

CHIP Outreach and Enrollment: A View from the States

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Background

The Balanced Budget Act of 1997 provides over \$20 billion dollars over the next five years for children's health. Established as Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP) was created "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children."¹ Expectations for CHIP are high as it is the biggest public health insurance initiative to be introduced since Medicaid. The first funding was available late in 1997, and by the end of 1998 states had enrolled nearly one million children in CHIP.

Since the inception of the program, a great deal of emphasis has been placed on outreach activities. In the state plan submitted to HCFA, states must include information about the outreach methods to be used to inform families of the availability of CHIP. Though outreach is an important facet of the program, there are some limitations on spending. Title XXI enables a state to claim federal matching funds, up to 10 percent of their total expenditures, for administration, outreach, and the direct purchase of health services. There has been some concern that this cap on administrative expenditures could prohibit states from adopting large-scale outreach campaigns. In the early phases of CHIP implementation, states would have high administrative costs but total expenditures would be low. A number of states identified that this was a problem, but it has been eased by generous support from foundations and community groups to assist in outreach efforts.

This study shows that the states are committed to finding and enrolling uninsured children. The report is based on a survey of state Medicaid and CHIP agencies and gives a picture of current CHIP outreach and enrollment activities in 33 states². At the end of 1998, there were 43 states and territories with approved CHIP plans. A number of plans at this date were only small "placeholder" plans, usually modest Medicaid eligibility

¹ "State Children's Health Insurance Program," Title XXI, Social Security Act, 1997, Section 2101(a).

² The following states responded to the survey: AL, AK, AZ, CA, CO, CT, DE, DC, FL, ID, IL, IA, LA, MD, MI, MN, MS, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, SC, TX, UT, and WV.

expansions, that were submitted to secure state allotments.³ Even states with modest plans began outreach campaigns to locate and enroll uninsured children.

Scope of Survey

This report summarizes the responses of 33 of the states surveyed in January 1999. The survey asked states for information on their outreach materials including their cost and effectiveness as well as how they were developed. States were also questioned about the partnerships they formed to assist with outreach, their nature, and effectiveness. Finally, the survey addressed state application and enrollment procedures asking for extensive details on application intake and outstationing of eligibility workers.

Part I: Outreach Materials

Of the 33 states that responded to the survey, 32 states volunteered substantial information on their outreach materials. 3 states reported information about intended activities but noted that they were still in the planning stages. One state responded to the survey but was only able to supply limited information because they had not launched a full-fledged outreach campaign for their small Medicaid expansion. All states reported using a variety of outreach approaches. Not all states were able to provide evidence as to the effectiveness of the various approaches since many CHIP programs were still in the early stages of implementation at the time of the survey. Some states are tracking effectiveness by asking how individuals heard about CHIP either when they call the state hotline or on the application.

The benefits and challenges of each type of outreach activity are described below. The results are summarized in Table 1. Effectiveness was ranked on a scale of 1 to 5 with one being not very effective and five being highly effective.

Pamphlets and Posters

Twenty-nine of the 33 states (88%) responding use pamphlets, posters, or fact sheets to give a brief overview of the program to families. Primarily, the materials communicated a simple message that families may be eligible for free or low-cost health insurance for their children. Pamphlets, often used in conjunction with posters, commonly included basic information about the state's CHIP program and eligibility guidelines. Both pamphlets and posters ranked high in their effectiveness. States stressed the importance of having a good distribution plan. Materials need to be available in numerous different places in order to reach the targeted population. States reported distributing informational materials everywhere from other government agencies to fast food restaurants and child care centers. The average amount spent on posters was under \$10,000 while the average cost for pamphlets ran over \$25,000. Posters and pamphlets proved an effective way for states to spread information about new child health programs.

³ In order to be guaranteed their full 1998 allotment, States are required to have an approved plan by September 30, 1999. Any unspent portion of a year's allotment may be carried over for three years.

Radio and Television Spots

Twenty-nine of the 33 states (88%) have used radio advertising and twenty-three states (70%) have used television spots to promote CHIP. This included both public service advertisements (PSAs) and paid programming. This proved to be a costly activity with the average cost for both radio and television being greater than \$25,000. Radio was used more regularly than tv spots, but both were perceived as moderately to highly effective. Some states reported that radio was particularly effective in large, rural areas. Many found advertising on foreign-language radio and television stations to be a good way to target minority populations.

Direct Mailings

Twenty-three states (70%) send direct mailings to potential beneficiaries. Direct mailings are an inexpensive and highly effective method of reaching potential beneficiaries. The biggest challenge is determining who are the potential eligibles. Some states report sending CHIP information with Medicaid redeterminations since families whose incomes rise above Medicaid eligibility levels should be eligible for CHIP. Delaware distributes information through the Child Support Office. Several states send direct mailings to those receiving other public benefits such as WIC or food stamps. A few states report that they send a mailing to a different group of potential beneficiaries on a regular schedule. New Mexico has found that direct mailings to potential eligibles generates the greatest volume of calls to their child health hotline.

Twenty-six states (79%) send direct mailings to providers. In some cases, mailings are sent to participating providers, often on an annual basis. A few states also send informational materials to all pediatricians in the state. Direct mailing to providers is seen as moderately to highly effective. Several states note that providers who receive materials contact the state and offer to distribute materials.

Notices in Newspapers and Other Publications

Twenty-seven states (82%) rely on notices in newspapers and other publications as an inexpensive method of spreading information about their CHIP programs. The average cost to states is under \$10,000. This can take the form of informational articles as well as paid advertisements. Some states have partnered with other organizations, such as the children's hospitals, to pay for advertising supplements in local newspapers.

Flyers in Other Mailings

Twenty-five of the 33 (76%) states include CHIP flyers in other mailings such as utility bills and church bulletins. This is a highly effective activity with a low cost. Overwhelming, states responded that distributing CHIP information and/or applications with school materials generates a huge response. This method of distribution enables states to target specific populations or communities in their outreach efforts.

Other Activities

In addition to the activities above, states reported numerous other efforts underway. Most states responded that a considerable amount of time is given to community presentations and informational meetings with stakeholders. Several states are carrying their media campaigns to outdoor advertising such as billboards and ads in buses and subways. Two states report awarding grants to local groups to provide outreach services. It is apparent that states are developing multi-faceted outreach campaigns in an effort to reach as many uninsured children as possible.

Table 1 - Summary of State CHIP Outreach Activities

Outreach Materials	Number of States Using This Type of Outreach Material	Average Cost	Average Effectiveness Rating
Pamphlets and Posters	29 (88%)	Over \$25,000 - pamphlets Under \$10,000 - posters	4
Radio and Television Spots	29 (88%) - radio 23 (70%) - tv	\$10,000 to \$25,000	3-4
Direct Mailings to Potential Beneficiaries	23 (70%)	Under \$10,000	5
Direct Mailings to Providers	26 (79%)	Under \$10,000	3
Notices in Newspapers and Other Publications	27 (82%)	Under \$10,000	3-4
Flyers in Other Mailings	25 (76%)	Under \$10,000	4

Toll-Free Hotlines

At the time of the survey, all 33 states had toll-free hotlines in operation. In February, the Administration in coordination with the National Governors' Association (NGA) launched a national toll-free number as part of the "Insure Kids Now" initiative. Calls to the national number are automatically forwarded to the hotline within the state they're calling. The hotlines provide callers with information and referrals and generally will send out an application to interested individuals. Nine states take applications over the phone. In addition to information and application intake, a few states utilize their

hotlines to assist in many aspects of the program such as HMO selection and case management. The toll-free number features prominently in CHIP media campaigns and is a vital outreach tool.

Websites

Twenty-three of the 33 states (70%) had websites up and running at the time of the survey while three other states had websites in development. As internet use becomes more common, websites can be an effective medium for disseminating information. Most of the websites provide visitors with basic information about the state's child health program and how applications can be obtained.

Part II: Outreach Development

When choosing which outreach approaches to use to reach the CHIP population, states took a variety of factors into consideration. Naturally, they relied on their own and other states' past experiences with social marketing campaigns. Several states formed CHIP workgroups or advisory committees that were instrumental in developing and/or reviewing outreach materials. A few states reported contracting with marketing and public relations firms to develop their outreach strategies.

While the findings of this survey reveal that states are adopting extensive marketing and outreach campaigns to promote CHIP, some states did note that they were initially cautious. For example, a state that secured its allotment by implementing a very small Medicaid expansion may have made the decision to hold off on any large-scale outreach campaign until a bigger program was approved. Other states began doing outreach but waited to intensify their campaigns until they knew the program was operating smoothly. When a significant activity such as a statewide newspaper supplement or television ad is released, states can expect a significant increase in calls to hotlines, requests for applications, etc. In order for the outreach activity to be a success, the state needs to be prepared to handle the volume.

Community Involvement

Nearly all states reported having formal community involvement at some stages of outreach development. The most common method was for states to convene focus groups to review outreach materials. Various community representatives including low-income individuals, parents, minority community representatives, and providers, have been included in these focus groups. Additionally, some states have established CHIP workgroups or committees. Eight states reported having standing groups who meet on a regular basis. The makeup of these groups differs but it is often similar to the Medicaid consumer advisory commissions that state Medicaid agencies have in place to review materials. Representatives may include advocates, parents/beneficiaries, providers, and community-based organizations. Finally, a few states have shifted outreach activities to the local, grassroots level. For example, North Carolina has a Statewide Outreach

Committee but Local Outreach Coalitions are established in each county. The local coalitions target initial outreach efforts which are supported through the statewide committee. The state reports that this approach has been a successful way of targeting their outreach efforts to the different communities.

Targeted Populations

Twenty-three states (70%) are targeting outreach activities at specific populations while several others report that they will begin targeted outreach in the future. Primarily, outreach efforts have been targeted at minority communities. Sixteen states (48%) are targeting outreach activities at Hispanic and other ethnic minority communities. Another five states report directing efforts at identifying and enrolling Native Americans. Outreach activities in seven states are aimed at children with special health care needs. Additionally, West Virginia has an outreach campaign targeted at rural and migrant farm workers.

In determining which populations to target, states most commonly rely on demographic data. For example, census data in one state showed that a large number of Native American children were potentially eligible for CHIP so efforts were made to target this population in its outreach campaign. Similarly, data reveals that, on the whole, Hispanics in the United States have a high uninsured rate. States also report that decisions to target outreach are also often influenced by their CHIP advisory committees and feedback from advocacy groups and community members. Finally, state may make determine a need for targeted outreach based on past experience. New Mexico reports that findings from their experience in implementing a statewide managed care program informed their decisions regarding CHIP outreach.

Targeted outreach can take many forms. In some cases, it is simply a matter of translating materials into different languages. However, some states have found it necessary to not only translate materials but to also alter their content to be culturally specific or sensitive. Distribution plans should include places where the targeted populations are easily reached. Working closely with appropriate community groups is another important strategy when targeting often hard-to-reach populations. Involving trusted representatives from within a community can greatly facilitate a state's outreach efforts. Clearly, the diverse outreach activities being pursued by states show their commitment to finding and enrolling hard-to-reach populations.

Part III: Outreach Partnerships

The survey asked states about the partnerships they have formed to enhance outreach efforts to uninsured, low-income families. All 33 of the states responding had formed multiple partnerships. In general, these partnerships were rated as highly beneficial. This early in the program, most of the partnerships involve literature distribution. The partnership efforts pursued usually were at a low cost to the state and have been an effective way to reach targeted populations. In an effort to make outreach materials

available to as broad an audience as possible, states are pursuing a variety of partnerships. The major organizations states are partnering with to assist in outreach are described below.

Title V and WIC Programs

All of the states reporting have formed partnerships with their Title V or Women's, Infant and Children (WIC) programs. The partnerships mostly involve distribution of informational materials and applications. In a few states, these programs do prescreening or provide application assistance and/or enrollment for CHIP. States note that this is a very natural partnership since Title V and WIC employees come in daily contact with families who are potentially eligible for CHIP or Medicaid coverage. In some states, both CHIP and the Title V/WIC programs are located in the public health department, thus making joint efforts easy to coordinate.

Other Government Agencies and Programs

Thirty states (91%) have formed partnerships with other state agencies while twenty-three states (70%) are working with various federal agencies or programs. A broad range of state agencies are involved in CHIP outreach efforts. Some examples are the Department of Education, Children's Rehabilitation, Department of Human Resources, Department of Motor Vehicles, and state employment departments. States are also working with federal agencies that serve low-income families. The most common federal partnerships reported were with Head Start programs. Others involved include the Social Security Administration, Housing and Urban Development, subsidized day care centers, and the Internal Revenue Service. These government agencies are well situated to pass on information about CHIP.

Provider Groups

Twenty-eight states (85%) have enlisted the help of provider groups to further their outreach efforts. Again, these partnerships mostly involve distribution of materials both from large provider organizations to their members and in individual provider offices. There are some states where certain clinics and hospitals are certified eligibility sites. States have found these partnerships to be highly successful since providers are in a prime position to identify potentially eligible children. One state noted that good provider relations have a positive impact on program accessibility. In addition to information dissemination and enrollment assistance, a few states have joined forces with provider groups to assist them in developing and/or funding their media campaigns.

Schools

As noted earlier, schools are a natural place to reach children. Thirty-one of the 33 states (94%) have or are in the process of developing partnerships with schools. Many states distribute CHIP information and applications to all school-age children annually. Often efforts coincide with the beginning of a new academic year or report card distribution.

However, a few states caution that at these times parents are overwhelmed and not as likely to want to deal with another form. States have overwhelmingly found this practice to result in a significant increase in applications and enrollment. A few states also mentioned the important role school nurses can play in outreach and encourage working closely with them.

Private Sector Employers

Eleven states already have formed outreach partnerships with private sector employers while thirteen others are in the planning stages. For example, some grocery and retail stores print CHIP information on the back of receipts. Fast food and pizza delivery chains have included flyers with orders. Often businesses such as these not only serve potentially eligible families but also have employers who are potentially eligible. Given the number of states that report plans to develop partnerships with the private sector, there is likely to be increased public-private outreach activities.

Others

In addition to the partnerships described above, the states responding to the survey are tapping into a wealth of other resources. As described in Part II, states are working closely with child health and advocacy groups to develop and take part in their outreach efforts. Other partnerships reported include: Boys and Girls Clubs, family courts, religious groups, Veterans' Centers, Indian Health Service, cultural groups, state bar associations, and health insurance underwriters. These partnerships are helping states to find and enroll children in CHIP.

Part IV: Application and Enrollment

Given the close relationship between CHIP and Medicaid, most states have coordinated application and enrollment procedures to some extent. Twenty-eight states (85%) have a single combined application for Medicaid and CHIP eligibility. Title XXI requires that any individual applying for CHIP must first be screened for Medicaid eligibility. If the applicant is found to be Medicaid-eligible, he or she cannot be enrolled in CHIP. A combined application is the easiest way for states to meet the screen and enroll requirement. Twenty-eight of the states (85%) use a combined CHIP and Medicaid application. As states have developed new combined applications, concerted efforts have been made to simplify the application and enrollment process. The majority of states reported that they had recently revised or were in the process of revising their applications. In many instances CHIP application are only two to five pages long.

In addition to combining and shortening application forms, states are making the enrollment process easier for families. Thirty of the thirty-three states (91%) accept applications by mail. Sixteen states (48%) will take application information over the phone, often through their toll-free hotline, then send it out to the family who just has to sign and return the application. Table 2 summarizes state application procedures.

Table 2: Summary of State Application Processes

State	Use Combined Application	Accept by Mail	Phone with Mail Follow-up	Face-to-face
Alabama	X	Phase I: Yes Phase II: No	Phase I: Yes Phase II: No	Phase I: Yes Phase II: No
Alaska	X	X		X
Arizona	X	X	X	X
California	X	X		X
Colorado	X	X		X
Connecticut	X	X	X	X
Delaware	X	X	X	X
District of Columbia	X	X		X
Florida	X	X	X	X
Idaho	X		X	X
Illinois	X	X	In future	X
Iowa	X	X	X	X
Louisiana	X	X	X	X
Maryland		X		
Minnesota	X	X		X
Mississippi	X	X	X	
Missouri	X	X	X	X
Montana		X		
Nevada		X		X
New Hampshire	X	X	X	X
New Jersey	X	X		X
New Mexico	X	X		X
New York	X (piloting)	X	X	X
North Carolina	X	X		X
North Dakota	X	X	X	X
Ohio	X	X	X	X
Oklahoma	X	X	X	X
Oregon	X	X		X
South Carolina	X	X		X
Texas	X			X
Utah	X	X	X	X
West Virginia	X	X		X

States are also trying to ease eligibility verification requirements. Seven states allow self declaration of resources by applicants while another sixteen states have eliminated any assets test. Six states (AL – phase II, FL, MD, MO, NY, OK) allow self declaration of income. Two others specified that they required only minimal verification such as proof of prior month income. Nine states report that they employ the services of an enrollment broker and another state contracts out its consumer hotline that is responsible for application assistance and intake.

Outstationing Eligibility Workers

States were also questioned about where they outstationed eligibility workers. Placing eligibility workers in locations that are frequented by and are accessible to potential eligibles has been a successful part of outreach efforts in the Medicaid program. As states have expanded their Medicaid programs under Title XXI and created new child health insurance programs, they have continued this practice. All of the states responding to the survey outstationed eligibility workers. The most common sites (other than traditional Medicaid and welfare offices) have been with health care providers such as community health centers (CHCs), hospitals, rural health centers (RHCs), and Federally Qualified Health Centers (FQHCs). Table 3 indicates the major sites where states have outstationed eligibility workers. In addition, states reported outstationing eligibility workers at day care and Head Start centers, Indian Health Service facilities, shopping malls, and with community action agencies. Certified eligibility workers are able to take an application and make an eligibility determination on the spot. States also outstation volunteers or enable providers to take applications, but they do not have the authority to make a final eligibility determination. Their presence in the community and frequent contact with potentially-eligible individuals make both types of outstationed eligibility workers an important tool in outreach and enrollment activities.

Table 3: Major Sites Where States Outstation Eligibility Workers

CE = Certified Eligibility Worker
V/P = Volunteers or Providers

State	Hospitals	RHCs	FQHCs	CHCs`	Other Govt. Offices	Schools
AL	CE	CE	CE	CE	CE	
AK	V/P	V/P	V/P	V/P	Plan to	
AZ	V/P		CE & V/P	V/P	V/P	
CA	CE at all sites for Medi-Cal; V/P at all sites for Medi-Cal & Healthy Families					
CO	V/P	CE & V/P	CE	CE	CE	
CT	All determinations made by a single point of eligibility services. Assistance is provided at various community sites.					
DE			CE	N/A	CE & V/P	
DC	V/P	N/A	V/P	V/P		
FL	V/P	V/P	V/P	V/P	V/P	V/P
ID						
IL	V/P	V/P	V/P	V/P	V/P	In Chicago
IA	All applications accepted at a central site but may be forwarded from a variety of locations.					
LA	CE & V/P	V/P	V/P	V/P	V/P	V/P
MN	CE & limited V/P	V/P	V/P	V/P	V/P	V/P
MS	V/P	V/P	V/P	V/P	V/P	V/P
MO	CE		CE			CE
NV	V/P	V/P	V/P	V/P	V/P	V/P
NH*	*	*	V/P	*	*	*
NJ	CE & V/P		CE & V/P	CE & V/P	V/P	V/P
NM	V/P	N/A	V/P	V/P	V/P	V/P
NY	Health plans responsible for accepting applications. State is developing outstationing plans.					
OH	Eligibility determinations are made by counties so practice varies.					
OK	CE & V/P	CE & V/P	V/P	CE & V/P	V/P	
OR	V/P	V/P	V/P	V/P	V/P	
SC	CE & V/P	CE & V/P	CE & V/P	CE & V/P	CE & V/P	CE & V/P
TX	CE		CE			
UT	CE	CE & V/P		CE	CE	
WV	CE & V/P					

*In NH, the state trains staff in these facilities to assist with applications

Conclusion

The results of this survey conclude that states are pursuing aggressive outreach campaigns for the Children's Health Insurance Program. Though all states are designing their own unique outreach efforts to reflect the needs of their communities, a few trends can be identified.

- States are employing multiple outreach activities to ensure that all groups of potential eligibles become aware of the program;
- Media campaigns in many states are professionally produced and distributed in a variety of markets that go beyond the scope of traditional public service announcements;
- States have involved community members and potential eligibles in the planning phases of their outreach efforts through focus groups and advisory committees;
- Partnerships are being formed primarily with public agencies and local community organizations, but it appears likely that the private sector will become more engaged in states' outreach activities as the program matures; and,
- States are working to simplify the application and enrollment process.

CHIP Phase Two

While nearly all states currently have CHIP programs in operation, the timing of the passage of the CHIP legislation prevented some states from being able to get necessary enabling legislation for their programs. Several state legislatures only met for short sessions in the winter of 1998 or were not convened until 1999. As a result, a number of states were not able to obtain state approval for a large CHIP program until this year. Already states are submitting amendments for program expansions and more are anticipated in the coming months. The experience states have gained in their initial CHIP ventures will help them as they expand and develop new initiatives to find and enroll uninsured children.

Appendix 1

State Children's Health Insurance Programs Implemented as of 1/1/99

State	Program Design	Implementation Date
Alabama	Phase I: Medicaid Phase II: Title XXI	Phase I: 2/1/98 Phase II: 9/1/98
Arizona	Title XXI	11/1/98
Arkansas	Medicaid	10/1/98
California	Combination	3/1/98
Colorado	Title XXI	4/22/98
Connecticut	Combination	7/1/98
Delaware	Title XXI	1/1/99
District of Columbia	Medicaid	10/1/98
Florida	Combination	4/1/98
Georgia	Title XXI	9/1/98 (pilot), 11/98 - full
Idaho	Medicaid	10/1/97
Illinois	Medicaid	1/5/98
Indiana	Medicaid	10/1/97
Iowa	Medicaid	7/1/98
Kansas	Title XXI	1/1/99
Kentucky	Combination	7/1/98
Louisiana	Medicaid	11/1/98
Maine	Combination	7/1/98
Maryland	Medicaid	7/1/98
Massachusetts	Combination	10/1/97
Michigan	Combination	5/1/98
Minnesota	Medicaid	10/1/98
Mississippi	Phase I: Medicaid Phase II: Title XXI	Phase I: 7/1/98 Phase II: 1/99
Missouri	Medicaid	9/1/98
Montana	Title XXI	1/1/99
Nebraska	Medicaid	6/1/98
Nevada	Title XXI	10/1/98
New Hampshire	Phase I: Medicaid Phase II: Title XXI	Phase I: 5/1/98 Phase II: 1/99
New Jersey	Combination	3/1/98
New Mexico	Medicaid	3/31/99
New York	Title XXI	4/15/98
North Carolina	Title XXI	10/1/98
North Dakota	Medicaid	7/1/98

State	Program Design	Implementation Date
Ohio	Medicaid	1/1/98
Oklahoma	Medicaid	12/1/97
Oregon	Medicaid	7/1/98
Pennsylvania	Title XXI	5/28/98
Rhode Island	Medicaid	5/1/98
South Carolina	Medicaid	8/1/98
Texas	Medicaid	7/1/98
Utah	Title XXI	8/3/98
Vermont	Title XXI	10/1/98
Virginia	Title XXI	10/22/98
West Virginia	Phase I: Medicaid Phase II: Title XXI	Phase I: 7/1/98