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Covering Kids & Families[®] Evaluation

*Case Study of North Carolina: Exploring
Medicaid and SCHIP Enrollment Trends and
Their Links to Policy and Practice*

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About the *Covering Kids & Families*[®] Evaluation

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

The evaluation focuses on these key issues:

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

Findings from the evaluations can be found at www.rwjf.org/special/ckfeval.

Executive Summary

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

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

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

Introduction

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

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

The second indicator, used to study program retention, measures the rate of program cycling—which we define as the proportion of children who disenroll from coverage within 18 months of their initial enrollment date and then re-enroll within four to 10 months of being disenrolled. The hypothesis is that many children picked up by this measure have remained eligible for coverage but were dropped for failure to meet administrative requirements.

With these measures, the evaluation team assembled a series of graphs showing the trend in new entries and “cyclers” in Medicaid and SCHIP for the period October 1999 through June 2004. This period covers nearly the entire period of RWJF’s original Covering Kids Initiative (CKI) grant to the state (awarded in mid-1999) and the first 21 months of the subsequent CKF grant (awarded in October 2002). With respect to enrollment, we also assembled a similar time line for each local program and for each county the projects served.

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

State Policy Context

Program Characteristics. In October 1998, after a fractious debate in its divided General Assembly, North Carolina established *N.C. Health Choice for Children* (Health Choice) as its SCHIP program. An important compromise feature was to establish Health Choice as a separate program with a limit on program enrollment. Though Health Choice is administered separately from the children's Medicaid program (called Health Check in North Carolina), the program is considered a "Medicaid look-alike"—the two programs share a logo for outreach materials, a common mail-in application, and an enrollment process that occurs through the county social services office. Their benefit packages are also closely aligned. The almost "seamless" relationship between Health Check and Health Choice is credited with minimizing disruption for families that have children in both programs. One of the more controversial aspects of the initial Health Choice program design, the six month waiting period, was later modified.

Outreach for children's public coverage programs is conducted through the Health Check Outreach Initiative. Established in 1993, this statewide initiative incorporates "Health Check Coordinators" whose job is to conduct outreach and enrollment for children's health insurance. The number of such coordinators varies by county and is not necessarily related to need, since some larger counties have few or no coordinators and some smaller counties have several. As of May 2006, Health Check Coordinators worked in 91 of the state's 100 counties (North Carolina Department of Health and Human Services 2007). Since the implementation of Health Choice, outreach activities have been primarily county-based, with considerable variation in the type and amount of outreach that each county undertakes. In addition to guidance, coordination, and provision of limited outreach materials to counties, the state operates an MCH hotline. The UNC Department of Maternal and Child Health began staffing the hotline (which is now bilingual) in 2002, after which service improved tremendously. The number of calls to the hotline has increased, and a high proportion (roughly 65%) of calls concern Health Choice.

One distinction between the state's two public health coverage programs for children relates to health care service delivery arrangements. North Carolina's Medicaid program is largely a Primary Care Case Management system, with the only exception being the use of a state-licensed HMO in the largest county, Mecklenburg. Health Choice, however, continues to use a fee-for-service reimbursement system administered through Blue Cross/Blue Shield. While the reimbursement levels remained different for the two public health insurance programs for children until very recently (with Health Choice being over 15% higher than Medicaid), we were told that provider access has been generally adequate for both programs.²

Major Program Developments. As shown in Table 1, two critical policy developments occurred in the three years after Health Choice was implemented. First, because of the very limited availability of private insurance for low-income working families in North Carolina, policy-makers were convinced over time that crowd out was not a problem for Health Choice. Consequently, the waiting period was reduced from six to two months within the first year of implementation; it was eventually eliminated in early 2002.

The second development relates to the limit on enrollment that was established at the time the program was enacted. The state budget underestimated the demand for SCHIP coverage, which led to the need to cap enrollment in January 2001. (North Carolina was the first state nationwide to establish such a cap on SCHIP enrollment.) The cap remained in place until the legislature reconvened and increased appropriations for the program in the fall of 2001. Respondents told us that the enrollment freeze disrupted outreach, an effect that continues to this day. Even though there has not been another freeze, policy-makers believe it could happen again and are thus reluctant to invest significantly in major outreach efforts to boost public program enrollment. But Medicaid and SCHIP officials reported some outreach strategies that were adopted during and subsequent to the freeze, such as improvements to a toll-free family health hotline, initiatives targeted to special populations, and efforts to increase access to care.

While not related to any particular change in health program policies, another important development in the state relates to shifting demographics. According to state and program officials, North Carolina has experienced a "tremendous" influx of low-income Hispanic residents, both documented and undocumented. For example, in Wake County about a fourth of Medicaid/Health Choice applications are completed in Spanish. Most of the children (those born here) are entitled to Medicaid/Health Choice, but their parents may not be familiar with health insurance or the application process.

TABLE 1

Key Events in Child Health Coverage in North Carolina, 1998–2003

<p>October 1998</p>	<p>North Carolina implements <i>NC Health Choice for Children</i>, a separate SCHIP program, covering children up to 200% of the federal poverty level not entitled to Medicaid.</p> <p>Income levels: <i>Infants:</i> Medicaid to 185%; Health Choice, 185%–200% of FPL <i>Ages 1–5:</i> Medicaid to 133%; Health Choice, 133%–200% of FPL <i>Ages 6–18:</i> Medicaid to 100%; Health Choice, 100%–200% of FPL</p> <p>Key features:</p> <ul style="list-style-type: none"> • County-based outreach • Enrollment system same as Medicaid • Moderate cost sharing including enrollment fee • Administered by Blue Cross • Generous provider reimbursement • Six-month waiting period • Limited cost sharing for children above 150% of FPL
<p>January 1999</p>	<p>Covering Kids grant awarded, administered by state Office of Rural Health/ Foundation for Advanced Health Programs; pilot counties were Buncombe, Cabarrus, Edgecomb, Forsyth, and Guilford.</p>
<p>March 1999</p>	<p>Six-month waiting period replaced by two-month waiting period.</p>
<p>October 2000</p>	<p>Two-month waiting period eliminated for Health Choice for children with special health care needs.</p>
<p>January 2001</p>	<p>Health Choice program enrollment frozen at 68,000.</p>
<p>October 2001</p>	<p>Enrollment freeze lifted.</p>
<p>January 2002</p>	<p>Two-month waiting period eliminated for all Health Choice children.</p>
<p>October 2002</p>	<p>Covering Kids and Family project began, administered by the North Carolina Pediatric Society. Local projects established in Buncombe, Moore, New Hanover, and Wake Counties.</p>

This development is significant in that outreach in some counties is increasingly targeted to uninsured Hispanic children.

Other than the change in the waiting period and the enrollment freeze, North Carolina has made no important changes to either Medicaid or SCHIP policies.³ Health Choice is a popular program that most legislators in both political parties support. North Carolina's economic circumstances have improved substantially since a devastating hurricane in 1999, job loss in the textile industry, and the general economic recession in the early years of Health Choice. Because of political popularity and the improved economy, funding for the program has become more secure over time. There are even discussions among advocates concerning a possible push for universal health insurance coverage for children in North Carolina.

History of the CKI/CKF Program in North Carolina

The Covering Kids Initiative (CKI) in North Carolina began in 1999 with a grant from RWJF to the state's Office of Rural Health. While this might seem like an unusual place to house a CKI grant, there were several reasons for this choice. North Carolina is a state of predominantly rural areas and small towns. There has been a long history of research and pilot projects to understand access to care and improve it on the part of the state, and the Office of Rural Health oversaw much of that work. To streamline the receipt of grants for these efforts, the Office of Rural Health established the Foundation for Advanced Health Programs, which was the CKI grantee.

The CKI program had five pilot projects, one each in Buncombe, Cabarrus, Edgecombe, Forsyth, and Guilford Counties.⁴ In a site visit to North Carolina for a national evaluation of SCHIP, we visited Guilford County and learned that the CKI project there had a very active outreach program, including extensive media and school outreach (Hawkes and Howell 2002). In addition, key stakeholders from that evaluation told us that the CKI coalition was active and was an important catalyst for the successful simplification of the application process for Medicaid/Health Choice, and for the seamless coordination between the two programs.

When the CKI grant program ended and funding opportunities for the successor CKF program were announced, key stakeholders decided that the North Carolina Pediatric Society was best-suited to lead the new grant. The primary reason for the change of lead grantee was a desire for the grantee to have an "independent voice" from the state. In addition, there was a belief that housing the grant in the Pediatric Society would both facilitate involvement of physicians and make it easier to sustain the coalition and activities after the grant expired. The membership in the coalitions for CKI and CKF were very similar, and this provided continuity between CKI and CKF activities and approaches. State officials continued to be very active in the new coalition,

and throughout the CKF grant period the program enjoyed a positive, collaborative relationship with Medicaid and SCHIP administrators.

North Carolina received its CKF grant rather late in the funding cycle (October 2002), so there was a nine-month gap between the end of the CKI grant and the start of the CKF grant. The Pediatric Society sponsored monthly coalition meetings in the interim and county-based outreach continued (but at a reduced level due to the recent enrollment freeze).

The Pediatric Society also undertook new efforts as the statewide grantee. It developed a fact sheet on children's health insurance for state legislators; sponsored or participated in various outreach events; and began (in 2003) targeting media efforts to Spanish language media (newspapers and radio). There have been just a few English-language media efforts, though these were never a large part of the CKI approach either. Since retention has been a problem in the state, during 2003 the CKF state grantee worked with state officials to simplify and develop procedures to "pre-populate" the renewal form for Medicaid/Health Choice, as well as to develop a "culturally appropriate" renewal letter (including Spanish translation).

The North Carolina CKF program funds three local projects (in Buncombe, Moore, and New Hanover Counties), and has a very close affiliation with a "partner project" in Wake County that is funded by the Rex Endowment. The local projects in these counties were chosen because each had a rather unique approach to outreach, as described below. Each of these projects also began in October 2002, when the statewide grant was funded.

Buncombe County is located in the mountainous western part of North Carolina, and contains Asheville, one of the larger cities in the state. Western North Carolina, including Buncombe County, has typically been poorer than the more populous "Piedmont" region in the center of the state, but in recent years Buncombe County has experienced an influx of prosperous retirees that has changed the economy.

The CKF local project, although housed in the Department of Social Services, was primarily a school-focused initiative. A dedicated staff member worked intensively with all of the approximately 70 schools in the county, in order to distribute flyers to all parents twice a year. These flyers advertise the availability of public health insurance and ask parents if they need help applying. After flyers are printed, the staff member counts the correct number for each class in each school, and then takes them to the school with instructions to the teachers about their distribution. This reduces the administrative burden for the school, which has led to good school cooperation and a wide distribution of the flyers. Program officials told us that about 70 percent of children's public coverage applicants in the county say they heard about the insurance program through schools. The school success seems to be due in part to the high energy and enthusiasm

of the designated CKF staff member, who—with the expiration of the CKF grant—plans to staff the DSS hotline and continue the school-based outreach work.

Buncombe County also sponsors other forms of outreach, though much of this activity is more recent than the time period for the case study. These other strategies include provider outreach, for example, including information on health insurance in the packets sent home with newborns and identifying uninsured children in emergency rooms. Beginning in 2002 the county has used an ACCESS database to track child health insurance applications and enrollment. This helps with sending reminder letters at the time of renewal. Most of these CKF-funded activities will continue now that the grant has ended, and will be sustained by the county DSS staff.

Moore County in the south central Piedmont region contains Pinehurst, a small city that is a vacation and retirement destination. There are large economic disparities between the “gated communities” and the rest of the population who may work in the tourist industry, farming, or other small businesses. The CKF local project is run by MooreHealth, a nonprofit coalition of private and public sector agencies, with strong ties to FirstHealth, the county’s nonprofit health system.⁵ According to the state grantee, MooreHealth was selected as the local project because it offered a private sector, employer-focused alternative to more traditional CKI/CKF outreach. Project officials in the county emphasized their belief that offering coverage through a private sector model destigmatizes insurance and makes it more attractive to working families. When MooreHealth staff conduct outreach to local employers regarding FirstHealth insurance products, they also provide information on children’s public health insurance for distribution to employees. The project has undertaken some other outreach, including active participation in Cover the Uninsured Week each spring.

During the CKF grant period, MooreHealth also attempted to market a structured product to small employers within Moore County that offered subsidized insurance to low-income workers and their families. This was not successful (few people signed up). A critical number—400 people working in small firms that were members of the Chamber of Commerce—was needed to entice hospitals to give the discounts necessary to put the product in place. It is unclear why they had fewer enrollees than anticipated, since premiums were low—\$75 a month for an adult and one child. Staff felt that the marketing period was very short (three months), and that it might have succeeded with more time.

New Hanover County is in the coastal part of North Carolina, and contains Wilmington, another of the larger North Carolina cities. This local project was chosen because of its focus on the Latino population and on using child-care centers as outreach sites. North Carolina has a statewide early childhood education project called Smart Start, begun by Governor Jim Hunt, which funds county efforts to expand and improve child care. The Smart Start program for New Hanover is the local project grantee. This

means that the majority of the families reached have young children, though many also include older siblings. One staff member works only with Latino families, and particularly targets new mothers who may be uninsured themselves and who may not know about insurance options for their children. They coordinate with the county Health Check Coordinator to do school outreach (but not as intensively as in Buncombe County). The project has worked to make the application and renewal process easy for Spanish-speaking families. They also educate families about health insurance and preventive care, often using Spanish-language media as an outreach tool.

Wake County, in north-central North Carolina, houses the state capital, Raleigh, and is part of the growing and prosperous Research Triangle area. Its children's health insurance outreach project is not funded by CKF, but because of the similarity in goals and geographic proximity to the CKF state grantee, the project is closely linked to CKF. The project is funded by the Rex Endowment for \$1.3 million over five years ending in 2007, coinciding closely with the CKF grant period. The funding for Wake's project is five times more than that of the CKF local projects.

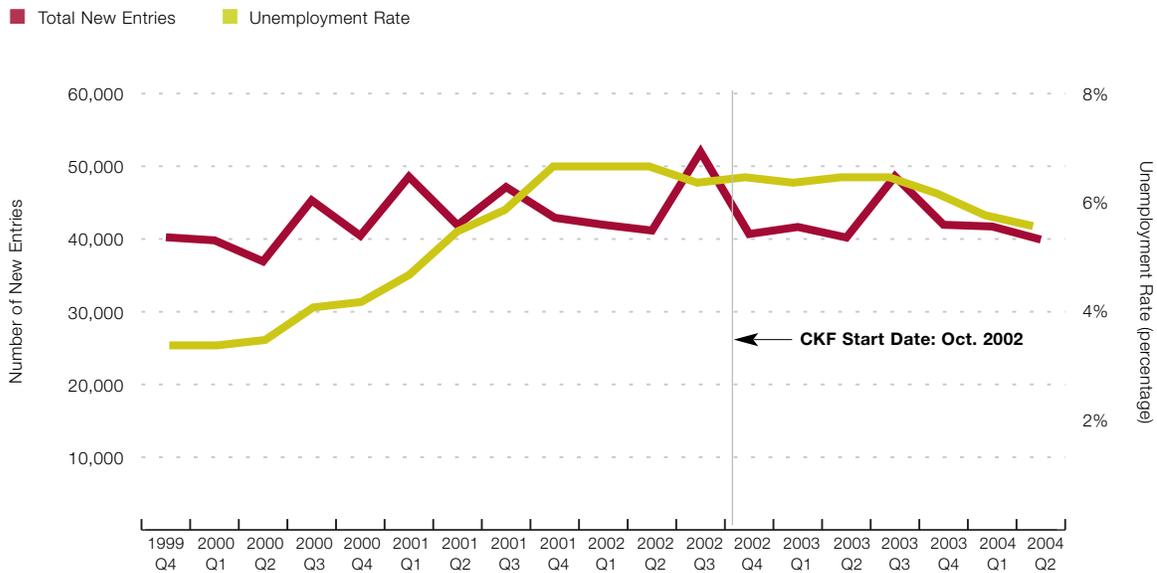
Project staff have adopted a provider-focused outreach/enrollment model in the Wake Medical Center clinics and emergency room. They consider this outreach to parents of uninsured children to be sustainable financially, since the efforts pay for themselves through increased insurance revenues for the county-supported medical center. Indeed, the county will absorb all of the outreach/enrollment workers previously paid for by the Rex Endowment grant. Other activities in Wake County include a promotora program begun in 2004 to reach Hispanic families, as well as providing incentives to workers at the Department of Social Services to increase children's health insurance applications.

State-Level Findings

Economic Trends. Starting in 2000 North Carolina's unemployment rate began a sharp increase (Figure 1), reflecting the effects of the major hurricane (Floyd) that struck the state the previous year; job losses in two major industries—textiles and manufacturing—and a general economic recession that continued through the early years of the CKF grant period. One might expect a downturn in a state's economy to correlate with a significant enrollment increase in public programs for low-income children (since an increasing number of unemployed families might seek public assistance). However, while unemployment rates increased considerably from about 4 percent in late 2000 to nearly 7 percent in mid-2002, there was only a slight increase in the number of children newly entering public coverage over that period. Specifically, between the fourth quarter of 2000 and the second quarter of 2002, total new enrollment rose by just over 700 children, an increase of less than 2 percent.

FIGURE 1

Unemployment Rate and New Entries to Public Health Coverage, North Carolina, October 1999–June 2004



Note: New entries are children enrolling in public health coverage plans for the first time in the past 12 months.
 Source: Medicaid Statistical Information System and Bureau of Labor Statistics

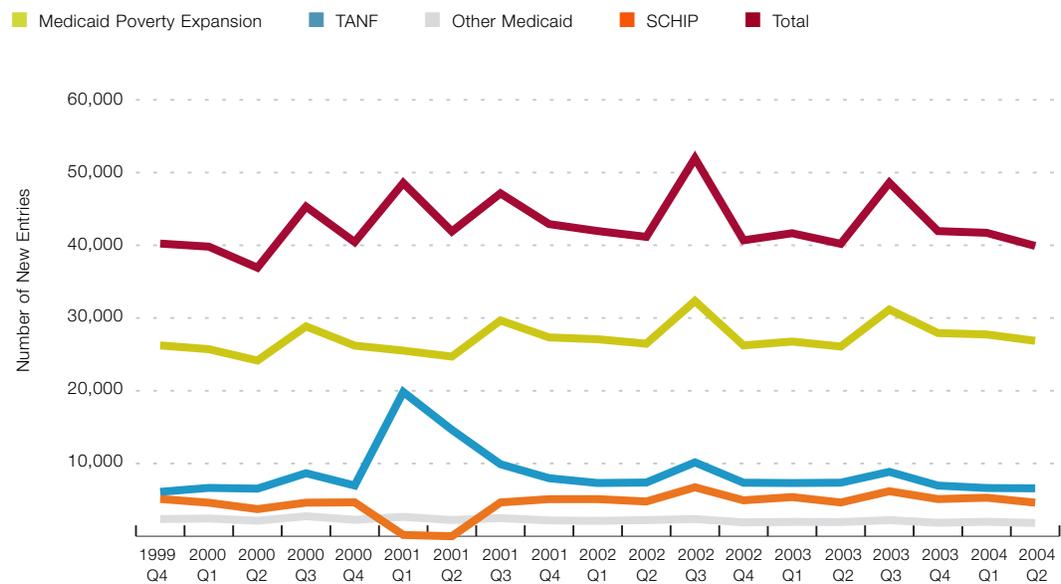
CKF and state officials thought that newly unemployed families, who may not have previous experience with public assistance programs, might not be aware of their child’s eligibility for Health Check/Health Choice. An alternative explanation for why unemployment and new entry trends do not correlate more closely concerns the state’s experience with Hurricane Floyd in late 1999. According to site visit interviewees, the natural disaster resulted in a significant number of new eligibles in the Health Check/Health Choice programs, as homes or workplaces of families in the most-affected counties were destroyed (resulting in loss of income/assets and subsequent eligibility for public coverage). Informants believed that many children who may have been impacted by the rise in unemployment already had public health insurance coverage at the start of the economic recession, because they became eligible after the hurricane.

Links Between Enrollment and State Policy Changes. As seen in Figure 2, a significant spike in new enrollment did take place within one program eligibility group—the Temporary Assistance for Needy Families (TANF) group—between the last quarter of 2000 and the third quarter of 2001. This spike is likely the result of the reinstatement of a large group of former welfare enrollees who may have been “inappropriately terminated from Medicaid as a result of welfare reform,” into the TANF eligibility group. The reinstatement began at the start of FY 2001 and at its peak, the reinstated group included over 70,000 persons (Medicaid Statistical Information System 2005).

The major impact of the Health Choice (SCHIP) enrollment cap, which was in effect from January–October 2001, is also evident in Figure 2. Predictably, new enrollment numbers are close to zero during the first and second quarters of 2001 when virtually no children were added to the program; in the following quarter, increased program appropriations allowed state officials to re-open enrollment. Health Choice then experienced a rapid rebound in new enrollment, with numbers reaching pre-cap levels of nearly 5,000 new enrollees per quarter soon after the enrollment cap was lifted.

FIGURE 2

New Entries to Public Health Coverage, by Program Types, North Carolina, October 1999–June 2004



Note: New entries are children enrolling in SCHIP, MCHIP and Medicaid Poverty Expansion for the first time in the past 12 months.
Source: Medicaid Statistical Information System data

Interestingly, the period of no new enrollment in Health Choice does not have a visible impact on the overall new enrollment trend for public coverage programs. The TANF enrollment spike occurs during the same period and effectively neutralizes any impact that the cap on new SCHIP enrollments may have had on overall new enrollments.

The other notable policy change adopted during the CKF study period—the elimination of the two-month SCHIP crowd-out waiting period in January 2002—shows no relation to the trend in new enrollment of children. Before and after this period, the trend in new SCHIP entries remains roughly constant at about 5,000 enrollees per quarter.

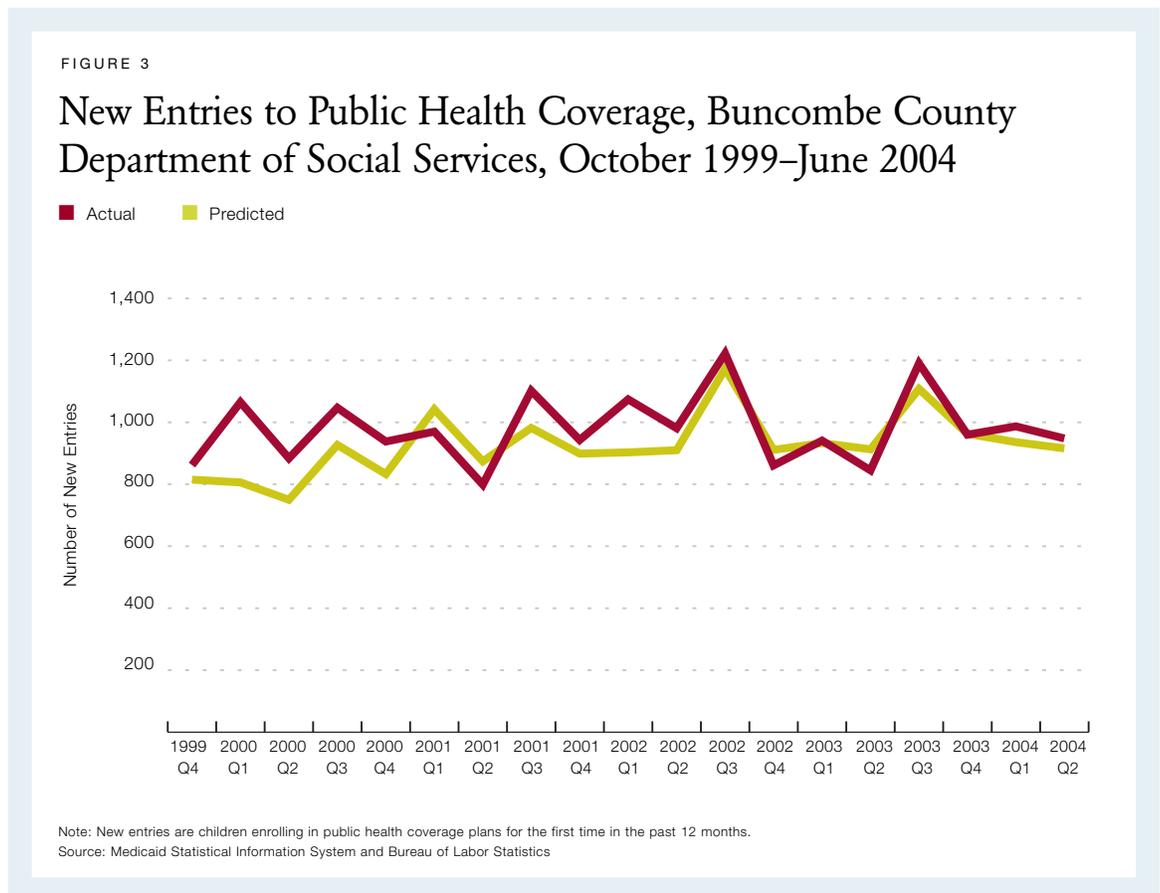
Links Between Enrollment and CKF State Activities. The two most notable peaks in new entries—in the third quarters of 2002 and 2003—take place at the same time as the CKF initiative’s Back-to-School campaign. However, key informants did not believe there was causal association between the two. Program staff reported that the threat of additional SCHIP program freezes curtailed Back-to-School outreach for most of the grant period, saying “2005 was the first year that we felt able to really promote Back-to-School.” Specifically they were concerned that intense efforts to promote Health Choice, and the resultant increase in the number of children enrolling in the program, could strain the program’s budget and spur another enrollment freeze. During those periods when the state grantee felt that the threat of an enrollment freeze hampered intensive (and very public) outreach activities, staff participated in less visible school-based efforts, such as using free and reduced school lunch program records to identify uninsured children.

State and CKF officials offered an alternative explanation for the third quarter spike in 2002 and subsequent years, which involved the concept of “freeze rumors.” They suggested that more families enrolled in the third quarters of the years following the original program cap because that was the period during which the state budget was debated, when any potential plans to reinstate an enrollment cap would be made public, prompting public discussion and ‘rumors’ about whether or not the Health Choice program would remain open for the coming budget year. These officials confirmed that there was indeed “talk of another freeze” in 2002 and again in 2003.

Local-Level Findings

To explore the possibility that local outreach activities by the CKF projects may have had an effect on the number of children enrolling in public coverage, we compared the trend in new entries for each of the four local areas with the trends we would have expected based on those in other parts of the state.⁶ If the actual trend in the area exceeded our expectations, it suggests that local outreach activities were relatively more successful than outreach activities elsewhere in the state. Likewise, if the actual trend in the area was less than our expectations, it suggests that local outreach activities were relatively less successful than outreach activities in other parts of the state. We also studied the trends in new enrollment for each county within the context of their local project activities, and asked project staff to note any periods of notable outreach activity that correspond to trends in new entries.

Findings from Buncombe County (Figure 3) show consistent good performance since 2000, the start of their Covering Kids Initiative grant; for most of the data period, the actual number of new entries generally exceeds the expected number. When asked to identify their most successful outreach strategy, key informants described the Buncombe



County school-based outreach initiative, during which project staff designed, printed, and distributed flyers about the Health Check/Health Choice programs to the school system twice each year: with students' orientation packets and with the January report cards. While the County's outreach methods are not unusual—local CKF projects across the nation have reported similar school-based mailings throughout the evaluation period (Stockdale, Howell, & Hill, 2003)—the project does appear to have been successful with the method. Peaks in new enrollment in the first and third quarters of each year correspond with the timing of the school-based initiative and may be evidence of its effectiveness.

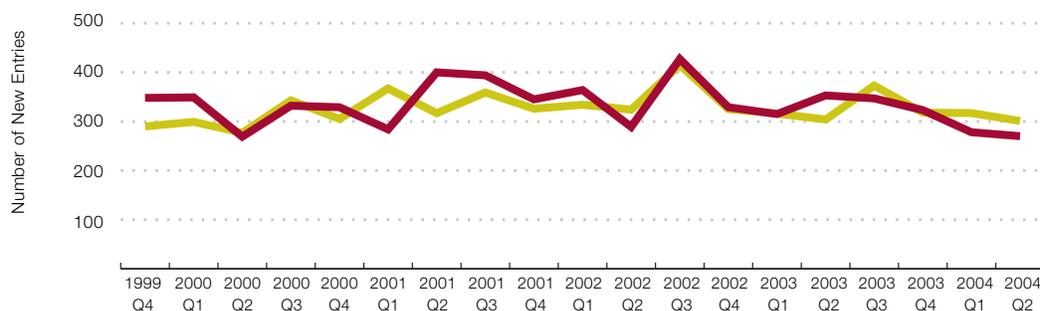
In Moore, New Hanover, and Wake counties, new entry levels are generally at or below those predicted by our model (Figure 4). Overall, patterns of enrollment in these three counties do not correspond with specific outreach activities conducted through CKF. Still, local project staff noted certain outreach efforts that may have had a minor effect on the total number of new entries into public health coverage during the data period. For example, the MooreHealth project noted that in the third quarter of 2002, when new entries hit their highest mark of the entire data period, the project had just released a major publication about First Plan, the county's small-business model private insurance plan. They surmised that this advertisement might have resulted in some spillover to Health Choice/Health Check enrollments, since information about First Plan is typically accompanied by information about the two forms of public health coverage available for children. In Wake County, new entries increase in the third quarter of every year in the data period—though this is generally the Back-to-School period, program staff reported little success conducting school-based outreach. They did note, however, that coordinating outreach with the free and reduced school lunch program has been 'somewhat promising' and described more recent initiatives involving outreach with school nurses and guidance counselors.

FIGURE 4

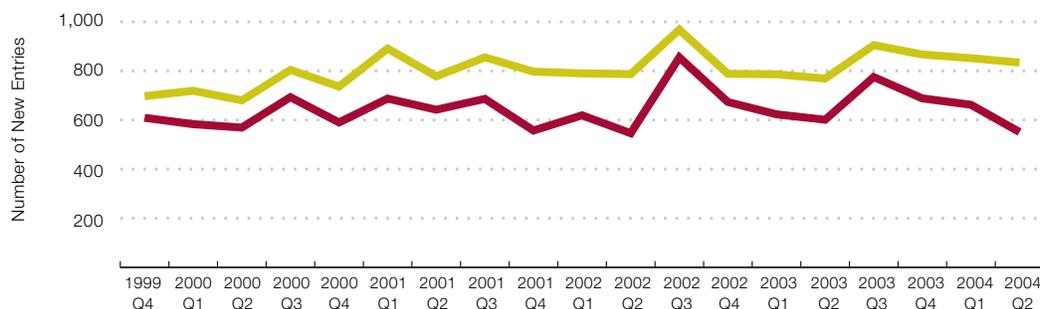
New Entries to Public Health Coverage, North Carolina Local CKF Projects, October 1999–June 2004

■ Actual ■ Predicted

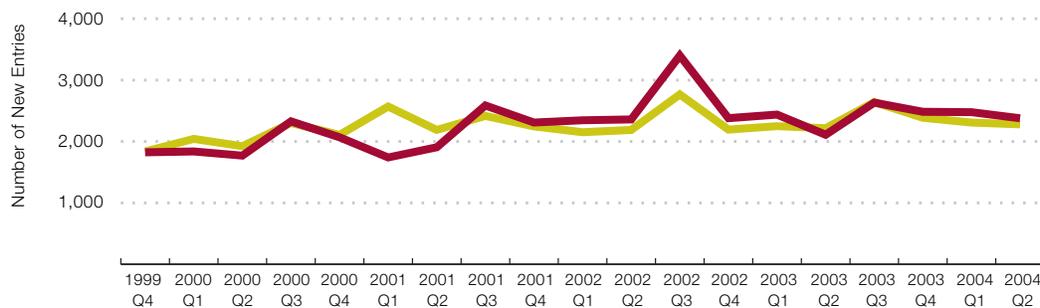
Moore County



New Hanover County



Wake County



Note: New entries are children enrolling in public health coverage plans for the first time in the past 12 months.
Source: Medicaid Statistical Information System and Bureau of Labor Statistics

Retention

This case study also set out to measure retention among children in North Carolina's Health Check program during the CKF grant period. Measuring the number of new entries over time allows for the assessment of how well a state is promoting public coverage, and how smoothly the enrollment process is working. However, measuring health insurance retention is just as critical to understanding how well a state health insurance program is working, since stable health insurance coverage is associated with improved access to health care and continuity of care (Fairbrother & Haidery, 2005).

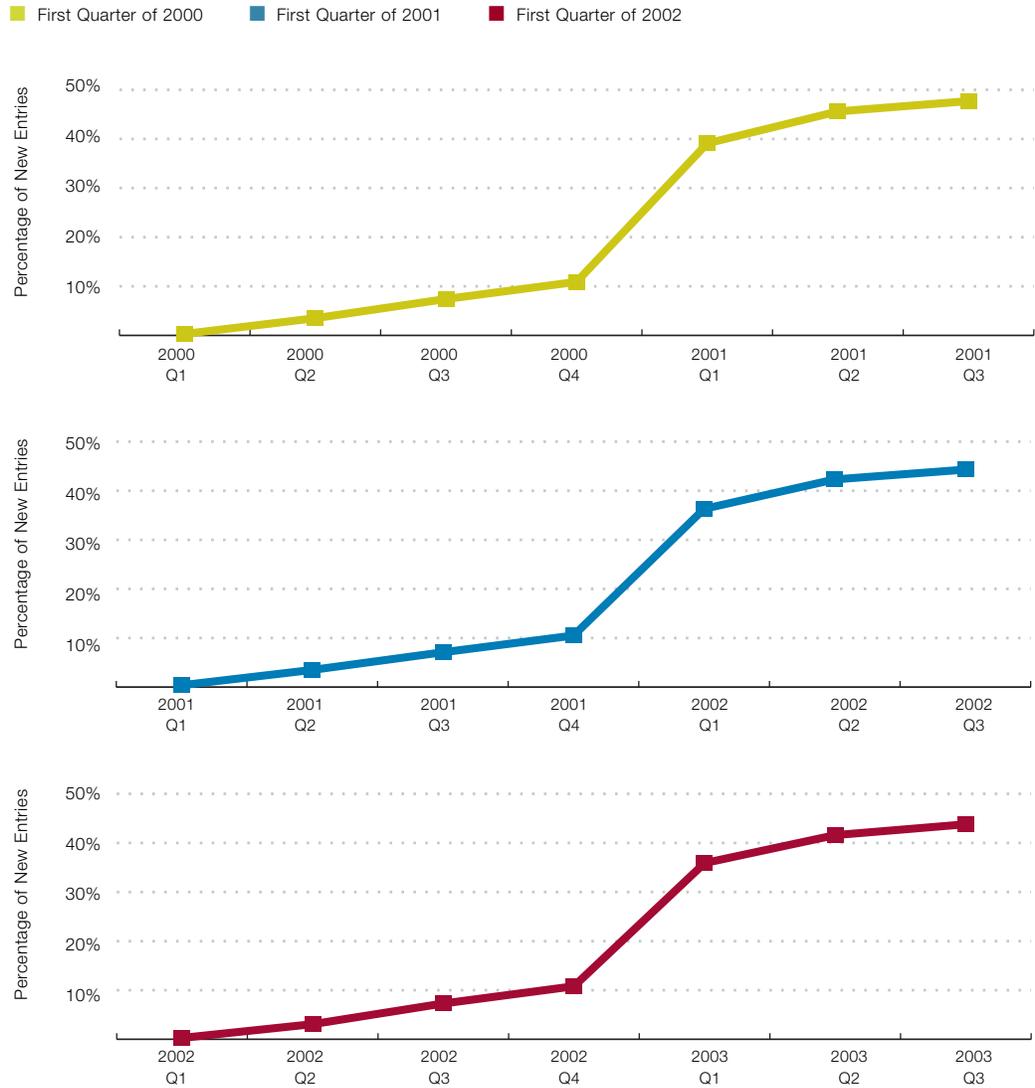
Figure 5 displays retention data for three separate cohorts of new entries—those that entered Health Check in: the first quarter of 2000; the first quarter of 2001; and the first quarter of 2002. The trend line for each cohort follows the percentage of each group that had disenrolled in each of the six quarters subsequent to their enrollment quarter.⁷ The rate of retention increased slightly across the three cohorts, with 48 percent of the 2000 cohort leaving after six quarters compared to only 44 percent of the 2002 cohort doing so.

Similarly, Figure 6 displays the percentage of children from the same three cohorts who disenrolled from public coverage *and* then re-enrolled (or cycled back) in the program four to 10 months later, for each of the six quarters after the initial enrollment.⁸ Because these disenrollees were found eligible for the program less than a year after their disenrollment, one can assume that most were eligible during their brief period of uninsurance as well. The proportion of children 'cycling' off the program decreased over the three-year period; 8 percent of the 2000 cohort had cycled in the six quarters following enrollment, compared to 6 percent of the 2002 cohort.

Key informants recognized that a sizable portion of enrollees do not maintain continuous coverage, and noted a need for more outreach and education on the importance of retention. While the 2001 Health Choice enrollment cap was in place, outreach and enrollment staff emphasized the importance of timely renewal to avoid losing coverage for both Health Check and Health Choice enrollees (since disenrollees from Health Choice would not be able to re-enroll in that program while enrollment was frozen). Indeed, state officials indicated that the Health Check renewal rate improved in the year following the Health Choice freeze, suggesting that implementation of the enrollment cap was an incentive for publicly insured families to maintain their child's Health Check coverage continuously (even though the cap did not directly affect children enrolled in that program).

FIGURE 5

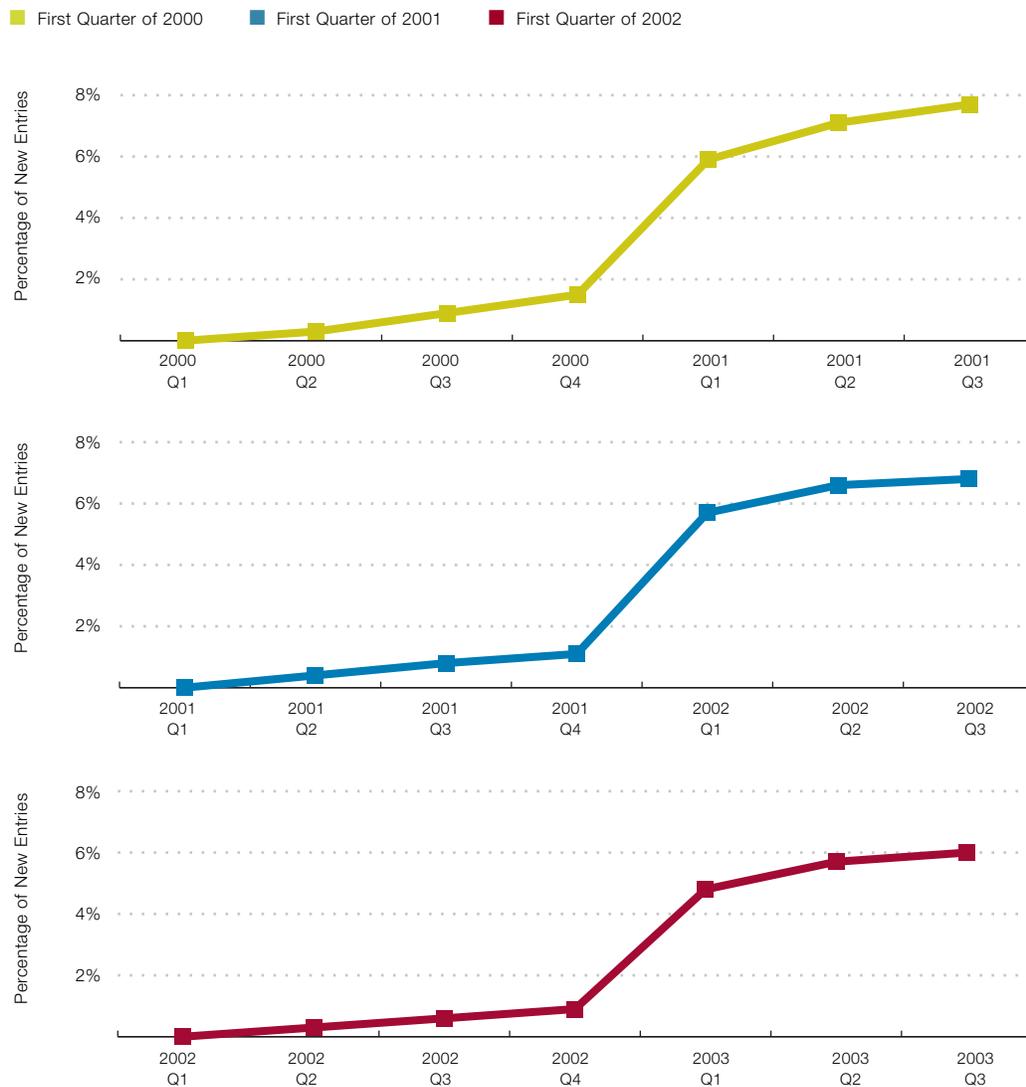
Cumulative Percentage of Q1 New Public Coverage Entries Who Disenroll, North Carolina, 2000–2002



Note: New entries are children enrolling in public health coverage plans for the first time in the past 12 months.
 Source: Medicaid Statistical Information System and Bureau of Labor Statistics

FIGURE 6

Cumulative Percentage of Q1 New Public Coverage Entries Who Disenroll and Cycle Back, North Carolina, 2000–2002



Note: New entries are children enrolling in public health coverage plans for the first time in the past 12 months.
 Source: Medicaid Statistical Information System and Bureau of Labor Statistics

State officials also indicated that CKF coalition meetings had provided a forum for local outreach projects to share their experiences and feedback with regard to existing state renewal forms and notices. These informants emphasized the value of CKF officials' input on ways the renewal process might be redesigned to promote retention. But CKF program staff expressed some frustration that the state had not yet adopted simplified re-enrollment procedures; they continued to describe the process at least as cumbersome as or more difficult than initial enrollment.

Conclusions

North Carolina Covering Kids and Families followed on the heels of a successful Covering Kids Initiative grant period, during which the state established a dynamic coalition and undertook several activities to simplify enrollment in and coordinate components of the Health Check and Health Choice health insurance programs for children. Building on the accomplishments of its predecessor, the North Carolina Pediatric Society maintained an active CKF state coalition, directed efforts to improving retention among publicly insured programs, and established a base for outreach to the state's growing Hispanic population.

Three local project sites (as well as a fourth, non-CKF site that worked closely with the state grantee) were an important part of the grant program in that they provided feedback to the state grantee on the effects of state policies and the success of different outreach strategies. In particular, the Buncombe County project successfully conducted outreach activities through local schools twice a year, which appear linked to new enrollments for the county.

Despite an ongoing economic recession and state budget constraints—conditions that often spur policy changes to contain costs and curb public program enrollment—it is notable that there were no major policy changes during the CKF grant period that had impact on children's enrollment. One major policy change that predated CKF funding was the Health Choice enrollment cap of 2001, which seemed to have had the effect of increasing enrollment and retention in the years immediately following its implementation (and subsequent lifting). Even during the cap period, as well as in subsequent years when a tight state budget prompted “freeze rumors,” the state maintained an outreach presence and supported CKF activities.

While retention rates improved slightly over the study period, CKF officials indicated that the current renewal process remained a potential deterrent for families. They believed that changes to the process, such as a simplified renewal form, could lead to further improvements in retention and in overall rates of coverage in the state.

Endnotes

1. In addition, within the Medicaid program, we focus on new-entry children whose program eligibility is based on income (either in the poverty expansion group or one of the eligible groups related to Temporary Assistance for Needy Families). Outreach efforts and enrollment simplification policies are more likely to affect these children than those enrolled for other reasons, such as disability or foster care status.
2. A change outside of our study period (effective June 2006) brought Health Choice provider reimbursement rates in line with Medicaid rates.
3. A significant change occurred outside of the data period for this study (1999–2004); effective January 2006, the state transferred all children ages 0–5 from Health Choice to Medicaid. Since Health Choice maintains a limit on enrollment (though the state has only reached this limit and needed to implement an enrollment cap once in its history), this shift effectively resulted in more open slots for enrollment into the Health Choice program.
4. We did not obtain detailed information on the CKI pilot projects as part of the CKF site visit, except for the Buncombe County project (which continued as a CKF local project and where there was essential continuity between CKI and CKF).
5. FirstHealth of the Carolinas is a private, non-governmental, not-for-profit health care network serving 15 counties in the mid-Carolinas. In addition to three hospitals and a range of outpatient programs and facilities, First Health has an insurance plan which includes a product specifically targeted to the uninsured in the network's coverage area.
6. Expected enrollment is based on a forecasting model that predicts, for each county and city in the state, the number of children enrolling in Medicaid or SCHIP in that quarter. Inputs to the model include: (1) the number of children below 200 percent of the FPL; (2) the population that has just moved into the county from out of state; and (3) the local unemployment rate.
7. For example, 3.5 percent of the children who entered the Medicaid program in the first quarter of 2000 disenrolled from the program in the second quarter of 2000.
8. Each data point represents the portion of disenrollees from that quarter who "cycled". For example, in the fourth quarter of 2001, 1.1 percent of the cohort that disenrolled that quarter eventually cycled back onto the program (within 4–10 months).

Sources

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