Washington: Coverage to All Children

Beginning in February 2009, Washington began enrolling children with family incomes up to 300 percent of the federal poverty level (FPL) in its new Apple Health for Kids program. The implementation of this expansion is only the most recent phase of a comprehensive effort to cover all children that began over 2 years ago when Governor Chris Gregoire signed legislation to provide health coverage to all children, regardless of immigration status, with family incomes up to 300% of the FPL. The expansion had originally been slated for a January 2009 implementation, but was put on hold due to budget pressures and the August 17th directive.

As a result of the new funds available through CHIP reauthorization along with the withdrawal of the August 17th directive, the state was able to move ahead on the planned expansion. Coverage was extended retroactively to families with income up to 300% of the FPL who applied since November 24, but were denied coverage due to the delayed expansion.

In addition to the expansion, the original legislation included directives for the state to simplify and streamline application and renewal processes and improve the quality of and access to care children receive through a medical home program in Medicaid and SCHIP. One of the biggest steps in this process was to repackage and relaunch Washington's Medicaid and CHIP programs into a seamless new program called Apple Health for Kids, which began in Summer 2008. Advocates are now undertaking efforts to use the new tools available through CHIP reauthorization to strengthen and enhance the simplification and streamlining measures that were called for in the original bill signed in 2007.

Background

Before the inception of the State Children's Health Insurance Program (SCHIP) in 1997, Washington covered children in families with incomes up to 200 percent of the federal poverty level (FPL) through Medicaid. In addition, the state provided coverage to children, regardless of immigration status, in families with incomes up to 200 percent of the FPL through a separate state-funded program. Washington developed a separate SCHIP program in 1999 to cover children in families with incomes between 200 percent and 250 percent of the FPL. Along with the coverage expansion, Washington adopted a number of policies to simplify the enrollment and application processes and invested in outreach to find and enroll eligible children. According to Washington State Population Survey data, by 2002 only 4.5 percent of all children in Washington were uninsured.

Washington's forward movement changed in 2002 when state policymakers began to face significant budget deficits. To obtain savings, state policymakers pushed a number of policy changes for Medicaid and SCHIP, including a shift from 12 months continuous eligibility to a 6 month renewal period, the elimination of self-declaration of income, and the elimination of the program for immigrant children not eligible for Medicaid or SCHIP.* According to data from the state Medicaid agency, the combined effect of these policy changes resulted in more than 50,000 children losing coverage between late 2002 and 2005.

A coalition of child advocates convened by the Children's Alliance, called the Health Coalition for Children and Youth (HCCY), worked against the policy changes and documented, on a monthly basis, what they meant for families. Members of the coalition include the Washington State Hospital Association, American Academy of Pediatrics, Community Health Network of Washington (representing many of the community health clinics), and the state's children's hospitals. In late 2004, the Children's Alliance, working with HCCY, issued a report Condition Critical: Washington's Curable Children's Health Crisis that quantitatively and qualitatively (through interviews with families) documented the impact of the policy changes on children's coverage.

*Note: when the program for immigrant children ended, funding to serve these children was transferred to the state's Basic Health Program (BHP). BHP is a state-funded program that was designed for and largely serves adults and has significant cost-sharing requirements. The transition to BHP was not automatic for these children and most children either did not transfer to the program or did not stay enrolled in BHP.

Legislative History

2005: The Tide Turns

Chris Gregoire (D) became Washington's Governor in 2005, with a campaign promise to cover all children in the state. Days after being sworn in she directed the Health and Recovery Services Administration (HRSA; the state agency responsible for Medicaid and SCHIP) to return to a 12-month continuous eligibility period for children in Medicaid and SCHIP and issued a postponement in implementing monthly Medicaid premiums for children. The 2005 legislative session also ended with a partial restoration of the program for immigrant children (a limited number of slots up to 100 percent of the FPL) and the establishment of a new state goal to cover all children in Washington by 2010.

2006: Continued Progress

The efforts to cover children continued during the 2006 legislative session. With advocacy by the Health Coalition for Children and Youth (HCCY) and continued support from the Governor, the Legislature eliminated the waiting list of over 15,000 children for the state program serving immigrant children and placed a permanent prohibition on proposed monthly Medicaid premium increases. Throughout these efforts, two champions in the House of Representatives emerged as key in laying the groundwork for finishing the job in the coming legislative session, Speaker of the House Frank Chopp (D) and Representative Judy Clibborn (D), the prime sponsor of the legislation to cover all children by 2010.

2007: Adopting the Policies

During the summer of 2006 until the start of the 2007 legislative session, the HCCY crafted a broad proposal that included the policies necessary to cover all children in the state by 2010. At the same time, staff from the Governor's Office, the Speaker of the House, and the Senate Majority Leader's Office remained committed to the 2010 goal and engaged in a process to develop a proposal for the 2007 legislative session. The resulting proposal by HCCY provided helpful input to this process and resulted in a strong consensus plan that could successfully be passed during the 2007 session. It included a children's coverage expansion, provisions to increase enrollment of eligible children, and policies to address problems with access and quality through linking children with a medical home. Many components of this proposal were incorporated into the Governor's requested legislation that was introduced in the House and Senate, both with Democratic majorities, during the 2007 legislative session. However, the Governor's legislation and budget only allowed coverage for all children, regardless of immigration status, up to 250 percent of the FPL (the state already covered

children eligible for Medicaid and SCHIP up to 250 percent of the FPL). Both the House and Senate amended the legislation so that it called for expanding health coverage for all children, regardless of immigrations status, up to 300 percent of the FPL and allowing families above 300 percent FPL to buy-in at the full cost of coverage. The later version of the Senate bill was passed by both chambers and signed by Governor Gregoire on March 13, 2007, a little more than two months after the start of the legislative session.

Primary Opposition

Vocal opposition was kept to a minimum because of the large groundswell of support for covering children that had been fostered throughout the state in recent years, as witnessed in polls and focus groups. The opposition that did exist was mostly from those who did not want to spend more money and those who did not want to cover immigrant children. Some of those opposed to spending more money cited concerns that expanding the program would result in the enrollment of children who already had employer-based coverage. These "crowd-out" concerns were generally addressed through education on the issue and by highlighting provisions in the legislation. The provisions include sliding scale premiums which require families with higher incomes to pay more for coverage and a four-month waiting period which requires children to be uninsured prior to enrollment.

The opposition to covering immigrant children (covered by state-only dollars) was countered by messages such as “kids are kids” and “we don’t play politics with kids” and by keeping coverage for immigrant children couched within the broader proposal to cover all children.

Program Elements

Washington creates new coverage opportunities for all children. Children with family incomes up to 300 percent of the federal poverty level (FPL) are eligible regardless of immigration status. The state intends to allow families with children above 300 percent of the FPL to buy into state-provided coverage without a subsidy. The legislation also stipulates that every child in the state with a family income up to 300 percent of the FPL is entitled to health coverage and thus the provision of such is not subject to "whether the money is available" in a tight budget environment. Other provisions of the program are:

- **Addresses barriers to coverage**. The initiative creates one seamless health care program for children with the same application and renewal processes and coordination among the different programs by income level. For example, since eligibility for the state's current SCHIP program requires that a child be uninsured for four months prior to enrollment, the same waiting period will apply for all SCHIP children (those with family income between 200 and 300 percent of the FPL) and for immigrant children in the state program at the SCHIP income level. Additionally, the state is directed to develop an improved online application and a plan to increase retention in the program.

- **Improves access to quality care in a medical home.** The legislation outlines the importance of a medical home in improving the quality of care children receive. It requires that the state work with stakeholders to develop quality measures to evaluate medical homes. These quality measures will then be linked to increased reimbursement for pediatric providers.

- **Invests in outreach to find and enroll eligible children**. The legislation directs the state to undertake a targeted outreach plan to enroll children in health coverage and assist parents with understanding health coverage and benefits. It requires that the state contract

with community-based organizations and local government entities, collaborate with other state and local agencies, and use existing systems such as school meals to identify eligible children. In addition, it uses assistors, paid $75 per successful application, to help families with completing applications. $4.4 million was appropriated in the fiscal year 07-09 budget for these outreach activities.

Funding

The new initiative, and any growth in current program enrollment, is funded by state dollars and federal matching dollars when applicable (federal matching dollars are not available for covering some of the immigrant children and those who are undocumented). The state funds are general revenue funds; no specific source of funds was identified to finance the expansion. In total, over the two-year biennial budget period that began July 1, 2007 and will end June 30, 2009, the program is expected to cost a total of $58.4 million; $32.5 in state general funds and $25.9 in federal matching funds. Funding after June 30, 2009 must be appropriated.

Results

The initiative is being implemented over a five-year period, beginning in July 2007 through 2012. Here are some of the results so far:

- **Coverage for Immigrant Children Implemented.** In July 2007, coverage for immigrant children was increased from 100 percent to 250 percent of the federal poverty level (FPL). When this was implemented, 8,000 children who were eligible for coverage because they had siblings who were enrolled in either Medicaid or SCHIP were automatically enrolled.

- **Launching of Apple Health for Kids.** As part of an overall outreach campaign, the state repackaged and relaunched the state's Medicaid and CHIP programs as a seamless new program called "Apple Health for Kids" in the summer of 2008. This rebranding is part of the ongoing effort to further simplify and streamline the state's health care programs for children.

- **Expansion up to 300 Percent Implemented.** Beginning in late February 2009, children in families with incomes up to 300% FPL were made eligible for coverage in Apple Health for Kids. This expansion had originally been slated to begin January 1, 2009, but due to budget pressures was put on hold. Following CHIP reauthorization and the withdrawal of the August 17th directive, the state moved ahead with the expansion. Coverage was also extended retroactively to families with income up to 300% FPL who applied since November 24, but were denied coverage. The state estimates that 800-900 children will receive coverage they were previously denied and an additional 2,500 children will be enrolled by June.

Finally the legislation requires an evaluation of key elements of the program including the efficacy of outreach to enroll eligible children, how many fewer children are uninsured, and overall improvements in children's health as measured by indicators such as well-child visits, immunizations, and dental visits. These results will be delivered in a report to the legislature and will be available at a later date.

Lessons Learned

- **Multi-year campaigns can create the momentum for larger change**. The success was the cumulative effect of years of advocacy. During some periods, Washington actually went

backwards. But, by documenting the harm to children for the media and policymakers, it was possible to turn children's health coverage into a high profile issue. In particular, children's coverage became a central issue during the state's 2004 Gubernatorial campaign, which resulted in a commitment by the winning candidate (Governor Gregoire) to take action soon after she was elected.

- **Identifying policymakers who can be champions and work strategically is critical for success.** Without the Governor's leadership from her first days in office, covering all kids would not have been possible. Her public commitment to the issue resulted in major inroads towards achieving coverage for all children. However, having key champions in the House and Senate allowed advocates to continue to have a voice when there were areas that needed more attention than what they were getting under the Governor's leadership. It was critical that the leadership and staff from the House and Senate regularly met with the Governor's office to discuss the common goal of covering all children. These conversations allowed the process to unfold and move quickly without many process-oriented obstacles.

- **A strong coalition where all members feel ownership helps solidify support.** The coalition consisted of representatives from the provider community, children's advocacy groups, hospitals, the insurance industry, and many other organizations. All members of the coalition had a role in helping to draft the proposal that the Health Coalition for Children and Youth (HCCY) developed. Because all members of the coalition were involved in the development of the proposal, they felt a strong sense of responsibility for getting it passed into law. Additionally, the sense of ownership about the proposal helped the coalition work towards consensus when there were areas of potential disagreement.

- **Coverage for immigrant children is best incorporated into an "all kids" message.** While Washington was able to secure some coverage for immigrant children prior to the 2007 session, these gains were small and very contentious. However, the comprehensive bill in the 2007 legislative session that addressed a wide range of policy improvements to cover all children and improve their access to care proved to be an effective strategy for covering immigrant children.

- **After policies are adopted, significant work is required to successfully implement them.** Now that the law is on the books, coalition members are working with the state agency on the subcommittees implementing the program. These subcommittees are co-led by members of the coalition and representatives from the state agency and are focused on three areas: outreach and enrollment, renewal and application simplification, and identifying performance measurement and accountability benchmarks for medical homes.

- **Once a policy success is achieved, it is vital that the results of the success are continually documented and shared with the public and policymakers.** Washington was an early leader in covering children—a fact not well known by the public at the time. Moreover, these gains in coverage were not seen as victories and positive investments in the future, but rather as financial burdens by policymakers. If instead, Washington's early successes in covering children had been understood and praised by the public and policymakers, the state might not have taken the backwards steps it did in 2002.

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Washington's Medicaid/SCHIP Programs: At a Glance

Program Element	Prior to Expansion	Expansion 1	Proposed Expansion 2
Implementation Date	n/a	July 22, 2007	February 23, 2009 (expansion to 300%); Buy-in implementation date to be determined
Program Type	Separate Medicaid and SCHIP programs	Separate program	Builds on phase 1 of expansion
Income Range and Population Covered	Medicaid: children with family incomes up to 200% of the FPL SCHIP: children with family incomes between 200% & 250% of the FPL	All children under 19 with family income up to 250% FPL regardless of immigration status	Children under 19 with family incomes up to 300% of the FPL regardless of immigration status; children with family incomes over 300% of the FPL are eligible to buy-in at the full cost
Cost-Sharing	Up to 200% of the FPL: no premiums or co-payments Between 200% and 250% of the FPL: monthly premiums of $15/child (max of $45/month per family); no co-payments	Remains the same by income level until April 1, 2009; monthly premiums will then be $20/child (max of $40/month per family)	Monthly premiums of $30/child ($60 max); the cost of the buy-in will be equal to the rate the state pays plus any administrative costs
Medicaid/SCHIP Coordination	Administered by Health and Recovery Services Administration, Division of Health Services; joint application for Medicaid and SCHIP; automatic transfer between programs when changes in eligibility	Administered by the same agency, with the same level of coordination	Same for expansion
Enrollment/Renewal Procedures			
Application	Mail-in application; no face-to-face interview or asset test required	Same application and enrollment process; improved online application (integrated with case management system) to be studied	Same for expansion

Continuous Eligibility	12 months for Medicaid and SCHIP	12 months	Same for expansion
Renewal	Joint renewal form for Medicaid and SCHIP; no face-to-face interview or asset test required; automatic continuation of benefits when an Eligibility Review is received, but not yet processed	Same renewal form and procedures	Same for expansion
Crowd-out Measures for Separate SCHIP	4-month waiting period for enrollment in SCHIP (incomes above 200%); state currently monitors substitution of coverage	Same 4-month waiting period for all children, regardless of immigration status, with family incomes above 200% of the FPL. Will report on the substitution resulting from this expansion by 2010.	Same for expansion
Linkage with Other Public Programs	Previous pilot program with Medicaid and free school lunch program; automatic renewal of Medicaid with Food Stamp renewal	Use of existing systems to identify eligible kids, including free school lunch, child care, WIC, and early childhood education to be studied	No change
Benefits			
Benefits	Medicaid/SCHIP covers medical, dental, vision, and hearing, as well as mental health, alcohol and substance abuse services	Same	Same benefits for expansion
Service Delivery System	Largely managed care (immigrant children and children in certain counties with less than 3 managed care options are served in a fee-for-service model)	New focus on connecting beneficiaries to a medical home and developing quality measures to indicate that a child has an established and effective medical home	Targeted provider rate increases will be linked to the quality improvement measures established in phase 1 of the expansion

Other Provisions			
Outreach	Outreach workers get $75 for each successful application submitted	Allocated additional funds for outreach for all children's programs, with a focus on hard-to-reach kids; campaign will include: media and new program information materials, contracts with community-based organizations	No further change
Premium Assistance	Small premium assistance program that has largely been operated as a pilot program	Families will be screened for access to employer-sponsored health care; the state will provide funds for purchase when cost-effective (as determined by state)	Same for expansion
Retention	n/a	Develop a targeted retention plan to improve program retention and decrease churn (pilot programs are under way)	Once results are available from pilots, efforts will be expanded

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