COVERING
KIDS AND
FAMILIES
EVALUATION

Case Study of New Jersey:
Exploring Medicaid and
SCHIP Enrollment
Trends and Their Links
to Policy and Practice

Final Report

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I. INTRODUCTION

Covering Kids and Families (CKF) is a national initiative, funded by the Robert Wood Johnson Foundation (RWJF), which works through state and local coalitions to increase enrollment in public health insurance for low-income children and adults who are otherwise uninsured. The program’s strategies are to (1) conduct outreach to children and families without coverage, (2) simplify enrollment and renewal processes, and (3) coordinate existing health care coverage programs. Mathematica Policy Research, Inc. and its subcontractors, the Urban Institute and Health Management Associates, are evaluating the CKF program.

This case study discusses the trends in new Medicaid and SCHIP enrollment in New Jersey from 1999 through 2003. In particular, we are interested in examining the potential links between new enrollment trends and major outreach strategies or policy changes that took place in New Jersey, especially those associated with the CKF grant. Ideally, we would examine such links through a more 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 source for the study is child-level and adult-level enrollment data from the Medicaid Statistical Information System, which we obtained from the Centers for Medicare &
Medicaid Services.\textsuperscript{1} Using these data, we developed a measure indicating the number of new entries in Medicaid or SCHIP during each month of the study period (1999 through 2003). Our definition of a new entry is any child enrolling in one of these programs who has not been enrolled in either of them in the past 12 months. (Thus it excludes anyone who is transferring between these programs or re-entering one of them after a short time.) We focus on this measure, rather than on the number of new enrollees or the total number of enrollees, because we expect new entries to be more sensitive to major outreach efforts or policy changes associated with new enrollment.\textsuperscript{2}

With these data, the evaluation team assembled a timeline showing the number of new entries in Medicaid and SCHIP for New Jersey from October 1999 through September 2003. This period covers nearly the entire period of RWJF’s original Covering Kids (CK) grant to the state (awarded in mid-1999) and the first 15 months of the subsequent CKF grant (awarded in July 2002).

In April and May 2005, we discussed these data in detailed interviews with the state CKF grantee and state officials. 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. These sources included the CKF Online Reporting System, program documents, and

\textsuperscript{1} While our analysis focuses mainly on children, we also examine enrollment trends among adults eligible for NJ FamilyCare, a major coverage expansion designed in part to encourage child enrollment by extending coverage to adult family members. See Chapter II for details on this program.

\textsuperscript{2} In addition, within the Medicaid program, we focus on new entries whose program eligibility is based on income (either in the poverty expansion eligibility 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.
demographic and economic data from the Bureau of Census and from the Bureau of Labor Statistics.

We found New Jersey’s commitment to insuring children and families eligible for Medicaid and SCHIP evident in its (1) generous benefits package for these programs, (2) intense outreach efforts, and (3) program expansion for adults. This commitment provided a supportive environment for the CK/CKF coalition to work in. Indeed, the successful collaboration between the CK/CKF grantee and the state gave rise to a highly simplified and coordinated enrollment process as well as joint outreach efforts. Despite these successes, the number of new entries in SCHIP was depressed for about 12 months during the study period without any subsequent catch-up, a finding attributable to an eligibility determination vendor that was unprepared to handle a large influx of applications from both children and adults.

II. STATE POLICY CONTEXT

New Jersey was quick to implement a generous SCHIP program after SCHIP legislation was enacted and was able to sustain and expand its SCHIP program to include higher income children and eventually adults (Table 1). Only the more recently introduced adult program was subject to cutbacks.

Effective January 1998, New Jersey implemented NJ KidCare, a robust program that contained a SCHIP Medicaid expansion component (NJ KidCare Plan A) that covered children up to 133 percent of the federal poverty level (FPL) and a separate SCHIP component (NJ KidCare Plans B and C) that covered children up to 150 percent FPL and 200 percent FPL, respectively. Plan A provided a full Medicaid benefit package at no cost to families. Plans B and C were modeled on an enhanced version of the Federal Employee Health Benefit Program, and both required a 12-month waiting period for the previously insured, although there were some exceptions to this waiting period. The NJ KidCare program shared a joint application with
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Medicaid that could be mailed in for processing—either to one of the 21 County Boards of Social Services (Plan A applicants) or to the state’s eligibility determination vendor (Plan A, B, or C applicants).

In 1999, New Jersey made several program changes that expanded coverage for children. First, in January 1999, the state halved the waiting period for Plan B and C applicants to six months. Second, in July 1999, a new NJ KidCare provision was implemented. NJ KidCare Plan D provided coverage to children up to 350 percent FPL, making the New Jersey SCHIP program the most generous in the nation. As with Plan B and C applications, the state’s vendor processed Plan D applications.

The state adopted a vigorous outreach program for enrolling children including:

- Back-to-School media campaigns
- Back-to-School parties for adolescents, held in collaboration with local YMCAs
- Distribution of insurance information to businesses that were closing down
- Development of classroom curricula about health insurance and distribution to every school in the state

Because there was a large and growing need for adult coverage in New Jersey, in September 2000 the state expanded its NJ KidCare program to parents and pregnant women up to 200 percent FPL and adults and couples without dependent children up to 100 percent FPL, renaming the program NJ FamilyCare. This expansion (which was strongly endorsed by child health advocates) was expected to increase the number of children enrolling for public coverage, as parent and child enrollment are often correlated.

The state sharply increased outreach immediately after this expansion with (1) a direct mailing to parents of children already enrolled in Plans A, B, or C to let them know about the expansion and (2) a $2 million outreach campaign that involved significant media coverage
throughout New Jersey, as well as in the major labor markets of Philadelphia and New York City. This campaign was concentrated during the three months after the expansion to adults. This outreach appears to have been highly effective—NJ FamilyCare adult enrollments surpassed program projections (125,000 adults in three years) within just nine months.

Concurrent with the program expansion to adults, New Jersey awarded the program eligibility determination contract for Plans A, B, C, and D to a new vendor (Maximus). The contract was bid before there was an adult program, with the scope covering only children’s applications. However, the vendor agreed to process adult applications pending a contract modification. Processing problems developed as a result of two factors: (1) the vendor was not experienced at eligibility determination in New Jersey and (2) there was an unanticipated deluge of adult applications as a result of the successful outreach campaign. As a result, a large backlog in both adult and child applications developed, and many applications were handled multiple times with families repeatedly asked to resubmit material. Our respondents indicated that thousands of applications may never have been processed. Moreover, the vendor was unable to produce reports on enrollment numbers; hence, there was no way of tracking the actual numbers enrolled during this period. In response to budget problems, New Jersey closed NJ FamilyCare to newly enrolling adults without dependent children in September 2001 and to newly enrolling parents in June 2002. (At this time, eligible adults were allowed to re-enroll if they were already on the program. If they did not re-enroll promptly, however, they lost the opportunity.)

In May 2003, the state made several small program changes. Premiums were increased for NJ FamilyCare enrollees above 150 percent FPL, and the state also announced that the premiums would continue to increase annually.

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3 Additionally, the state developed a long-term media campaign plan geared toward enrolling adults.

4 It also discontinued its long-term media campaign geared toward enrolling adults.
III. HISTORY OF THE CK/CKF PROGRAM IN NEW JERSEY

In late 1998, a coalition of children’s health insurance advocates in New Jersey applied for a CK state grant. This group proposed that the Health Research and Education Trust (HRET), the non-profit arm of the New Jersey Hospital Association, become the lead agency for New Jersey’s CK program. The mission of HRET—to perform research and develop educational materials for a variety of health care issues, including the expansion of health insurance coverage—aligned well with the goals of CK, and HRET became the state grantee in mid-1999. The CK grant funded five local projects:

1. La Salud Hispana, providing bilingual outreach and home-based and telephonic application assistance to the Latino communities in Hudson and Bergen counties
2. St. Joseph’s Medical Center, providing multilingual hospital-based outreach and application assistance in Passaic county
3. Gateway Maternal and Child Health Consortium, providing hospital-based outreach and application assistance in Essex, Union, and parts of Bergen and Middlesex counties
4. Cathie Family Life Development Center, providing faith-based outreach and application assistance to the city of Plainfield in Union county
5. Tri-County Community Action Agency, providing provider outreach and application assistance to WIC/Head Start participants, migrant families, young mothers and other eligible groups in Cumberland county

During the three-year CK grant period, the CK state coalition and its local projects made strides in outreach, simplification, and coordination. They provided outreach to schools, hospitals, and other health care facilities. They trained outreach workers statewide, who were recruited from community-based organizations, on NJ KidCare application and policies. They also identified barriers to enrollment, using the coalition’s own barrier reporting system to which coalition members and enrollment sites could contribute. As family-specific and other enrollment barriers (such as application length or format) were recorded, the coalition formulated recommendations for improvement. The coalition, which had a collaborative working
relationship with the state, brought these recommendations to the attention of the state. For example, at the urging of the coalition, the state reduced the documentation required for verifying income from all pay stubs in one month to one pay stub and added the option of accepting payment of premiums by credit card.

At the urging of the coalition, New Jersey reapplied for a CKF state grant in early 2002, again proposing HRET as the lead agency. HRET received a $1,000,000 four-year CKF grant award in July 2002, just after New Jersey had closed NJ FamilyCare to new adult enrollment. The grant funded three local projects, each housed in a maternal and child health consortium. Together, these local projects serve close to three quarters of the counties in the state:

- Gateway Northwest Maternal and Child Health Network and Kids Corporation, providing designated outreach workers to work in schools, summer camps, and immigrant communities in Essex, Bergen, Union, Middlesex, Morris, Passaic, Warren, and Sussex counties and the city of Newark (Gateway previously a CKF grantee)
- Hudson Perinatal Consortium, working with local agencies to train outreach workers and to institutionalize enrollment assistance in Hudson county, where they have designated outreach workers to work on weekends and evenings in federally qualified health centers and hospitals
- Southern NJ Perinatal Cooperative and Community Health Care, providing immigrant outreach to migrant and Hispanic residents in Atlantic, Camden, Gloucester, Salem, Burlington, Cape May, and Cumberland counties

Both the state and local coalitions continued the types of simplification and outreach activities begun by Covering Kids in 1998, often in tandem with state efforts. For example, each year, the state CKF coalition undertakes a major Back-to-School outreach campaign. In 2002, the coalition distributed thousands of pieces of material at local health departments during their

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5 Initially, New Jersey had four CKF pilot projects serving three regions. The Kids Corporation II pilot, which operated in the same region as Gateway, became a subcontractor to Gateway because it did not meet certain grant eligibility criteria.
immunization drives around Back-to-School. At the same time, the state teamed with the state CKF coalition to sponsor events such as NJ FamilyCare Awareness Days at minor league baseball parks around New Jersey. Additionally, while the state coordinated with organizations such as Scholastic Marketing Partners, Inc. and the New Jersey Interscholastic Athletic Association to disseminate information about NJ FamilyCare in the schools, the state CKF coalition coordinated with several other groups in its school outreach efforts. It placed announcements about health insurance in the New Jersey Association of School Boards’ newsletter, which reaches 500 school districts, and worked with school nurses’ associations and principals to generate school staff support. Furthermore, each of the local projects continued to conduct outreach with schools and health care facilities. Likewise, the state and local coalitions continued to identify enrollment barriers, to share this information with the state, and to recommend strategies for removing barriers.

The state CKF coalition also has provided several types of educational programs focused on increasing enrollment. First, the state coalition has held a yearly conference to (1) educate administrators and staff from hospitals and community agencies about the importance of children’s health insurance coverage and relevant state and federal policy developments and (2) showcase community outreach programs that could be replicated throughout New Jersey. Second, the state CKF coalition has a subcontract with the New Jersey Immigration Policy Network to hold regional training sessions on how to enroll immigrants for outreach workers from community-based organizations working with immigrant populations. Admissions and billing staff from hospitals and clinics also attend these trainings. Third, the state coalition charged each local pilot project with providing at least 12 application assistance training sessions per year. These sessions are designed to teach outreach workers from any type of organization how to complete applications, focusing primarily on health care and educational institutions.
The HRET and its coalition members have maintained very good working relations with the state. The state has continued to respond to the concerns and recommendations of the coalition, including most recently adopting a single-page application in an effort to simplify the process. In addition, the statewide CKF coalition, the state, and the County Boards of Social Services have coordinated closely on application assistance and outreach efforts across New Jersey. For example, when conducting its statewide outreach events, the state has regularly used the local CKF projects to staff the events in their regions, allowing the state to focus its resources on the remaining regions that are not served by a local CKF grant. This support has in effect led the local projects to serve the entire state. For this reason, our assessment of enrollment trends in New Jersey, discussed below, focuses entirely on the state level.

IV. FINDINGS

In the last quarter of 1999, the state added roughly 30,000 newly enrolled children, or new entries, to Medicaid and SCHIP, a figure that remained fairly constant each quarter over the next four years (Figure 1). The most notable change occurred between mid-2000 and mid-2001, when the number of new entries each quarter declined to a low of about 25,000 children before returning to the 30,000 level by the end of 2001. There were also two other dips, one in the last quarter of 2002 and one in the second quarter of 2003, after which the number of new entries again returned to roughly 30,000 per quarter.

The lack of major fluctuation in these enrollment numbers is consistent with the stability of the state’s SCHIP and Medicaid programs for children, which changed little from 1999 through

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6 As indicated previously, new entries include all children newly enrolling in Medicaid or SCHIP who have not been covered by one of these programs for at least the prior 12 months. It therefore excludes children transferring between programs or reentering Medicaid or SCHIP after a short period, groups that are not likely affected by CKF and related enrollment activities and policies.
2003. Nevertheless, it is perhaps surprising that the number of new entries did not rise in response to either the annual Back-to-School campaigns or the economic downturn in the state that began toward the end of 2000. For example, we do not see a strong pattern of increases in the third quarter of each year, which we would expect to see if the Back-to-School campaign was a major factor in increasing enrollment. Moreover, although New Jersey’s economic downturn led to a doubling in the unemployment rate, from around 3 percent at the end of 2000 to greater than 6 percent by 2003, the number of new entries during this period remained at or below the 30,000 figure seen at the end of 1999 (Figure 2).

The notable decline in new entries from late 2000 through 2001 can be traced to New Jersey’s SCHIP program, in particular its separate (S-SCHIP) component that operates independently from Medicaid. As shown in Figure 3, the number of new entries in S-SCHIP was at or above 5,000 through the third quarter of 2000 but fell sharply over the next two quarters to fewer than 2,500 and did not recover until late 2001. This decline is not nearly as evident in any of the Medicaid eligibility groups examined, nor is it evident for the Medicaid component of SCHIP (M-SCHIP) that serves children with family incomes just above the threshold for traditional Medicaid.

The NJ FamilyCare program, which expanded SCHIP eligibility to uninsured adults in the state, began in September 2000 and continued through June 2002, at which point the state curtailed all new adult enrollment. To support the program expansion, the state implemented an outreach campaign in the fall of 2000 that included letters to parents of SCHIP enrollees and substantial regional media advertising of the expansion to adults. The expansion resulted in a dramatic increase in the numbers of adults newly enrolling in Medicaid and SCHIP—from a

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7A second decline is evident from late 2002 through early 2003, though it is not as long-standing or as substantial.
Figure 2
Total New Entries in Public Coverage and Unemployment Rate by Quarter, New Jersey, Fall 1999 - Fall 2003 (Children)

Source: Medicaid Statistical Information System and Bureau of Labor Statistics
Figure 3
Quarterly New Entries in Public Health Coverage, by Coverage Type, New Jersey, Fall 1999 - Fall 2003
(Children)

CKF Start Date: July 2002

Source: Medicaid Statistical Information System
fairly stable rate of 6,000 adults per month prior to the program’s adoption to more than 13,000 in the program’s first month (September 2000) and to more than 21,000 in the program’s second month (see Figure 4). In subsequent months of the program, the numbers of adult new entries in SCHIP or Medicaid remained high, between 8,000 and 16,000 adults per month, far exceeding the state’s expectations and well above the numbers seen previously.

As Figure 4 shows, the adoption of the NJ FamilyCare program and sharp rise in adult new entries occurred at the same time that the numbers of children newly entering S-SCHIP began to decline sharply. The question therefore arises—is there a link between the expansion to adults and the downturn in new child enrollment? There may be. The potential link is the limited capacity of a new and relatively untested eligibility determination vendor to handle new child enrollments while large numbers of adult applications flowed in. The marketing of the adult program may simply have worked too well, given the system’s capacity to handle applications.

Shortly after the policy change, the state’s new eligibility vendor began to receive hundreds of applications daily, far exceeding the number the state had expected. The vendor was not immediately prepared to process adult applications, only having won the contract from the state a few months before the policy change. According to the state grantee, this immediately led to severe problems in the state’s eligibility and enrollment system. Processing of thousands of applications was significantly delayed, and some applications may never have been processed at all. Families were commonly asked to resubmit paperwork that had been properly completed and could not reach anyone by phone to have questions answered. The state began receiving a large volume of complaints from families who were upset about delays in the processing of their application or about the lack of assistance or other information from the vendor. The problem

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8 We define an adult new entry to be any adult enrolling in Medicaid or SCHIP who has not been enrolled in one of these programs in the past 12 months. (Thus it excludes anyone who is transferring between these programs or re-entering them after a short time.)
Figure 4
Public Health Coverage New Entries: Total Adult and Child S-SCHIP
New Jersey, January 2000 - December 2001

Policy Activities
A-Adult enrollment begins
B-New eligibility determination vendor
C-Intensive media campaign begins
D-Intensive media campaign ends
E-Program closed to single adults; parents enrolled through June 2002
became so severe that, by late 2000, the state decided to end its major outreach campaign in an effort to slow the number of new adult applications.

In follow-up conversations with state Medicaid and SCHIP staff, they expressed some skepticism that the problems with the vendor could explain the decline in new children’s enrollment in S-SCHIP in 2000 and 2001. They pointed out that while the vendor problem did lead to severe delays, the applications should have eventually been processed and therefore the 2001 dip should have been offset by a later rise in entries as the vendor caught up. However, they conceded that the vendor problems had a long-lasting effect on the program, not only blunting the substantial momentum that the expansion in family coverage had generated but also leading to significant criticism of the program.

The fact that the decline in new entries took place only in the separate component of SCHIP offers additional evidence that the vendor problem may have been responsible. In contrast to applications for S-SCHIP, which were the vendor’s responsibility, applications for M-SCHIP and Medicaid were the responsibility of the County Boards of Social Services. Therefore, if vendor problems were the source of the dip in new entries, it should be evident only for S-SCHIP, which was exactly the case.

V. CONCLUSIONS

New Jersey is in many respects an example of an ambitious and successful effort to insure children eligible for Medicaid or NJ FamilyCare. The state was one of the first to implement a coverage expansion through SCHIP and by mid-1999 it had expanded eligibility for the program to 350 percent of the FPL, the highest level in the nation. The state also took immediate steps to simplify and coordinate the enrollment process for public coverage. For example, the state instituted a joint SCHIP-Medicaid application form and dropped the face-to-face interview
requirements that had been in place for Medicaid. By 2000, the two programs had essentially the same eligibility policies; for example, neither program required asset tests and their remaining verification requirements were identical. Moreover, in 2000, the state expanded coverage again, this time to parents and single adults, through the creation of NJ FamilyCare. At the time, this change was heralded by child health advocates as a breakthrough, helping to encourage families with children eligible for SCHIP to enroll.

New Jersey is furthermore an example of a successful collaboration between the CK/CKF grantees and the state. From the start, the state solicited the CK grantees for ideas on how to simplify the eligibility process and better coordinate Medicaid and SCHIP. Since implementing its initial joint SCHIP-Medicaid application, the state has made a series of revisions, all with input from the grantees. The grantees have greatly facilitated access to providers and health facilities for conducting outreach and other promotions. The state and grantee collaborated on training and outreach, with the local project staff often serving as direct support for statewide events. The grantee has also provided the state with many of the outreach materials used statewide, particularly for the Back-to-School campaigns, and outreach staff with both the state and the grantees have shared and used the same promotional materials.

Despite the state’s strong commitment to covering children and families, seen in its generous eligibility policies, attention to simplification of application, and extensive outreach in collaboration with the CK/CKF grantees, new enrollment of children in SCHIP lost momentum because of the problems generated by a new and overwhelmed vendor. New children’s SCHIP enrollment was depressed for about 12 months without any subsequent catch-up. The vendor’s inability to report on enrollment numbers in this period also made it impossible to monitor local outreach activities as they were happening. Moreover, the state was forced to scale back on its
most ambitious outreach efforts and to defend itself against criticism that it was failing to insure eligible families.

New Jersey’s experience illustrates how a state can enthusiastically embrace the goals of the CK/CKF initiative and work collaboratively with the CK/CKF grantee to simplify and coordinate enrollment and reach out to families. Yet this collaboration does not necessarily translate into achieving the initiative’s goal of increasing coverage among eligible children. The apparent reason in this case is instructive. The expansion was introduced and promoted before the infrastructure was available to handle the ensuing applications.