

Improving Public Coverage for Children: Lessons From CKF in Colorado

SUMMARY

Colorado has consistently had one of the highest rates of uninsured children in the nation, due, in part, to reduced outreach budgets as a result of state fiscal pressures. An historical review of the Robert Wood Johnson Foundation's *Covering Kids & Families*® (CKF) grant in Colorado reveals that, as policies changed, the Colorado CKF project succeeded in targeting its work to the areas of greatest need in order to mitigate the effects of policy changes. CKF also took on a monitoring role, earning legislative respect and leading to its continued inclusion on key policy and procedural discussions. A new state funding commitment in 2008 to Medicaid and SCHIP—as well as an eligibility expansion to cover higher-income uninsured children—hold great promise for increasing coverage levels. However, there is still much to be done to achieve universal children's health insurance coverage in Colorado.

BACKGROUND

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 Medicaid and SCHIP enrollment (Wooldridge 2007). In 2002 RWJF expanded the program to include parents, renaming it *Covering Kids & Families* (CKF).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 Colorado 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 Colorado and discusses lessons learned from the efforts of the CKF project there.

In this brief, we draw from a variety of qualitative and quantitative data sources, including: the Centers for Medicare & Medicaid Services (CMS); the U.S. Census Bureau; the Covering Kids Online Reporting System (a system for CKF grantees to report on policy changes affecting coverage from 2002 to 2006); other reports on CKF grantees from RWJF's CKF evaluation; surveys administered as part of the CKF evaluation to Medicaid and SCHIP officials and state grantees; and personal communication with Medicaid and SCHIP officials and state grantees, both from a site visit in 2003 and phone calls in the ensuing years. Unless otherwise cited, it is from these data that we review the context of health reform in the state and how the relationship between the Colorado state CKF grantee organization and state government supported Colorado's Medicaid and SCHIP outreach, simplification and coordination activities.

STATE POLICY CONTEXT

In May 1997, just months before federal legislation enacting SCHIP was passed, the Colorado legislature created a public insurance plan for children, the Child Health Plan (CHP), to provide basic medical services to children 18 years of age and younger with family incomes up to 185 percent of the federal poverty level (FPL). In 1998, after the passage of SCHIP, Colorado created a separate SCHIP program called Child Health Plan *Plus* (CHP+), essentially an enhanced version of the earlier CHP program (CHP+ hereafter is referred to as SCHIP). CHP was then discontinued.

Colorado's initial SCHIP program provided coverage to families who did not qualify for Medicaid, but whose earned income was at or below 185 percent of the FPL.² The program required small co-payments, not exceeding \$5. Children enrolled in CHP were automatically enrolled in CHP+, the new SCHIP program, if they met the federal guidelines for SCHIP eligibility. Colorado conducted some outreach, including a marketing campaign, to advertise the availability of SCHIP in the state.

Coinciding with CKF's implementation in Colorado in May 2002, the state began expanding SCHIP benefits (such as dental benefits) and eligibility, by adding coverage for prenatal care for pregnant women earning up to 185 percent of the FPL. However, budget constraints arose during the state's 2003 legislative session, which required cuts to public insurance programs. Colorado stopped SCHIP marketing activities, suspended enrollment into the SCHIP prenatal care program and froze SCHIP enrollment in November 2003.

In July 2004 Colorado lifted the SCHIP enrollment freeze. But later that year, the state eliminated presumptive eligibility for pregnant women enrolled in Medicaid. The state also implemented an administrative change at this time—the Colorado Benefits Management System (CBMS)—a new statewide computerized eligibility system for all public assistance programs including Medicaid and SCHIP. The switch to a computerized eligibility system was not smooth; it created a mounting backlog of 20,000 to 30,000 Medicaid and SCHIP applications, causing enrollment and renewal numbers to drop dramatically. The backlog was so severe that the Colorado Center on Law and Policy, a member of the CKF Steering Committee, successfully filed suit against the state of Colorado over problems related to CBMS.

In December 2004 the Colorado District Court mandated a 40 percent reduction in the backlog by February 28, 2005, another 40 percent reduction by April 30, 2005, and incremental reduction thereafter (Colorado Center on Law and Policy 2004). The court also mandated the immediate creation of an emergency processing unit with a toll-free hotline number for families experiencing emergencies. Cases were to be resolved within five business days following a phone call. Then-Governor Bill Owens created an executive level office to oversee compliance with the court-ordered backlog reduction, which included hiring a vendor to process backlogged applications. This office remained in place until February 2007, when responsibility was transferred back to the departments of Human Services and Health Care Policy and Financing (Bartels 2007).

In 2005 Colorado's legislature passed new legislation to expand Medicaid and SCHIP eligibility. They restored presumptive eligibility for pregnant women enrolling in Medicaid (including legal immigrants). In addition, funding from a tobacco tax approved by voters in 2004 allowed the state to:

- Expand SCHIP eligibility from up to 185 percent of the FPL to up to 200 percent of the FPL;
- Restore state-sponsored marketing for SCHIP outreach.

CKF IN COLORADO

RWJF selected the Colorado Community Health Network (CCHN) as the Colorado state CKF grantee.² Founded in 1982, CCHN is a provider organization that represents the 14 community health centers in the state that form the backbone of the state's safety net (CCHN 2007). CCHN received a \$950,000 CKF children's grant in May 2002. As required, it distributed half of these funds to the three local CKF grantees in the state, who were charged with working on outreach and identifying barriers to enrollment at the local level.

To improve CKF grantees' chances of success, RWJF required state CKF grant recipients to engage state officials in the work of CKF. The grant program required grantees to form a statewide coalition that included Medicaid and SCHIP officials as well as representatives from other groups focused on expanding insurance coverage for children and families, including other government agencies, advocacy groups, community-based organizations, health plans, providers, businesses, schools, and others. CCHN formed what one state official called a particularly strong coalition, with representation from more than 170 organizations in the state, and two "very active" workgroups—the "Agency Partners" workgroup, which focused on enrollment in Medicaid

and SCHIP—and the “Health Policy” workgroup, which monitored and discussed legislation or regulations that might impact Medicaid or SCHIP. State officials praised the relationship between the CKF coalition and the state and said CKF staff were “...professional...smart, analytical, and respectful of State staff,” adding that “the coalition has been a beneficial collaboration for both the state and CKF.”

OUTREACH

The Colorado state CKF grantee conducted many traditional outreach activities, such as training nearly 780 people and sending more than 200 mailings over the period of the CKF grant. However, within the grant’s first year, the state cut its entire marketing budget for Medicaid and SCHIP and froze SCHIP enrollment. State CKF grantee staff quickly realized that conducting outreach in Colorado would require them to change their planned approach from outreach to new enrollees—to retention of current enrollees and monitoring the effects of the policy changes.

The CKF coalition first focused on evaluating the effects of the SCHIP enrollment freeze, which revealed:

- **The state’s projection of future SCHIP enrollment was elevated.** The state based its cuts on projected enrollment using average monthly enrollment estimates, rather than actual enrollment. Using actual enrollment numbers, CKF showed that the existing budget would have supported nearly 4,000 more enrollees. It concluded that the state could have postponed the enrollment freeze.
- **An unexpectedly high attrition rate in SCHIP.** Based on CKF’s research, the number of families failing to renew was higher than state estimates. Renewal notices sent to families during the enrollment freeze period did not inform families that the program had an enrollment freeze. As a result, many families were unaware of the importance of renewing on time. Prior to the enrollment cap, families could re-enroll after the renewal deadline (and were counted as having renewed, not as new enrollees) because the program was open to new enrollment. However, this was not possible with an enrollment freeze in effect. The coalition determined that the freeze contributed to the higher-than-normal attrition rate.

- **Outreach is essential to enrollment.** Although the coalition knew outreach increased enrollment, it found outreach was essential for reaching families who qualified for SCHIP but did not qualify for other human service programs; without contact from other human service programs, such families were less likely to learn about SCHIP in the absence of marketing and outreach. More importantly, CKF also reported that negative media coverage of the Colorado Benefits Management System discouraged families from applying for Medicaid and SCHIP. Families believed that they would not receive coverage even if they applied. Given these facts, CKF advocated for new marketing and outreach money to dispel families' fears. Subsequently, when an increased tobacco tax was approved by Colorado voters in 2004, \$540,000 of the revenue was allocated to SCHIP outreach and marketing in 2005.
- **Certain groups were disproportionately affected by the SCHIP enrollment freeze.** Although Colorado's population is only 17 percent Latino, CKF's research revealed that 33 percent of children trying to enroll during the enrollment freeze were Latino.

The SCHIP cap led the CKF coalition's outreach workgroup to focus on retention because it wanted to ensure that enrollees stayed enrolled, since new enrollment was curtailed by the freeze. In September 2004, however, the coalition shifted its focus back to enrollment because problems arose in the introduction of the CBMS, the computerized eligibility determination system for state public assistance programs. Problems included incorrect eligibility determinations and inaccurate and conflicting notifications, which often resulted in enrollees being incorrectly dropped from or denied eligibility for public health insurance and, as discussed above, a backlog in processing of applications. The CKF outreach workgroup developed a detailed mapping process to monitor and document how CBMS prevented families from enrolling in Medicaid and SCHIP, as well as whether problems with CBMS were resolved in a timely fashion, and shared its findings with the Department of Health Care Policy and Financing.

Since the outreach workgroup had identified Latinos as a vulnerable, underserved population, CKF also fulfilled its outreach mission by trying to reach, enroll and retain Latino citizens eligible for Medicaid and SCHIP. CKF worked with Community Health Centers to train staff to complete applications and obtain proper income documentation or other supporting documents.

State Medicaid and SCHIP officials reported that—on a scale of 1 to 10, with “10” indicating that the training had a critical effect on the number of children and parents enrolled in public programs—they would rate the impact of the training as a “7” and that it would not have occurred without CKF.³ They also stated that CKF was vital to Medicaid and SCHIP outreach in Colorado and felt very confident that the effects of CKF’s outreach would remain in effect permanently.

SIMPLIFICATION

The Colorado state CKF grantee pursued several strategies to simplify Medicaid and SCHIP enrollment and renewals, as well as to encourage simplifications to eligibility criteria. For example:

- According to state SCHIP officials, CKF was vital to improving the readability of the application form, making it easier for applicants to complete and for eligibility staff to enter data into the Colorado Benefits Management System. As of June 2008, the improved application form was still in use and was expected to stay in use for at least two more years. State Medicaid and SCHIP officials reported that this change would not have occurred without CKF.
- In 2003 CKF helped to reduce income verification requirements for applicants from one month’s worth of paystubs to one paystub. The state CKF grantee viewed this change as permanent and reported that it would not have occurred without CKF. At the same time, the CKF coalition began monitoring the enforcement of administrative rules in Medicaid and SCHIP to assure that application procedures, such as the reduced documentation requirements, were being followed.
- CKF helped the state to incorporate a simplified renewal system into the new computerized eligibility determination system. At the appropriate time for renewal, the system automatically produces and mails a “statement of facts.” Rather than complete a new application, a form is autopopulated with information on file and sent to the beneficiary, who then only needs to inform the state if there are any changes. As of January 2007, this procedure was still in effect and state Medicaid and SCHIP officials reported that they were very confident it still would be in effect in four years. Critically, they reported that this change would not have occurred without CKF.

- CKF advocated for the passage of legislation in 2005 to implement the voter-passed tobacco tax to increase funding for SCHIP, which eventually led to an eligibility expansion for children and pregnant women from 185 percent of the FPL to 200 percent of the FPL and removal of the asset test for Medicaid. The removal of the asset test helped to improve coordination between Medicaid and SCHIP because there was no asset test for SCHIP. On a scale of 1 to 10, with “10” indicating that the change in legislation had a critical effect on the number of children and parents enrolled in public programs, state Medicaid and SCHIP officials rated the impact as a “10” and also reported that they expected the legislation to be permanent. Although state officials said this would have occurred without CKF, CKF staff believe they helped to accelerate the removal of the asset test by advocating for this change.
- CKF worked to reinstate presumptive eligibility for pregnant women in 2005 after its repeal in 2004. CKF mobilized the coalition to prevent the implementation of state regulations to repeal presumptive eligibility. The coalition advocated successfully for the reinstatement of the presumptive eligibility program through legislation passed on July 1, 2005. Though state officials did not name this change among the three most important policy changes CKF influenced, the state CKF grantee reported that reinstating presumptive eligibility would not have occurred without CKF and rated the significance of the change on the number of children and parents enrolled in public programs as a “9” on a scale of 1 to 10.

COORDINATION

The state CKF grantee reported that its most successful activity relating to improving coordination was providing technical assistance to county eligibility offices to enroll SCHIP applicants. After Colorado’s new computerized eligibility system was implemented, county eligibility offices were responsible for processing both Medicaid and SCHIP applications, but processing SCHIP applications was new for them. Colorado did not provide training for these workers, so CKF staff stepped in to offer what they considered necessary training to the eligibility workers across all 64 county offices. This training was critical in reducing cross-county variation in the interpretation and implementation of SCHIP enrollment rules. According to the CKF grantee, it would not have occurred without CKF.

SUSTAINABILITY

CKF grantees were required to raise funds during the grant: they had to match 50 percent of their CKF funding by the third year of the four-year grant.⁴ 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.

Although the Colorado CKF grant ended in April 2006, the CKF project and coalition have survived, sustaining their work at the same level as they did under the grant. CCHN, CKF's host agency, was able to find funding support, mostly from a group of local foundations, so it has not had to scale back CKF activities. Examples of recent activities include:

- CKF has partnered with the Colorado Health Institute (CHI) to research the effect of the Deficit Reduction Act (DRA) (2005) on SCHIP enrollment. The DRA requires that pregnant women and parents applying for Medicaid coverage submit proof of citizenship for themselves and for their children; although the law concerns Medicaid, not SCHIP, CKF and CHI discovered that it has affected SCHIP. For example, SCHIP applications were delayed or denied because outreach and enrollment workers asked parents for proof of citizenship and identity, when in fact such proof is not a requirement for SCHIP enrollment. CKF continues to advocate for better adherence to DRA rules and procedures. CKF also trained outreach and eligibility staff on DRA policies and procedures in Colorado (and, was the only group to offer such training).
- CKF has helped lead two parallel efforts toward achieving universal coverage for children by 2010. In the first effort, CKF joined with other organizations that advocate for children's health to promote passage of legislation to cover all children in the 2010 All Kids Covered Initiative (discussed below in the "After CKF" section). In the second effort, CKF advocated for an advisory committee to oversee implementation progress toward universal coverage for children. The current CKF project director is the chair of the state-appointed committee.

- CKF staff are currently participating on a task force organized by the Colorado Department of Health Care Policy and Financing that is soliciting stakeholder input on a plan to modernize the eligibility process for all public health insurance programs. By “modernizing” the eligibility determination process, Colorado aims to make sweeping reforms to the step-by-step application process beginning from eligibility determination to enrollment. Centralizing the current eligibility determination system to one vendor, as opposed to each of Colorado’s 64 counties conducting eligibility determinations separately, is also being considered. CKF is carefully monitoring the progress of this initiative; though it supports modification to the state’s eligibility determination process it also hopes that the state can maintain some local presence for eligibility assistance.
- In June 2008 CKF helped launch the Denver Outreach and Enrollment Partners with Denver Public Schools, a new coalition of outreach, application assistance and eligibility workers. CKF participates in similar coalitions in other Colorado counties and continues to work on coordinating outreach and application assistance across the state. CKF staff finds these coalitions are valuable tools to coordinate advocacy and outreach at the local level. Local outreach staffers and others from the community have a centralized site to share information and work through barriers to enrollment.
- The CKF Agency Partners and Health Policy workgroups continue to meet monthly, monitoring Colorado’s Medicaid and SCHIP enrollment numbers and keeping the state up to date on progress and problems pertaining to health insurance coverage for children in Colorado. CKF recently recommended that Colorado increase its outreach budget for Medicaid and SCHIP (discussed in “After CKF” on page 13).

TRENDS IN CHILDREN'S HEALTH COVERAGE

Colorado has one of the highest rates of uninsured children in the nation. Between 2004 and 2007, uninsurance rates among children in Colorado ranked higher than the national average, placing it consistently among the top 10 states in the nation with the highest uninsurance rates for children 18 years of age and younger. Table 1 shows that the rate of uninsured children declined 2 percentage points between 1999 and 2007, but the decrease is not statistically significant. Moreover, methodological changes to the Census Bureau data collection instruments likely account for this change.⁵ Public and private coverage rates have fluctuated throughout this period. Researchers believe that the increase in public coverage from 1999 to 2003 is statistically significant, even if some of the increase is attributable to methodological changes in data collection, but that the changes in later years fall within the range of sampling error and are not statistically significant (John Czajka, Senior Fellow, Mathematica Policy Research, personal communication, September 23, 2008).

To more closely investigate the annual fluctuations in public coverage, we also reviewed the total monthly enrollment in SCHIP and Medicaid in Colorado from June 2001 to June 2006 (see Table 2). The public coverage numbers in Table 2 are not directly comparable to those in Table 1, since those in Table 2 include adults, but they correspond closely to Colorado's policy changes and help to explain annual fluctuations in public coverage seen in Table 1.

TABLE 1

Colorado 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	13.0	19.1	71.3
2006	14.6	19.4	70.3
2005	13.7	20.6	71.9
2004	14.6	19.5	71.8
2003	13.3	22.5	69.5
2002	13.6	20.0	72.2
2001	12.9	16.6	75.0
2000	14.2	20.4	71.8
1999	15.0	18.0	72.0

Source: U.S. Census Bureau 2008

TABLE 2

Total Monthly Enrollment in SCHIP and Medicaid in Colorado, 2001–2006

Month and year	SCHIP	Percentage difference from prior year	Medicaid	Percentage difference from prior year
June 2006	53,894	+32.4	401,700	-2.2
June 2005	40,696	+9.8	410,800	+7.3
June 2004	37,069	-30.2	382,800	+12.6
June 2003	53,118	+21.6	340,000	+10.0
June 2002	43,679	+24.6	309,000	+9.7
June 2001	35,059	—	281,800	—

Source: Kaiser Commission on Medicaid and the Uninsured October 2007; Kaiser Commission on Medicaid and the Uninsured May 2007
 Note: The data in this table reflect point-in-time monthly enrollment counts, as reported by Colorado.

For example, SCHIP enrollment climbed from 2001 to 2003, as new benefits and an expansion of eligibility to pregnant women were added. As a result of the SCHIP enrollment freeze, the lack of state marketing, and the implementation of the CBMS, June 2004 SCHIP enrollment ended by 30 percent over the previous June. By June 2006, the state ended the enrollment freeze, reinstated marketing, and expanded eligibility; SCHIP enrollment surpassed the 2003 peak. Until June 2005, Medicaid trends showed a consistent increase in enrollment, with total monthly enrollment increasing by 129,000 between June 2001 and June 2006—a nearly 50 percent increase in total monthly enrollment in this period. Although there were policy changes in this period that negatively affected enrollment, such as implementation of the CBMS, CKF’s focus on retention, and support of outreach organizations, as well as the worsening economy in the state, likely led to the overall increase in monthly Medicaid enrollment.

LESSONS LEARNED

To make Medicaid and SCHIP more easily accessible, Colorado CKF used outreach, simplification and coordination strategies, such as simplifying administrative processes, establishing uniformity in application processes, and advocating for expanding eligibility to more groups. CKF also took advantage of the skills and expertise of its coalition members, as well as input from local grantees, to gather data to evaluate what was not working well in the Medicaid and SCHIP programs and identify ways to either mitigate the effects or fix the problems.

Two lessons emerge from this review. Monitoring the effects of administrative changes is critical, and advocates can play a key role as monitors. The switch to a computerized eligibility system had a profound and prolonged effect on enrollment and retention in Medicaid and SCHIP. The state did not solicit CKF's input at its implementation, but CKF played a key monitoring role in resolving problems by tracking and communicating new and continuing problems with the system and notifying the state when initial solutions did not permanently fix problems. CKF's work earned it the respect of state Medicaid and SCHIP officials, as well as the legislature, and it has since been asked for input on key policy and procedural changes, including covering all children by 2010 and centralizing eligibility.

CKF's resources and activities can be most effective when they are targeted to areas of the greatest need. For example, when the 2003 legislative session led to a SCHIP enrollment freeze and termination of Medicaid and SCHIP outreach, CKF focused on retention by targeting outreach to groups already eligible and to those already enrolled, and by reducing barriers to enrollment. Conversely, when the state budget and legislative environment were more conducive to public insurance expansion, as in the 2005 legislative session when eligibility was expanded and the Medicaid and SCHIP outreach budget was restored, CKF activities shifted to advocacy for increased income eligibility levels and outreach to those newly eligible. Furthermore, in the post-grant period, CKF continued pushing for increased outreach, and in 2008 it helped secure a doubling of the state's Medicaid and SCHIP outreach budget.

AFTER CKF: ACHIEVING COMPREHENSIVE INSURANCE COVERAGE IN COLORADO

CKF remains an aggressive advocate for coverage policies in Colorado, and the current political landscape is more receptive to this agenda than when CKF began. A new governor, elected in 2006, and the state legislature have supported and passed into law several important measures in 2007 and 2008 that CKF promoted, including:

- Expanding SCHIP eligibility from 200 to 205 percent of the FPL in 2007. Colorado also approved a \$23 million budget towards goals supported by the 2010 All Kids Covered Initiative, which includes plans to increase eligibility to 225 percent of the FPL for children by March 2009 and for pregnant women by October 2009, and a Medicaid and SCHIP outreach budget of \$1.4 million, representing twice the amount previously spent on outreach. Funds permitting, eligibility for children and pregnant women will increase to 250 percent of the FPL after October 2009.
- A bill that allows use of the Department of Labor's income and wages database to verify income, a measure that further simplifies enrollment.
- Expanding SCHIP eligibility from 200 percent to 205 percent of the FPL. Colorado plans to increase eligibility to 225 percent of the FPL for children by March 2009 and for pregnant women by October 2009. Funds permitting, eligibility for children and pregnant women will increase to 250 percent of the FPL after October 2009.
- Passage of "cushion funding" for SCHIP. Through this legislation, Colorado has set aside extra funds to delay or prevent an enrollment freeze in SCHIP, should the state budget dictate a freeze.

With the most recent Census estimates indicating that 13 percent of Colorado's children were uninsured in 2007, the need for coverage remains. The state's 2007 and 2008 policy changes demonstrate a commitment to increasing children's health insurance coverage and improving enrollment, retention, and efforts to reach vulnerable populations. However, advocates, including CKF, remain concerned that the state economy will again falter, given the state's ambitious budget plans and the unstable national economy. In this uncertain time in Colorado, CKF plans to continue in its advocacy and monitoring roles.

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Endnotes

1. RWJF invested nearly \$150 million in the two programs, through funds and technical assistance to community-based grantees in every state (RWJF 2008). RWJF funded 46 state CKF grantees in 45 states and the District of Columbia; grantees included community-based organizations, service agencies, government agencies, academic institutions and health care providers (Wooldridge 2007). (RWJF also funded smaller liaison grants in the other five states.) In turn, these state grantees funded 152 local grantees—at least two in each state—using half of their grants (the average state grant was \$828,215) (Wooldridge 2007). Local grantees were intended to be local laboratories for innovation that could report to state grantees on barriers to enrollment and the most effective types of outreach (Wooldridge 2007).
2. Families paid monthly premiums between \$9 and \$30 depending on family size and household income. However, a state law passed in 2001 eliminated monthly premiums and families earning more than 150 percent of the FPL paid annual enrollment fees of \$25 for one child and \$35 for two or more children.
3. CCHN was not the grantee of the predecessor CKI program; the Colorado Department of Public Health and the Environment, a state agency, was the CKI grantee.
4. In 2005 staff from Mathematica Policy Research, Inc. and Health Management Associates interviewed the state CKF grantee and Medicaid and SCHIP officials. Each respondent was asked to name the three most important policy or procedural changes that CKF affected through its work, and then to indicate for each policy change mentioned whether it: (1) would have occurred without CKF; (2) would have occurred with CKF, but more slowly; or (3) would not have occurred without CKF—CKF was vital to securing changes.
5. In some states, local grantees helped the state grantee meet the matching requirement.
6. 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 population for the years 2000 and beyond (John Czajka, Senior Fellow, Mathematica Policy Research, personal communication, September 22, 2008). Nationally, there is about a 2 percentage point reduction in the uninsured rate that can be attributed to methodological changes between

2000 and 2005. Although this impact is likely to vary by state, the Census Bureau has not produced estimates of state-level effects. Given these methodological discrepancies, we believe that the decline of 2 percentage points from 1999 to 2007 in Colorado is likely not a true decline in the rate of uninsured children.

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.

Our Commitment to Evaluation

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