington's ability to achieve universal children's coverage can be affected by a weak economy, which may reduce the funding available to subsidize low-income children's coverage. CKF's response to a similar environment was to focus on mitigating the effects of policy changes that otherwise might have reduced enrollment and retention in public programs. With the worsening economy in 2008, advocates may find themselves in a similar position.

Building on the groundwork laid by the CKF project, consumer advocacy groups are gearing up to shape the state's coverage policies, aided by two new foundation grants: RWJF awarded a grant to the Washington Community Action Network and Research Fund in 2008 to work towards universal coverage in Washington; and The David and Lucille Packard Foundation is funding the Children's Alliance to promote expanded children's coverage. It remains uncertain whether these advocacy groups and their coalitions will be able to sustain the political will to continue expanding health coverage despite the economic downturn.

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Appendix A: Key Events in Washington’s Child Health Insurance History (1988–2007)

| Date | Event |
|----------------|--|
| June 1988 | Washington implements the Basic Health Plan (BHP) as a pilot project in King and Spokane counties. Features include: – Cost-sharing for premiums and co-payments based on age, income, family size and choice of plan. |
| October 1993 | CMS approves Washington Healthy Options 1915(b) Medicaid waiver. Features include: – Contracted MCOs agree to provide primary care and specialty services at prospectively negotiated rate – Income eligibility for pregnant women up to 185% FPL, children up to age 19 up to 200% FPL, TANF and TANF-related populations. |
| January 1993 | The BHP becomes permanent and is expanded statewide. Features include: – Subsidized BHP for low-income populations up to 200% FPL – Non-subsidized BHP for employers and individuals who do not qualify as low-income. |
| May 1999 | RWJF's Covering Kids Initiative begins in Washington. Washington Health Foundation is the lead agency. |
| February 2000 | Washington implements separate SCHIP program administered by Department of Social and Health Services (DSHS) to cover children. Features include: – Income eligibility between 200% and 250% FPL. |
| April 2001 | Washington eases enrollment in Medicaid and SCHIP. Features include: – Self-declaration of income – Elimination of interview requirement and asset test – Implementation of 12-month continuous eligibility – Development of shortened, two-page joint application for Medicaid and SCHIP. |
| April–May 2001 | Medicaid eligibility determined by local community service office, by phone, or Help for Working Families hotline. SCHIP eligibility determined only by MEDS. |
| January 2002 | RWJF's Covering Kids Initiative ends. Covering Kids & Families grant begins. Washington Health Foundation continues role as lead agency. |

| | |
|-----------------------|---|
| October 2002 | Washington discontinues Children's Health Plan (CHP) and offers opportunity to enroll in BHP or Medicaid if eligible. |
| January–March 2003 | Washington freezes enrollment in BHP. Features include: – New applicants are wait-listed – Self-declaration of income eliminated – Signature required for Medicaid and SCHIP applications. |
| April 2003 | Income verification required for Medicaid and SCHIP |
| July 2003 | Medicaid and SCHIP eligibility changes from 12-month continuous eligibility to 6 months. |
| October–December 2003 | Income verification for Medicaid and SCHIP required at enrollment and renewal |
| January–March 2004 | CMS grants Medicaid waiver to impose premiums on Medicaid optional children's coverage |
| February 2004 | Medicaid/SCHIP premiums increased, effective 2/1/04, from \$10 per child/month to \$25 per child/month to a maximum of \$75 per family |
| April–June 2004 | Washington governor delays premiums on Medicaid optional children's coverage until at least July 2005. BHP resumes accepting applicants. |
| March 2005 | Washington governor approves change to 12-month eligibility review process (from 6 months) for children's Medicaid. |
| July 2005 | Washington governor approves change to 12-month continuous eligibility (from 6 months) for children's Medicaid. |
| January 2006 | Washington reinstates CHP for noncitizen children on a limited-enrollment basis. |
| July 2007 | Washington governor signs Children's Health Access Law. Features include: – Monthly income limits determining free and low-cost coverage – Low-cost coverage at \$15 per month per child, to a maximum of \$45 per month per family – Coverage for medical, dental and vision care. |

Source: Washington Covering Kids & Families 2008; The Children's Alliance 2008; Holahan and Pohl 2002; Schott and Logie 2002; Washington State Health Care Authority 2008

Endnotes

1. RWJF invested nearly \$150 million in the two programs, through grants awarded to 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 used half of their grants to fund 152 local grantees—at least two in each state; the average state grant was \$828,215 (Wooldridge 2007). Local grantees were intended to be laboratories for innovation from which state grantees could learn about barriers to enrollment and the most effective types of outreach (Wooldridge 2007).
2. Although Washington's spending was limited by Initiative 601 (I-601), which limited the state's general fund spending growth to a three-year average of inflation and population growth, several factors permitted Washington to maintain public coverage programs, including: (1) a decline in welfare and Medicaid caseloads in the mid-1990s; (2) lower rates of medical care inflation than in previous years and relatively low health care costs through the use of managed care in BHP, CHP and Medicaid; (3) slow salary growth rate among state employees; (4) revenues from the tobacco settlement, which helped offset other revenue declines; and (5) strong financial returns on state investments in the police and fire department pension fund (which enabled the state to lower its contributions to the fund in the late 1990s).
3. Examples of other programs it offers include one that links individuals with primary care providers and other providers and one that helps children in foster care with developmental disabilities access coordinated services (Washington Health Foundation 2008).
4. Under CKF, there were six local grantees, although two closed in mid-2003; like WHF, four local grantees completed their grants in December 2005.
5. These outreach efforts were funded through the "Medicaid \$500 million fund," created by the federal government when federal welfare reform legislation delinked Medicaid eligibility from receipt of Aid to Families with Dependent Children (AFDC), now called Temporary Assistance for Needy Families (TANF). States received an enhanced federal Medicaid matching rate of 90 percent for "allowable activities," which included eligibility determinations and re-determinations that arose as a result of delinking; beneficiary educational activities; the production and airing of public service announcements;

outstationing, hiring and training eligibility workers; designing, printing and distributing new eligibility forms; identification of TANF recipients and applicants who are at risk of either losing Medicaid or not being enrolled in Medicaid; and assuring access to Medicaid for low-income families who are not eligible for TANF but are eligible for Medicaid under the section 1931 eligibility category (Ross 2000).

6. This group has since changed its name to Community-Minded Enterprises.
7. In some states, local grantees helped the state grantee meet the matching requirement.
8. WHF initially kept both employees who worked on the CKF project; one left shortly thereafter to form a new nonprofit agency, the other remained at WHF for 1.5 years, later leaving because the new position at WHF was “far afield” from the type of work she had done for children and families in the CKF position.
9. Staff from the Children’s Alliance also participate in the Healthy Washington Coalition, which focuses on adult coverage.
10. We use the Census data with caution: a questionnaire revision, the use of new population controls, and the discovery of editing errors introduced in 1996 affect Census Bureau estimates of the uninsured, publicly covered, and privately insured populations for the years 2000 and beyond (John Czajka, Senior Fellow, Mathematica Policy Research, personal communication, September 22, 2008). Although this impact is likely to vary by state, the Census Bureau has not produced estimates of state-level effects. Nationally, there is about a two percentage point reduction in the uninsured rate that can be attributed to methodological changes between 2000 and 2005. For public coverage, the 95 percent confidence interval is roughly plus or minus 4 percent in recent years in Washington, meaning that a change in the public coverage rate in nonconsecutive years would need to be greater than 4 percent to be statistically significant. In Washington, the change from 1999 to 2007 is a 5.7 percent increase in public coverage, thus, the change in Washington likely reflects a real increase in public coverage, even though some of this increase is attributable to methodological changes.

This brief is part of the Covering Kids & Families evaluation. For more information on this and other RWJF national program evaluations please visit www.rwjf.org.

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