Overcoming Barriers to Enrollment:
A 50-state assessment of outreach and enrollment simplification strategies for the State Children's Health Insurance Program (SCHIP)

by

Jennifer Maier Snow

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Executive Summary

With the creation of the State Children's Health Insurance Program (SCHIP) in 1997, nearly all low-income uninsured children are now eligible for some public health insurance; however, millions of eligible children still lack coverage. Lack of information about the program, problems associated with the enrollment process, and welfare stigma are common barriers that inhibit children's enrollment in public health programs. States have taken deliberate steps to overcome these barriers when creating their SCHIP by using outreach mechanisms and by simplifying the enrollment process; however, each state uses a unique combination of strategies. This exploratory research attempts to determine if an association exists between specific outreach and/or enrollment simplification strategies and the states' progress in enrolling eligible children. Based on empirical statistical analysis, this paper offers suggestions to policy makers and program officials about how to improve SCHIP enrollment processes and subsequently the health of children in the respective states.

Children's Lack of Health Insurance and SCHIP

Health insurance plays a critical role in ensuring that children obtain timely medical care that is appropriate to their developmental needs.[1] Uninsured children are more likely to be sick as newborns, less likely to be immunized as preschoolers, less likely to receive medical treatment when they become injured, and less likely to receive treatment for illnesses.[2] Despite the clearly documented benefits of health insurance, one of the largest groups of uninsured persons in this country is children.[3] In 1996, nearly 10.6 million children, or about 14 percent of all children in the United States, did not have health insurance coverage.[4]

Since the failure of President Clinton's health care reform initiative in 1994, legislators have sought more incremental approaches to expand public health insurance to targeted subsets of the population. Advocates maintain that extending health insurance coverage to uninsured children was a logical first step because they are relatively inexpensive to insure and could gain considerable benefits from coverage.[5] The Balanced Budget Act of 1997 established Title XXI of the Social Security Act, creating the State Children's Health Insurance Program (SCHIP). SCHIP is a federal grant-in-aid program that entitles states to federal allotments to provide "child health assistance to targeted low-income children" who are ineligible for other insurance coverage, including Medicaid.[3] As the largest expansion of the federal commitment to children's health insurance since the enactment of Medicaid in 1965, SCHIP marks a historic milestone.[6] The law is authorized for ten years and the total federal allotment is nearly $40 billion over the life of the legislation. Annual federal allocations to states are based on the state's share of low-income and uninsured children using estimates from the Current Population Survey.[7] SCHIP targets low-income children whose family incomes do not exceed 200 percent of the federal poverty level or 50 percentage points of a state's Medicaid income-eligibility level, whichever is higher.

During the debate leading up to the passage of SCHIP, states demanded and received a great deal of flexibility when designing their SCHIP program.[8] This state programmatic flexibility has resulted in great variety among SCHIP programs, in terms of program type, benefit package, delivery system, outreach strategies and enrollment process. As of February 2000, there is an SCHIP program in place in all 50 states, the District of Columbia, Puerto Rico, and the four US territories. (See Appendix A for a complete listing of program design by state.) In fiscal year 2001, a total of 4.6 million children have gained health insurance through SCHIP.[9]

Unexpected Problem

Efforts to implement SCHIP have been generally well received by state legislatures, advocates, communities, and beneficiaries; however, enrollment of uninsured eligible children has been gradual. According to an analysis of Census data, 94 percent of all uninsured children with family incomes below twice the poverty line qualify for Medicaid or a separate program supported by SCHIP funds.[10] Thus, most children should be eligible for some health insurance coverage. Nevertheless, it is estimated that there are currently several million children who are eligible for SCHIP but have yet to be enrolled.[11] As a consequence of low enrollment, overall spending on SCHIP has fallen short of the federal funds available in the majority of states. At the end of FFY 2000, there was approximately $2 billion in unspent FFY 1998 funds.[12] Thus, states are facing the major challenge of reaching and enrolling these children who are eligible for coverage but remain unenrolled and uninsured.

Removing Barriers to Enrollment in SCHIP

Possible barriers that inhibit enrollment in SCHIP include the following: lack of information about the program, problems associated with the enrollment process, and welfare stigma.[13] Additional barriers include language and cultural issues,[14] perceived unequal treatment of program recipients by health care providers,[15] and parents who did not want or perceive the need for public health insurance coverage.[16] Since the enactment of SCHIP, states have made efforts to address these barriers and have invested significant resources to find uninsured children and enroll them in Medicaid or SCHIP.[17]

States have taken deliberate steps to overcome common barriers to enrollment by using a variety of outreach and enrollment simplification strategies. Outreach strategies have included a variety of media campaigns such as posters, newspapers, television, billboards, radio, and print advertising.[18] Outreach has also occurred through community-based organizations and institutions, such as schools, child-care centers, and health care providers.[19] Enrollment simplification strategies include the following: eliminating the asset test from the application process, eliminating the face-to-face interview, allowing presumptive eligibility, allowing self-declaration of income, and allowing 12-month continuous eligibility. To reduce the barrier from perceived stigma associated with government programs, states have taken explicit measures to show that SCHIP is no longer linked to welfare. Many states have attempted to create more user-friendly programs that resemble private commercial health plans.[11] Some states have also given new, catchy names to their SCHIP to separate it from the Medicaid program. Some examples include Alaska's Denali KidCare, Georgia's PeachCare for Kids, Iowa's HAWK-I (Healthy and Well Kids in Iowa), Oklahoma's SoonerCare and Wisconsin's BadgerCare.

Although states have taken deliberate steps to overcome enrollment barriers, every state uses a unique combination of strategies. Much anecdotal evidence about the best strategies to increase enrollment has been produced, but the results have been inconsistent.[20] Given that SCHIP regulations restrict states from spending more than 10 percent of federal funds on administrative functions, including outreach and enrollment efforts, it makes sense for states to know how to use these funds in a way that most effectively results in enrollment. This research attempts to determine if an association exists between the outreach and/or enrollment simplification strategies and the overall enrollment of eligible children in the 50 states and the District of Columbia.

Data and Methods

A multivariate logistic regression analysis was performed in an attempt to determine if specific outreach and/or enrollment simplification strategies are associated with successful SCHIPs. Logistic regression is a variation of ordinary regression, useful when the observed outcome is restricted to two values. It estimates the probability of a certain event occurring, in this case, whether an eligible child will be enrolled in SCHIP.[21]

Three different dependent variables were used in an attempt to provide a proxy for measuring success of SCHIP. The first dependent variable represents an enrollment rate for SCHIP-funded programs. It is calculated by taking the total number of children enrolled in SCHIP-funded programs in December 2000, as a percent of the total number of children estimated to be eligible based on state program provisions that were in effect in September 1999. The eligibility estimates were calculated by Mathematica Policy Research in a report to the Department of Health and Human Services.[22] States that enrolled more children than the analysis estimated to be eligible were given a 100% enrollment rate.

The second dependent variable is an enrollment rate for SCHIP and Medicaid. It is calculated by taking the total number of children enrolled in SCHIP or Medicaid in 2000 as a percent of the total number of children estimated to be income eligible. The eligibility estimates were calculated by the American Academy of Pediatrics.[23] This measure attempts to capture how outreach strategies for SCHIP might have transferred into additional success for enrolling children in Medicaid.

Using enrollment rates as a proxy for success does not always portray an adequate picture of states' efforts to find and enroll eligible children in their SCHIP. For example, North Carolina had received national acclaim for enrolling eligible children in their version of SCHIP, called NC Health Choice. Yet, in 2000 officials were forced to freeze enrollment in the program due to projected state fiscal constraints. Thus the enrollment rate for North Carolina would have been much higher if it had included the more than 12,000 children who were on a waiting list, ready to be enrolled. To address this, the third

dependent variable looks at how much money states have spent on their SCHIP. The variable is calculated by taking the total amount of money states have spent on SCHIP as of December 15, 2000,[24] as a percent of the total federal allotment they received.

The independent variables include a measure of state political culture as well as the presence or absence of certain outreach and enrollment simplification strategies. These include:

Enrollment Simplification Strategies:

- Eliminated Face-to-Face Interview on SCHIP
- Eliminated Asset Test on SCHIP
- Eliminated Asset Tests on SCHIP and Medicaid
- Presumptive eligibility on SCHIP
- 12-months continuous eligibility on SCHIP
- Aligned 12-months continuous eligibility on SCHIP and Medicaid
- Self-Declaration of Income on SCHIP
- Frequency of Re-determination (in Months)

Outreach Strategies:

- Out-stationed Eligibility Workers
- Family-Friendly Web-site
- Funding Community-Based Organizations
- Involving Employers
- Involving the Business Community
- Public/Private Partnerships
- Multi-lingual
- Electronic Media (Radio or Television)
- Print Media
- Target marketing to minority groups
- Billboards
- Incentives for Outreach Workers
- Direct mail by state/enrollment broker/ contractor

A description and data source for each independent variable is included in Appendix B.

Limitations

There are some fundamental limitations to this data analysis. The first two models use population estimates to determine the percent of eligible children who are enrolled in the program. Thus, these measures are only as accurate as their population estimates. There are flaws in the way estimates of uninsured children are made and the number of uninsured can vary widely from survey to survey.[25] There are many variables that contribute to variance in survey estimates, such as the length of time uninsurance is measured, how insurance is defined, how respondents are asked about insurance and the focus of the survey.[25] The Current Population Survey (CPS) is the most widely cited source of data on the uninsured, and provided the base estimates for the first two models used in this analysis. The CPS, however, has been criticized because its state samples are inadequate to provide state estimates of uninsured children with sufficient statistical precision to serve policy needs.[26] The simple fact that some states have enrolled more children in SCHIP than were estimated to be eligible for the program illustrates the obvious inaccuracy of such estimates. However, while these eligibility estimates are not ideal, they still represent the best available proxy for evaluating enrollment rates.

There are also some limitations to the independent variables used in this analysis. This analysis does not attempt to measure the extent of a state's outreach strategies, rather it looks only at the presence or absence of certain strategies. In addition, the independent variables do not attempt to evaluate the content of the outreach strategies. Thus, a state might have used a particular outreach strategy, but not in an effective way.

Results and Discussion

The first two models showed a statistically significant association between outreach and enrollment simplification strategies and two models assessing enrollment. (See Appendix C for complete Logistic Regression Results.) The first model revealed a statistically significant association ($p<.05$) for

public/private partnerships and having a multi-lingual statement on brochures and/or applications; significant association (p<.10) was also revealed for eliminating the face-to-face interview and the asset test. The second model revealed a statistically significant association (p<.05) for presumptive eligibility on SCHIP and having a multi-lingual statement on brochures and/or applications. The third model, that addresses how much money each state had spent as a percent of the money allotted, did not yield any statistically significant results.

Logistic Regression Analysis			
Variable	**Model 1- SCHIP Enrollment Rate**	**Model 2- Medicaid/SCHIP Enrollment Rate**	**Model 3- Percent of Allotted Money Spent**
	Logit coefficients	**Logit coefficients**	**Logit coefficients**
Eliminated Face to Face Interview on SCHIP	0.76	0.58*	0.67
Eliminated Asset Test on SCHIP and Medicaid	-0.74	0.67*	1.04
Presumptive eligibility on SCHIP	0.87	0.64**	0.29
Public/Private Partners	1.58**	0.13	0.23
Multi-lingual	-1.24**	-0.52**	0.62
**p<0.05, *p<0.10			

The first model reveals that the use of public/private partnerships had a positive association with SCHIP enrollment rates. This promising finding shows that states that have partnered with private organizations to increase public awareness, distribute information, and assist potential enrollees in filling out applications have had success enrolling eligible children. In addition, eliminating the asset test and the face-to-face interview also had a positive association with enrollment rates. Eliminating the asset test helps limit the amount of documentation needed to verify eligibility. Eliminating the face-to-face interview makes applying for SCHIP less of an intimidating and invasive process. It is logical that these two administrative features have increased enrollment because they make the application process become less of a burden on applicants.

In the second model, presumptive eligibility on SCHIP has a positive association with enrollment rates in SCHIP and Medicaid. Presumptive eligibility is an eligibility determination process that allows qualified health care providers to determine that a child is eligible for SCHIP, and enroll him/her on a temporary basis on the spot. The child then needs to follow through with a formal application process to remain enrolled. Presumptive eligibility brings the enrollment process to the community and this research has shown that it helps increase opportunities for enrollment.

The variable of most interest in this analysis is the presence of a multi-lingual statement on the SCHIP application or brochure because it is shown to have a negative association in both models dealing with enrollment rates. It is possible that states that placed a multi-lingual statement on their application and/or brochure are more likely to have large populations of citizens with limited-English proficiency (LEP). Such LEP populations might also contain large numbers of immigrants. There are both perceived and real barriers to enrollment for immigrant families. Since SCHIP is considered to be a "federal means-tested public benefit," certain immigrant children cannot receive SCHIP during their first five years of residency.[3] Citizen children of immigrant parents are eligible for SCHIP on the same terms as citizen children of native parents, yet citizen children of immigrant parents are less likely to receive publicly-funded coverage.[27] Some immigrant families may have thought that their children were not eligible or were afraid to participate because of a belief that their children's use of SCHIP might jeopardize their immigration status.[27] Thus, the negative association between enrollment rate and the multi-lingual statement might be more of a consequence of low enrollment rates among immigrant populations.

There is also a surprising lack of association between high enrollment rates and other forms of outreach and enrollment simplification strategies. This might suggest that some forms of outreach, such as billboards and electronic media might increase brand-recognition about SCHIP, but might not effectively convince people to seek out such insurance. In addition, the enrollment simplification strategies might make the application easier for people who have already decided to apply, but might not compel people to apply.

Recommendations and Conclusions

The results of this analysis indicate that many common outreach and enrollment simplification strategies do not have statistically significant effects on the enrollment of eligible children. Some of the results are expected and others are surprising. The results do bring to light some broader issues and recommendations.

- ***Continue efforts to simplify the enrollment process.*** As this research indicates, simplifying the enrollment process, specifically by eliminating the face-to-face interview and the asset test, has a positive effect on enrolment rates. These actions make the enrollment process more user-friendly and convenient and seem to increase the likelihood that families complete the application process. States that have not yet adopted such strategies should be encouraged to take such administrative action.
- ***Expand presumptive eligibility option.*** Presumptive eligibility has a positive effect on enrollment rates by bringing enrollment efforts to the community. Yet, few state are currently using the option to conduct presumptive eligibility determinations. States should be encouraged to use presumptive eligibility as a tool for enrollment.
- ***Assess adequacy of efforts to target non-English speaking populations.*** As this research indicates, multi-lingual statements on SCHIP applications or brochures are associated with lower enrollment rates. This result should not discourage states from making efforts to target LEP populations. States, however, should try to explicitly address the real and perceived barriers to enrollment for immigrants. Effective strategies will vary from state to state and community to community, but likely should aim to inform and educate immigrant families about SCHIP, in a culturally appropriate manner.
- ***Improve mechanisms for estimating the number of Medicaid and SCHIP-eligible children***. While the CPS might be a standard means for estimating the number of uninsured, it has weaknesses. Improving the precision in which the number of eligible children are estimated would only improve the validity of quantitative evaluation. More accurate estimates would also help the federal government's financial allocations more accurately reflect the target population.
- ***Continue to explore state-specific initiatives***. Some states have utilized the flexibility allowed by SCHIP to formulate unique enrollment strategies that could not be measured this analysis. For example, in Alabama, enrollment and outreach was conducted at a Bike Rodeo festival. In New York, McDonald's offered to assist in promoting the program by advertising SCHIP on their trayliners.[28] The New Jersey Nets basketball team helped spread the word by hosting a NJ KidCare Night.[29] Michigan sent informational letters to licensed migrant labor housing operators urging them to share program information with migrant workers. States should continue to investigate and develop unique outreach strategies that will work in their state.

This research has highlighted some expected and some surprising results. Overall it has demonstrated that administrators can take steps to help increase the enrollment of eligible children in their state's SCHIP. Even though SCHIP has had problems finding and enrolling all eligible children, the great strides it has made in improving access to health insurance should not be overlooked. Since the enacting legislation, SCHIP has greatly helped decrease the percent of uninsured children in the US, from 13.9% in 1997 to 11.2% in 2001.[30] Continued monitoring and evaluation of SCHIP will help states ensure that money is used most appropriately to help find, enroll and provide health care services for children.

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[23] Children's health insurance status and Medicaid/SCHIP eligibility and enrollment: state reports, 2000. Division of Health Policy Research, American Academy of Pediatrics. . Retrieved April 1, 2002 from www.aap.org.

[24] States initially had three years to use each year of their federal SCHIP allotment before it would be redistributed to states that spent all of their allotment. For example, a state can use its fiscal year 1999 allotment in fiscal year 1999, 2000, and 2001.
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Appendix A- Overview of SCHIP*

States that chose to create SCHIP by expanding their existing Medicaid program had the advantage of building on an existing institutional structure with relatively little program modification. Using Medicaid as the vehicle for SCHIP, however, could create financial risks for the states because a Medicaid expansion would be an entitlement program obligating the state to cover all eligible children, even if the cost exceeded the SCHIP allotment. In addition, enrollment may be difficult if some low-income families forgo coverage because of the stigma they perceive to be associated with Medicaid. A separate SCHIP was a good option for states that already had programs in place that provide insurance coverage for children who are not eligible for Medicaid. A separate SCHIP could be less expensive to a state because it can cap program enrollment, impose cost-sharing requirements and limit benefit packages. Also, a separate SCHIP gave states the flexibility to design a program to satisfy its specific need, but requires the establishment of additional administrative structures. The following chart shows the programming choices for each state.

STATE	PROGRAM TYPE	SCHIP PROGRAM NAME
Alabama	Combination	ALL Kids
Alaska	Medicaid Expansion	Denali KidCare
Arizona	State-designed	KidsCare
Arkansas	Medicaid Expansion	Arkansas Children's Health Insurance Program (AR CHIP)
California	Combination	Healthy Families and Medi-Cal
Colorado	State-designed	Child Health Plan Plus (CHP+)
Connecticut	Combination	HUSKY (Healthcare for UninSured Kids and Youth)
Delaware	State-designed	The Delaware Healthy Children Program (DHCP)
District of Columbia	Medicaid Expansion	DC Healthy Families
Florida	Combination	Healthy Kids
Georgia	State-designed	PeachCare for Kids
Hawaii	Medicaid Expansion	Children's Health Insurance Program (CHIP)
Idaho	Medicaid Expansion	Idaho Children's Health Insurance Program (ID CHIP)
Illinois	Combination	KidCare
Indiana	Combination	Hoosier Healthwise
Iowa	Combination	HAWK-I (Healthy and Well Kids in Iowa)
Kansas	State-designed	Health Wave
Kentucky	Combination	Kentucky Children's Health Insurance Program (KCHIP)
Louisiana	Medicaid Expansion	LaCHIP
Maine	Combination	Cub Care
Maryland	Combination	Maryland Children's Health Program
Massachusetts	Combination	MassHealth
Michigan	Combination	MIChild
Minnesota	Medicaid Expansion	MinnesotaCare
Mississippi	Combination	Mississippi Children's Health Insurance Program (MS CHIP)
Missouri	Medicaid Expansion	MC+ for Kids
Montana	State-designed	Montana Child Health Insurance Plan (MT CHIP)
Nebraska	Medicaid Expansion	Kids Connection
Nevada	State-designed	Nevada 4 Check Up
New Hampshire	Combination	Healthy Kids Gold
New Jersey	Combination	NJ KidCare
New Mexico	Medicaid Expansion	SALUD!
New York	Combination	Child Health Plus (CHPlus)
North Carolina	State-designed	NC Health Choice for Children
North Dakota	Combination	Healthy Steps
Ohio	Medicaid Expansion	Healthy Start
Oklahoma	Medicaid Expansion	SoonerCare
Oregon	State-designed	Oregon Children's Health Insurance Program (OR CHIP)
Pennsylvania	State-designed	Pennsylvania Children's Health Insurance Program (PaCHIP)
Rhode Island	Medicaid Expansion	RIte Care
South Carolina	Medicaid Expansion	Partners for Healthy Children (PHC)
South Dakota	Combination	South Dakota Child Health Insurance Program (SD CHIP)
Tennessee	Medicaid Expansion	TennCare
Texas	Combination	Texas Children's Health Insurance Program (TX CHIP)
Utah	State-designed	Utah Children's Health Insurance Program (UT CHIP)
Vermont	State-designed	Vermont Health Access Plan (VHAP) and Dr. Dynosaur
Virginia	State-designed	Virginia Children's Medical Security Insurance Plan (VCMSIP)
Washington	State-designed	Washington Children's Health Insurance Program
West Virginia	State-designed	West Virginia Children's Health Insurance Program (WV CHIP)
Wisconsin	Medicaid Expansion	BadgerCare
Wyoming	State-designed	Kid Care

*Center for Medicare and Medicaid Services (CMS) State Children's Health Insurance Program Plan Activity Map. Retrieved February 20, 2002.

Appendix B- Definition of Independent Variables

Enrollment Simplification Strategies

- *Eliminated Face-to-Face Interview*: SCHIP applications do not require applicants to complete a face-to-face interview. Families no longer have to apply in person at a welfare or Medicaid office. [a]
- *Eliminated Asset Test*: SCHIP applications do not require applicants to complete an asset test. Typically an asset test counts the value of a family's assets as part of the total income. By not requiring as assets test, eligibility is based only on a family's gross income.[a]
- *Eliminated Asset test on SCHIP and Medicaid*: Both Medicaid and SCHIP applications do not require an asset test. [a]
- *Presumptive eligibility:* SCHIP program allows presumptive eligibility. Presumptive eligibility enables children who appear income-eligible to enroll temporarily and receive services, giving families time to complete the formal application process. [a]
- *12-months continuous eligibility:* SCHIP program allows 12-month continuous eligibility. Under the Balanced Budget Act of 1997, states were given the option to enroll children for up to 12 months, without regard to changes in their family income. [a]
- *Self-Declaration of Income:* SCHIP applications allow families to self-declare their income. This eliminates the need for the family to provide documentation. [a]
- *Frequency of Re-determination in Months:* Children have to reapply for SCHIP to remain enrolled. Most states require a re-determination every 6 or 12 months.[a]

Outreach Strategies

- *Out-stationed Eligibility Workers:* Placing eligibility workers in nontraditional, community locations. [b]
- *Family-Friendly Web-site*: A web site designed to be viewed by consumers. The site is easy to read and provides basic information about the application, eligibility levels and the enrollment process.[b]
- *Funding Community-Based Organizations:* [b] Some states have provided money to community-based organizations to conduct outreach.
- *Involving Employers:* Employers and the business community, especially those employing eligible parents or providing services to children, may assist in outreach efforts by enclosing fliers in employee paychecks, posting SCHIP outreach posters, distributing SCHIP applications, or by identifying and assisting potential enrollees in filling out applications, and educating individuals about the program. [c]
- *Involving the Business Community:* see above.[c]
- *Public/Private Partners:* May include state and local governments, tribal entities, community-based organizations, places of worship and/or non-profit corporations serving children. These partnerships assist in increasing public awareness through educating communities, distributing information about SCHIP, informing families of SCHIP enrollment sites, assisting potential enrollees in filling out applications and facilitating enrollment campaigns. [c]
- *Multi-lingual:* SCHIP applications contain a multi-lingual statement on brochure and/or applications.[c]
- *Electronic Media:* Radio or television media used as a vehicle for promoting Medicaid/SCHIP [d]
- *Print Media:* Print media used as a vehicle for promoting Medicaid/SCHIP.[d]
- *Target marketing to minority groups*: SCHIP marketing is specifically targeting minority groups.[d]
- *Billboards:* Billboards used as a vehicle for promoting Medicaid/SCHIP. [e]
- *Incentives for Outreach Workers:* State provides an incentive to outreach workers for each child they enroll [e]
- *Direct mail by state/enrollment broker/contractor:* [e] Information/applications can be mailed to children.
- *Political culture*: A numerical description of a state's political culture. Political culture is defined as the particular pattern of orientation to political action in which each political system is imbedded. The scale ranges from 1-9, ranging from moralist to individualist to traditionalist culture. Moralist orientation considers participation to be the duty of all citizens, who should involve themselves in politics for the sake of the commonwealth, and Individualist culture holds that participation is something to be engaged in more narrowly for the sake of improving one's own position, and in the Traditionalist culture, participation is ideally reserved for those with elite status.[f]

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[a] Kaiser Family Foundation *Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*- July 2000
[a] National Governors Association *Outreach and Simplified Enrollment Strategies in SCHIP Plans*- December 2000
[a] National Conference of State Legislatures, *State Children's Health Insurance Program Outreach Strategies*- February 2000
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Appendix C- Logistic Regression Analysis

Logistic Regression Analysis			
Predictor	**Percent Total Eligibles Enrolled in December 2000- Mathematica Estimates**	**Percent Medicaid/State Program Eligibles enrolled- AAP Estimates**	**Percent of FFY 1998 Allotment Spent by December 2000**
	Logit coefficients	**Logit coefficients**	**Logit coefficients**
Political culture	0.09	0.01	-0.07
Eliminated Face to Face Interview on SCHIP	0.76	0.58*	0.67
Eliminated Asset Test on SCHIP	-0.49	0.30	1.79
Eliminated Asset Test on SCHIP and Medicaid	-0.74	0.67*	1.04
Presumptive eligibility on SCHIP	0.87	0.64**	0.29
12-months continuous eligibility on SCHIP	-0.41	0.37	-0.67
12-month continuous eligibility on all	0.30	-0.20	-0.01
Self-Declaration of Income	-0.25	-0.04	-0.10
Frequency of Redetermination in Months	-1.35	-0.11	5.56
Out-stationed Eligibility Workers	1.79	0.09	2.15
Family-Friendly Web-site	0.21	0.14	0.39
Funding Community-Based Organizations	-0.07	-0.04	-0.03
Involving Employers	-0.28	0.06	0.25
Involving the Business Community	0.14	0.23	-1.19
Public/Private Partners	1.58**	0.13	0.23
Multi-lingual	-1.24**	-0.52**	0.62
Market testing first?	0.28	0.08	-2.44
Electronic Media (Radio or Television)	-0.08	-0.08	-2.39
Print Media	0.61	-0.46	-3.17
Billboards	-0.20	0.24	1.46
Incentives for Outreach Workers	0.46	-0.01	-0.82
Direct mail	-0.31	0.03	-1.78
Targeting	0.52	-0.18	0.00
*p<0.10, **p<0.05			

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