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On December 7, 1997, the National Center for Education in Maternal and Child Health (NCEMCH) hosted a seminar of the Georgetown University MCH Policy Collaborative, "Outreach and the State Children's Health Insurance Program (CHIP)." The purpose of the GU MCH Policy Collaborative is to advance interdisciplinary research and educational opportunities in the area of maternal and child health. Mary Brecht Carpenter and Laura Kavanagh prepared this white paper for seminar attendees to provide general background information about the CHIP legislation and to underscore the importance of outreach efforts to find, enroll, and assure health care services for children eligible for CHIP across the states. The paper also stresses the pressing need for analysis of current outreach strategies and the wide dissemination of findings from these analyses. Feedback and comments about this paper are welcome. Please e-mail Mary Brecht Carpenter at marycarpenter@ncemch.org or Laura Kavanagh at kavanagh@ncemch.org.

Outreach and the State Children's Health Insurance Program: Helping States Enroll Children and Assure Access to Care

by Mary Brecht Carpenter, RN, MPH and Laura Kavanagh, MPP

With the passage of the Balanced Budget Act of 1997 (P.L. 105-33), states were given a new opportunity to improve the health and well-being of children. The Balanced Budget Act added Title XXI to the Social Security Act, creating the State Children's Health Insurance Program (CHIP). The program, authorized for 10 years, includes $20.3 billion in new federal block grant funding to the states over the next five years, beginning with fiscal year 1998. States can use their allocated funds to expand their Medicaid programs, create or expand a child health insurance program, or implement some combination of both. Whatever approach they choose, states must spend some of their own funds to draw down the federal dollars. Title XXI, or CHIP, also includes other Medicaid provisions that affect child health that bring the total funding to $23.8 billion over five years.[1]

This new law and the opportunities it presents build on the experience all states have had since the mid-1980s expanding Medicaid for children and pregnant women in response to Congressional legislation which mandated certain expansions and offered states options for others.[2] The CHIP law also builds on the work of many states to create separate health insurance programs to cover uninsured children with incomes

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[1]Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997*, Washington, DC, August 12, 1997.

[2]Under federal law, children under age six with family incomes below 133 percent of the federal poverty level are eligible for Medicaid. The 1997 federal poverty level for a family of four is $16,050. In addition, children between ages six and 14 are eligible if their family income is below 100 percent of federal poverty. Finally, coverage for children between ages 14 and 19 with family incomes below 100 percent of federal poverty is being phased-in on a yearly basis so that by 2002 all children under age 19 will be eligible for Medicaid.

higher than Medicaid limits. As of May 1997, eight states had state-funded insurance programs and 24 had privately-funded or mostly privately-funded insurance programs, such as the Caring Program for Children sponsored by Blue Cross and Blue Shield Corporations.[3] In order to reach even more uninsured children, CHIP now permits states to use their new federal funds along with state funds to cover children with family incomes at any level up to 200 percent of federal poverty.

Challenges to achieving the goals of CHIP

In addition to the opportunities the new law presents, however, it also includes challenges that are all too familiar to states. One of these challenges is to *find, enroll, and serve* as many children as possible. The enactment of Title XXI has been greeted with great enthusiasm and hope that this law will lead to many more insured and, ultimately, healthier children. However, this goal will not be achieved unless states purposefully commit themselves to initiate effective outreach strategies to enroll eligible children and assure that they receive services. Outreach will be crucial to all states implementing CHIP, whether they chose to expand their Medicaid programs or create/expand a child health insurance program.

States' experiences in reaching newly eligible pregnant women and children as they have expanded their Medicaid programs over the past decade are relevant and instructive for this new effort. Most importantly, despite the expansions and states' efforts to reach the targeted populations, eligibility for coverage has not translated into actual coverage for millions of children. According to a recent state-by-state analysis of 1994 Census data by the Center on Budget and Policy Priorities, one-fifth of all children[4] whose family incomes made them eligible for Medicaid were not enrolled in the program, nor were they covered by any other form of insurance. This totals 2.7 million children.[5, 6]

The Center on Budget and Policy Priorities also examined the 1994 data for those children whose families did not qualify for cash assistance (AFDC or SSI), but who were poor enough to qualify for Medicaid only. While, historically, families who qualified for cash assistance were automatically enrolled in Medicaid, those with somewhat higher incomes could still be eligible for Medicaid due to expanded eligibility in their state, but they would have to learn about that, learn how and where to apply, and then take steps to actually enroll. When the Center reviewed the 1994 data for this Medicaid-only group, they found that almost two thirds, 62 percent, of these eligible children were not enrolled in Medicaid.[7] Not only is this is a key indicator of the lack of effectiveness of some states' outreach and enrollment efforts since the Medicaid

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[3]National Conference of State Legislatures, *State Options for Expanding Children's Health Insurance*, Washington, DC, May 1997.
[4]Eligibility is being phased-in by age group. This 1994 figure includes children under age 11.
[5]Summer, Laura, Sharon Parrott, and Cindy Mann, *Millions of Uninsured and Underinsured Children are Eligible for Medicaid*, Center on Budget and Policy Priorities, Washington, DC, April 1997.
[6]Estimates differ for the number of eligible but unenrolled children. GAO estimates 3.5 million.
[7]Summer, Parrott, and Mann.

expansions began in the 1980s, it also is important as states move to plan and implement CHIP which targets a very similar population.

The welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), adds more challenges to enrolling eligible children in Medicaid and in CHIP. The law replaces the AFDC entitlement with the Temporary Assistance for Needy Families (TANF) block grant and gives states much more flexibility to design new rules concerning time limits for receiving welfare cash payments and work requirements. For instance, under PRWORA states are no longer required to automatically enroll families in Medicaid who receive cash aid through TANF. Also, children may still be eligible for Medicaid once their families leave welfare for work but, as indicated above, most families not receiving cash assistance do not enroll in Medicaid. It also cannot be assumed that these families will be covered through work. Nearly 80 percent of uninsured children who were eligible for Medicaid in 1994 were in families with someone in the workforce.[8]

More recent Census data from 1996 reveal that one million children were dropped from Medicaid during that year alone. While the exact causes of this are unknown, it may well be that as families move from welfare to work, low income children are being dropped from Medicaid rolls, yet many if not most are still eligible for benefits.[9] Children in low income, working families such as these will be targeted for CHIP programs. Given the historically low Medicaid participation rates among poor working families, it remains to be seen how successful states will be in identifying and enrolling these children in CHIP.

Finally, once a child is enrolled, he or she must have access to the preventive and acute care he or she needs. It does little good to invest in outreach to find and enroll children in a program without also assuring that the system of care is well run and easily accessible. However, that has been a key issue with outreach for pregnant women and children under the Medicaid expansions.[10] Barriers to care have included systemic as well as personal issues, including:

- lack of transportation,
- overcrowded clinics with long delays in getting appointments or long waits in the waiting room,
- fear of doctors and medical tests,
- denial of being pregnant,
- doctors' unwillingness to see Medicaid patients,
- inconvenient clinic hours,
- the inability to get off work for an appointment, and
- no child care for other children.[11]

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[8] Ibid.

[9] Center on Budget and Policy Priorities, *Poverty Rate Fails to Decline as Income Growth in 1996 Favors the Affluent*, News Release, Washington, DC, October 14, 1997.

[10] Hill, Ian T., *Reaching Women Who Need Prenatal Care*, National Governors' Association, Washington, DC, 1988; and Brown, Sarah S., ed., *Prenatal Care: Reaching Mothers, Reaching Infants*, Institute of Medicine, National Academy Press, Washington, DC, 1988.

[11] US General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Receive Insufficient Care*, GAO/HRD-87-137, Washington, DC, September 1987.

Through collaborations with Title V Maternal and Child Health agencies and others, many state Medicaid agencies have worked to understand the problems facing this population and reduce the barriers to care they face, as will be discussed below. States will need to be alert to these types of barriers and possible solutions as they design, implement, and evaluate their CHIP initiatives.

States' Outreach to Medicaid Eligible Children

All states have worked to enroll eligible children in Medicaid, with mixed results. While research into why families do not enroll is quite limited, experience in the states have shown that they have many reasons. Some include:

- they may not know they are eligible,
- they may want to avoid the stigma of Medicaid as a "welfare" program,
- they do not see having Medicaid coverage as important,
- the application itself can be long and require documentation that the family does not have or does not produce in the time required for completing the process, or
- the program information may not be in the language they speak and/or they may be undocumented residents, resulting in their being unable to complete the entire process or being afraid to come forward, even if their children are citizens.

Most states, and to some extent Congress, have recognized these issues and have simplified the administrative and application processes, developed outreach systems and programs, and passed laws to facilitate the enrollment of children and families. States will be looking at these experiences as they design their new CHIP programs.

Administration and marketing. In many states, Medicaid agencies have collaborated with Title V Maternal and Child Health agencies to develop a more coherent and appealing program that will attract eligible families. Clearly worded and attractive brochures in various languages explain the availability of coverage and how to apply for it. Public service announcements and advertisements on billboards and the sides of buses have been used. Twenty-five state Medicaid agencies allow applications to be mailed in rather than brought to the welfare office.[12] Many states also run toll-free hotlines staffed with people knowledgeable about public health and related programs, available prenatal and pediatric care providers, and other information. Finally, in the interest of de-stigmatizing the welfare image of Medicaid, some states have renamed their expanded Medicaid programs, such as Vermont's Dr. Dynasaur and Rhode Island's RIteStart.

Simplify and shorten application forms and eliminate asset tests. The complexity and length of Medicaid application forms is a well known deterrent to enrolling in the program. It also has contributed to the welfare stigma of Medicaid and sends the message of exclusion rather than inclusion for those in need. As part of their effort to attract and enroll eligible children and families, most states have shortened the forms by reducing the number of questions and limiting the amount of documentation needed to

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[12] National Governors' Association, *MCH Update: State Medicaid Coverage of Pregnant Women and Children*, Washington, DC, September, 1997.

verify eligibility. Not only has this shortened the forms, it has decreased the time it takes applicants to complete them and states to determine eligibility. A related step that helps simplify and shorten applications that most states have taken is to eliminate questions about an applicant's assets for those applying only for Medicaid (that is, those not applying for cash assistance). As of August 1997, 31 states had dropped the assets test for pregnant women and 29 had done the same for children applying for Medicaid.[13]

Outstationing Medicaid eligibility workers. Another important step states have taken is to contract with community-based organizations familiar with the target populations to conduct outreach and enrollment activities. For these activities, states can use Medicaid administrative funds specifically designated for outreach and Title V Maternal and Child Health Block Grant funds. States are able to "outstation" Medicaid eligibility workers or train other individuals in community health centers and other locations frequented by low income families so they can perform the initial processing of Medicaid applications and help applicants complete the entire process. In some community-based organizations, these individuals do much more than just take applications. They are care coordinators who perform risk assessments, develop a plan of care, coordinate referrals of their clients to appropriate providers, and follow-up and monitor to ensure that services are received.[14]

Presumptive eligibility. Finally, presumptive eligibility is an eligibility determination process that Congress passed into law in 1986 that states can use to improve the enrollment of pregnant women in Medicaid. It allows "qualified" health care providers serving Medicaid beneficiaries, such as community health centers, to determine that a woman is eligible for Medicaid based on income information she provides, enroll her on a temporary basis right on the spot, offer her services, and receive reimbursement. From there, the woman has to follow through with a formal application within a certain time period to maintain enrollment.

Presumptive eligibility is used by 25 states[15] and seems to be an important strategy for boosting enrollment among pregnant women. A 1991 GAO study examined 10 states that had implemented a range of methods to expand eligibility and enrollment for pregnant women in Medicaid. The study found that states that both implemented presumptive eligibility and dropped the assets test experienced the fastest growth in enrollment. [16]

Moving children beyond enrollment to receiving services. In addition to encouraging the enrollment of children and pregnant women in Medicaid, many states have implemented strategies to help them gain access to services, especially preventive care such as prenatal care and well child visits. Medicaid and Title V funds have been used

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[13] National Governors' Association.
[14] Hill, Ian T., and Trude Bennett, *Enhancing the Scope of Prenatal Services*, National Governors' Association, Washington, DC, 1990.
[15] National Governors' Association.
[16] US General Accounting Office, *Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions*, Washington, DC, February 1991.

to employ and train care coordinators who work in community-based clinics and other local sites, as mentioned above. Care coordination can be effective in helping clients receive needed care and improve health outcomes. In a 1992 study of North Carolina's Baby Love (expanded and enhanced Medicaid program for pregnant women and infants) program, maternity care coordination was found to have been effective in reducing low birthweight, infant mortality, and newborn medical costs among babies born to women enrolled in the Baby Love program.[17]

Another strategy to help families gain access to services is home visiting. Medicaid and Title V funds have been used by several states to hire and train home visitors, either professionals such as nurses or lay workers from the community. In its review of home visiting, the US General Accounting Office found that home visiting can be an effective strategy for reaching at-risk families; educating them about healthy behaviors, good nutrition and the importance of prenatal care and well baby care; and assisting them in obtaining the services they need.[18]

Some states also have worked to coordinate and even co-locate services to create one-stop shopping for health, nutrition, social, and other services. Such efforts enhance access to care by improving the integration among programs and providers and increasing the ability of families to receive a range of appropriate services without having to go to multiple sites.[19]

These outreach strategies are quite varied and represent policy and programmatic means of identifying, enrolling, and serving the target population in Medicaid. Although a few individual states have evaluated the effectiveness of their outreach programs, and anecdotal evidence is plentiful concerning how well these methods work, broader based research has been very limited. Studies on outreach in other state-funded or privately-funded child health insurance programs are also quite limited. Nonetheless, these are key strategies states will turn to as they plan and implement CHIP.

Outreach and Related Provisions in the Balanced Budget Act of 1997

The need for outreach is recognized in the new law, but restrictions are placed on how much states can spend on such activities. In its plan for CHIP, the state must describe the outreach strategies it will implement using the new funds. Outreach should be targeted to families likely to be eligible for CHIP or another public or private health insurance program. The purpose of outreach is to inform them of the availability of coverage. States are limited in how much they can spend on outreach. Only 10 percent

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[17] Buescher, Paul A., *An Evaluation of the Impact of Maternity Care Coordination on Medicaid Birth Outcomes in North Carolina*, Center for Health and Environmental Statistics, Raleigh, North Carolina, 1992.
[18] US General Accounting Office, *Home Visiting: A Promising Early Intervention Strategy for At-Risk Families*, GAO/HRD-90-83, Washington, DC, July 1990.
[19] *One-Stop Shopping for Perinatal Services: Identification and Assessment of Implementation Methodologies*, Maternal and Child Health Bureau, Health Resources and Services Administration, Washington, DC, 1990.

of the amount of federal and state dollars a state spends can be used for purposes other than insuring children, one of these being outreach.[20]

States' plans must also describe how CHIP will be coordinated with other public or private health insurance programs. These include Medicaid, state employee benefit plans, and the Blue Cross and Blue Shield Caring for Children programs, among others.

The new law also includes two Medicaid provisions to improve children's enrollment and coverage in that program that can be used by any state regardless of whether they choose to expand Medicaid coverage or design their own insurance program under CHIP. These provisions, presumptive eligibility for children and optional 12 months of continuous coverage for children, are described below. If states coordinate these efforts with those they implement for CHIP, they have the potential to make significant contributions to states' efforts to enroll and effectively serve the maximum number of children possible.

Presumptive eligibility. The law allows states for the first time to implement presumptive eligibility procedures for children, similar to those discussed earlier for pregnant women, to improve enrollment of children in Medicaid. "Qualified providers" are like those allowed for pregnant women, but also include pediatricians, WIC programs, and Head Start programs. Other rules also are similar to those governing presumptive eligibility for pregnant women. Presumably at least the 25 states[21] who now use presumptive eligibility procedures for pregnant women will extend the process for children as well. Given the effectiveness for pregnant women of coupling presumptive eligibility with dropping asset tests (which most states also have done for children), this could be a powerful method for assuring enrollment of children.

Continuous coverage. The law gives states the option of providing 12 months of continuous Medicaid coverage for children regardless of changes in family circumstances during that period that would otherwise render them ineligible.[22] Once ineligible, families often do not reapply even if they may once again be eligible for coverage. Having coverage for a full year improves the likelihood that children will receive the vitally important preventive as well as acute care they need. Continuous coverage is particularly important for children in managed care plans because it gives their families time to understand the system and use it appropriately, the children can receive the scheduled child health supervision visits and immunizations they need, and the managed care organizations have the incentive to assure that children get needed preventive and acute care. This also may make it easier for other children's programs that have 12-month eligibility, such as Head Start, to coordinate their outreach and enrollment efforts with those for Medicaid.[23]

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[20] The four purposes are the provision of other child health assistance for targeted low income children, administrative costs, outreach, or direct health service initiatives for targeted and other low income children.
[21] National Governors' Association.
[22] States already had to provide continuous coverage for pregnant women through 60 days postpartum and for infants through age one.
[23] Center on Budget and Policy Priorities, *Facilitating Enrollment of Children in Medicaid*, Washington, DC, August 5, 1997.

Outreach provisions under welfare reform

As noted earlier, with the "delinking" of Medicaid eligibility from welfare eligibility under the TANF program, it is likely that even more children will not enroll in Medicaid unless states undertake outreach and educational steps to find them. In recognition of this, Congress included a total of $500 million in federal Medicaid matching funds in PRWORA, the welfare reform law, at enhanced rates to help states ensure that children and parents do not lose Medicaid coverage because of welfare reform. While outreach is considered an administrative activity and is matched at a 50 percent rate, states now may receive federal funds for as much as 90 percent of their efforts to inform potential beneficiaries about Medicaid and facilitate their enrollment. Presumably, at the same time, states could use this process to also inform families of the new CHIP program. Not much is known yet about what states will be doing with their funds, but this is a significant source of help that, if used to its greatest extent, could contribute considerably to reducing the number of uninsured children throughout the states.[24]

Topics for potential research for GU Collaborative consideration

Although the new CHIP holds great promise for insuring children, several challenges that have confronted states in their attempts to translate Medicaid eligibility into enrollment will also confront them as they work to enroll children in CHIP. What they have learned from their successes and failures with Medicaid and with state-only insurance programs will be very helpful to their efforts to create effective CHIP programs. Sound information will lead to effective use of funds, including the new infusion of federal dollars available through PRWORA.

Other than analyses and evaluations of their own experiences, states have little data to rely on as they implement CHIP. A review of the literature revealed limited research on outreach or enrollment strategies in Medicaid and nothing on state-only insurance programs. While discussions of enrollment issues and case studies of state efforts are available,[25] in depth analyses of what works, in what circumstances, with what populations, and at what costs, was not found. However, the need for such research has been well documented. [26] Another related concern is that those now planning and implementing CHIP are not necessarily the same people who implemented the Medicaid expansions. Their ability to learn from previous Medicaid experiences in their own states may be limited.

For the purposes of the Georgetown University MCH Policy Collaborative seminar and discussion, we have defined outreach along a continuum from strategies to improve

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[24]Cohen Ross, Donna, *New Medicaid Funding for Outreach and Enrollment Activities*, Center on Budget and Policy Priorities, Washington, DC, August 18, 1997.
[25]Summer, Parrott and Mann; and US General Accounting Office, *Prenatal Care.*
[26]Gauthier, Anne K., and Stephen P. Schrodel, *Expanding Children's Coverage: Lessons From State Initiatives in Health Care Reform*, Alpha Center, Washington, DC, May 1997; and Dubay, Lisa and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?", *Health Affairs*, vol. 16, no. 1, January/February, 1997.

case-finding, to increase enrollment, and to improve the target population's actual receipt of care. Several of the questions below focus on outreach efforts that move a child beyond enrollment in Medicaid or a CHIP program to actually receiving services. Being enrolled in a program doesn't necessarily mean a child will receive appropriate services in a timely manner. For many children from low income, high risk families, efforts beyond just giving them an insurance card are very important. Research on this aspect of outreach is of interest to the federal government, states, and the National Center for Education in Maternal and Child Health and may be of interest to GU Collaborative members as well. Questions are grouped by discipline area to facilitate review, even though many will clearly require cross disciplinary study. This list is not meant to be exhaustive, but rather to be illustrative of possible areas. Speakers at the seminar will bring many more suggestions to the table as well.

Public Policy Issues

1. Federalism—CHIP exemplifies another move toward devolution, with tremendous authority given to the states to design and administer these child health insurance programs. Will states develop widely disparate CHIP programs? How will states use this new authority to design outreach programs? What state characteristics will determine how expansive or restrictive their efforts will be, particularly with respect to designing outreach programs to draw in the most children possible? What are the appropriate roles of government at the federal, state and local levels as CHIP unfolds to assure that the program's national goals are met?

2. Performance measures—CHIP includes a requirement to provide data on performance measures, as will be required of all federal programs by 1999 through the Government Performance and Results Act. The ability of states to achieve improved health outcomes for children will be highly dependent upon how well states use outreach strategies to find, educate, enroll and provide services to children. How much of an incentive is this requirement to the states to design and implement effective outreach and what else, if anything, would help move them in that direction? Will the CHIP performance measures be influenced by other block grant programs that require such measures, such as the Title V Maternal and Child Health Services Block Grant? Other questions that could be studied include: a) did the state use all of the block grant funds available to them? b) how many children were served through the program? c) what services are included in the benefits packages, and d) did states report improvements in health outcome measures?

3. Agency mission—Outreach includes strategies for increasing enrollment in health insurance programs AND helping children to gain access to health system providers. How will government agencies which have traditionally been responsible for administering or overseeing health benefits (e.g., Medicaid agencies and state insurance commissioners) handle this dual mission? What factors, internal or external, make such an agency more effective in carrying out both missions?

Ethical Issues

1. Undocumented residents—Undocumented resident children are not eligible for benefits through the CHIP program and are only eligible for emergency services through Medicaid. What are the ethical implications of this policy and its effects on outreach strategies?

2. Children born in the United States to undocumented residents—Undocumented residents may hesitate to enroll their eligible children in CHIP for fear of deportation. What are the ethical implications and questions states should address as they design CHIP and, particularly, outreach strategies?

3. Distributive justice—Some states may choose to provide a less rich benefits package to more children, while others choose to provide a richer benefits package to fewer children. What are the ethical implications and questions states should address as they pursue any of these diverse approaches?

Public Health Issues

1. Community based providers—It is important to note that, historically, public health agencies and community based providers, such as community health centers, WIC clinics, and Title V funded clinics, have been at the forefront with the most experience conducting outreach for this population. A good understanding of how they can best continue to provide this service to children and their families in a changing health care environment would be valuable.

2. Managed care and outreach—State Medicaid programs are increasingly turning to managed care organizations (MCOs) to provide services to children and families, and enrollment in managed care for the general population is rapidly growing. Undoubtedly as states implement CHIP, many if not most will turn to MCOs to provide services to enrolled children. To date, a number of states have contracted with MCOs to educate current Medicaid beneficiaries about managed care and enroll them in their plans.[27] It is conceivable that states may choose to have MCOs conduct some aspects of outreach and enrollment for their CHIP programs. How best could MCOs contribute to this traditional public health function? Can conflicts of interest be avoided and how?

3. Enrollment brokers—A different, new twist on outreach to raise enrollment in managed care has been for states to contract with enrollment brokers to educate and enroll Medicaid beneficiaries. Brokers range from national claims processing firms to local, county-based companies that are familiar with the Medicaid or cash assistance population. While the use of enrollment brokers has been limited to switching current beneficiaries from fee-for-service Medicaid into managed care, such strategies themselves or information about them could be useful to states implementing CHIP. Little has been written about how enrollment brokers work,

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[27] Some states have contracted with MCOs to enroll Medicaid beneficiaries in managed care. In a number of states, this has led to MCOs' engaging in unscrupulous practices to maximize enrollment without providing services. As a result, many states have banned or restricted their direct-marketing activities. (US General Accounting Office, *Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care*, GAO/HEHS-96-184, Washington, DC, September 1996.)

but their numbers are likely to rise as more states implement and expand their use of managed care for Medicaid as well as for CHIP.[28]

4. Reaching different target populations —States will need to implement different outreach strategies for different populations, such as children in families at varying income levels, those with parents who work and those who do not, or those living in rural versus urban areas. What have states learned from their Medicaid experiences that will help as they now plan CHIP?

Economic Issues

1. Premiums and co-payment levels—The effect of personal economic issues on enrollment rates, such as the level of premiums and subsidies charged for coverage, have not been well investigated, but some states have considerable experience with trying different approaches with varying results. This should be of particular importance to states that decide to implement a child health insurance program rather than or in addition to Medicaid because they will have wide latitude to decide how to set up and administer these programs. Co-payment levels need to be determined which provide program funds without significantly decreasing the demand for services.

2. Sustainability—What will happen to the funding strategies for CHIP programs when the economy changes?

The opportunities states now have with the enactment of Title XXI of the Social Security Act, the State Children's Health Insurance Program, are tremendous. The goals of the program, however, will not be met unless states do an effective job of finding and enrolling children. Unfortunately, states' successes in outreach and enrollment for their expanded Medicaid programs over the past decade have been mixed. While they have instituted a number of strategies and administrative procedures to identify eligible children and raise enrollment, the success of these programs has not been well studied or disseminated. Thus, states have limited information to go on as they design their new CHIP programs. Research from various perspectives on these topics would benefit state program managers, policymakers, and others who are interested and involved in improving children's health and well-being.

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[28] US General Accounting Office, *Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care*, GAO/HEHS-96-184, Washington, DC, September, 1996.