REACHING OUT: Enrolling and Keeping Kids in the SCHIP Program
Alliance for Health Reform and Robert Wood Johnson Foundation
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ED HOWARD: Hottest health and policy topic in town, that is getting decent affordable health insurance to low-income and moderate-income children. Our partner today is the Robert Wood Johnson Foundation, the largest health and health care philanthropy in the country, and one that has taken a very active role for many years to see the kids who qualify for low-cost or free health insurance actually get it. And we'll be hearing from Andy Hyman of the Foundation in just a few minutes.

You know, again and again, we've been told that seven out of 10 uninsured kids in America are already eligible for public coverage. And today, we're going to take a look at why that's the case, and what we can do about, how Congress and the president can keep the promise that was made 10 years ago when the SCHIP statute was enacted.

We're looking, I guess, at the 70-percent solution. And at our kick-off briefing on this topic a couple of weeks ago, Senators Collins and Rockefeller made it clear by their presence and their words that they care deeply about this subject, and they can't be with us today. But we're incredibly fortunate to have with us some pivotal players in the Senate debate on SCHIP 10 years ago who are just as important in this year's debate on renewal.

And first we're going to hear from the chairman of the Senate Help Committee, who's been at the heart of every congressional debate about expanding coverage in memory. I'm proud to say he was an active member of the PEPPER Commission several years ago, from whose ashes the Alliance for Health Care Reform strung and he does need no introduction and he's not going to get what he deserves in the way of an introduction from me. Thank you for joining us, Senator Ted Kennedy.

[Applause]

SENATOR EDWARD KENNEDY: Well, thank you very much, Ed, and for your leadership and thank all of our wonderful panelists that are here today, an extraordinary group of men and women who have a lot of good wisdom to share with all of us, I know. And thank all of you for being willing to spend some time on an issue which is, I think, of central importance to our country and our society and certainly of underlying importance to our children.

We have just finished a debate on the floor of the U.S. Senate. First of all, I want to thank Jay Rockefeller and Senator Collins for their leadership. Jay has been a very special friend over a long, long period of time. He's enjoyed a personal relationship even before he was elected to the Senate. He's been a tireless advocate for children on the Finance Committee.

Senator Collins, we've worked with closely on a number of different issues, particularly in the areas of education and I'm very, very grateful to both of them for their continued work in this endeavor.

And I want to also acknowledge at the very beginning my colleague and friend Senator Hatch. Usually, when Senator Hatch and I co-sponsor legislation, most people say, well, one of them hasn't read it, and that is not true with regards to this legislation. But Orrin Hatch was an indispensable figure in the time that the SCHIP program was passed some 10 years ago, and I have enormous both respect for his continuation and as a member of the Finance Committee working with Senator Rockefeller and a number of us on that committee.

This indicates the continuation of a very important tradition on this legislation and that is, with regards to, I was just excusing you, Orrin. I was just saying nice things about Orrin Hatch. He can stand it now. He's just gotten re-elected. I have too, so we can be nice to each other. But I said to the audience, Orrin, this legislature never would had been successful, it never would have passed, unless you at a very critical and important time, it was my markups that Finance Committee and really dug in your heels and talked about the importance of insuring that where we're going to develop a real program that's going to have obviously strong state

involvement to reach out and cover the children of this country.

Just to get back, and I'm not going to take a great deal of time. But having concluded the debate on the issue on the minimum wage, one of the extraordinary facts is, that came through, time and time again, was the fact that of all the industrial nations of the world, we have the highest number of children that are living in poverty, and in all the industrial nations of the world, we provide less health care coverage than any other nation of the world.

And that, we don’t have to say, well, that in and of itself ought to be a reason. But we ought to, sort of, think back a little bit about what were the reasons and what were the justifications and what were the purposes of other nations, that they felt such an extraordinary reason for moving ahead in terms of the coverage, and they're rather basic and rather fundamental. Not really like we have seen, that so many of those that are the parents of these children have lost their health insurance in recent time, and therefore, if there hadn't been the SCHIP program, that these children that are covered, that are in that gap between the Medicaid and the SCHIP program would certainly have lost any kind of coverage, because we have seen the growth of the uninsured in this country. And that’s another issue for another time. But its implications with

regard to children is very profound, and it's putting enormous pressure even at the present time.

Secondly, if you look over the incomes of the groups, you take even college graduates, those individuals with children anywhere from two to seven, nine, 10 years old, and you look over all the different groups in our society, you'll find that those particular groups both men and women, incomes have been stabled over the last five or seven years or actually declined over the last. So, it's putting increasing pressure on families with children, when they're also finding that they have other kinds of responsibilities on food in terms of housing, in terms of where their own repayment of student debt and many other obligations. So there's an increasing pressure on this. There's an increasing fracture and course that these children are more vulnerable now because we're seeing the pressure on them, because of the decline in terms of health insurance.

If you look at what's happened in state budgets over the period of the recent years, in my state alone in Massachusetts we are $1 billion, $200 million short in terms of the funding of these. And if you look over with the exception of certain states, quite frankly, that have been fortunate enough because of the energies issues, I mean, the dramatic surplus you have down in Texas, close to $7 billion and some of the other states that have these mineral resources. But if you

look at where the poor children are, where the needy children are or where the profiles for these children, you'll find that the states have been hard-pressed to provide the resources on this.

Now, we could say that these are all useful and maybe somewhat interesting. But I'm, as someone who's concerned about education, I have listened to too many teachers who have come before our committee and say that they have too many children in their classrooms that can't see the blackboard or can't hear the teacher, and they are not getting the kinds of attention or dedicating the focus, they're not getting the health care that they so vitally need.

I've traveled to too many parts of this country to listen to too many parents that wonder whether their child is going to be $150 or $250 or $300 sick, because that’s what they have to pay if they go to the emergency room, and they’ll say maybe I'll just wait another day and see if my child is going to get better. That is happening in the United States of America, at this time, and it is putting a burden primarily on younger people, primarily on workers and primarily it's a burden that is placed upon children. If you read Elizabeth Warren's book from the Harvard Law School, where she talks about what is going to be the future of the middle class and what is going to be the future of children in our society, you

find that the trend lines that are impacting children are all going in the wrong direction.

And one aspect, it's a well-worth-reading book. She's a magnificent professor there, and has really done in analysis about what is happening to the middle class and the young couples, and particularly the young couples with children and the implication with regard to children, that is very, very important and profound. So, we have this extraordinary pool and the function and the central purpose of your group is how you're going to reach out, how you're going to find those children and how you're going to make sure that they're going to be involved in this program. But there's an underlying factor, and that is whether the resources are going to be there in order to pay for this program.

I was impressed this morning to see that the governors have come together, Democrat and Republican, governors have come at the opening day of the Governor's Conference, and virtually unanimously have urged the Congress and the president and the distinguished secretary, all Republicans and Democrats to come together on a program they know is working and they know that they can administer and they know that they can work and know the critical need.

And the real kind of issue is whether we, in the Congress, I think, are going to prioritize the needs of the children over this period of time, whether we're going to just

say that those at the lower end of the 200-percent of poverty are going to be the cupboard or whether were going to recognize the opportunity to make a very important difference of really making sure that we're reaching not only those that are eligible in the Medicaid, but we're also going to try and work with the states, like my own state of Massachusetts, that's moved up to 300-percent poverty and try to say that this is going to be a matter of national priority.

In the early 1960s, in the early 1960s, this country said, as a matter of national priority we are going to recognize that we as a national responsibility have an obligation to educate poor children. That is title one. That's title one. And we've been working on that and shaping that and changing that and we're going to work on it again in a revised matter and the No Child Left Behind. But why aren't the world, are we making this as a national priority if that we're going to save health care for children? We're making it on education, and why aren't we going to do it? It's the same children. It's the same needs. They're actually intertwined in terms of what the needs are and this ought to be a matter of national priority. In a budget of $2 trillion, 900 billion, we ought to be able to find the billions of dollars, whether it's this year or whether it's over the period the next five years to allocate the $50 billion over a five-year period for it.

And if we can't find it in that $2.9 trillion, we ought to be able to find a sufficient loophole closing in terms of the whole budget, the tax expenditures to be able to say, as a matter of national priority, what is more important for us? That we're going to invest in our children, so that they're going to have a more prosperous and hopeful future? That is going to make a difference in terms of our national security. Having an investment in children is a national security issue. It's a global economy issue because we're going to need it in order to be able to United States to be able to compete. In the global economy, it's essential in terms of our values, it's essential in terms of our values as a democracy to have people who are going to be healthy and are going to be educated and understand and involved in terms of making our democratic institutions work.

If you get whatever the criteria, whatever the test, finally it is in our self-interest, if we're looking about how we're going to get a handle on health care cost in the future. The best investment that you can make on this is investing in the children. You're going to have healthier children that are going to have, dealing with the chronic challenges that they're going to have in a more comprehensive way and that is going to have a very important, dramatic impact in terms of the cost and expenditures.

So, whether you're interested just in bottom-line issues, or whether you're interested in the shape of our democracy or where the United States is going to be in terms of the world, whether your chagrinned by where we are and how we treat our children in terms of this industrialized nation, or whether you're motivated by the fact the every child in this country ought to be able to start off with a healthy start, whatever the criteria, the SCHIP program working, and effectively, tied in to the Medicaid program and having the kind of support that your panelists have suggested and Outreach support, I believe is the way to go. Thank you.

[Applause]

ED HOWARD: Thank you so much, Senator Kennedy. Talk about your one-two punch. We're now really honored to welcome to the discussion about kid coverage, one of the key authors of the original SCHIP legislation, and Senator Rockefeller has told the story many times of the meeting in the finance committee where Senator Hatch and his colleagues decided they could get along without staff support and come to an agreement to break a logjam when this legislation was foundering back in 1996. So, we're so pleased to have you with us Senator Hatch.

SENATOR ORRIN HATCH: Well, I'm honored to be with you today, and especially with my colleague Senator Kennedy, who gives me a lot of angst from time to time, but as he does almost everybody. [Laughter] I do think - Happy birthday,

Senator Kennedy, I do think— [Applause] — however, I have to say about my friend that I think a full solid week of birthday parties is a little bit excessive. [Laughter]

However, I have a great respect for him. We went up and down this land giving speeches all over the place and bringing the liberal children's groups together, the conservative groups together and even irritating the daylights out of some of out colleagues who felt that we were a little excessive on some of our comments about how important this is, but it wouldn’t have happened without Senator Kennedy. But I also want to mention it would not have happened without Senator Rockefeller and Senator Collins, and I don’t think they’ve received nearly as much credit at they deserve for their [inaudible] excellent program. But thank you, Ed, for inviting me to speak here today and I also do want to think Senators Rockefeller and Collins for hosting this savannah for their dedication that's just surrounding children's health. And of course, again, I want to thank my partner. We've done an awful lot in health care and in other areas as well, and we fight each other most of the time, but we're always able to be friends in the end.

Thanks to Senator Kennedy, whose vision and drive were integral to the development of the SCHIPs program, and I'm grateful that he could be here today. Senator Kennedy was the co-author with me of the child bill, which became when melded

with the Chaffe/Rockefeller bill expanding Medicaid coverage for children. And it's no coincidence that we are here together again today as we continue to have great interest in this program. In fact, almost everybody does who looks at this program. At last, but certainly not least, I extend my thanks for our moderators and the expert panel that you have here today. We truly appreciate your insight and your expertise today as we explore Outreach and Enrollment possibilities for CHIP.

And as you know, the balanced act of 1997 created the state Children's Health Insurance Program, better known as SCHIP, with a new title 21 of this Social Security Act. SCHIP provides states with federal matching funds to cover uninsured children of families with incomes that are above Medicaid eligibility levels. Today, 10 years later, all 50 states, the District Of Columbia and five territories have SCHIP programs. And as allowed and is allowed by law 17 states, use Medicaid expansions. Eighteen states use separate state programs and 21 states use a combination approach of both their Medicaid program and the state program. So state flexibility is a very strong component of the program's success.

I can still remember two couples coming from Provo, Utah, to me early on in this matter - in fact, at the beginning of this matter. In both instances, the husband and the wife worked, but neither family made more than $20,000 a year. And

they could not afford health insurance for their children. These were the working poor. And SCHIP was designed to try and help children of the working poor, who were the only ones left to of the health care process. And we still find a number of them left out today. When we drafted this legislature in 1997, our goal was to cover several million children who had no health insurance coverage at all, and I'm extremely pleased to report that approximately 6.2 million children,have their health insurance coverage through the SCHIP program today.

Now, we've gone a long way in meeting that goal, but we're clearly not there yet. It is estimated that there are between 2 million and 2.8 million children nationwide who are eligible for the SCHIP program but are still not enrolled. Coverage of these uninsured children should be our top priority. I know they are in the case of Senator of Kennedy and myself and Senator Rockefeller and Senator Collins as well.

I know some may disagree with me but, in my opinion, we should not consider expanding this program to other populations, until we've covered all eligible children who do not have health care coverage. It is important to note here that the federal dollars and the budget baseline allocated for the SCHIP program over the next 10 years, as Senator Kennedy has so eloquently expressed, will not even cover current SCHIP beneficiaries. That amount is $5 billion annually over the next 10 years. Some estimates claim that we would need another

$12 billion to $15 billion over the next five years just to sustain the program that current capacity, and that doesn’t include adding the others who really deserve to be helped.

As it is estimated that there are well over 2 million children nationwide who are eligible for the SCHIP program that are still not enrolled. Expansion of the program poses a very valid a very real fiscal concern. But I know we're not here to talk about money. My subtle sense of humor doesn’t work as well. [Laughter] We here to examine outreach activities to increase enrollment in this very important program.

My home state of Utah uses a variety of strategies to identify and enroll eligible children. And although Utah runs a separate SCHIP program as opposed to a Medicaid expansion or a contribution program, there is coordination between SCHIP and Medicaid. Medicaid eligibility work is already in place and almost 100 locations determine eligibility for SCHIP.

These eligibility determination sites are located in hospitals, community health center, local health departments, department of work force services, offices and many other allied agencies. SCHIP information is broadcast through community presentations, press coverage, toll-free telephone lines, brochures, flyers and postcards. Information is also disseminated by housing assistance organizations, hospitals, medical care sites, community-based organizations, and other Medicaid Outreach Campaigns.

Now, as I mentioned, state flexibility is important. And we tried to write it in to the bill. Not all strategies will work for every state and it is likely the some outreach methods may not have worked for any state. That is why I am very concerned in hearing what our panel of experts have to say today, and we will have people here to listen to them. To provide health care coverage for those eligible-but-not-enrolled children remains my primary goal and concern. In exploring the way outreach influences enrollment is a very important step in reaching that goal.

Now, let's be honest about it, we have a lot of budgetary problems up there. If we didn’t have Katrina, the other national disasters, 911, the war in Iraq, we would be well over a balanced budget. And we would have plenty of money it seems to me, to resolve an awful lot of these problems. On the other hand, if we take SCHIP and we make it into a universal health care program because it's so popular, I think we'll wreck SCHIP in the end, and we may never get that program through. So, I hope that we can work together to get SCHIP modified, improved, rearranged, whatever it takes to make it work better after all these years of experience and re-authorize it and provide enough funds for these children out there who are not covered by any other form of health insurance.

I have to say it's a pleasure to work with these people that I've worked with on this. Senator Kennedy and I go back a long, long way together, and I think we've passed as many health care bills as any two people in the whole Congress. Senator Rockefeller is playing a significant role on the finance committee and of course, Senator Collins is one of the great women leaders in the United States Senate. And there are others who were very, very helpful in this program.

I'll never forget the day we passed CHIP in the Senate. You know, SCHIP was the glue that brought together the first balanced budget in over 40 years. The Republicans wanted the balanced budget, Democrats wanted SCHIP and some Republicans as well, and that's what really brought us together. I'll never forget, I was standing at the dais the marble dais there with my elbow on it and one of the leading Republicans came up to me and he said, I hate this bill. Then he voted aye — [Laughter]— which tickled me to death, and I've never forgotten it. All I can say is today he and a number of others claim that this SCHIP bill is their bill as well. [Laughter] And frankly, it is.

So, let me just say it's a privilege to be with you, it's a privilege to be with people who are willing to make a difference for our children in our society. It's always a privilege to be with my friend Senator Kennedy. As you know, we get along pretty well for two completely opposite individuals

and I have nothing but respect for him and his wife and his family. Over the holidays, I read the book, *Sarge*, about Sergeant Schreiber. As you know, Eunice and Sergeant Schreiber have been great leaders in this country for a long time, and I have to say that it was one of the great books I read, because Sergeant Schreiber had a lot to do with Job Corps, the Peace program, with Head Start. A lot of the programs that help children and families came right from the Kennedy family and from Sergeant Schreiber, and it was a real thrill to be able to read that and to, again, renew my fondness for the Kennedy family, and particularly the Schreiber family. Eunice has always been my secret weapon, because we have gotten along very, very well, as we worked on some of her great projects, the Special Olympics being one of them. And every time I have a particularly tough time with Ted Kennedy. I just, okay, I'm going to go talk to Eunice — [Laughter] — and Teddy always says, no, no, no don't do that, don't do that. We can work it out. Having read that book and seeing how really powerful Eunice is in the family and elsewhere I understand now why he is definitely afraid of her. All I can say is three great people, Sergeant Schreiber, Eunice and Ted Kennedy. Well, four. Vicky, his wife, is a tremendous human being and could I go on and on and I just — I can't claim that for the Hatches. All I can say is that we're a very poor peasant family and I'm

the only one who ever had a college education so... and some even deny that.

But it's great to be with all of you, keep up the great work, this is a very, very important thing that we're doing. And I've got my Save The Children tie on, just for you today. God bless all of you, thanks.

[Applause]

ED HOWARD: Thank you so much, Senator Hatch, and thanks to both of you for taking the time out of incredibly busy schedules and fighting the weather to get here, to talk to some of the congressional staff who we're going to be relying on for the background information you need to work on this legislation over the next few months. I mentioned that the Robert Wood Johnson Foundation was our co-sponsor today, and I want to thank you so much.

[Applause]

Yes, absolutely. So you know when you come up with the solution we can get it through. And by the way, I want to thank Senators Rockefeller and Collins for doing some high-powered, high-pressure recruiting to get us the full panel today. As I say, I mentioned the Robert Wood Johnson Foundation, and representing the foundation today, the leader of its health coverage team and a senior program officer there, is Andy Hyman. Andy I want to give you a chance to [interposing] here.

ANDREW HYMAN, J.D.: Thank you, Ed. Good afternoon everybody. Thank you all for joining us this afternoon, and thanks for holding this briefing, Ed. We at the Robert Wood Johnson Foundation are particularly pleased to be working with the Alliance to bring together this terrific panel. Each of the participants here have played unique roles in studying, shaping, managing, implementing the SCHIP program over 10 years. We're very fortunate to have them here to reflect some of the key issues at play in the SCHIP program and to consider, of course, what comes next.

The foundation has worked hard itself over the life of the program to make it a success. RWJF has committed more than $150 million on programs such as covering kids and families to work in every state to increase enrollment in the program through simplification and coordination and Outreach strategies. Now, at a time when in this country there's much for us to be glum about, when considering the direction of the health care system, we've had one shining success: the shining success in the SCHIP program and the coverage of America's children. During this period, while the number of uninsured adults have gone up almost 20-percent, the number of uninsured children has decreased more than 20-percent. And so, because of SCHIP, millions of children have been able to get the health care they need, when they need it. And Congress, and

particularly the two senators who were just here, should be tremendously proud of this achievement.

So, with the reauthorization of the SCHIP program, Congress has a great opportunity to celebrate its success, but perhaps most importantly, I have an opportunity to use the information for lessons that our expert panel, this afternoon will share with us, help us move forward and to shape the program to cover all eligible children. Thank you, and take care.

ED HOWARD: Thank you, Andy. And I should note that Najaf Ahmad is in the audience from the foundation staff, whose efforts on behalf of this program were also stellar and essential for its success.

We have an incredible array of speakers and I'm going to offer two apologies to all of them. One is that I'm not going to give them the introductions they deserve. There's information in your packets. And the other is were going to be draconian about the time limits because of our extended program. We wanted to make sure that all of them get a chance to share their thoughts with you and that you get a little bit of a chance to question them as well.

So, with that in mind, let me turn to Cindy Mann, who's our first speaker. She directs the Georgetown Health Policy Institutes Center for Children and Families and was responsible

for children's health programs within HHS, so we're happy to be able to tap in to your expertise, Cindy.

CINDY MANN: It's, great to be here. Thank you so much. I'm going to share the podium for a while with Senators Kennedy and Hatch.

So, turning to the topic for today, when SCHIP was first enacted in 1997, a major change in the paradigm occurred around public coverage. For years before Medicaid was enacted in 1965 and for many decades before SCHIP, children were sometimes made eligible for public coverage, but there was very little effort and in some cases, absolutely no effort at all, to actually reach and enroll eligible children. And that change in the paradigm really occurred when CHIP was enacted.

States around the country, communities around the country, community-based organizations and some foundations - most notably the Robert Wood Johnson Foundation - really invested a tremendous amount of energy and effort in to actually trying to reach, find and enroll and retain the kids who are eligible for public coverage. And these changes resulted in an enormous gain for children.

And we found out an answer to a question that we really didn't know in 1997, which was if you set up these programs, if you establish expanded coverage, would we enroll eligible children? If you build it right, they will come, is really what we found out. So, I'm going to review a little bit of

what the trends have been in terms of public coverage, and I'll move along. My flow with my timer here.

There's been several references to the gains and successes that have been achieved. This data from the Centers for Disease Control show that between 1997 and 2005 the uninsured rate of low-income children dropped by one-third. That is a stunning achievement, particularly when you consider the fact that the overall number of people grew during this period of time. We had higher rates of un-insurance among adults, we had rising health care costs, we had declines in employee based coverage and during some of this period, we had a significant fiscal hiatus at the state level, which made it more and more difficult for public coverage programs to do their job, but do their job is indeed what happened and we saw a remarkable change in the coverage.

And I want to stress an important point that I think has been alluded to already in the panel, which is that this success is due to both the SCHIP program and the Medicaid program. About half of the children who gained coverage during this period of time gained coverage in the Medicaid program. There was a great amount of coordination, a great amount of simplification and changes that occurred in Medicaid as a result of SCHIP, so while we say that SCHIP prompted a lot of these changes, the actual enrollment that occurred was both within the SCHIP program and in the Medicaid program.

And we see also that we found its successes in many different areas, including narrowing the disparities in the coverage among our racial and ethnic groups. The disparities certainly continue and that's a big issue that we need to look forward to dealing with in the next period of time, but the disparities have narrowed.

So, why did we see the success that we've seen? Well, two things. One is, obviously, states expanded their coverage programs. This map gives you a sense of the eligibility levels in each state for the Medicaid and SCHIP program. A survey conducted by a colleague of ours, Donna Cohen Ross at the Commission on Medicaid and the Uninsured, gives us a lot of these data. But we also found out as part of the success story, just as important to this success story as increasing the eligibility levels was increasing the participation rates. The change in the paradigm. Reaching and enrolling the eligible kids. And so these data show you some changes in both the Medicaid program starting in 1997 and in the SCHIP program starting in 1999, in terms of actually boosting the participation rates. What percentage of the eligible kids were actually gaining coverage in these two programs? And you see that Medicaid bumped up to an 82-percent participation rate in 2002, and SCHIP about 68-percent.

What does it matter that we have better participation rates? Well, I think the importance of taking the kind of

steps that we're here to talk about to improve enrollment and retention is demonstrated by the experience of many states. This is some data from the state of Louisiana. This graph shows enrollment changes in that state, not because during this period of time this state changed eligibility but because step after step after step, the state changed its rule and its procedures for how they were bringing in to the program and very importantly in the state of Louisiana and for most states, how they were renewing eligibility, so that they were not losing kids once they were on the program. And so, these gains were not because of the change in eligibility. These things were because of some of the simplification steps that were taken that boosted participation rates.

So, where are we now? This sides [inaudible] in station. Well, we've heard already, Ed's talked about that we need the 70-percent solution. There are about seven out of 10 of the eligible children who are uninsured in the nation today are actually now eligible for the Medicaid program or for the State Children's Health Insurance Program, and among low-income kids, that number's about 87-percent. That may sound counterintuitive, given that I've just talked about how successful we've been in boosting participation rates.

So, I want to go behind these numbers and talk about what's been driving these numbers. We have boosted participation rates but, of course, there's been other factors

that explain why today the success story that we've had both in terms of increasing eligibility and in boosting participation leaves us with, many and most of the kids who are uninsured being eligible for coverage. We have more children in the nation. That's actually a relatively small factor. We don't have a lot more children in the nation in the last 10 years, but still more. But we haven't significantly expanded the program, so the universal kids who are now eligible for public coverage is much greater than it was 10 years ago. Similarly, we have more children who actually need the coverage, who are among those who are eligible because of the decline in the employer-based coverage.

So, while we've boosted participation rates, we actually have more eligible but unenrolled children. A high percentage of eligible but unenrolled children. So, this [inaudible] which I won't go through, give you some of the data in the percentage of children eligible for Medicaid and SCHIP and how that has expanded since SCHIP was adopted. Okay? So, we have a larger group of kids who are now in the universe and potentially getting coverage. That's a good thing. And we have more kids needing public coverage and it's a good thing that we have public coverage there to receive them because we've seen declines in employer-based coverage. And it's important to note, that the declines have been for kids as well as for parents, but for kids we have the public coverage

programs, Medicaid and SCHIP to be able to pick up what's going on.

An important thing also to keep in mind, both as we think about today, that seven out of 10, and as we think about what the tasks are going forward, is that it's not evenly split across the country. Whenever you look at these data, you always realize that the national numbers really mask significant variations across states. And so, what we've given you here is some participation rates for the three top states in terms of participation rates and the three states at the bottom of the rankings. And you see a considerable variation. And so, while you may have nationwide seven out of 10 of the uninsured children are eligible for Medicaid or for SCHIP, in some states we have participation rates that are 90-percent, 92-percent, that’s Arkansas and Vermont, and in some states we have participation rates that are 50-percent or 60-percent.

So, where do we go in terms of trying to make progress from where we are today? Here's some data on who are the eligible but uninsured children and I'm not going to get through the details, I think it's familiar to a lot of you. Most of them are in families whose parents are working. They're in small firms, they're self-employed, they're families who both because of the types of firms they work for and their income levels have a difficulty affording private health insurance even if it's offered to them.

We've had states take a number of many important steps over the last several years and other panelists were going to talk more in detail about some of these steps. Some of them are the most obvious ones that we had to confront early on in the year, getting rid of the acid test, which turned out to be just a paperwork area for the most part, eliminating the requirement that you actually have to physically go to welfare office to apply for public health insurance coverage and eliminating that face-to-face interview also at the renewal stage. We just don’t have all states doing that activity, but as you see, most states do.

There are lots of other measures that some states have taken. Some of them are really hard to quantify. There's a couple at the beginning of this table that shows the states that have adopted continuous eligibility, which has been a measure that has been found to be very successful in keeping and enrolling eligible children, presumptive eligibility. But some other things are also a little bit more elusive and harder to nail down. What's the documentation look like? How many pieces of paper do people have to bring or send in to the office in order to get coverage? What additional forms are needed beyond the application form? Is the state system fully automated?

What we saw a lot after welfare reform is that state eligibility systems relied a lot of computer go-arounds, where

you have to avoid your computer system because the computer system was doing it wrong and whenever you rely on manual changes, you would lose a lot of kids who were eligible, and who should be retained on the program and, of course, we have seen a lot of outreach come and go, some being more successful than others. I think the overwhelming point is that it matters enormously what states do in this area and a lot of what goes on goes back to the issue that Senator Hatch joked about, which is, it's about money.

This is the experience of the state of Washington, it took a number of the steps, a number of taking advantage of the tools that many states understand will increase participation rates that will bring in the eligible kids and you see at the beginning of this graph that it was very successful.

Then the state ran into a fiscal problem and it took back many of these steps and the barriers were resurrected because when the state is successful in enrolling eligible children it has to confront some coverage costs. And so, you saw enrollment then drop down and when the state recovered, it went back up.

So, let me just summarize and end my talk here by talking about where we can go in terms of federal opportunities. First and foremost, adequate funding for the Medicaid and SCHIP program. You certainly can't enroll eligible children if there isn't financing there. We've seen

there are freezes now instituted in Georgia because of inadequate federal dollars on the table. We also could think about some additional measure that would really help the underlying fiscal incentives. When states like Washington experienced, decide that they can't afford to take the steps they know will lead them to success because of the added state coverage cost, we could address that if the federal government stepped in and said, you know states, if you are successful, if you enroll more eligible children, we will boost the federal participation, particularly in the Medicaid program which has a lower match rate.

Some new tools like express lane is one that would be useful and helpful for a lot of sates and of course, eliminating some of the barriers that the federal government itself imposes. Most notable is the recent barrier imposed by the deficient reduction act, which is to require citizen children to bring in documentation and, sort of, take a major step backwards in this simplification that was achieved over the last several years.

The debate over SCHIP reauthorization and the activity going on in states really around the country right now are reinvigorating the interest in covering children, really demands that we pay a lot of attention to the issue that we're here today to talk about. We calculated if the nation as a whole could bring their participation rates up to the higher

levels, that some states have all ready achieved, these are achievable goals. Not just in Vermont, but in Arkansas, and we could reduce the number of uninsured children in this country by half. Thank you.

[Applause]

ED HOWARD: Thank you, Cindy. Our next two speakers come from Virginia, both of them. Both of them work on health care coverage for children. They often agree on difficult policy issues. One's inside state government, one's head of a public-private partnership that promotes wider and better kids coverage, so we're pleased to have them as point-counterpoint or at least complementary presentations. And we're going to start with Linda Nablo, she runs Virginia's SCHIP program, known as is it FAMIS. The Famous SCHIP program in Virginia, and as part of her duties that program falls within the Division of Maternal and Child Health which she directs in the state's Department of Medical Assistant Services. Linda, thanks for being with us.

LINDA NABLO: Thank you, thank you very much to the Alliance and to Robert Wood Johnson for having me here today on this, unexpectedly for me, distinguished panel. If anybody asks, I've got a picture of me sitting next to Senator Kennedy, would you send it to me, so I can show my kids? Thank you very much. Okay. [Laughter]

I really want to pick up very much on what Cindy Mann was talking about, especially at the end of her remarks. It matters hugely how states administer these programs and what barriers there may or may not be in place as to how many other citizens or residents can take advantage of the program. Any state SCHIP director could be sitting here today in my place and talking about the importance of outreach and in simplifying the process in order to get kids enrolled. I think Virginia is here in part, besides the fact that we're close, I think it's also here in part to tell a story that illustrates how you can do it right or how you can do it wrong, and then how you can turn it around and fix it and do it right and what matters in accomplishing that.

Virginia has actually had, sort of, three separate SCHIP programs in its short 10-year history. The first one was named CMSIP. I'll go to that in just a minute. That one didn’t work very well. If that one didn't work very well, it was replaced in 2001 by the program FAMIS, obviously named by the same person who is not a marketing expert, because everybody does in fact, mispronounce it and doesn’t know what it is. That’s the first challenge we overcome in Virginia and then when the FAMIS program wasn’t living up to hope for expectations, it was refined, if you will. We didn’t change the name that time, but in my book, sort of, the son of FAMIS or new-and-improved FAMIS, that actually took effect in 2002.

Our first try, CMSIP, Children's Medical Security Insurance Plan, it was born from a very stormy state legislature session in Virginia. When SCHIP was passed at the national level and the money became available to the various states, the then-administration in Virginia did not look very favorably on this program. It was during the time right after welfare reform and in fact, our then-governor characterized SCHIP as backsliding on welfare reform, so it wasn't exactly embraced at the state level. However, the advocates got together, a wide and diverse coalition of advocates got together to push the Virginia legislature to pass the most possible generous SCHIP program which have been an expansion of the Medicaid program up to 200-percent of poverty. As I said, a very stormy session and, finally, in the veto session that year, since it was approved and it was implemented in October of '98.

It was, sort of, a clone of Medicaid in terms of its benefits and how you got to it, but it did have some significant policy barriers embedded in it. Including for example, a 12-month waiting period since the child was last insured and several other barriers like that, that made it very difficult. There was also very little outreach, very little commotion of the program. Virginia did get a first round of RWJ grants, as all states did. It was then called covering kids. It was not handled particularly well. Some of the

initiatives that were funded by that first round of money never really came to fruition and pretty much was squandered, that money, I think, in the first round of grants. No surprise then, enrollment was very low in Virginia and we became what some would call a donor state.

We began to, after the first three years, according to the SCHIP formula, it never spent all your money, you give it back, or at least you give part of it back to those states who are in fact enrolling children. And so, Virginia became one of those states that other states liked a whole lot, because we kept giving back federal money instead of spending it on Virginia kids.

So, on a second try, this obviously began to build some political pressure because Virginia was not enrolling kids, was not spending federal dollars on Virginia kids and was, in fact, helping to provide coverage to North Carolina and Maryland and other state kids. Other contiguous states to us. That built political pressure, the governor and the legislature agreed to change the program, they changed it to more of a private health insurance-based program. It was modeled after the state employee plan at that time. It did have comprehensive benefits, but not as generous as Medicaid. It did have at that time monthly premiums and co-payments, and you couldn’t get to it any longer through your local Department Of Social Services. It was totally severed from the Medicaid program.

If you went to Social Services and applied for your children, about 45 days later, you'd find out you were $1 over the level and you'd be told to go elsewhere and fill out different forms, come up with different documentation, and apply to a different source to the SCHIP program, at which was at that point established to a central process inside because you got through mail and phone calls.

A lot of families gave up, or delayed the process out of frustration until their child got sick. So, there was some improved outreach in the FAMIS program, but still enrollment was disappointing in Virginia. So, along came a gubernatorial campaign, I don't know if you are aware or not, but Virginia is the only state in the union that has a one-term governor. So, it became a campaign issue. The candidate running, Mark Warner, pledged to get out kids enrolled, he was elevated and we set about much more aggressive outreach, especially with the help of the second RWJ grant, which was far more successful and we ultimately came to much improved enrollment.

And these are some of the kinds of things, Cindy Mann alluded to these. These are things other states had done before Virginia, but in terms of simplifying the process, making it much easier for people to apply, reduced waiting periods, we did create a Medicaid expansion as well as a separate SCHIP program. We allowed people to apply at either their local departments of social service or to the central

processing site. We did very aggressive outreach, often involving the governor and special appearances, et cetera. And this was the immediate result.

The yellow bar will show you the average monthly gain in enrollment, the average net gain in enrollment in the 13 months prior to the implementation of those changes in September of 2002. The blue bar shows you the average monthly net gain, for the 13 months following those improvements and the last two [inaudible] columns there will show you the combined SCHIP Medicaid. And you can see we more than doubled our monthly growth, just as a result of those simplification measures and aggressive outreach. We've continued to make improvements for the FAMIS program. Some of these things have come along after our big change in September of 2002, including changing the name of Medicaid to FAMIS Moms and instituting an electronic application. By the way, about 25-percent of the people now who apply, apply online and about 40-percent of new applications come to us online. A significant number of Medicaid applications come to us online.

This is just a growth chart of what's been going on since September 2002, with our SCHIP program in Virginia. You'll see a very steady growth pattern. I'll come back to that a little bit later in this presentation. Virginia is also no longer a donor state. If we had to rely today, if our 2007 program had to rely on our 2007 federal allocation and state

matched, we too would be in shortfall this year. But because we got off to a fairly slow start, we did have carryover funds, and even at the beginning of this year we had a little bit of 2006 carryover money, so we are not in shortfall, but we are projected to be in shortfall by 2009, if we're level funded. And this from a state that runs a fairly conservative program.

We cover kids up to 200-percent of poverty. The only adults we cover are a small group of pregnant women, from 133 to 166, so as you see it's even less than 700 women right now. Our heavily managed care state, we pay fairly low provider rates. Again, we had cherry over dollars and yet we too will be facing shortfall fairly soon if we don’t get significant more dollars.

We're here to talk a little bit about outreach. I just want to make the point that outreach is a multi-faceted thing. There's not just one way to do it. Different states have different needs, different populations have different needs. We do some media, but that of course is very expensive. Judith is going to talk to you about how we came up with our new Meet Julia campaign. We do fund some community projects as RWJ did but those tend to be an expensive way to go about it although a very helpful way to go about Outreach.

We do annual campaigns every year. We do collaborate with other state agencies whenever possible. Some agencies you might not think of, like the Department of Taxation, if you

call during tax season, if you call and get them on the phone and you're on hold for a long time, you'll hear a message about SCHIP. Any opportunity like that, that we can find with our other state agencies. Certainly with community programs, we do a lot of training for a project called Silent Now, they help through a foundation of ministers for us. And of course, lots of printed material and lots of things in other languages.

What we've learned is, money is absolutely essential, you can't do it without it, but leadership is key. After all, you can waste money, you know, if you're not careful. So, leadership, the right people and the right places with the right ideas are absolutely essential. Whatever you do will have a dramatic impact on Medicaid. In Virginia, it's easily two to one. We do that when we do outreach, we get two to one Medicaid SCHIP kids. There are states where it's even higher than that.

Families absolutely need to hear the message more than once. Take a lesson from the commercial market. The reason they play those commercials at you over and over and over again is because you need to hear it more than once before it really sinks in. And we don’t have the money to pay television commercials a lot, but if you hear it from the school nurse and you hear it from your health care provider, and you hear it on television and you see a poster somewhere, eventually the message does get through.

Generally, states have learned over these past two years what works for the majority. So, how to reach people, how to make things more family-friendly, but there are some families who will always need some direct help, some hand-holding to get through what is essentially bottom line of bureaucratic processes, and every attempt to make it as easy as possible.

ED HOWARD: Linda, could you summarize in about a minute?

LINDA NABLO: Okay.

ED HOWARD: Thank you.

LINDA NABLO: Again, we've learned a lot of lessons, I'm sure all the other states have as well. What we need in the future is certainly adequate funding. No state needs to be able to have to make the choice between outreach or covering kids with medical care. And that's what states oftentimes come down to when the funding gets too tight. And that we need the ability to tailor our outreach to our markets to those kids who are left who are uninsured.

We certainly need assistance with things like express lane eligibility, bringing different means-tested programs more in to alignment, so eligibility for one can serve for eligibility for another. How to target to different cultures and who those remaining uninsured children are, and how we reach them. That's not something you want to spend money on

individually 50 states, one at a time, really is a national role there at play with all of those.

And I want to end this with, to make the point, the dramatic point, I think, that all the outreach in the world, as good as it is, cannot overcome the harm that can be caused by certain kinds of barriers. And as an example of that, I'll use the new requirement for U.S. citizen to document their citizenship and identity when applying for Medicaid which of course, has an impact of separate SCHIP program. Just these two comparison slides here. This has been our growth over just since September '04 in our separate SCHIP program FAMIS which is not subject to citizenship and identity and we'll see at the end the growth spurt from our Back to School Campaign.

At the same time created this is kid from Medicaid subject and you'll see what happened to our one. We hope we're now beginning to come out of it, but in my book what we really did was delay U.S. citizen children from getting health care that they needed.

[Applause]

ED HOWARD: Great, thank you so much.

[Applause]

All right, next we're going to hear from Judith Cash. I think I may have promoted her inadvertently and I don’t want to get her in trouble with her boss. She is the deputy director of Virginia Health Care Foundation, which is a non-profit.

That’s the lead agency for Virginia's Covering Kids and Families Coalition. Covering Kids and Families may have been third is an initiative of the Robert Wood Johnson Foundation, so Judith, thank you for being with us to complete the story about Virginia.

JUDITH CASH: Thanks, Ed, and thanks to the Alliance for pulling it together. And thanks especially to Andy Hyman in the RWJ foundation for their leadership and partnership in this issue along the way.

I'm going to talk quickly about the success that Virginia has had and, as Linda mentioned, Virginia is a good example of a state that really paid attention, so that lesson that we try to teach our children, we should have been hit when you’ve made a mistake, do what you have to do to fix and learn from those mistakes and we think we've done that.

Some of the things that were most important in our success and outreach when we did begin to turn this big ship around, was strong leadership at the executive level as Linda mentioned. We had a governor come in who made this a campaign promise who said we don’t want to be a donor state, we don’t want to give money back to the federal government, we want to enroll kids, and from the very beginning of his campaign, through his administration maintained that level of leadership. He put knowledgeable professionals in key state positions. Those folks, including Linda, who were part of identifying what

we were doing wrong, came in then and he empowered them to fix it. We had private sector leadership, clearly that the Virginia health care foundation has been engaged in building and strengthening the help safety net for years, and we really did have a good understanding of what was going on at the local level, and the kinds of things the could help to make this successful.

And then we included key state and local stakeholders all along the way from the very beginning, and those included state and local government folks to Indian-based organizations, advocates, providers health plans, all of those folks were engaged from the beginning. We also recognize that this was clearly something that required both public and private engagement, so that we had publications at the state level which in previous administrations have not been particularly transparent, who now were seeking out feedback from the public sector and from the local sector, to really tell them how things were going. We had leadership at the health plan levels. Clearly, the health plans have a stake in this. And they too wanted to be engaged in making it successful in Virginia, and all of our advocacy organizations stepped up to the plate as well.

One of the clear future [inaudible] we keep an eye from the prize. We really knew that we had to focus on those numbers. We had regular data collection that told us how many

children we were enrolling, we had set a goal for enrolling the remaining eligible uninsured kids, and we kept our eyes on that all along. I heard somebody say once that if you don’t keep score, it's only practice. So we really did keep score all along the way and identify how many kids did we have to enroll yet and really where those kids were.

We had regular coalition meetings both at our statewide coalition and at the local levels and we publicly acknowledged when we were successful and when we had failed. We had lots of celebrations when we were enrolling more and more kids, and those celebrations often included chocolates, sometimes even champagne, but we also acknowledged when we didn't do things well. We had a local brantee [misspelling?] who was not having a lot of success, for example in one of their school-based efforts. We were able to say to the, we know this isn't working, let's look at how we can change it to make it work better. And everybody was engaged in that process.

The three key components of the Covering Kids and Families Program imitative of the national level, for outreach simplification and coordination. And so we engaged in efforts in all three of those components to get more kids enrolled. In terms of outreach activities we knew from our earlier experiences, we knew from the work we had tried to do with CMSIP as well as the early covering kids program that one-on-one assistance was critical. We still needed to sit down with

families and help them to fill out those applications. And so we were looking at projects that could really make this successful. We looked at people who were in the community, who could identify families, bring them in and sit down with them.

We knew we could do school-based partnership where our children are spending a lot of their time. And still, if you look at the remaining uninsured eligible children by age group, most of those children are school-age kids. So we knew that we had to focus on school-based partnerships and in public sector partnerships. For example, we have growing numbers of unemployed in parts of Southwest Virginia as we're seeing more and more of our plants closing. And so the Virginia Employment Commission engaged in a partnership with us in providing outreach on their rapid response teams, in providing outreach through their local VEC offices, so that people who were losing their jobs, coming in for unemployment insurance also knew their kids may be eligible for our FAMIS program and would be able to apply there.

We had three of the best partnerships, we could [inaudible] outreach, and Linda made reference to what we have really recognized as an awesome marketing campaign. One of the things that came out of our Covering Kids and Families, one of our task forces, was a need to change our message. We really wanted to do two things with this message, we wanted to improve in enrollment and retention in the SCHIP program and we wanted

to really influence opinion leaders with some positive branding.

So, Anthem, one of Virginia's largest Medicaid managed-care organizations, offered some support and offered to give us some initial consultation with their advertising agency. And one of the first lessons we learned with that was that if you attempt to speak to everyone, you end up speaking to no one. So, we knew from that, that we had to do some market research.

So, we commissioned some market research with some additional support from all of or MCOs from the Virginia Hospital Health Care Association and the Virginia Primary Care Association to do this market research. Surveying over 400 income-eligible families to find out their values about health care and health insurance, their opinions about government programs and whether they'd be interested in enrolling their children in them and their responsiveness in marketing.

What kinds of strategies might work best for this population? And from that the market tiers then identified, population segments, two of which were most important to us. We identified one segment that the market tiers called the grateful beneficiaries. Those folks who have coverage for their children and they value what the government can do for them. And the other population that was a target for us was those that were dubbed the dependent worriers. And these are folks who really have serious financial concerns, don’t know

where they're going to get their health care for this children but really want to be able to do that.

So, we then, also learned from our market tiers that a second important lesson was people listen to people, not to products. And so, our plan then, was to find Wanda. Wanda was a name, I think, of the grandmother of one of the public relations folks we were working with, but we dubbed our plan to Find Wanda, which was to find a spokesperson who clearly could be one of those grateful beneficiaries to speak to those dependent worriers, those people that we wanted to bring in whose kids were eligible, didn't have insurance but were a little skeptical about what the government could do for them.

Well, we didn't find Wanda, but we found Julia, and Julia became our face of FAMIS. Julia is a single mother of three children, working couldn't afford health insurance for her kids. But she found FAMIS and FAMIS worked for her and for her children. And she was a wonderful spokesperson. She was able to really get out there and speak to people's concerns and fears and bring them in. So, we ended up with Julia on our brochure, our posters, television commercials, radio ads, and a wonderful added benefit is that Julia is bilingual, so we were able to do our commercials in both English and Spanish and she really did become and has become the face of FAMIS. And that campaign truly worked. This was launched in our back-to-school efforts in September and from the previous September, we saw a

27-percent increase in the applications that were requested and while we have had television ads before, this one was clearly much more effective in reaching the people that we wanted to reach.

The second component after outreach, of course, is simplification, and Linda talked about the simplification efforts that we engaged in, in our plan to get more kids enrolled, and these are the things that go on our policies, policy wish list. These are the things that we said earlier on, we have to change these if we're going to really get children enrolled. So we did things like flatten the Medicaid eligibility across the line, so that we'd have families that would have all their children either in one program or the other, not split across two as what we had going in.

I remember the premiums simplified the application process, as Linda mentioned, we implemented a 12-month eligibility and we changed our employer sponsored health insurance program and redefined that to a project that we call FAMIS Select. We still have two separate programs in Virginia. SCHIP and Medicaid are two separate programs, but we coordinated them to the degree that we could and bringing them under one umbrella name, using that no wrong door policy, so that families could apply either at the local Department of Social Services, which manages all of our Medicaid cases, or

the central processing unit, and we conformed the program to the degree the we could with a single application.

I'm discussing this quickly. From that what we accomplished in the time period during which we had our Covering Kids and Families Program, 134,000 children were enrolled in Medicaid and SCHIP and that’s more than the combined capacity of Virginia's football stadiums at our two major universities at Virginia Tech and the University of Virginia. We think that’s pretty awesome. We also know we have better coverage and a better program for those children. And it continues to grow.

But in moving forward, as we go beyond covering kids and families, our project ended in June. We worked hard in that last year to institutionalize our efforts to make sure that every local community took responsibility for enrolling kids in health insurance. This wasn’t just the job of one or two Outreach folks in a community, but in fact everybody had a responsibility in that. We keep up the pressure at the state level, we have frequent conversations with DMack [misspelling?] and with out social services organizations to make sure that their still working to get kids enrolled. And we still have some outreach projects that are funded so that there is still some marketing done in the local communities.

Just when we thought we were safe, we got hit with the government reduction act and see some concerns about that.

We're moving forward in time to adjust some of those concerns. Finally looking forward to implications for SCHIP, despite the Senator Hatch said about we're not really here for the money, it is indeed about the money, and we need to make sure that there's adequate funding to keep all of our car kids enrolled and enroll the remaining eligible uninsured children.

And finally, we really looked to national leadership. We know the states have been successful but they can't do it alone. We need flexibility so that states can do what works for them and some control over that, but also opportunities to pilot promising practices from one state to another, and to facilitate others' partnerships. Thank you.

[Applause]

ED HOWARD: Thank you very much, Judith.

[Applause]

We promised them chocolate, we gave them chocolate, but there will be no champagne. [Laughter] Finally, as we round out our panel, we're going to have an abbreviated time for questions so I want you to prepare for that. And also take note of the fact that there is a [inaudible] evaluation form in your packets, which I would appreciate if you would pull out and start to fill out right now and we'll give you a chance to complete it later.

Finally, you're going to hear from Judith Wooldridge. SCHIP has probably been one of the most evaluated programs that

the federal government's ever put together and our final speaker, Judith Wooldridge, has directed many of those evaluations. She's an official with Mathematica. These studies are commissioned by both government and private entities, including Robert Wood Johnson Foundation, and, Judith, we are looking forward to hearing the results of your evaluations and the recommendations for the [inaudible], thank you.

JUDITH WOOLDRIDGE: Okay, thank you. Hello, everybody. Today I'm going to tell you about some of the lessons from Covering Kids and Families Program through rolling in SCHIP and Medicaid and implications of that for SCHIP reorganization.

ED HOWARD: You might want to come and get another microphone—

JUDITH WOOLDRIDGE: Can you walk?

ED HOWARD: Yes.

JUDITH WOOLDRIDGE: Okay, I [inaudible].

ED HOWARD: I can swallow it.

JUDITH WOOLDRIDGE: All right. And after Congress decided with SCHIP program in 1997, the Robert Wood Johnson Foundation [inaudible] initiative to increase children's enrollment in SCHIP and Medicaid. There was two fazes Covering Kids and subsequently Covering Kids and Families Program, which ran from 2002 through 2006. There were 46 city-funded state grantees, who in turn founded local grantees, 152 of them. The

foundation also funded an evaluation, which is what I'm going to talk about today and the problems with the evaluation health management services and [inaudible] institutes.

When SCHIP gave the states new opportunities to enroll children and the opportunity to have a lot of flexibility in their program designs, the Robert Wood Johnson Foundation saw this as a real opportunity to, sort of, make the most of it. And they built a program of which [inaudible] four strategies, you've heard most of them, I think all ready. Outreach to inform families and enroll their children, simplifications to make it easier for families to enroll their children, coordination of SCHIP and Medicaid so that when their families' circumstances changed their children didn't fall off, but they would move from one program to the other. And finally, the program Covering Kids and Families, [inaudible] collaboration through coalitions, each granting what is required to have the coalition. Or which would include community based organizations, schools, businesses, advocacy groups and at the state level, state program officials, in Medicaid and CHIP whenever possible. So, our evaluation looked at these four elements and their implications for enrollment.

So, lesson one: Sustained and comprehensive outreach is crucial for sustaining new enrollment. Let's take the case of California here as an example. California expanded eligibility and they simplified enrollment during the 2001 to 2003 era, yet

new enrollment stagnated. Because of the economic downturn, the state [inaudible] for ad groups. For example, they cut back on the statewide media advertising that they had been doing and they ended support both for the certified application assistant program that worked with families who enroll in them and their programs in schools and community based organizations. Yet there were some parts of the state where new enrollment didn't stagnate and those parts were, for example, Sonoma County, where a very innovative group working together was able to sustain and increase the enrollment by [inaudible] state funds for Outreach and so maintain enrollment.

And such programs got [inaudible] as well, Virginia was a case in point, where there was a program in Fairfax County where it was quite an intensive program in schools. Where uninsured children were identified, and they worked closely to get parents to get those children enrolled.

Second lesson: As you would expect, when enrollment was simpler, more children enrolled. And examples you've heard about already but things like shorter forms, allowing families to mail their applications in and providing alternative bases to the welfare offices where families can go to enroll their children. And as you've already heard in some detail, Virginia changed their application process with SCHIP families. They no longer needed to go to the department of social services

offices to apply. And then subsequently, they did the same thing for Medicaid families. And the result of that was in both cases, when those changes were made, there was a sharp onset in new enrollment. Both, initially for SCHIP and subsequently for Medicaid.

Third lesson: When you coordinate SCHIP and Medicaid, you can increase enrollment. Examples here are putting programs under a common name, so that people recognize them as one program. Having joint application forms. And in the case of Arkansas, which I've used for an example, this is exactly what Arkansas did. And in the year 2000, they renamed their program [inaudible] both components together, and simplified the enrollment process. Again with the [inaudible] enrollment increasing.

Now, the fourth lesson's a little different. It's about collaboration. And collaboration-improved program implementation. Collaboration can provide sources of information that they would not otherwise had. And this helps them to make their policies more effective. And I want to talk about two issues in Covering Kids and Families Program, to promote collaboration.

One of them was a collaboration across states and within states to try and improve offices enrollment and renewal. This was funded specifically for 22 of the 46 grantee states and this collaboration lasts to [inaudible] a one-year

period and what happened was that within the state, the state officials and the local [inaudible] eligibility workers worked together with Covering Kids and Families all on one team to try to improve the processes to make them more efficient, which would save the states money and to make them more accessible to families, so that more children could enroll. And this process of collaboration was so effective that some of the states who were involved in this aspect of the program have gone on to incorporate it in to all of their operations so that they always do process reviews on small-scale fashion before they make procedural changes, to make sure that they get what they wanted.

The other component was, of course, the coalitions that I mentioned earlier but were embedded in Covering Kids and Families Program. When you provided the feedback mechanism, for states to hear a few front lines, what was happening, whether there were barriers to enrollment and what those barriers were. And I should say that we serve as state vehicles for SCHIP and Medicaid and they were virtually unanimous in saying that Covering Kids and Families had been effective through their culminations in improving state policies for CHIP enrollment and renewal. And Medicaid but that might [inaudible] for that matter.

And many of the changes that came about wouldn’t have come about without Covering Kids and Families help. And they [inaudible] things were going to be sustained.

So, what are the indications for reauthorization? If you want to insure that the SCHIP program [inaudible] reaches it's source potential, enrolling all the eligible uninsured children, it seems that these four elements that I just reviewed with you, do need to be present. They're a necessary condition of sustained enrollment. That’s not to say that I'm recommending that they should be mandated in some form in the reauthorization, because I think it's very important that the states are able to maintain the flexibility that they've had because as you’ve heard from other speakers no one size fits all for any of these approaches outreach [inaudible] coordination. Now there will be [inaudible] when even in these necessary conditions for sustained enrollment just aren't enough. And our biggest example in reducing, there was a period of the year where after doing all of the right things, all of these things you have a very generous income eligibility besides. New enrollment sank and the reason was that there was a new vendor who was not prepared to handle the volume of applications, so those kinds of infrastructure issues are important as well.

But perhaps more important and more widespread are the economic actions that everybody mentioned today. So during the

economic downturns that we saw in 2001 through 2003 and onward, it was very difficult for states to maintain enrollment because they were making choices. And they if they [inaudible], they spent less [inaudible] outreach or [inaudible] improve eligibility just when more families needed coverage for their children.

So, I should like to end by saying that SCHIP would benefit more children if it was structured to encourage states to enroll children just when the going is hardest, when there's less money and there's more uninsured children. Thank you.

[Applause]

ED HOWARD: Thank you. Thank you very much, Judith. Now we have about 15 minutes for questions. There are microphones to which you can repair, there are green cards in your packets that you can write on and let me remind you about those blue evaluation forms on the left hand side I guess it is. Yes, would you identify yourself, please.

KAREN TEAL [misspelled?]: I'm Karen. Is this turned on? I'm Karen Teal from Patton Bogs. I have a question about retention too difficult. It's the same enrollment. The figure that Senator Hatch quoted as 6.1 million children enrolled, means enrolled not state-enrolled, and we know from the Mathmatica 10-state study that the average length of time enrolled in the program is terribly short, actually, rather than what you'd love to see out sustained enrollment.

And we also know of the studies of reducing enrolled children that a portion of those are going up in the private insurance or down in to Medicaid but a huge portion of those are still uninsured. So for the panel, the question would be, what can be done to enhance enrollment in the next 10 years of the program? Is it just administrative simplification or do we have to think about the type of ongoing services, like ongoing prevention and wellness services that we offer children, so that there's some reason to stay enrolled in the program?

ED HOWARD: Good day, question. Cindy, want to try it?

CINDY MANN: It's a great question. Retention is really, I think, very important and at the earlier years of SCHIP overlooked and until states began to realize they were getting the kids in and the kids were losing coverage. Most of the change in the enrollment levels that I showed in Louisiana was because they had really tackled aggressively the issue of renewals. One of the most successful things that they did that actually, in some respects, is required at least in the Medicaid program is that before a state takes steps to stop eligibility, they need to first see whether they have the information on hand to determine whether the child is eligible.

And what Louisiana found when it's under this procedure is that in about 68-percent of the cases, they didn’t need to send out a renewal form to the family because the family had been in to the agency or a related agency. Food stamps, child

support, child care agency. They had that information on hand, they could determine that the child is eligible, and their retention rate went up enormously and so did their enrollment.

So, a lot of the same simplification steps that we're taking are for eligibility application process can be carried over to renewal but then some additional steps that you can take that really keeps the child in the system and presumes the child continues to be eligible unless you have information telling you otherwise.

JUDITH WOOLDRIDGE: I'd just like to point out the [inaudible] reports that they refuse to close the rate [inaudible] from about 25-percent of kids to about 6-percent as I really felt were paying close attention to their renewal process and they instituted a telephone renewal process statewide, which really made a big difference. They also tried calling families, which is also part of that too.

ED HOWARD: And I should point out that, that and the other fascinating information is in the issue brief in your packets that Judith Wooldridge authored and that Jeff Scott completed in the last few days that’s in your packets.

Actually, let me jump in with a question from a card. And it has to do with many of the tools that so many of you mentioned as ways of improving participation ways. Is there a correlation between participation and particular outreach for simplification steps? Are we at that stage?

JUDITH WOOLDRIDGE: Well, Covering Kids and Families [inaudible], we set out to try and lead specific Outreach approaches to enrollment events, and soon had to be just critically difficult for all kinds of technical reasons. What we do know is that – what we know that attempts to sustain Outreach does sustain with new enrollment. And when I say new enrollment, I mean new SCHIP enrollments who hadn't enrolled before, I'm not talking about the whole stock of the number of children who enrolled at a given time, I'm talking about just new enrollment. We know that but we don't know exactly which are the most effective outreach processes, and that's something that we would really like to know.

ED HOWARD: Linda.

LINDA NABLO: I'd like to jump in and say I think you have to say that for every piece of paper you eliminate, has just been a huge benefit for enrollment. And for every time you put somebody through some kind of an enrollment process or a renewal process, you've just made it more difficult. People are, myself included, I'm not particularly good at keeping documents paper, on hand, getting them, getting them copied, getting them mailed in when they get lost. Anything you put people through like that, costs you many months and many of thousands of children. So, simpler you can make it the more electronic you can make it, the more you can rely on other sources, the better off you are.

In terms of outreach strategies, I'd have to say you'd have to go where the kids are. First, you go to the schools and next you probably go to health care providers because that's where you're going to get the families to pay attention.

ED HOWARD: Yes, Cindy.

CINDY MANN: We did a study with a number of different states, including Virginia, and looked at some of the literature particularly on this issue of churning where kids are on the program, off the program and it looked like they remained eligible. And we really found four key areas the seemed to make an enormous amount of difference and of course, lots of other steps were important as well. One was to really limit the number of renewals that happen. And it goes to Linda's point which is the more processes you have to put people through, the more opportunities there are risk factors that you're going to lose the kid.

So, going to 12-month predeterminations, going to continuous eligibility. Keep the number of renewals down because renewals are the place where kids lose coverage. Use information on hand when you have it as in the Louisiana situation that I mentioned. Pay careful attention to premiums, states were adopting more premiums over time and sometimes the levels of premiums or the ways in which the premiums were collected were causing a lot of people who otherwise were eligible from kids losing coverage because their families

couldn’t afford the premiums or weren't getting them in, in a timely basis.

And then, the flip side of the coordination is while it's important to coordinate with other programs, we also found in a number of states sometimes inappropriate coordination occurred. Which is that sometimes your eligibility for food stamps or cash assistance changed, sometimes you were losing your medical assistance coverage or your SCHIP coverage even though you remained eligible for health insurance. So really, making sure those systems knew when to coordinate and also knew when to trifurcate.

ED HOWARD: Okay. Yes, sir.

MIKE BARTH [misspelled?]: I'm Mike Barth of Healthy Steps for Young Children. I'm wondering what reading level Virginia's information is targeted to. And then, for anybody, if there's any research on what's the appropriate reading level for the SCHIP and Medicaid populations, assuming those two differ?

CINDY MANN: We try very hard in Virginia whenever we're creating any kind of written material or even on our Website. We try to keep things at the sixth-grade reading level or below. There's some built-in problems with that. The word eligibility alone can give you [laughter] difficulty, but with a few minor exceptions, we do try to keep the reading level sixth grade or below and it could probably stand to go

below that as well. I'm not really sure what the literature says.

ED HOWARD: Judith Cash.

Judith Cash: Actually, I think most of what we found, from the research in what we were taught by our marketing post was that it was the sixth-grade level which they seemed to recommend most things be written at. And in fact, there's been a fair bit of work, down around Help Literacy, in trying to make applications for example as well as the brochures et cetera really accessible to people and that’s really where they were recommended as well.

CINDY MANN: I just would add a related point, which is language translation is incredibly important and some of the most simple obvious steps in terms of making sure that information is available in different languages in the commercial really makes an enormous difference on addressing what people think with this [inaudible] our region, so-called hard to reach community sometimes really dealing with the language barriers are intended to make an enormous amount of difference.

ED HOWARD: I'd like to follow up on something that Judith Wooldridge said in her presentation. Judith, it's just about the last thing on your last slide when you talk about encouraging states to enroll children during economic downturns. How do you do that? Even the most enlightened

legislature and governor have to have a balanced budget in 49 of the 50 states, so what do you have in mind?

JUDITH WOOLDRIDGE: That's a good question, of course, I don't have the answers. The only thing that I can think is that if you could build an [inaudible] that the federal matching rate went [inaudible] under those circumstances, but maybe that could be got to work. I don't know if it could be got to work right now. Where we are today, it seems to me to be a potential solution.

ED HOWARD: Cindy.

CINDY MANN: I think that's exactly right. We had that situation in the Medicaid program during the recession earlier around 2002, where we were seeing states having to cut back on eligibility, benefits and Outreach activities. The Congress implemented an increase or adopted a small increase for 18 months in the match rate for Medicaid program with a provisional that if you want this increase and match rate, each man change your eligibility levels, and in fact, it had a very significant effect as indicated by both the enrollment levels and by states own sense of what needed to be done.

So, I think that changing the match rate for economic sensitive times can really make a big difference. And the other issue I think is just, when you enroll more kids. There are more coverage costs, so even when you don't have a very

difficult fiscal environment, it's still a lot of costs that states sometimes are unable or unwilling to bear.

So, I think one of the considerations that I know is being debated around SCHIP reauthorization is whether a state that improves its participation rate or maintains a high participation rate ought to be able to get some more help with those coverage costs from the federal government. Again, in the form of an added match rate.

ED HOWARD: Related question. There was some talk about, I guess it was in Judith's official brief about the importance of involving in the state coalitions, state officials with the power to actually do something about what came out of those meetings and I wondered, how many state coalitions were able or are able to really involve state coalitions are able to involve state officials at that level?

JUDITH WOOLDRIDGE: Actually, the large major did but not all. And the ones that were had better coordination and [inaudible] together and if they work on the collaborative program that special supplement that they talk about, it was critical to have that kind of state leadership involved, otherwise nothing could be made to happen.

ED HOWARD: Panelists' final words? Andy?

ANDREW HYMAN, J.D.: Just on that same point, I mean, it's pretty clear that there's still a lot to be learned about what is successful and [inaudible] quantify each of the various

interventions where sates should apply. Clearly, probably the most important thing is if the state is not involved, the state is not energized and eager to take on this problem, it's going to be quite difficult to get anywhere. The state has to be a willing enthusiastic partner and for that, of course, that’s where the funding comes in.

ED HOWARD: Okay. Well, we've come to the end of our time. I want to thank you for staying with us here through lots of presentations and lots of information which I hope you were able to digest and use. I want to thank the foundation for its involvement both in putting the program together and in helping to support it. I want to thank our special key note speakers at the beginning of the program, and before we thank our speakers I just want to take a note right here.

We have an alum present, or at least she was present, Ann Montgomery, who spent most of the last few weeks working on this program, but she deserted us last week to go back to the hill where she is now, the brains behind the long-term care expertise of the centered aging committee. So, I want to thank Ann for her work, not only on this program but over the last three years. She's been very helpful.

[Applause]

[END RECORDING]