Chapter 7.
Reaching the Uninsured through Outreach

by Andy Fouché and Ben Salinas

Federal SCHIP

Many states have launched aggressive statewide campaigns aimed at enrolling uninsured low-income children in SCHIP. States can spend up to 10 percent of their SCHIP allotment on program administration, direct child health services, and outreach.[1] In order to receive the federal funds for outreach the state must first spend money on outreach activities. Once this has occurred, states can then submit a claim to the federal government and be reimbursed for a proportion of that amount. Methods for outreach have included school-based strategies and partnerships with community-based organizations (CBOs). Some states have targeted hard-to-reach populations, for example, those with language barriers or those who are isolated geographically.

Recent research indicates that SCHIP is not utilized by many of the children who are eligible for it. Because the program is relatively new, many start-up issues confront the program, one of the most prominent being lower-than-expected enrollment levels. According to the Health Care Financing Administration (HCFA), an estimated 1 million children in the United States were enrolled in SCHIP as of December 1998, and 2 million during FY 1999.[2] More than 1.2 million of these children are served by separate state programs, while about 700,000 took part in Medicaid expansions. According to HCFA, 3,333,879 children were enrolled in either SCHIP or Medicaid expansions for fiscal year 2000.[3] According to the American Academy of Pediatrics, over two-thirds of the total number of uninsured children, or 11.2 million, are Medicaid- or SCHIP-eligible but are not enrolled in either program.[4]

Applications for SCHIP must first be screened for eligibility for Medicaid. As a result, CBOs believe that when outreach is widely implemented to inform individuals about SCHIP, Medicaid will experience increased participation as well, potentially affecting 460,000 children a year through FY 2002. The Congressional Research Service (CRS) reports that between December 1998 and June 1999 Medicaid participation rates rose by 216,874, with “28 percent due to enrollment via expansions of Medicaid through SCHIP.”[5] It is important to note, however, that many states are operating under a joint Medicaid and SCHIP program, which accounts for some of the 28 percent increase.

Significant increases in SCHIP enrollment can be explained by greater significance being placed on outreach efforts. HCFA states that nearly 2 million children were covered by SCHIP between October 1, 1998, and September 20, 1999. This is double the amount of enrollees in December 1998. HCFA also estimates that these trends are continuing, with estimated enrollment increasing by more than 80 percent between the second quarter of FY 1999 and the second quarter of FY 2000 in the 43 states in which data was available. Nineteen of these states reported doubling, and nine reported tripling, their number of enrolled children.[6]

Outreach

A study by the Robert Wood Johnson Foundation illustrates just how important outreach efforts are in getting children enrolled into SCHIP. According to that study, six out of ten families that qualify for SCHIP do not believe that the program applies to them.[7] In addition, the study found that 82 percent of these families would enroll their children if they believed that they qualified for the program.[8] This illustrates the importance of outreach efforts, because it seems that the main barrier to getting children enrolled is parents' lack of information.

The belief that "SCHIP does not apply to me" has made it increasingly difficult to reach families between 150 and 200 percent of poverty. These families, unfortunately, often believe that they earn too much money to be on SCHIP, but at the same time they lack the resources needed to purchase their own insurance. For this reason the new wave of advertisements for SCHIP will touch on the idea of "people like me." The new ads will reach across Texas to help inform a large range of families with different backgrounds about the program.

The SCHIP program also has another advantage in getting eligible children enrolled: it lacks the "welfare stigma" because it is not associated with Medicaid. Since SCHIP has been marketed as insurance, complete with a small monthly premium, families have a sense of ownership and do not see it as a handout. This makes more families likely to enroll their children. As Rosa Gomez, an East Austin resident and a single parent of two SCHIP children, said, "I can take care of my boys and get them insurance and not have to get help from the government. I pay for it with my money."[9] Ms. Gomez feels responsible for providing for her children and is proud that this is not a handout, even though the government sponsors it. In addition, by being given personal assistance with the application process, candidates are less likely to make errors on the application that might prevent them from becoming insured.

According to some CBOs in the Lower Rio Grande Valley, is that because SCHIP has tried to distance itself from the State of Texas, it has run into the problem that some families fear its merits are too good to be true. As a result, some SCHIP literature has started to include an endorsement by the State of Texas in order to reassure these families. Trying to prevent the welfare stigma from setting in now must be balanced with the need to prove legitimacy.

Schools are one of the most effective and trusted places to focus outreach efforts. Because schools operate within a small area, they are better able to understand the specific needs of the community. As a result, the schools already have this information and have interacted with those students who may be eligible for SCHIP. In addition, parents trust schools to provide valuable information. Because of this, some welfare stigma can be avoided because the school instead of some government agency suggesting the program. Parents already trust their children to the care of the school for education, and sometimes to that of school nurse for health concerns. The only real problem is that schools do not always have the resources available to effectively focus attention on outreach efforts for SCHIP; they still can aid, however, in outreach efforts. According to

TexCare Partnership, 50 percent of the Texas families enrolled in SCHIP first heard about the program from their children's schools.

Since schools have limited resources, it is sometimes difficult to convince them to participate in outreach efforts. After all, education is the schools' primary focus. On the other hand, there is evidence that students without health care are more likely to miss class, and when more students attend class, the average daily attendance count is raised, which increases school funds.[10] In addition, if schools are rewarded for their efforts with public praise for getting students enrolled, both the students and the schools will benefit.

Texas has made an effort to attach the SCHIP program to public schools' free-lunch programs. An estimated 96 percent of all public schools participate in the free-lunch program.[11] In order to qualify for free lunch, a family's income must be at or below 185 percent of poverty. SCHIP eligibility, on the other hand, is 200 percent of poverty. Those who qualify for free lunch are likely, therefore, to be eligible for SCHIP or Medicaid. Texas is including a brochure about SCHIP in the free lunch enrollment package. This process could even be modified to allow schools to share information about free lunch program enrollees with the SCHIP and Medicaid office by including a check box on the free lunch application to give permission to share this information. New Jersey's KidCare program uses such a check box. One important drawback of school outreach is that it only reaches children of school age and their siblings.

SCHIP Budget in Texas

Constraints on resources is one important element of the picture that must be considered when examining SCHIP outreach. Money is, unfortunately, a concern and lack of funds will limit the amount of outreach possible. It is obvious that with more resources available for outreach Texas could do much more.

Table 7.1 illustrates a general breakdown of how SCHIP outreach money is being spent. Advertising and community-based organizations receive the largest chunk of this money because these are believed to be the most successful forms of outreach. In fact, other forms of outreach are not even being budgeted for in 2002 and 2003. Table 7.1 also demonstrates the increasing cost of administrating this program. For a complete breakdown of the SCHIP budget in Texas, including the costs of benefits, see Appendix E.

Table 7.1. SCHIP Budget in Texas

	Expended FY 2000	Budgeted FY 2001	FY 2000/ 2001 Totals	Requested FY 2002	Requested FY 2003	FY 2002/ 2003 Totals
Advertising	$1,488,970	$7,417,062	$8,906,032	$4,000,000	$4,000,000	$8,000,000
CBOs	1,629,757	4,781,587	6,411,344	6,500,000	6,500,000	13,000,000
Other Outreach	80,032	160,027	240,059			
Other Administrative Costs	6,095,093	25,781,711	31,876,804	25,964,055	25,176,611	51,140,666
Total	$9,293,852	$38,140,387	$47,434,239	$36,464,055	$35,676,611	$72,140,666

Source: Telephone interview by Andy Fouché with Marla Young, Budget Analyst, Health and Human Services Commission, Office of Budget Analysis, Austin, Texas, March 5, 2001.

Successful Outreach Programs

Perhaps the most effective outreach mechanisms in Texas are those implemented through community-based organizations. The reasoning for this is simple: individuals tend to trust local organizations more than those mandated by the state or federal government. The personal connection that CBOs have with their local constituents fosters an environment extremely beneficial to the outreach process. A complete list of CBOs can be found on the TexCare Partnership website at http://www.texcarepartnership.com.

The West Texas CHIP Coalition, located in Lubbock, is a perfect example of the interpersonal relationships developed to facilitate enrollment. At town hall meetings chocolate chip cookies are served, and movies are provided to keep children entertained while the parents listen to presentations. Another way of spreading the message in Lubbock was to add slips of black and orange CHIP messages to trick-or-treat bags at Halloween, with the message that it is scary for kids to be without health insurance.[12]

The Shackelford County Resource Center, in Region 1, uses its Promotora program as well as one-on-one assistance to get completed applications. This CBO has enrolled 76 percent of the SCHIP-identified population by using individual attention.[13] Individual attention is considered one of the most effective outreach tools for enrollment because it establishes trust between parents and the SCHIP contact person. Working one-on-one is much more preferable to being shuffled through a government bureaucracy.

HCPHES, a Harris County CBO, has partnered with local Head Start providers to train counselors for enrollment. Each family that enrolls its children in Head Start without insurance receives assistance in completing the TexCare application, ultimately resulting in hundreds of completed applications. The Houston area has also had great success with Fiesta supermarkets in creating "CHIP Enrollment Days." In the last year, four Fiesta campaigns held on weekends assisted over 3,182 families. Other methods of assistance in the Houston area include training school nurses and Harris County Hospital staff on

application procedures, training ministry groups, and training the managers of the Free and Reduced School Lunch program.[14]

SCHIP outreach and CBOs have also found great success when teaming up with religious institutions. Many families trust information gained from religious figures and organizations. Since religion touches many aspects of people's lives, it is a powerful tool in helping families find the healthcare they need.

Outreach is an effort that is a public process, as can be seen from these examples. A collective community effort is demonstrated in the relationships that CBOs attempt to build with the people whom they serve. By building these relationships and providing much-needed assistance, insurance coverage for all of Texas' children becomes a greater possibility.

To further aid the CBOs, the Texcare Partnership has started gathering a list of best practices from them. Since Texas allows the CBOs great latitude in performing outreach, many CBOs discover effective and exciting methods to get people enrolled. To help spread good practices, the Texcare Partnership then distributes these lists to other CBOs to decide if some of these plans may work in their areas. An open flow of information is vital to the program's success.

Enrollment Facilitation and Outreach

Successfully enrolling all Medicaid and SCHIP-eligible children "will depend at least in part on two different, but interrelated activities—enrollment facilitation and outreach."[15] Although at first glance these two methods might appear the same, they have different characteristics. Enrollment facilitation involves simplifying the outreach process. Applicants gain easier access to the process through changes such as using implementation of school lunch programs and allowing faxed or mailed-in applications. Outreach of SCHIP involves marketing the program with advertisements and establishing communication outlets such as informational hotlines. As mentioned earlier, one of the largest problems that SCHIP faces is the image of a welfare program. Through outreach programs, the attempt is to educate the public about the benefits of SCHIP in order to start the application process.

Texas SCHIP Performance

In order to understand what must be done to enroll more eligible children in SCHIP, the progress made so far must first be analyzed. The enrollment goal for the program is 428,000 children by September 1, 2001, averaging 29,000 per month. After six months of operation, the SCHIP program enrolled 20.9 percent of the targeted amount, "equaling 100,033 children who [were] previously uninsured as defined by SB 445, 76th Texas Legislature."[16] For fiscal year 2000, Texas enrolled 130,519 children through Medicaid expansion (45,545) and SCHIP (84,974).[17] As of February 26, 2001, the estimated number of children enrolled in SCHIP was 267,097. The actual number of children receiving services totals 265,805, and there are an estimated 1,292 enrollees not yet receiving services.[18]

The following state comparisons are made because the states' Medicaid income eligibility standards and demographics are comparable to those of Texas. Six months after initiating SCHIP, these states enrolled the following percentages of their targeted population:

- 9.15 percent in California
- 9.00 percent in Florida
- 7.24 percent in Michigan
- 16.75 percent in New York.

To achieve the level of enrollment experienced in six months in Texas, it took

- 11 months in California
- 13 months in Florida
- 13 months in Michigan
- 8 months in New York.[19]

The other side to this story is that Texas got a late start on the program and as a result was one of the states that had to return money to the federal government. This was due in part to the biennial legislative system in Texas. Most states had been participating in the SCHIP program much longer than Texas, and this allowed Texas to learn from other states' examples. Considering that according to the U.S. Census Bureau, 23.3 percent of Texans are without insurance, Texas—one of the worse states for coverage—should have been more of a leader in developing this program.

SCHIP Outreach

As the Committee on Public Health noted, "Initial outreach expenditures were constrained by the federal and state statutory requirements limiting administrative outlays for the program which could be matched with federal dollars."[20] As knowledge has been gained on how to expand outreach efforts, including the addition of funds, original projected levels will continue to increase.

One of the many challenges that faced the program in 1997 when the federal government allocated $48 billion to SCHIP was the limited resources for program management. In Texas in 2000, with an estimated 22,000 application contacts and more than 151,000 telephone contacts, the call center was often overloaded with information seekers, which resulted in slow response times to the customers. In response to this the Health and Human Services Commission implemented a strategy that included immediate resolution of consumer-specific complaints; consultation with CBOs, advocates, and contractors; and identification and resolution of shortcomings in the system.[21]

This strategy included the hiring of additional call center staff, introduction of a system for forwarding calls to specific staff members who could best answer certain questions,

automation improvements, clarifying written materials sent to applicant families, and the improvement of community-based organization communication.[22]

As was mentioned earlier, outreach efforts are expanding rapidly in order to serve as many Texas children as possible. Community-based outreach efforts currently being used are:

- Back-to-school activities, including as many as four million fliers being sent home with Texas school children
- Telethon planning underway in several communities
- Applicant contact information being shared with contract CBOs to conduct local follow-up upon incomplete applications.[23]

Because of the size of Texas and its great level of diversity, outreach efforts are vital to the success of the SCHIP program. In order to reach as many people as possible, Texas has developed a series of approaches to its outreach efforts. As reported by Don A. Gilbert, Commissioner of Texas Health and Human Services:

> Through the CHIP Medicaid expansion the state did learn that dissemination of information is not enough to guarantee that consumers will apply for health insurance. A multi-faceted outreach effort needs to be utilized. Media mainly serves as a vehicle for program awareness and a call to action to apply. Meanwhile, grassroots outreach efforts including application assistance is the most effective way to ensure consumers will apply for health insurance.[24]

As Commissioner Gilbert's comments point out, informing people about the program is not enough by itself. Not only must people be aware of the program, but they must also know how to enroll and complete that process successfully. Outreach efforts in Texas not only aim at informing people about CHIP, but helping people through the process.

The first step of the Texas outreach plan is to inform people of the program. To achieve this goal, Texas used both Spanish and English in its media campaign to reach as many people as possible. Already, the State of Texas has produced 60,000 posters and 300,000 flyers in both languages and allowed them to be adapted at local levels to add to the program's appeal.[25] This local level appeal included sending materials to school principals to promote in schools.[26] Because the program was given a local flavor, potential applicants felt that the program was designed for people like themselves and, as a result, were more likely to apply.

In addition to the fliers, Texas has produced television and radio commercials in both languages and teamed with local television and radio stations to produce public service announcements. Some television stations have even agreed to do telethons to supply viewers with information around the news hours. One useful spot is known as the "Children's Health Minute," a series of 60-second radio spots that focus on child safely and are distributed to Texas radio stations. Often, the stations chosen for this free

exposure are those with the largest audiences. By utilizing these resources, a large range of people can be exposed to the SCHIP program while spending little or no money on actual outreach.

Besides mass marketing, it is important that the SCHIP program has a human element. Focus groups have found that people are more likely to apply when they have one-on-one contact. In order to achieve this, Texas has worked "closely with the entire network of public health providers to disseminate outreach materials to providers so that they may supply information to families with potentially eligible children."[27] This has led to the program working in conjunction with Texas' EPSDT program, Texas Health Steps, and its Title V program.[28] Both the Texas Workforce Commission and Attorney General's Office promote the CHIP program in their daily business. In addition, TexCare application assistance is offered at targeted hospitals.

The CBOs' trained staff performs outreach through strategies including face-to-face and telephone meetings and home visits in approximately 500 local offices of the Texas Department of Human Services.[29] This process adds the human element that is so vital to SCHIP enrollment and keeps the SCHIP representatives informed about the specific needs of the people affected. This has been found to be especially useful to immigrants who may be afraid that this program will affect their immigration status.[30]

In addition, these workers are stationed at health clinics and provide referral services to potential applicants. For example, "applicants for food stamps and Temporary Assistance to Needy Families will be screened for potential Medicaid eligibility."[31] If the worker believes the applicant may be eligible for SCHIP or Medicaid, then he/she will be informed about the potential of accessing these programs. By making the different programs work together, a lot of frustration can be prevented for the applicants. In addition, making use of resources available at no additional cost once again saves money.

To further this one-on-one interaction, the TexCare Partnership has teamed up with companies such as HEB, Randall's, Reliant Energy, Diamond Shamrock, and Kmart, among others, to reach the public in the stores that they trust. By having this sponsorship, TexCare is able to distance itself from the "welfare stigma" and reach people who may miss other outreach activities. H&R Block, for example, suggests SCHIP to families that appear to qualify when they come into the office to file their taxes. Walmart has also placed TexCare brochures in the baby sections of their stores. When the stores that people trust suggest SCHIP, it makes parents more likely to look into the program.

Additionally, outreach spending of $4 million will be added to the existing $7 million already in use for 2000-01. The additional money comes from the unspent money that is being returned to the states. This additional funding will be utilized for the enhancement of state and local advertising and media campaigns in English and in Spanish, provide additional funding to CBOs for assistance and outreach activities, and allow revisions of printed materials.[32]

All of these activities are important. As State Representative Glen Maxey pointed out in an interview, however, the most effective motivator is a trusted person who knows the system, can recommend the program, and will help the applicant apply. As a result, the closer the connection to the outreach, the higher the rate of successful applicants. It is for this reason that places like San Antonio, especially with the Hispanic populations, have found great success when utilizing religious institutions in their outreach efforts. Since CBOs have a good feel for what appeals to specific areas, outreach is most successful when it is targeted through the CBOs, because they provide individual attention to facilitate the enrollment process. Maxey points out that outreach must go from knowledge of the program (recognition base), to acceptance, to the final stage of implementation (action base).[33]

Medicaid Outreach and Expansion

Instead of relying on Medicare for seniors, the option of expanding Medicaid to cover seniors, as well as persons with disabilities (with income levels below 100 percent of poverty), should become more accessible. The federal government has given this option to many states to increase the coverage of these groups; however, the states have not taken advantage of this or other possible means of Medicaid expansion.[34]

Most seniors and persons with disabilities rely on Medicare for health coverage. Just as important, however, is the use of the Medicaid program for these same individuals, because it pays Medicare premiums, deductibles, and copayments, as well as paying for programs that might not be offered under Medicare. For example, all states' Medicaid provisions pay for a portion of prescription drugs, and some states' Medicaid coverage pays for podiatry, eye examinations, eyeglasses, dental services, and assisted living services.

Several studies have shown that Medicaid increases access to health care by increasing the rate at which seniors and disabled individuals visit a doctor. They are less likely to worry about costs if covered by Medicaid and more likely to get regular check-ups than they would if covered solely by Medicare.

The role of the federal government is an important one, with regard to both its matching dollars and outreach capabilities. The federal government hopes to help expand the role of Medicaid by "informing states of their ability to liberalize eligibility for seniors both by providing poverty-level coverage, and by liberally disregarding income and resources under Section 1902(r)(2) of the Social Security Act."[35]

National Policy

While it is still too early to understand the full effects of the SCHIP program, it will be important in the future to more fully evaluate the extent to which SCHIP has been successful in meeting its goal of insuring low-income children. Several methods of analysis could be useful in assessing the SCHIP program. These methods include case studies, focus groups, and surveys.

One group that outreach could be directed toward is employers. Many employers want to provide insurance to their employees, but may not be able to afford to. In addition, many employers may not provide coverage to an employee's entire family. By reaching out to the employers, they will then be able to suggest alternatives to their employees. Most people who do not have insurance are employed. This tool can be especially powerful if outreach is done to small businesses.

One major problem for CHIP is that of transferring children from Medicaid to CHIP and vice versa. The same application, unfortunately, is not used for both programs, even though requirements are similar. As a result, parents get shuffled between the two, which often causes confusion, frustration, and lapses in coverage. Since the goal is to provide health insurance to children, this process should be made as easy and fluid as possible.

This policy problem could be easily remedied if some simplification steps were taken. First, a uniform application for kids to participate in both programs should be developed. If this were done, parents would not have to worry about figuring out which child should apply for which program. In addition, as a child ages, parents would not have to go through the process of switching them from one program to another, because a computer system could then automatically perform these switches. Parents would have to worry only once about filling out the application and then mailing in a tax return once a year to show that their incomes have not changed. By adopting these changes, lapses in coverage that are due to the transfer process between the two programs would be avoided.

At the present time, much concern is being shown about Medicaid enrollment and quality in light of the state's implementation of SCHIP and the recent court decision in *Frew v. Gilbert*. The judge's written opinion laid out many flaws in the state's Medicaid system, especially with regard to access, enrollment, and quality. This decision has led many to compare the complexity of the Medicaid enrollment process to the simplicity of SCHIP enrollment. The ease in completing the SCHIP application can be credited mostly to there being to requirement for face-to-face interviews or an assets test, SCHIP's two-page application, minimal verification, and a 12-month continuous enrollment, as contrasted with the required steps in the Medicaid application process. Many are trying to change these frustrating differences between the two programs.

Another important outreach method is that of helping families grasp that insurance and prevention are important. Some families do not understand the need for insurance because coverage has never been offered to them. When they learn about the SCHIP program, therefore, they do not see why it is necessary, because if their children become sick, they go to the emergency room. If families are taught about the importance of prevention, finding eligible SCHIP applicants may become even easier.

Learning from Other States

Simply because it got a late start, Texas has been able to learn a great deal from other states. Because HCFA maintains an outreach clearinghouse on its website, states can see what is working in different states. Texas has relied heavily on other states' experiences

and has made their successes work for it while avoiding their mistakes. The following are a few interesting state examples that may further help the state of Texas fine-tune its outreach efforts.

New Jersey

New Jersey has been a leader in school outreach efforts. By using the resources available within schools, the state has been able to target eligible kids. For example, KidCare presents enrollment events during registration for kindergarten and pre-K, and provides information at other times, for example by including brochures in report cards.[36] As a result, the family of every child entering a public school is at least exposed to the program. Also, to further help families, school nurses and child study team members have been trained to assist in identifying eligible students and to help families complete the application.[37] Families view schools as credible sources of information.

In addition to training, New Jersey has teamed up with other agencies to target specific groups of people. For example, the Department of Taxation processed family statistics, including children's ages and income levels. Using these records, the New Jersey Department of Taxation has "identified some 359,000 families that meet the KidCare income definition. DMAHS recently targeted a sample of 1,000 to receive information on KidCare."[38] By limiting mailouts to families that appear to qualify based on data already collected, both time and resources can be saved and used for other outreach methods.

Other participating agencies include the Department of Motor Vehicles, which has begun to include KidCare brochures in mailings for car registration and license renewals.[39] Although this method is not as targeted as the Department of Taxation's mailout, it is still useful in getting the word out. Also helping spread the message are the banking and insurance industries. Banks have agreed to display materials and include KidCares message with bank statements. Both of these measures are based on the idea that more exposure and access will increase enrollment. At the same time, the state saves money on outreach costs by using resources already available.

New York

Like Texas, New York has worked to team up with private business to reach as many children as possible. One such company is McDonald's, which has agreed to print CHIP information on their tray liners.[40] Since McDonald's is a restaurant targeted to children, it is the ideal place to market the program.

Also, in an attempt to reach children, New York has targeted state agencies that primarily deal with children's issues. One such important agency is Child Support Enforcement.[41] Since single parents already trust this agency, it is seen as an ideal candidate to approach parents about children's health care needs.

Florida

Florida has begun using technology in an outreach effort to simplify the process. Currently, the state is attempting to develop scanning procedures to transfer an applicant's information from one computer to another.[42] This will allow for greater ease in processing applicants to and from different programs as well as speeding up their reenrollment.

Florida is also interested in tracking current trends in outreach efforts. By creating an Interagency Coordination Project, Florida is developing methods to track changes in enrollment and "develop linkages to hard-to-reach populations."[43] By better understanding such trends, improved outreach methods may be developed.

Notes

[1] U.S. Department of Health and Human Services, *HHS Fact Sheet: The State Children's Health Insurance Program (SCHIP)*, (Washington, D.C., February 24, 2000), p. 3.

[2] Health Care Financing Administration, *The State Children's Health Insurance Program, Annual Enrollment Report, October 1, 1998-September 30, 1999* (Washington, D.C., January 2000), p. 2.

[3] Health Care Financing Administration, *HCFA's FY2000 SCHIP Aggregate Enrollment Statistics*. Online. Available: http://www.hcfa.gov/init/fy2000.pdf. Accessed: March 5, 2001.

[4] American Academy of Pediatrics (AAP), *SCHIP Update*. Online. Available: http://www.aap.org/advocacy/69wkrep.pdf. Accessed: March 5, 2001.

[5] Congressional Research Service, Report for Congress, *Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?* (Washington D.C., May 1, 2000), p. 9.

[6] Health Care Financing Administration, *Aggregate Enrollment Statistics for Federal Fiscal Years 1999 and 2000*. Online. Available: http://www.hcfa.gov. Accessed: March 5, 2001.

[7] American Academy of Pediatrics (AAP), *SCHIP Update*. Online. Available: http://www.aap.org/advocacy/69wkrep.pdf. Accessed: November 16, 2000.

[8] Ibid.

[9] Interview by Andy Fouché with Rosa Gomez, Austin resident and CHIP consumer, Austin, Texas, March 3, 2001.

[10] Interagency Task Force on Children's Health Insurance Outreach, *Report to the President on School-Based Outreach for Children's Health Insurance* (Washington, D.C.: Secretary of Health and Human Services, June 18, 1998), p. 2.

[11] Ibid., p. 1.

[12] Lynn Denton, TexCare Partnership, "CBO Best Practices" (Austin, Texas, draft February 2001), p. 1.

[13] Ibid., p. 2.

[14] Ibid.

[15] Congressional Research Service, *Reaching Low-Income,Uninsured Children,* p. 9.

[16] Committee on Public Health, Texas House of Representatives, *Interim Report to the 77th Texas Legislature* (Austin, Texas, October 2000), p. 7.3.

[17] Health Care Financing Administration, *HCFA's FY2000 SCHIP Aggregate Enrollment Statistics*.

[18] Texas Health and Human Services Commission, *Eligibility and Enrollment Activity Report*. Online. Available: http://www.hhsc.state.tx.us/chip. Accessed: March 5, 2001.

[19] Committee on Public Health, *Interim Report*, p. 7.4.

[20] Ibid., p. 7.5.

[21] Ibid.

[22] Ibid., p. 7.6.

[23] Ibid.

[24] Don A. Gilbert, Commissioner of Texas Health and Human Services, "Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act." Online. Available: http://www.hcfa.gov/init/txeval98.pdf. Accessed: December 7, 2000. p. 60.

[25] Health Care Financing Administration, *Texas Outreach Practices*. Online. Available: http://www.hcfa.gov/init/outreach/facttx.htm. Accessed: December 7, 2000.

[26] Ibid.

[27] Health Care Financing Administration, *Texas Title XXI Fact Sheet*. Online. Available: http://www.hcfa.gov/init/chpfstx.htm. Accessed: December 7, 2000.

[28] West Governor's Association, *The State Child Health Insurance Plan (SCHIP) Western State SCHIP Implementation Update for the Fifth Annual Western Summit on Indian Health Care*. Online. Available: http://www.westgov.org/wga/publicat/schip898.htm#q. Accessed: December 7, 2000.

[29] Health Care Financing Administration, *Texas Title XXI Fact Sheet*. Online. Available: http://www.hcfa.gov/init/chpfstx.htm. Accessed: December 7, 2000.

[30] Don A. Gilbert, Commissioner of Texas Health and Human Services, *Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act*. Online. Available: http://www.hcfa.gov/init/txeval98.pdf. Accessed: December 7, 2000, p. 37.

[31] Health Care Financing Administration, *Texas Title XXI Fact Sheet*. Online. Available: http://www.hcfa.gov/init/chpfstx.htm. Accessed: December 7, 2000.

[32] Committee on Public Health, "Interim Report," p. 7.7.

[33] Interview by Andy Fouché with Glen Maxey, State Representative, Austin, Texas, February 8, 2001.

[34] Families USA, "Could Your State Do More to Expand Medicaid for Seniors?," (Washington, D.C., December 1999), p. 2.

[35] Families USA, "Could Your State Do More to Expand Medicaid for Seniors?" p. 5.

[36] Health Care Financing Administration, *New Jersey Outreach Practices*. Online. Available: http://www.hcfa.gov/init/outreach/factnj.htm. Accessed: November 15, 2000.

[37] Ibid.

[38] Karen Squarrell, "Children's Health Insurance Program, New Jersey Presentation." Online. Available: http://www.hcfa.gov/init/outreach/tap2nj.htm. Accessed: November 15, 2000.

[39] Ibid.

[40] Health Care Financing Administration, *New York Outreach Practices*. Online. Available: http://www.hcfa.gov/init/outreach/factny.htm. Accessed: March 6, 2001.

[41] Ibid.

[42] Health Care Financing Administration, *Florida Outreach Practices*. Online. Available: http://www.hcfa.gov/init/outreach/factfl.htm. Accessed: March 6, 2001.

[43] Ibid.