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# Evolution of State Outreach Efforts Under SCHIP

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*States have shown creativity and adaptability in developing outreach strategies to promote State Children's Health Insurance Program (SCHIP) enrollment. As the program has matured and the fiscal environment has tightened, States have learned what efforts are successful and have tailored their approaches accordingly. This article reviews the evolution of State outreach strategies under SCHIP, using qualitative information from all 50 States and the District of Columbia. Early campaigns were aimed at building broad awareness of SCHIP. Over time, States have adapted their outreach campaigns to close the gaps in enrolling hard-to-reach populations, by modifying their target populations, messages, methods, organizational strategies, and emphasis.*

## INTRODUCTION

Since the initiation of SCHIP in 1997, States have recognized the importance of outreach in raising awareness and facilitating enrollment in the program. States have shown creativity and adaptability in developing a wide range of strategies to promote SCHIP enrollment, including providing assistance in the application process and educating families about the appropriate use of services. As the program has matured and the fiscal environment has tightened, States have learned what efforts are successful and have tailored their approaches accordingly.

Prior to SCHIP's enactment, States did little to actively market Medicaid or other public programs to children or adults (Perry et al., 2000). However, Title XXI explicitly provided States with a limited amount of funds for administrative costs, such as marketing activities.<sup>1</sup> In addition, the legislation required States to describe outreach efforts in their plans and to document their progress in annual reports.

As part of their initial goal to market SCHIP to the general population and establish brand recognition, States developed and conducted outreach and marketing efforts at both the State and local levels. These efforts were aimed at educating eligible families about SCHIP, answering their questions, and assisting them with program enrollment. Over time, States became engaged in a learning-by-doing approach to refine their outreach initiatives. Using evidence from focus groups, hotline referrals, surveys, and other sources, States learned important lessons about how to improve efforts to reach eligible, uninsured children and their families (Rosenbach et al., 2003). As a result, they shifted from broad efforts intended to establish name recognition to more targeted approaches directed at families who were eligible, but not enrolled.

This article develops a framework for defining and tracking the evolution of State outreach strategies under SCHIP. It documents, using qualitative information from all 50 States and the District of Columbia, how States have modified their outreach

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The authors are with Mathematica Policy Research, Inc. The research in this article was supported by the Centers for Medicare & Medicaid Services (CMS), under Contract Number 500-96-0016 (T03). The statements expressed in this article are those of the authors do not necessarily reflect the views or policies of Mathematica Policy Research, Inc., or CMS.

<sup>1</sup> Title XXI limits the amount of SCHIP funding that States can devote to administrative activities (including outreach) to 10 percent of the total amount they spend on their SCHIP programs.

strategies, including target populations, messages, methods, organizational strategies, and emphasis. This study provides the first national assessment of how States have adapted their outreach campaigns to close the gaps in reaching hard-to-reach populations. The analysis presents examples from more than one-half of the States to highlight how they learned from their early outreach efforts and made changes to their approaches.<sup>2</sup>

The primary data source for this analysis is the SCHIP State annual reports for Federal fiscal years (FFY) 2000-2004 that States submitted to CMS. These reports include information about State outreach plans and activities and emphasize changes since the previous year. We abstracted information from narrative text contained in the annual reports to develop a framework for assessing the evolution of State outreach efforts. The examples included in this analysis are intended to illustrate the shifts in States' strategies, but are not intended to represent an exhaustive inventory of their outreach efforts. Additional background information was obtained from a review of the SCHIP outreach literature.

The State annual reports provide an important chronicle of State outreach activities for all 50 States and the District of Columbia. However, they have certain limitations that restrict the types of analyses that can be conducted. Because the annual reports are not an exhaustive account of all SCHIP outreach efforts, it is not possible to derive counts of the number of States performing specific activities. In addition, it is not possible to link changes in specific outreach strategies to SCHIP enrollment and retention outcomes. Finally, it is not possible to ascertain associations between State program

characteristics and State strategies. Despite these limitations, a descriptive analysis of the evolution of State outreach approaches under SCHIP can offer important lessons for expanding enrollment in other public insurance initiatives.

## EVOLUTION OF OUTREACH STRATEGIES

Early evidence about the large proportion of uninsured children who were potentially eligible for Medicaid, but not enrolled, reinforced the need for effective outreach for SCHIP as well as Medicaid. Title XXI mandated that States assess the effectiveness of their early outreach efforts. States relied on a variety of data sources including enrollment trends, hotline statistics, and application data. Less frequent sources included surveys, contractor or agency reports, focus groups, and event data. Some States were able to assess outreach effectiveness by linking specific efforts to application and enrollment rates (Rosenbach et al., 2003). These assessments led States to use their flexibility under SCHIP to experiment with different outreach approaches.

During the early years of SCHIP (FFY 1998 to 2001), enrollment grew rapidly as States promoted the availability of SCHIP coverage for uninsured low-income children. In subsequent years, enrollment growth slowed and States shifted their focus to finding and enrolling harder to reach populations. Based on our review of the annual reports, we developed a conceptual framework for describing the evolution of State outreach efforts across five key dimensions:

- **Target Population**—Potential enrollees that States want to reach through their outreach efforts.
- **Message**—Communication about SCHIP tailored to the characteristics of the target population.

<sup>2</sup> Although some States scaled back their outreach efforts, this article captures how States adapted their outreach strategies in response to budget pressures.

- **Method**—The process for effectively educating uninsured, eligible families about the program and its benefits.
- **Organizational Strategies**—Formalized arrangements and infrastructure developed to implement outreach efforts at the local level.
- **Emphasis**—The focus of State approaches on enrolling new families versus retaining existing families in SCHIP.

As shown in Table 1, States modified their strategies across all five dimensions to move from broad-based outreach campaigns to more targeted strategies.

## TARGET POPULATION

When SCHIP was implemented, States focused their initial outreach efforts on the general population. At this point, getting the word out was essential for building general awareness among all potential beneficiaries. As a result, SCHIP enrollment climbed steadily during the program's first few years (Ellwood et al., 2003). Even with early enrollment successes, however, States recognized that certain groups of eligible children were not being reached with the broad scope of outreach efforts.

These underrepresented groups included such hard-to-reach populations as minorities, immigrants, working families, and rural residents.

Identifying these populations presented new challenges, and States obtained feedback from a variety of approaches to determine which populations were not being reached with general outreach efforts. Many used input from outreach workers or SCHIP helplines to identify which families lacked awareness or understanding about their potential eligibility. For example, Iowa identified that the needs of individuals with limited English proficiency were not being met by current outreach efforts, while Pennsylvania discovered that higher-income families lacked awareness about their potential eligibility. Other States, such as West Virginia, conducted surveys to identify specific geographic areas with high rates of uninsured children. As a result of this feedback, States modified their outreach strategies to target specific groups who were not enrolling in the program. Many hired marketing consultants to produce new materials or launch new campaigns to reach families of children who were eligible, but not enrolled.

**Table 1**  
**Dimensions of SCHIP Outreach Strategies**

Dimension	Early Program Focus	Recent Program Focus
Target Population	General Population	Eligible, but not Enrolled Populations
Message	Creating Broad Awareness of SCHIP	Promoting Eligibility and Value
Method	Mass Media and Wide-Ranging Types of Partnerships with Public and Private Organizations	Schools, Community-Based Organizations, Health Care Providers, and Employers
Organizational Strategies	Broad, State-Directed Efforts	More Formalized Arrangements Between State and Local Partners
Emphasis	Attracting New Families to Enroll in SCHIP, Such as Those with Uninsured Children who Participate in Other Public Programs	Retaining Existing SCHIP Enrollees and Encouraging Use of Services

NOTE: SCHIP is State Children's Health Insurance Program.

SOURCE: Williams, S.R. and Rosenbach, M.L.: Data from Federal fiscal years 2000-2004.

## MESSAGES

Initial outreach messages were broadly targeted to the general population to raise awareness about the availability of low- or no-cost health insurance for children. During the early years of the program, many States employed strategies to build brand recognition and distance SCHIP from the stigma associated with other public programs. Mass media messages frequently were designed to look like commercial insurance products (Perry et al., 2000). In addition States often created program names or logos to foster a strong brand identity, positive image, and more widespread recognition. Many simultaneously reinvented their Medicaid Programs by jointly marketing SCHIP and Medicaid coverage. South Carolina, for example, renamed its entire child Medicaid Program, including the SCHIP Medicaid expansion component to, “Partners for Healthy Children.” Outreach messages emphasized the importance of preventive care (“...do it now to save money down the road...”) and the link between health care and education (“Healthy Children Learn Better”). Other basic messages pertained to eligibility and benefits (“Free Health Insurance” and “You Might Be Eligible So Apply Now—Don’t Wait”). South Carolina estimated that approximately three children enrolled in traditional Medicaid for every one child that enrolled in the Medicaid SCHIP expansion program.

Many States with separate SCHIP programs also jointly marketed traditional Medicaid and SCHIP coverage. During the early years of SCHIP, Kansas found that many children transferred between Medicaid and its separate SCHIP program due to fluctuating incomes. In 2001, the State began marketing both programs under the HealthWave name, with the message “health insurance coverage for kids.”

The marketing materials asked, “How Will You Qualify If You Don’t Apply?” and avoided any reference to government programs or Medicaid. The use of consistent themes and visuals presented a unified message about HealthWave for both Medicaid- and SCHIP-eligible families.

As SCHIP successfully enrolled the easier-to-reach families among the general population, many States conducted market research to fine-tune their messages targeting eligible populations not enrolled in SCHIP. States found that eligible, but not enrolled working families presented a special challenge for them because this group typically did not have prior experience with public programs. Several studies documented that many families were confused about the basic eligibility rules and believed they were not eligible for SCHIP (Wirthlin Worldwide, 2001). In addition, some families indicated that stigma associated with the public welfare system often affected their decision to apply for public benefits (Stuber et al., 2000). As a result of feedback from surveys, focus groups, hotline statistics, and other sources, later outreach messages emphasized the easy application process and the value of having insurance to cover preventive care and unexpected health care costs. Many State marketing campaigns also used diverse spokespeople and culturally specific themes to increase the salience of their messages to hard-to-reach populations. Table 2 highlights changes in outreach messages aimed at working families and racial/ethnic minority populations in three States (California, Florida, and Pennsylvania).

## METHODS

In the early years, all States combined mass media and in-person outreach strategies to disseminate outreach messages to potentially eligible populations. Mass media



**Table 2**  
**Evolution of SCHIP Outreach Messages Targeted to Hard to Reach Populations**

Early Broad-Based Outreach Message	Recent Outreach Messages to Hard to Reach Populations
<p><b>California</b></p> <p>State conducted television, radio, and print advertising that (1) promoted the availability of low and no-cost insurance for children up to age 19, and (2) urged viewers to call the campaign's outreach toll-free number for information and an application.</p>	<p>State introduced a new round of mass media advertising and awarded numerous community-based outreach contracts.</p> <p>Themes for Eligible, but not Enrolled Working Families</p> <ul style="list-style-type: none"> <li>• Eligibility: "Working families qualify."</li> <li>• Low Cost: "\$4-\$9 month per child for Healthy Families."</li> <li>• Benefits: "Dental and vision services provided."</li> <li>• Ease of Application: "Short, easy, mail-in application" and "Free local assistance is available."</li> </ul> <p>Themes for Racial/Ethnic Minority Groups</p> <ul style="list-style-type: none"> <li>• A television ad introduced "Tia Remedios" preparing soup for her sick great-nephew who is able to receive medical care under SCHIP. The announcer discussed comprehensive coverage, cost, and the ease of application, and emphasized that "more kids qualify."</li> <li>• Actress Sheryl Lee Ralph of TV's "Moesha" encouraged viewers to call the toll-free number for more program information.</li> <li>• Radio ads providing detailed information about program costs were recorded in Cantonese.</li> </ul>
<p><b>Florida</b></p> <p>Marketing materials conveyed a simple message: "Free or low-cost insurance available for uninsured children."</p>	<p>State established links with community partners to direct potentially eligible children to the program.</p> <p>Themes for Eligible but Not Enrolled Working Families</p> <ul style="list-style-type: none"> <li>• A multimedia campaign promoted a new message of "one less worry."</li> <li>• A 12-minute video loop describing the SCHIP program was distributed to State workforce development sites, health departments, medical provider offices, and other locations where waiting room time could be used to provide detailed information about SCHIP.</li> <li>• New ads were created to promote the value of maintaining health insurance coverage and using preventive care.</li> </ul> <p>Themes for Racial/Ethnic Minority Groups</p> <ul style="list-style-type: none"> <li>• A poster targeting American Indians indicated that there are no premiums or copayments for families who submit required documentation of American Indian heritage.</li> <li>• Spanish-language messages targeted rural Hispanic male heads of household using music popular with this group.</li> </ul>
<p><b>Pennsylvania</b></p> <p>State established a statewide toll-free number to provide information about SCHIP. Children with distinctive blue and gold SCHIP hats said, "I'm covered" and encouraged viewers to call the SCHIP hotline.</p>	<p>State determined that "one message does not fit all" and developed core messages, materials, and events for families falling into the following target audiences:</p> <ul style="list-style-type: none"> <li>• Influencers: "They know someone who can benefit from SCHIP." A faith-based project shared information about health care coverage to encourage families to enroll their children.</li> <li>• Unaware/Not Me's: "Take a look at how SCHIP can help your family." Revised marketing tools persuade parents that SCHIP is available to families just like them.</li> <li>• Transitionals: "When change leaves your kids uninsured, SCHIP can help." Local marketing and outreach events target areas of high unemployment and business closures.</li> <li>• Renewers: "Make sure your kids stay healthy—don't forget to renew." Improved renewal notices contain information regarding the importance of continual coverage.</li> </ul>

NOTE: SCHIP is State Children's Health Insurance Program.

SOURCE: Williams, S.R. and Rosenbach, M.L.: Data from Federal fiscal years 2000-2004.

efforts included radio, television, and print ads, and outdoor billboards (Rosenbach et al., 2003). Local outreach activities supported these statewide efforts and typically involved partnerships with a wide variety

of public and private organizations. These local efforts included disseminating printed information, one-on-one outreach, and application assistance (Schwalberg et al., 1999). In-person, one-on-one efforts

provided families a local point of entry for obtaining in-depth program information, education about eligibility guidelines, and guidance through the application process.

Based on an increasing amount of evidence, States acknowledged the importance of local in-person outreach to ensure that parents understood the benefits of SCHIP and how to apply. Many States, such as Alabama, reported that direct contact with families was most effective in providing parents with a clear understanding of the program, correcting any misunderstandings about the program, and assisting families with the application process. These successes at the local level prompted many States to shift the balance of their outreach efforts to increase the role of community members in helping to identify and enroll eligible populations in SCHIP. Because locally led efforts could be customized to the needs of the community, States felt they were able to target selected populations more effectively. For example, after tracking referral sources for families that inquired about and applied to SCHIP, New Hampshire shifted its efforts from a broad-based outreach strategy to one that used local outreach coordinators to develop relationships with community partners and provide outreach support through training and promotional materials. Texas found that immigrants were more comfortable contacting a local, well-known agency for program information versus calling a 1-800 number to an unknown location. Although most States maintained mass media efforts, these types of grassroots efforts became incorporated as a more formalized component of their outreach strategies to target hard-to-reach populations. Evidence suggests that SCHIP enrollment increased as a result of States' involvement with organizations that low-income families trust (Felland and Benoit, 2001; Wooldridge et al., 2003).

## ORGANIZATIONAL STRATEGIES

States found that while mass media reached a large number of families quickly and efficiently, local in-person efforts were necessary to ensure that families understood and completed the application or renewal process. Increasingly, States turned to community-based agencies to assist with one-on-one SCHIP outreach efforts. As a result, many States formalized their outreach infrastructure to reflect the increasing importance of local efforts. We found that States typically used three organizational strategies to establish efforts at the local level: (1) partnerships, (2) contracting, and (3) outstationing. These strategies were often used in combination with each other to strengthen their local presence. While State/local partnerships have been sustained in recent years, many States have cut back on their contracting mechanisms and outstationing efforts due to funding constraints and reduced focus on outreach for new enrollees.

### Partnerships

One means of establishing communication at the local level was to foster relationships with community-based partners that had the resources and knowledge necessary to effectively reach non-enrolled populations. These partners often belonged to the same community as the individuals States were trying to reach. As highlighted in Table 3, States have partnered with a wide range of private organizations, such as faith communities, voluntary programs serving immigrants and refugees, chambers of commerce, and State professional associations representing providers and educators.

The Covering Kids and Families (CKF) initiative has been key in building partnerships between States and local

**Table 3**  
**Examples of Community-Based Partners That Collaborated**  
**with States to Conduct SCHIP Outreach**

<p><b>Educational</b></p> <ul style="list-style-type: none"> <li>• Schools and School Districts</li> <li>• School-Based Health Clinics</li> <li>• After-School Programs</li> <li>• Local Universities</li> <li>• Private K-12 Schools</li> <li>• Professional Associations Representing Educators</li> </ul> <p><b>Community-Based Organizations</b></p> <ul style="list-style-type: none"> <li>• Big Brother and Big Sister Programs</li> <li>• Children's Advocacy Organizations</li> <li>• Local Philanthropic Organizations</li> <li>• Legal Aid Offices</li> <li>• Local Park Associations</li> <li>• Neighborhood Associations</li> <li>• Parent-Teacher Associations (PTAs)</li> <li>• Voluntary Organizations Serving Immigrants and Refugees</li> </ul> <p><b>Health Care Providers</b></p> <ul style="list-style-type: none"> <li>• Community Health Centers</li> <li>• Hospitals</li> <li>• Immunization Clinics</li> <li>• Individual Physician Offices</li> <li>• Professional Associations (e.g., State Pediatric Association, State Dental Association)</li> <li>• Minority Health Groups (e.g., the Interagency Farm Workers Coalition and the African-American Health Committee)</li> </ul>	<p><b>Private Businesses</b></p> <ul style="list-style-type: none"> <li>• Chambers of Commerce</li> <li>• Child-Care Providers</li> <li>• National Chains (e.g., Wal-Mart, K-Mart)</li> <li>• Restaurants (e.g., McDonald's Franchises)</li> <li>• Supermarkets</li> <li>• Shopping Malls</li> </ul> <p><b>Public Agencies</b></p> <ul style="list-style-type: none"> <li>• Local Fire and Police Departments</li> <li>• City Parks and Recreation Departments</li> <li>• Municipalities</li> <li>• National School Lunch Program</li> <li>• Public Libraries</li> <li>• State Department of Education</li> <li>• State Department of Health</li> <li>• State Department of Economic Security</li> <li>• Women, Infants, and Children (WIC) Program</li> </ul> <p><b>Faith Communities</b></p> <ul style="list-style-type: none"> <li>• Ecumenical Groups</li> <li>• Faith-Based Charities</li> <li>• Local Churches</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>• County Fairs and Rodeos</li> <li>• Tribal Organizations</li> <li>• Covering Kids and Families Coalitions</li> </ul>
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NOTE: SCHIP is State Children's Health Insurance Program.

SOURCE: Williams, S.R. and Rosenbach, M.L.: Data from Federal fiscal years 2000-2004.

organizations.<sup>3</sup> Working with 45 States and the District of Columbia, this initiative fostered the development of broad-based coalitions comprised of major public and private organizations involved in children's health and advocacy. The coalitions support the design and implementation of outreach programs to expand children's health coverage and to coordinate existing coverage programs for low-income children.

Schools consistently emerged as States' primary partners for disseminating information, often as part of a joint CKF—and State-funded effort intended to educate

families about SCHIP. Partnerships with schools were often cited by States as one of the most effective means of reaching potential enrollees because schools provided a natural setting for States to reach children and their parents. Moreover, schools often provided in-kind support for State outreach efforts. However, States varied in the level and degree of collaboration formally negotiated with schools. For example, some found school-based strategies time intensive, as they often required negotiations with each school district individually. Given their limited resources, this affected their ability to target all the schools in their State.

States that established successful partnerships with schools often distributed

<sup>3</sup> The Robert Wood Johnson Foundation sponsors the Covering Kids and Families initiative and its predecessor, the Covering Kids initiative (1997-2002). They have provided more than \$100 million in grants to support outreach and enrollment efforts to expand children's health insurance coverage.

information to students through back-to-school outreach campaigns. To identify potentially eligible children, many States developed targeted methods in conjunction with other programs, such as the National School Lunch Program. Many States or school districts included a check-off box on the school free and reduced-price meal application where parents could request more information about free or low-cost health insurance. In Massachusetts, some schools used nurses to provide application assistance to families who requested this information, while other schools partnered with local community agencies. Other States provided onsite application assistance with the support of school personnel, including nurses, teachers, and coaches. In Nebraska, school nurses used a referral card to document a child's health information for health care providers and to give parents information about the availability of health care coverage under SCHIP.

Community-based organizations (CBOs) also were attractive grassroots partners for targeting and enrolling diverse populations because they have the expertise with, access to, and trust of community members. This is particularly important for certain populations, namely immigrant families, families with language or cultural differences, families with negative past experience with government agencies, low-wage workers in small businesses, and families in rural areas (Silow-Carroll et al., 2002). For example, a partnership between the State of Alaska and the Alaska Native Tribal Health Consortium led to the production of radio public service announcements in 12 Alaska Native languages recorded by tribal elders to lend credibility to this government program.

States also forged important relationships with hospitals and safety net providers. They realized the importance of help from health care providers who were able to identify

uninsured children at the time they used health care services and provided them with in-person application assistance. Several States, such as Michigan, built relationships with hospital emergency room staff who provided information and referred families to SCHIP when they arrived without coverage. South Dakota worked with health providers at vocational schools, colleges, and universities to distribute brochures and application packets to nontraditional students and students under age 19 who lived on their own.

To target higher-income families whose children may be eligible for SCHIP, States also developed partnerships with private employers, unions, and business associations. Companies such as McDonald's, K-mart, and Wal-Mart lent support by providing store sites for outreach activities and by advertising the SCHIP toll-free number on bags and tray liners (Moore, 1999). In addition, chambers of commerce, such as the Chicagoland in Illinois, worked to get information about SCHIP out to families by setting up informational telephone lines for employers to request information or in-person presentations, distributing newsletters to employers or trade associations, and coordinating with union groups to educate workers about SCHIP. Other States, such as New Jersey, partnered with government agencies to include information in presentations to businesses slated for closings or layoffs. These types of coordinated efforts helped to increase the understanding of working families about the potential benefits available to them.

## **Contracting**

To ensure that outreach became entrenched at the grassroots level, many States established funding mechanisms to help CBOs conduct outreach. This trend contrasts with the SCHIP program's early



years, when few States provided seed money or reimbursement for CBOs that assumed these responsibilities (Schwalberg et al., 1999). Some States used competitive mini-grants to allocate the funds available for enrolling hard-to-reach groups. Mini-grant amounts ranged from as little as \$5,000 to as much as \$100,000 per year, per organization. Georgia funded 24 CBOs under its competitive mini-grant program to move beyond traditional outreach approaches and find new ways of reaching non-participating eligible families that addressed issues of trust, cultural variance, immigration status, language differences, and illiteracy. The program emphasized culturally appropriate ways of encouraging enrollment that increased the State's application rate by 16 percent.

Some States reimbursed community partners or schools based on the number of applications that were submitted or approved. California, for example, trained staff of community-based organizations to be Certified Application Assistants (CAAs). CAAs were paid \$50 for assistance they provided to families that resulted in successful enrollment in the Healthy Families or Medi-Cal programs. The State found that the CAAs helped to improve the completeness of applications, which resulted in quicker enrollment and improved access to medical services. These families were successfully enrolled 79 percent of the time, compared to 63 percent for families who did not utilize CAAs (National Health Foundation, 2006).

### **Outstationing**

Many States found that outstationing their workers to conduct outreach and application assistance at CBOs, schools, or provider sites gave them access to families who were eligible, but not enrolled. One of these States included Minnesota where

outreach workers were placed at neighborhood clinics with large numbers of Spanish-speaking patients to provide application assistance and refer families to a bilingual caseworker to make an eligibility determination that same day. Several States also realized the benefit of placing enrollment workers in settings beyond traditional government offices to expand opportunities for potentially eligible families (especially racial and ethnic minorities) to learn about SCHIP and apply for coverage. For example, Mississippi received a higher number of applications from American Indians after assigning two outreach workers to complete applications onsite at the reservation. In many States, outstationed workers were able to make preliminary eligibility decisions and help families complete application forms, thereby increasing the enrollment rates from these communities.

### **CHANGING EMPHASIS FROM OUTREACH TO INREACH**

In 2000 and 2001, as the U.S. economy began to slip into recession, many States' SCHIP enrollment successes coincided with increased budgetary pressures. State responses to budget shortfalls varied as some curtailed outreach and others shifted their focus from outreach to inreach to ensure timely renewal and appropriate use of services for current SCHIP enrollees. Communication with current enrollees, also described as inreach, was intended to improve retention.

Studies have shown that roughly one-half of all enrolled families fall off the program during the renewal period, even though they continue to qualify under a State's eligibility criteria (Dulio and Perry, 2003). Some experts suggest that helping those who already have insurance retain their coverage may be an important and cost-effective method not only for reducing

the uninsured rate, but for improving the continuity and quality of people's health care. States have found that it is less expensive to retain eligible enrollees than to have them drop off the program only to reapply after a break in coverage. In addition, continuous coverage through SCHIP saves money because enrollees use fewer services over time. Even brief gaps in coverage can contribute to problems in accessing care, obtaining prescriptions, and paying medical bills. Stable coverage helps patients maintain continuous relationships with doctors, which improves the use of preventive and primary care (Ku and Ross, 2002). States' inreach messages often communicated two complementary themes: (1) promoting the value of health insurance to encourage timely renewal for families who might lose coverage, and (2) educating families about the appropriate use of health insurance to access care. Some researchers suggest there is a correlation between use of health services and retention in SCHIP; if families use necessary services, they may be more likely to value the program and, therefore, stay enrolled (Dulio and Perry, 2003).

States promoted the value of health insurance through in-person education activities, such as in Kentucky where outreach workers contacted families through home visits or telephone calls to assist families who had not renewed their children in Kentucky Children's Health Insurance Program (K-CHIP). Ohio redirected its outreach strategies to focus on education and retention of current enrollees rather than enrollment of new enrollees and staff developed a member services guide, distributed a provider newsletter, and participated in events sponsored by community partners. In addition, some States trained community partners and agencies to assist families with the renewal process. For example,

Arkansas continued working with many of the same partners, such as school nurses and providers, but changed the message of outreach materials to promote the need for timely renewals. States found that the use of these efforts helped keep families enrolled and minimized gaps in coverage.

Another new inreach emphasis involved educating families about the appropriate use of primary and preventive services and explaining how to access these benefits through SCHIP. States developed creative ways of communicating with enrollees, such as Montana's "CHIP Chat" newsletter that educated families about the different types of benefits available to children and explained how to access these services. Many States used in-person strategies at the community level to deliver these messages. For example, Arizona's outreach contractors conducted followup communications, including telephone calls and home visits, to educate families about the appropriate use of services. Health plans assisted parents with scheduling first-time appointments; used postcard reminders or letters to remind parents to make appointments for periodic exams; and used incentives such as gift certificates to encourage members to obtain well-child visits, dental exams, or immunizations. States found that implementing these types of practices helped families understand the value of SCHIP coverage, thereby improving rates of retention.

## **ADAPTING OUTREACH DURING ENROLLMENT FREEZES**

Enrollment freezes heightened the need for clear communication to families in States that were not able to maintain open enrollment due to fiscal constraints. Seven States—Alabama, Colorado, Florida, Maryland, Montana, North Carolina, and

Utah—froze SCHIP enrollment at differing points in time (Ross and Cox, 2003).<sup>4</sup> While some of these States discontinued outreach efforts, others redirected communication efforts to inform current enrollees about the freeze to ensure they protected their eligibility. The communication needs, however, varied according to whether States established a waiting list versus periodic open enrollment periods. North Carolina, for example, froze enrollment for nine months in 2001, and established a waiting list during this period. The State developed various materials for families that explained the freeze and the waiting list, and that notified families on the waiting list when enrollment reopened.

In contrast, when States used periodic open enrollment periods, they used a variety of approaches to get the word out to motivate families to apply immediately. After implementing an enrollment freeze in 2001, Utah held periodic open enrollment periods. Beginning about 2 weeks before enrollment opened, the State would run media blitzes on television and radio, post billboards in low-income areas, and make applications available online. Over time, Utah expanded its partnerships with CBOs to reach minority and non-English-speaking populations.

Enrollment freezes required special attention to the reenrollment process, and particularly the messages used to communicate the importance and urgency of renewing coverage. Educating families about proper renewal procedures helped reduce their risk of losing coverage and either being locked out of re-enrolling or placed on a waiting list until the next open enrollment period. For example, Alabama's renewal notice contained the message "Renewing your children ON TIME is more

important than ever." The notice described the renewal process and provided instructions on how people with questions could contact the program. Maryland's notice reminded families to pay their monthly SCHIP premiums and complete the annual renewal application on time.

## DISCUSSION

SCHIP outreach strategies have evolved from broad-based efforts to raise general awareness about the program to more focused efforts to attract specific hard-to-reach groups. Based on early feedback from focus groups, surveys, hotline statistics, and other data sources, States revised their outreach messages to provide more information on program eligibility, cost, and the value of having insurance to cover both preventive and unexpected health care costs. The strides States have taken in targeting outreach messages to different populations also reflect their emerging relationships with community partners. Increasing the reach of State outreach messages required developing closer linkages with schools, CBOs, health care providers, and private business groups. To sustain information campaigns and provide in-person outreach and application assistance, States developed various organizational strategies for working with these partners; these included providing funding to local CBOs, conducting training, and placing personnel at community sites.

States also learned that decentralizing outreach increases the salience of the message and provides more enrollment opportunities for families. Promoting SCHIP at the local level allows communities to tailor activities to the targeted populations; however, there is no one-size-fits-all outreach strategy. Each State has designed its own approach, depending on the particular characteristics of its eligible uninsured

<sup>4</sup> As of July 2005, all of these States had lifted their freezes and were once again enrolling children in their programs (Ross and Cox, 2005).

population, the resources available, and the nature of the relationships among CBOs in the area. State approaches continue to evolve as these factors change and States learn from their earlier efforts.

Adverse economic conditions and tighter State budgets led to a growing recognition of the importance of inreach to current enrollees. As the program has matured, States are focusing their marketing efforts on current enrollees who are eligible for renewal and developing messages that emphasize the importance of retaining health care coverage. By emphasizing the retention of health care coverage and appropriate use of services, inreach efforts are designed to reduce the churning of families on and off the program, which reduces program costs and improves the continuity and quality of care.

The ongoing evolution of SCHIP outreach had a spillover effect on traditional Medicaid enrollment. State refinement of messages to emphasize eligibility for and the value of health insurance led not only to increased SCHIP enrollment, but also increased Medicaid enrollment. Many families who applied for SCHIP coverage were found eligible for Medicaid, thereby increasing overall rates of public insurance coverage. Although the magnitude of the spillover effect is unknown at the national level, many States documented that outreach and enrollment initiatives implemented through SCHIP brought in more uninsured low-income children to Medicaid than SCHIP, often helping to reverse declines in traditional Medicaid Program enrollment that began in the mid-1990s.

While there has not been a formal evaluation of the effectiveness of SCHIP outreach efforts, this study has shown how States assessed their own efforts and learned from their experiences. For policymakers seeking to increase enrollment in other public programs, such as the Medicare

Part D prescription drug program, this longitudinal assessment of State efforts under SCHIP provides valuable lessons. Early outreach efforts may include universal strategies to reach the general population, whereas later efforts may involve selected strategies aimed at specific, high-priority populations. The later efforts typically evolve as a result of mounting evidence about unmet needs (for example, which populations are underrepresented). The framework developed in this article highlights the multidimensional outreach features that can be tailored to changing program circumstances and emerging priorities, including refinement of the target populations, messages, methods, organizational strategies, and emphasis.

The evolution of State outreach efforts under SCHIP reflects an orientation toward ongoing assessment of what is working well and what could be improved. However, to better gauge the effectiveness of State outreach strategies under SCHIP, future research would need to explore quantitative approaches that can be used to measure the impact of outreach strategies on enrollment rates overall and within specific target populations. For example, because most States have used statewide mass media and local one-on-one outreach efforts in combination with each other, little is known about the relative success of these strategies. Likewise, little is known about the return on investment of specific outreach strategies relative to various enrollment simplifications (such as the use of joint applications, mail-in or internet applications, or reduction of documentation requirements). In the absence of a comprehensive national database on State outreach efforts, however, such analyses may be challenging.

In conclusion, SCHIP plays an important role as a safety net for low-income children who need health insurance. States



have learned that creative and diverse approaches are required to bring more uninsured children into SCHIP and Medicaid. These important lessons from the early years of SCHIP are even more valuable as States face uncertain fiscal climates due to funding shortfalls. The reauthorization of SCHIP provides an opportunity for States to reassess and prioritize their outreach strategies to retain coverage for current SCHIP enrollees and to reach the large number of uninsured children that still need health care coverage.

## ACKNOWLEDGMENTS

The authors would like to recognize the valuable contributions of Cheryl Young who abstracted and synthesized information from the 2000 and 2001 State annual reports. We would also like to thank Judith Wooldridge for reviewing and commenting on an earlier draft, and Margaret Hallisey for her assistance in providing production support.

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