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**THE RELATIONSHIP OF MEDICAID  
AND THE  
CHILDREN'S HEALTH INSURANCE PLAN (CHIP):  
IS IT A BARRIER TO CHIP ENROLLMENT?**

by  
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Presented in partial fulfillment of the requirements  
for the degree of  
Master of Science

Department of Health and Human Performance  
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The University of Montana  
June 13, 2001

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## Abstract

Leifer, Bonnie R. Hoffmann, M.S. June 2001

Health and Human Performance

**The Relationship of Medicaid and the Children's Health Insurance Plan (CHIP): Is it a Barrier to CHIP Enrollment?**

Committee Chairperson: K. Ann Sondag, Ph.D. <sup>AS</sup>

The Medicaid screen and enroll requirement stipulates that CHIP applications must be screened for Medicaid eligibility first, and that Medicaid-eligible children must be enrolled in Medicaid rather than CHIP. Many who work with the Children's Health Insurance Plan (CHIP) in Montana assume Medicaid screen and enroll is a barrier to CHIP application/enrollment due to Medicaid stigma; time, energy and funding have been spent on efforts to minimize this presumed barrier. No research was found that tested this assumption. Therefore, this study examined: whether Medicaid is a barrier to CHIP enrollment and, if so, what contributes to the barrier – a Medicaid stigma or other factors associated with Medicaid; if Medicaid is not a barrier, what are the barriers to CHIP; and whether a relationship exists between demographic factors and barriers.

The research design was cross sectional. The target population consisted of 1615 parents from Missoula and nearby counties who had inquired about CHIP through the state or local Covering Kids Program; a sample population of 230 subjects was randomly selected. A total of 148 phone interviews were completed in April-May 2001 using a valid, pilot tested survey instrument, and following study protocol designed to control for bias. Descriptive statistics – frequencies, mean, range – and Chi Square tests for significance were used for data analysis. Results indicated Medicaid was not a barrier to CHIP enrollment for 88% of the respondents. Medicaid stigma was a concern to only three people (2%), most concerns (70%) regarding Medicaid centered on the paperwork and process. Barriers to CHIP were paperwork and “no immediate need,” e.g. a sick child or change in income. One significant relationship was found between number of children and paperwork as a barrier. More research is needed regarding the “no immediate need” barrier.

Results will be useful in promoting policy decisions to overcome identified CHIP barriers, and to re-direct energies and funding from Medicaid to the actual barriers. Findings will also be helpful in furthering discussions to incorporate CHIP as a Medicaid expansion, rather than the current separate program. Administrative cost savings realized by this change would allow additional children to be enrolled in CHIP.

## **Acknowledgements**

There were a great many people who offered support and encouragement along the way with this project, and for each and every one, I'm grateful. However, there were a few who were key to bringing it to completion. First, my committee chair, Dr. Ann (Annie) Sondag – what would I have ever done without you?! You were always there with good suggestions and guidance; and when I most needed it, you'd tell me I was "rockin'!" And Karen Elliott – who so expertly organized and conducted all the phone interviews, and then provided immeasurable assistance with the data analysis. Your sunny personality and total reliability were a gift. My supervisor, Yvonne Bradford, who – as always – was unfailingly supportive, helpful, and understanding. My sister, Mari, who though far away in the Philippines with Peace Corps was my e-mail sounding board. And last, but certainly not least, my husband, Tim, who through it all had to get reacquainted with the stove, grocery stores, and vacuum cleaner – among other things – and yet was always supportive of my efforts. A huge THANK YOU to you all!!!

## **Dedication**

This work, and the completion of my Master of Science degree, I dedicate to my mother, Ruth Bird Hoffmann, who graduated from the University of California, Berkeley in 1932 before women graduates were commonplace, and who – by so doing – made college a "given" for me and my sisters; and to my father, Richard Hoffmann, who always taught us that if you were going to do something, do it well, and do it right. I think this would have pleased them both.

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## **CHAPTER I: Introduction**

The number of uninsured children in the nation has been a concern of child and family advocates and the government for the last two decades (Davidoff, Garrett, Makue, & Schirmer, 2000; Newachek, Pearl, Hughes, & Halfon, 1998; Selden, Banthin & Cohen, 1998; Holl, Szilagyi, Rodewald, Byrd, & Weitzman, 1995; Center on Budget and Policy Priorities [CBPP], 1998). It is well documented that uninsured children are more likely to have unmet health needs that can lead to poor school performance and lower long term prospects in life (Perloff, 1999; Szilagyi et al., 2000; Children's Defense Fund [CDF], 1997, 2001; Interagency Task Force on Children's Health Insurance Outreach [ITF], 1999; Byck, 2000). From 1986 to 1990 Congress enacted a series of initiatives that instituted an unprecedented expansion of children's Medicaid eligibility guidelines. As a result, an additional 4.8 million children were enrolled in Medicaid between 1989 and 1993 (Perloff, 1999; Avruch, Machlin, Bonin, & Ullman, 1998). Yet, despite the increased Medicaid enrollment, the number of uninsured children remained high. By 1993 there were 9.3 million uninsured children nationwide (Avruch et al., 1998). In 1997, in an effort to reverse this trend, Congress appropriated \$40.6 billion over a ten year period and created the Children's Health Insurance Plan (CHIP) (CDF, 1997; Halfon, Inkelas, DuPlessis, & Newachek, 1999; Perloff, 1999; CBPP, 2000). The number of uninsured children declined in 2000 for the first time since 1995 (CDF, 2001).

CHIP is designed to provide health coverage to children ages 0 -19 in low to moderate-income families who are not eligible for Medicaid. As authorized by Congress, CHIP has broader eligibility requirements, broader state discretion in program design,

and higher federal reimbursement to the state than does Medicaid (CDF, 1997; Serafini, 1999). To ensure that neither the states nor the parents drop children from Medicaid to enroll them in CHIP, Congress attached a requirement that all potentially Medicaid-eligible children applying for CHIP be screened for Medicaid eligibility first (CDF, 1997; Perloff, 1999). Children found to be Medicaid-eligible are enrolled in Medicaid, thereby preserving CHIP availability for children not Medicaid-eligible. Parents may, of course, choose not to enroll their child in Medicaid, but the child will nonetheless be ineligible for CHIP. This “screen and enroll” requirement as it is called, concretely links Medicaid to CHIP (CDF, 1997; Serafini, 1999).

No prior research was identified that studied whether the association of Medicaid with CHIP created a barrier to CHIP enrollment. Nonetheless, Medicaid stigma was found listed as a barrier, or a possible barrier, to CHIP enrollment in some literature (Byck, 2000; Perloff, 1999; Selden et al., 1998), which suggests an assumption that Medicaid posed a barrier to CHIP enrollment.

In Montana many of those involved with CHIP outreach and enrollment share in such an assumption. As recently as October 2000, seven out of thirteen family advocates in Montana, working under the auspices of the Covering Kids program (a nationwide outreach initiative of the Robert Wood Johnson Foundation to assist parents of uninsured children find appropriate health coverage), listed Medicaid stigma as a barrier to CHIP application in their quarterly reports (Covering Kids [CK], 2000).

Because of this assumption, the Medicaid screen and enroll requirement has been a source of concern to those involved with CHIP in Montana. Staff time and energy has

been devoted to finding ways to minimize or mask the Medicaid connection to CHIP in outreach and printed materials. For example, although CHIP is administered by Blue Cross Blue Shield, it is funded entirely with public money; yet in promotional material CHIP is routinely characterized as private insurance (see Appendix A). Another attempt to minimize the association with Medicaid can be found on the application. Great care was given to ensure the CHIP application design bore no similarity to the Medicaid application.

This begs the question: are such efforts needed? Does the Medicaid screen and enroll requirement actually create a barrier to CHIP application for parents? And if so, what is of concern; a social stigma attached to Medicaid, or other factors associated with the Medicaid system? Also, are sociodemographic factors such as the number of children, parents' age, gender, level of education, and socioeconomic status (SES) related to the barriers?

Additionally, CHIP was established in Montana as a separate program rather than an expansion of the existing Medicaid program; therefore, a new bureaucratic infrastructure for CHIP was developed that largely duplicated that of Medicaid. A combined program and infrastructure would be more cost effective due to the elimination of duplicate administrative costs, and a streamlined screen and enroll process.

This study examined these issues to describe the current situation through the collection and analysis of primary data. Results of this study will prove useful in guiding policy development and outreach strategies for both the CHIP and Medicaid programs.

## **Statement of the Problem**

Though no prior research was identified that studied whether Medicaid created a barrier to CHIP enrollment, evidence of an assumption that Medicaid is a barrier, or a possible barrier, to CHIP enrollment was found in the literature (Byck, 2000; Perloff, 1999; Davidoff et al., 2000; Selden et al., 1998; ITF, 1999). Such an assumption exists among CHIP staff and outreach workers in Montana (CK, 2000). As a result, staff time and energy has been devoted to finding ways to minimize or mask the association of Medicaid and the screen and enroll requirement with CHIP. These efforts may have been futile. To develop effective outreach strategies, policies and procedures to overcome a barrier it is important to first know if the barrier exists and, if it does, to understand what factors contribute to the barrier. The purpose of this study was to determine whether the Medicaid screen and enroll requirement is a barrier to CHIP application/enrollment, and if so, what contributes to the barrier – a social stigma attached to Medicaid, or other factors associated with the Medicaid system. Additionally, if Medicaid is not a barrier, to determine what are the barriers, and to determine whether sociodemographic factors such as the number of children, parents' age, gender, level of education, and SES relate to the barriers.

## **Research Questions**

This study was guided by the following research questions:

- 1) Is the Medicaid screen and enroll requirement a barrier to applying for the CHIP program and, if so, what contributes to the barrier – a social stigma or other factors associated with Medicaid?

- 2) If Medicaid is not a barrier to CHIP application, what are the barriers?
- 3) Is there a relationship between sociodemographic factors and barriers?

### **Significance of the Study**

The assumption that the Medicaid screen and enroll requirement is a barrier to CHIP enrollment has resulted in administrative expense due to staff time and energy being spent on efforts to minimize or mask the association of Medicaid with CHIP. However, no prior research was identified that studied whether the Medicaid requirement creates a barrier to CHIP enrollment, and if so what factors contribute to the barrier. Without such information it is difficult, if not impossible, to know whether the expenditure of time, energy and money has been – or is – needed, or whether policy decisions and outreach strategies have been appropriate. Results of this study will be useful to the CHIP program in guiding development of program policy, outreach, and advocacy services.

Additionally, the state Legislature chose to establish Montana CHIP as a separate program rather than as an expansion of Medicaid (CBPP, 2000). This decision required the establishment of an entirely new bureaucratic infrastructure for CHIP; an infrastructure that largely duplicated that of Medicaid. Duplication of infrastructures serves to funnel funding to administrative costs that otherwise could be used to provide insurance for additional children. It also results in delayed CHIP enrollment for children whose applications must be referred to the Medicaid office to meet the screen and enroll requirement. Results of this study will be useful in promoting discussion regarding the advantages or disadvantages of a combined Medicaid and CHIP infrastructure.

## **Limitations**

Limitations exist within every research study. Limitations for this study included:

- Only those persons with a phone could be included in the study.
- The honesty of the participants in responding to questions during the phone interview.
- Participants had initially called for CHIP information, which could suggest more concern about lack of health insurance than non-participants.

## **Delimitations**

Delimitations for this study included:

- Data collection occurred via phone interviews only.
- Participants in the study were delimited to those persons who had either:
  - 1) contacted the state Covering Kids (CHIP) toll free information number;
  - 2) contacted the Missoula Covering Kids (CHIP) Program;
  - 3) submitted a CHIP application and checked the advocate box on the application to permit release of their contact information to the Missoula CHIP Program advocate.
- Participants in the study were delimited to those who volunteered to participate in the phone interview.

## **Definition of Terms**

**AFDC:** The acronym for the Aid to Families with Dependent Children welfare program; Medicaid was directly linked to this program until 1986 when the first federal

Medicaid expansion initiative was implemented; AFDC was replaced with Temporary Assistance for Needy Families, or TANF, in 1996 due to welfare reform (CBPP, 1998).

**Balanced Budget Act 1997, Title XXI:** Federal legislation that established the CHIP Program (CBPP, 1998).

**Block grant funding:** Federal grant monies allocated as a lump sum to states, rather than as individual grant offerings, to cover a broad category of needs or services usually done on a match basis, the block grant allows each state local control in how the monies will be distributed among the allowed services (CBPP, 1998).

**CHIP:** The acronym for the Children's Health Insurance Plan, a publicly funded insurance program designed for children who are not eligible for Medicaid, meet CHIP eligibility guidelines, and who have no other insurance (CBPP, 1998).

**CHIP-eligible:** A child who meets the eligibility guidelines for CHIP enrollment.

**Covering Kids:** A nationwide outreach initiative of the Robert Wood Johnson Foundation to assist parents of uninsured children in finding appropriate health coverage.

**DPHHS:** The acronym for the state Department of Health and Human Services within which the CHIP and Medicaid divisions are located.

**Family advocate:** A professional or volunteer who assists families obtain and learn how to use health insurance for their children.

**Federal match :** Funds a federal grantee is required to contribute to the grant budget based on the "match" required in the grant; e.g. in an 80/20 match federal funding



would cover 80% of the budget, and grantee match funds would cover 20% of the budget (Perloff, 1999).

**FPL:** The acronym for Federal Poverty Level, an annual gross household income set by the federal government each year based on family size; a family whose gross household income falls below the FPL is considered to live in poverty. Eligibility guidelines for federal assistance programs like CHIP and Medicaid are based on the FPL; 100% FPL is the Federal Poverty Level established by the federal government; 150% FPL is 100% FPL plus another 50% (1/2) of the FPL, and so forth.

**MCCHD:** The acronym for the Missoula City-County Health Department.

**Medicaid:** The health coverage entitlement program for eligible poor and low-income Children (and some adults); originally (mid – 1960’s) directly linked to the Aid to Dependent Families welfare program, a “de-linking” began in 1986 (CBPP, 1998).

**Medicaid-eligible:** A child who meets the eligibility guidelines for Medicaid enrollment.

**Medicaid expansion:** Originally referred to broader eligibility guidelines for Medicaid enrollment to include non-AFDC children and a phase in of children 11-18 years of age that were established in a series of four federal initiatives passed by Congress between 1986 and 1990; now used also in reference to state CHIP programs that have been incorporated as a further expansion into the existing Medicaid program (CBPP, 1998).

**Participant or Respondent:** Subjects in the sample population who were contacted, agreed to participate in the survey, and responded to the interview questions.

**Screen and enroll:** The term used for the federal requirement that CHIP applications be screened for potential Medicaid eligibility first and, if eligible, the child enrolled in Medicaid rather than CHIP (CBPP, 1998).

**TANF:** The acronym for Temporary Assistance for Needy Families, a block grant program that replaced the welfare cash assistance AFDC program in 1996; Medicaid and TANF were delinked (not directly linked) so, unlike AFDC, families on TANF must apply for Medicaid insurance (CBPP, 1998).

**Welfare reform:** Changes in the welfare system since the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted August 22, 1996; it eliminated the AFDC cash assistance welfare program and replaced it with TANF (CBPP, 1998).

## **CHAPTER II: Review of Literature**

No prior research has been identified that examined whether the Medicaid screen and enroll requirement posed a barrier to CHIP enrollment and if so, what contributed to the barrier. Numerous studies have addressed the identification of barriers to enrollment for Medicaid-eligible children (Davidoff et al., 2000; Perloff, 1999; CBPP, 1998, 2000; ITF, 1999), and a variety of CHIP progress reports and outreach handbooks have reviewed and analyzed CHIP outreach and enrollment (usually in combination with Medicaid) during the first three years of the program (ITF, 1999; CBPP, 1998, 2000; CDF, 2000; National Conference of State Legislatures [NCL], 2000). A few prior research studies included Medicaid stigma as a barrier to enrollment, though little or no information was provided as to the nature or cause of the stigma (Byck, 2000; Perloff, 1999; Selden, 1998; National Academy for State Health Policy [NASHP], 1999).

A review of the available literature will contribute to an understanding of the Medicaid and CHIP programs, the populations they serve, and issues surrounding each that relate to the focus of this study. In addition, previous research findings regarding Medicaid enrollment barriers, and progress report conclusions, can provide useful insights to assist in the interpretation of results of this study. The review of literature is comprised of four sections: the importance of health insurance for children, Medicaid, CHIP, and a summary.

### **The Importance of Health Insurance for Children**

It is well documented that uninsured children are less likely to have adequate access to health care, and less likely to have a regular source of care. They are also less

likely to receive routine preventive care (including immunizations), less likely to see a physician when they are ill or injured, and less likely to receive proper dental care (Davidoff, 2000; Halfon, 1999; Newacheck, 1998; Holl et al., 1995; ITF, 1999).

According to the Children's Defense Fund (1999), in 1993 one in four uninsured children had unmet health needs. Children with inadequate health care suffer from reduced wellbeing and increased absence from school, which in turn increases the chance of poor school performance. Poor educational achievement can adversely affect future education and employment opportunities, and otherwise limit the child's opportunities (Perloff, 1999; Szilagyi et al., 2000; Children's Defense Fund [CDF],2001; Interagency Task Force on Children's Health Insurance Outreach [ITF], 1999; Byck, 2000). Therefore, routine preventive care, and a regular source of care are particularly important to a child's overall wellbeing and long term life prospects. According to the Children's Defense Fund (2001):

Health care coverage is vitally important for ensuring that every child has a healthy start. Children need to feel well, see well, and hear well in order to do well in school. Yet uninsured children are far less likely to receive medical and dental care when they need it. Compared with insured children, they are:

- More than four times as likely to have an unmet medical need,
- Three times as likely to have an unmet dental need,
- More than three times as likely to go without prescription medication, and
- Almost two times as likely to have an unmet need for vision care. (paragraph 8)

The importance of adequate health care for children, and the high number of uninsured poor and low-income children, led to the creation of Medicaid in the mid-

1960's, expansion of Medicaid eligibility between 1986 and 1990, and to the creation of CHIP in 1997.

## **Medicaid**

*Background.* Congress created Medicaid in 1965 (CDF, 1997) to provide health care coverage for young children of families enrolled in the Aid to Families with Dependent Children (AFDC) welfare program. Because of the direct link to welfare only children on AFDC cash assistance were eligible (CBPP, 1998). By the mid-1980's the number of poor and low-income children not on AFDC (and therefore ineligible for Medicaid) was high (Perloff, 1999; Holl et al., 1995; Newacheck et al., 1999). In response to this need, between 1986 and 1990 Congress enacted a series of four federal initiatives that mandated expansion of state Medicaid eligibility rules to include children not on AFDC cash assistance, and phased in coverage of children ages 11 through 18 (CBPP, 1998; Newacheck et al., 1998). The phased in age increase is due to culminate Sept. 30, 2002. The expansion allowed the enrollment of an additional 4.8 million children in Medicaid between 1989 and 1993 (Perloff, 1999; Avruch et al., 1998).

During the same time, 1989 – 1993, employer sponsored health coverage for children decreased significantly. In 1997 the Children's Defense Fund reported that:

The employer-based health insurance system is collapsing for children, as businesses cut their support for dependent coverage. Since 1989, children have lost private health coverage at twice the rate of adults, according to Census data. As recently as 1980, the majority of employees at medium to large companies had employers who paid 100% of family health insurance costs. Today, less than a quarter do. More than three-fourths of workers must pay some or all of those costs, and the employee's share averages \$1,900 a year, even for HMOs offered by the very largest employers. And 1 in 4 workers today has no [emphasis in original] access to employment-based family health coverage, at any price. (p. 2)

By 1993, despite the increased Medicaid enrollment there were 9.3 million uninsured children. Of these, 2.6 million children were Medicaid-eligible but not enrolled (Serafini, 1999). By 1995, there were 10 million uninsured children, 4.7 million who were Medicaid-eligible but not enrolled (Selden et al., 1998; Rosenbach, Irvin, & Coulam., 1999; Summer, 1997), and by 1998 there were 11.1 to 11.9 million uninsured children, 4.8 million who were Medicaid-eligible but not enrolled, plus another 3.1 million uninsured children from low-income families who were not eligible for Medicaid but who were unable to afford private health insurance (Selden et al., 1999; ITF, 1999).

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), commonly called the welfare reform act, was enacted in August 1996 (CBPP, 1998). Under welfare reform AFDC was replaced with the Temporary Assistance to Needy Families (TANF) program that was not directly linked with Medicaid. As parents left AFDC their children were dropped from Medicaid as well. Though many of these children were still eligible to enroll in Medicaid either the parents were not informed of this option or chose not to apply for coverage (Serafini, 1999; CBPP, 1998).

*Barriers.* Barriers to Medicaid enrollment most frequently identified in research are: 1) parents are unaware of potential eligibility, 2) a burdensome application process, 3) Medicaid stigma (Byck, 2000; Perloff, 1999; ITF, 1999). Factors that contribute to the first two identified barriers – unaware of potential eligibility, and a burdensome application process – are well defined and documented in the literature (Byck, 2000; Perloff, 1999; CBPP, 1998, 2000). In contrast, factors that contribute to the third barrier,

Medicaid stigma, are unclear. The suggestion of stigma as a vestige of Medicaid's prior link with welfare is sometimes suggested, as is the perception of burdensome paperwork and a complex application process (Perloff, 1999; CBPP, 1998, 2000; ITF, 1999; NCL, 2000).

Stigma is defined as "a mark of shame or discredit" by Webster's Dictionary (Online, 2001), which would lead to the logical conclusion that reference to a Medicaid stigma would mean a social stigma. To carry the logic one step further, if the historical existence of a stigma associated with welfare is assumed, a Medicaid stigma could have resulted from the linkage of Medicaid with the cash assistance AFDC welfare program as has been suggested in some literature (CBPP, 1998, 2000; Perloff, 1999; NCL, 2000; ITF, 1999). As mentioned previously, however, AFDC ended in 1996 due to welfare reform and the replacement program, TANF, was never directly linked to Medicaid. In addition, since 1986 Medicaid has been available to children not on welfare as a result of the federal Medicaid expansion initiatives.

Certainly, if Medicaid stigma is a barrier to Medicaid enrollment, it could be a barrier to CHIP enrollment as well. The current lack of definition of the Medicaid stigma barrier, plus the changed status of Medicaid since 1996 due to welfare reform, indicate a need to identify, or re-identify, whether a Medicaid stigma exists, and if so, what factors contribute to it. Such knowledge is essential to enable the development of effective outreach strategies, policies and procedures to overcome any barrier. This need is reflected in a cautionary note included in the Children's Defense Fund September 2000 progress report:

. . . focusing on Medicaid's poor public image or stigma as a deterrent to enrolling [in CHIP] misses the following key points: the majority of parents in the Kaiser [2000] study tried to enroll their children, said they liked and appreciated the program, and wanted coverage for their children. (p. 65)

*Access to care.* Access to care for children on Medicaid, though not usually included as a barrier to enrollment, is a subject of considerable concern and study as evidenced by the literature (Byck, 2000; Newacheck et al., 1999; Halfon et al., 1999; Marquis & Long, 1996; Rosenbach et al., 1999). Low Medicaid reimbursement levels have been found to affect access to care and quality of care for children enrolled in Medicaid due to a low provider participation rate (Marquis & Long, 1996). Research findings consistently show Medicaid coverage to be superior to no insurance for access to care, but inferior to private insurance (Byck, 2000; Perloff, 1999; Newacheck et al., 1998; Shi, 2000; Marquis & Long, 1996).

Newacheck et al. (1998) studied access to care issues for children on Medicaid as compared to uninsured children and children with either private insurance or CHIP in an effort to determine whether the health care needs of poor children are met by Medicaid. Children with private insurance were found to have the least access problems, and the most consistent and highest quality of care, followed by children on CHIP, and then children with Medicaid. However, when compared to uninsured children, children on Medicaid were found to have significantly greater access to care and quality of care.

A recent study by Shi (2000) reached similar conclusions. Shi examined quality of primary care as measured by access to care, first contact, longitudinality, comprehensiveness, and coordination, in relation to type of insurance. Findings were that



the “insured are more likely to experience good primary care than are the uninsured . . . similarly, the privately insured are more likely to experience good primary care than are the publicly insured” (Shi, 2000, p. 1854).

## **CHIP**

*Background.* Congress established CHIP under Title XXI of the 1997 Balanced Budget Act in an effort to meet the needs of the 3.1 million uninsured, low-income children, ages 0 – 18, who were ineligible for Medicaid. A total of \$20.3 billion in federal match block grant funds was appropriated to fund the program for a five-year period, with a similar amount projected for another five years (Halfon et al., 1999; Perloff, 1999; CBPP, 2000). Congress set broad mandated guidelines for CHIP eligibility requirements and benefit provisions, but within these guidelines states were left to decide specific program and policy issues (CDF, 1997; Halfon et al., 1999; Perloff, 1999; CBPP, 1998). For instance, under federal guidelines children in families with gross annual earnings up to two times the established poverty level, or 200% FPL, can be eligible for CHIP coverage, however the income limit for each state program is determined by the state government (Selden et al., 1999; Perloff, 1999). Current income limits across the nation range from 133% FPL to more than 350% FPL, although those higher than 200% FPL are only eligible for federal match up to 200% (CDF, 2000; CBPP, 2000). States also determine whether to operate CHIP as a separate program or roll it into Medicaid as a Medicaid expansion, and states determine the exact benefit package CHIP will provide as long as it meets minimum standards set by Congress (CBPP, 1998, 2000; CDF, 2000; Perloff, 1999).

*Screen and enroll.* One key element of the CHIP program not left to state discretion was the link between Medicaid and CHIP due to the screen and enroll requirement. As discussed previously, under the screen and enroll mandate every CHIP application must first be screened for potential Medicaid eligibility. Children found to be Medicaid-eligible are not CHIP-eligible, and can only be enrolled in Medicaid. One reason for this is the nature of Medicaid. Medicaid is considered an entitlement program and as such can not be denied to any eligible child regardless of funding availability. In contrast, the number of children who can be covered by CHIP is limited to the funding available in the child's state of residence (CBPP, 1998, 2000; Perloff, 1999). Consequently, a Medicaid-eligible child enrolled in a CHIP program at maximum enrollment could prevent the enrollment of a CHIP-eligible child due to lack of space available. The issue of entitlement versus limited enrollment based on funding may well be part of the reason 32 states have chosen to establish CHIP as a separate program rather than as an expansion of Medicaid (Byck, 2000; CBPP, 2000). Such reasoning may lead to false economy, however. Though fewer children may be able to obtain coverage due to a CHIP enrollment limit, the cost of dual program infrastructures may offset any financial gain.

Another reason for the screen and enroll mandate was due to federal match fund requirements. Both CHIP and Medicaid receive federal match funds, but the match for CHIP is higher than is the match for Medicaid, i.e. states receive a higher percentage of federal funding for CHIP than for Medicaid. Congress was concerned that states would be tempted to move children off Medicaid enrollment and onto CHIP enrollment due to

this financial incentive. The screen and enroll mandate was implemented to prevent such transfer from Medicaid to CHIP (Perloff, 1999).

*Sociodemographic characteristics.* Research has shown a difference in the sociodemographic factors of families with CHIP-eligible children as compared to those of Medicaid-eligible children. CHIP-eligible families tend to have higher income, are more likely to be two parent families and have at least one, if not both, parents as wage-earners, are more likely to have at least one parent with some college education, and are less likely to be Black or Hispanic than are Medicaid-eligible families (Byck, 2000; Perloff, 1999).

*Barriers.* As discussed in the Medicaid section, barriers to CHIP enrollment mentioned in the literature are generally the same as those for Medicaid; including lack of awareness of the program, burdensome paperwork, and a Medicaid stigma (Davidoff et al., 2000; ITF, 1999; CBPP, 2000). No formal research studies have been identified that specifically examined CHIP barriers as opposed to Medicaid barriers. The Kaiser Commission on Medicaid and the Uninsured commissioned the Center for Budget Policy and Priorities to conduct a study of the enrollment process in both Medicaid and separate CHIP programs (CBPP, 2000). A nationwide survey of CHIP and Medicaid program officers and a limited number of interviews and focus groups with clients of a medical clinic provided the research data. Findings indicated that a complex application process with extensive, complicated paperwork serves as a significant barrier to enrollment for both CHIP and Medicaid (p. 1). Though Medicaid stigma was occasionally referenced in the report, it was not studied.

The lack of prior research studies specific to CHIP enrollment barriers is perhaps understandable, since CHIP has been in existence only since 1997. Many states – Montana among them – did not initiate a CHIP program until 1999 (CDF, 2000). For CHIP outreach, policy, and procedures to be as effective as possible there is a need to study enrollment barriers specific to CHIP. This is particularly appropriate in view of the sociodemographic differences reported in prior research between CHIP and Medicaid families (Byck, 2000; Perloff, 1999).

### **Current Level of Need**

In 1999 there were an estimated 3.1 million uninsured CHIP-eligible children out of a total 10.8 million uninsured children. This total was down from 11.9 in 1998; the first drop in the number of uninsured children since 1995 (CDF, 2001; Selden et al., 1999). The decline in number of uninsured children has been variously attributed to the success of CHIP enrollment (CDF, 2001), and to an increase in workplace plan enrollments (American Public Health Association [APHA], 2000). Whatever the cause, and however hopeful the decline in numbers, there remain 10.8 million uninsured children. Under current eligibility guidelines it is estimated that 66% - 90% of the uninsured children could be enrolled in either Medicaid or CHIP (CBPP, 2000; Selden et al., 1999). Clearly, more needs to be done to encourage eligible, uninsured children to enroll ( Byck, 2000; Perloff, 1999; American Academy of Pediatrics, 1999; CDF, 2000; Selden et al., 1999). To meet this need an understanding of enrollment barriers, and what factors cause each to be a barrier, will be essential to the development of effective outreach strategies and wise policy decisions.

## CHAPTER III: Methodology

### Research Setting

This research study was conducted through the auspices of the Missoula City-County Health Department (MCCHD) Covering Kids (CHIP) Program. As such, the names and contact information of parents who had inquired and/or received a CHIP application through the program could be used for the target population without infringing on confidentiality issues. All phone interviews were conducted on site at MCCHD.

### Procedures

*Target Population.* The target population consisted of 1615 parents or guardians of children ages 0 – 18 who, between the inception of the CHIP program in October 1999 and April 1, 2001, had either: a) called the state toll-free Covering Kids (CHIP) information number; b) called the Missoula Covering Kids (CHIP) information number; or c) submitted a CHIP application with permission to release contact information to the local CHIP advocate. The target population resided in Missoula, Mineral, Sanders, or Lake County. Since data was collected via a phone survey, only individuals for whom a phone number was listed, or for whom a phone number could be found, were eligible for the target population.

*Sample Selection.* A sample population of 230 subjects was randomly selected from the target population by use of a computerized random sample generator (<http://www.randomizer.org>). Each and every member of the target population was therefore assured of an equal and independent chance of selection. The sample was of sufficient

size to be representative of the target population and to meet the a priori assumption of normality.

*Instrumentation.* No validated instrument was found to collect data for this study, therefore a questionnaire was developed, structured upon the major constructs of the Health Belief Model (See Appendix E). Questions probed the participants perceived importance of health insurance for their children; reasons for applying or not applying for CHIP; attitudes about Medicaid and the Medicaid screen and enroll requirement; preference – if any – for either CHIP or Medicaid, and the reason for a preference. Sociodemographic information collected included the parents' age, gender, education, number of children, and SES. The final question solicited any additional comments or suggestions about CHIP or Medicaid.

The survey instrument included a total of 15 questions; some questions included sub-questions. The questions were tailored to address three possible circumstances: 1) participants who had already applied for CHIP; 2) participants who had received an application but had not yet applied; and 3) those who had not requested an application when they called for information. Answers to the first two questions determined whether the interviewer would need to use Page 2 or 3 (respective to the above) of the instrument.

The majority of questions were the same for all three variations (or pages) of the instrument, however questions were numbered consecutively, 1-30, from page one to page three. Because of this, several questions had three different numbers; for data analysis all three numbers were combined. No participant was asked more than 12 questions. The survey instrument was reviewed by a panel of experts for face and content

validity, and revisions were made accordingly. After receiving approval from the Institutional Review Board (IRB), the instrument was pilot tested with 20 randomly selected subjects and minor revisions were made.

*Data Collection.* Primary data was collected by telephone interviews, five to seven minutes in length, conducted by a trained interviewer. Interviews were administered within a one-month period. To minimize the risk of interviewer bias the interviewer was not the primary researcher. Interview protocol (see Appendix C), and interviewer training (see Appendix D) was based on guidelines for telephone surveys detailed by Frey and Oishi (1995). The trained interviewer followed the strict protocol for each interview. Each question was asked verbatim and in the same order for each interview, probes were structured and limited in scope, and comments were written on the instrument as the interview progressed. Intra-rater reliability was strengthened by the protocol and survey instrument design that limited subjective interpretation or undue expansion of subject responses.

### **Research Design**

No prior research was identified that addressed the primary questions being asked in this study, therefore this was initial, descriptive research. A cross-sectional design was used, so results describe the situation at the time of the study. The Health Belief Model provided the theoretical framework for the research design.

The Health Belief Model posits that if four factors are present a person will likely take action to protect or promote their health. The four factors are: 1) perceived susceptibility to a problem; 2) perceived severity of consequences if action is not taken;

3) perceived benefits of the preventive action; and 4) barriers to taking action (Nutbeam & Harris, 1999, pp. 19-22; McKenzie & Smeltzer, 1997, pp. 110-111).

Of the four factors, research has shown perceived benefits and barriers to be the most predictive of behavior. According to Nutbeam and Harris (1999) a person will take action if they believe the action will “reduce their susceptibility, or minimize the consequences, and that the benefits of taking action outweigh the costs or barriers” (p. 19). In addition, Strecher and Rosenstock (1997) found that “the component of perceived barriers was the most powerful single predictor among the HBM dimensions across all studies and [sic] behaviors” (p. 49). Therefore, exploration of perceived benefits and barriers will primarily guide this study.

In the context of this study, then, based on the Health Belief Model parents of uninsured children will likely submit a CHIP application if the following beliefs exist: 1) they perceive themselves to be susceptible to potentially severe consequences due to lack of insurance; 2) they believe CHIP enrollment will alleviate the consequences of no insurance; 3) the benefits of having CHIP insurance will outweigh the barriers encountered in applying for it.

*Data analysis and statistical procedures.* The data consisted of answers to questions on the completed telephone interview questionnaires. Since this was primary research, descriptive statistical procedures were used for data analysis. Quantitative data was entered into the SPSS computer program. The data as a whole, and in subsets including males, females, participants who had applied, and those who had not applied was analyzed. Frequency counts were reported for all questions, and the mean, range,



and mode were reported for sociodemographic data. Chi Square tests of significance were used to explore relationships between sociodemographic factors and barriers; an asterick denotes a statistically significant relationship,  $P < .05$ .

Qualitative data consisted of responses to Question 10 (19 & 28) by participants who preferred either CHIP or Medicaid, and to Question 12 (21 & 30) that solicited additional comments or suggestions. Responses to Question 10 were analyzed for common themes or patterns (see Appendix F for raw data). Responses to Question 12 were very limited and were therefore reported in their entirety.

## CHAPTER IV: Results

The sample population consisted of 230 randomly selected subjects. Of the total number, 81 subjects could not be reached: of those 81 subjects, 25 (10.9%) were wrong numbers; 49 (21.3%) were disconnected numbers with no forwarding; and 7 (3%) were duplicates. Of the remaining 149 (64.8%) subjects, 148 (64.3%) agreed to participate in the survey and one declined to participate. Participants included 36 males and 112 females. Two survey participants (1%) terminated the survey before completion: one was ineligible for CHIP due to alien status, the other for unknown reasons. Four participants (3%) chose not to provide sociodemographic data, and one participant provided all sociodemographic data but SES.

### Sociodemographic Summary

A total of 142 participants, 34 males and 111 females, provided sociodemographic information including age, education, number of children, and SES; one participant provided all but SES. Results for the total number of participants, and subsets including males, females, those who applied, and those who had not applied are found in Tables 1-5 below. Bar graphs describing results for the total number of participants can be found in Appendix G.

**Table 1**  
**Mean Sociodemographic Results (n=142)**

Demographic	Mean	Range	Majority range
Age (years)	29	21 – 70	24 – 33 (88%)
Education (years)	13.5	10 – 18	12 – 16 (98%)
# Children	1.86	1 – 4	1 – 2 (90%)
SES	\$17,000	\$10,000 – 40,000	\$10 – 20,000 (81%)

**Table 2**  
**Males: Mean Sociodemographic Results (n=34)**

Demographic	Mean	Range	Majority Range
Age (years)	30.6	23 – 50	24 – 33 (88%)
Education (years)	13.9	12 – 17	12 – 16 (94%)
# Children	2.00	1 – 4	1 – 3 (94%)
SES	\$17,600	\$10,000 – 40,000	\$10, - 20,000 (91%)

**Table 3**  
**Females: Mean Sociodemographic Results (n=111)**

Demographic	Mean	Range	Majority Range
Age (years)	28	21 – 70	22 – 33 (91%)
Education (years)	13.6	12 – 18	12 – 16 (99%)
# Children	1.92	1 – 4	1 – 2 (93%)
SES	\$16,400	\$10,000 – 40,000	\$10 – 20,000 (99%)

**Table 4**  
**Those who Applied: Mean Sociodemographic Results (n=90)**

Demographic	Mean	Range	Majority Range
Age (years)	31	22 – 70	24 – 33 (90%)
Education (years)	13	10 – 18	12 – 16 (97%)
# Children	1.94	1 – 4	1 – 2 (86%)
SES	\$17,300	\$10,000 – 40,000	\$10 – 20,000 (98%)

**Table 5****Those Who Did Not Apply: Mean Sociodemographic Results (n=49)**

Demographic	Mean	Range	Majority Range
Age (years)	27	21 – 36	21 – 30 (86%)
Education (years)	13.2	12 – 16	12 – 14 (86%)
# Children	1.74	1 – 3	1 – 2 (94%)
SES	\$16,600	\$10,000 – 40,000	\$10 – 20,000 (98%)

**Questionnaire Results**

Frequency counts were reported for responses to each question on the survey instrument using the SPSS statistical program. Results of the frequency counts for each question are reported below. The percentage of the total respondents is given first, followed by the number of respondents in parentheses.

**Question 1: Have you received an application for CHIP? (n=148)**

- Yes 96% (142)
- No 4% (6)

(See Questions 22 and 23 for follow-up to “No” answers)

**Question 2: Have you applied yet? (n=142)**

- Yes 65% (91)
- No 35% (51)

(Question 13 identifies reasons for “No” answers)

**Question 3: Did you apply immediately or wait a while? (n=91)**

- Immediately 76% (69)
- Waited 24% (22)

**3A: What caused you to wait? (n=22)**

- Paperwork 50% (11)
- No immediate need 27% (6)
- Other priorities 14% (3)
- Too busy/other 9% (2)
  - Income change

Table 6 summarizes the barriers to application reported in Question 3A and Question 13.

**Table 6**  
**Barriers to Application (% and # of participants)**

Barrier	Overall (n=72)	Those Who Waited to Apply (n=22)	Those Who Did Not Apply (n=50)
Paperwork	40 (56%)	11 (50%)	29 (58%)
No Immediate Need	16 (22%)	6 (27%)	10 (20%)
Other Priorities	9 (12%)	3 (14%)	6 (12%)
Too Busy	2 (3%)	1 (4.5%)	1 (2%)
Other	5 (7%)	1 (4.5%)	4 (8%)

*Note:* The relationship of the two primary barriers and sociodemographic factors can be found in Table 7 on page 33.

**Question 4: What in particular prompted you to apply? (n=91)**

- Income change 48% (44)
- Sick child 36% (32)
- Stress or worry 16% (15)

**Questions 5, 14, & 24: When did you realize your application would be screened for Medicaid eligibility? (n=140)**

- Didn't 59% (82)
- Before applied 41% (58)

**Questions 6, 15, & 25: How did this affect your decision to apply? (n=57)**

- Not at all 88% (50)
- Some 9% (5)
- A lot 3% (2)

**Questions 7, 16, & 26: What was it about Medicaid that affected your decision? (n=7)**

- Application process 43% (3)
- Paperwork 29% (2)
- Social implications 14% (1)
- Access to care 14% (1)

**Question 8: Are your children enrolled in CHIP or Medicaid now? (n=91)**

- Yes 75% (68)
- No 25% (23)

**8A: Which – CHIP or Medicaid? (n=68)**

- CHIP 79% (54)
- Medicaid 18% (12)
- Both 3% (2)

**8B: Were they ineligible or did you choose not to enroll? (n=23)**

- Ineligible 83% (19)
- Declined 4% (1)
- Waiting to hear 13% (3)

**Questions 9, 18 & 27: On a scale of 1-5, one being lowest and 5 highest, how would you rate the importance of having health insurance for your children? (n=146)**

- 5: Highest 99% (145)
- 3: Moderate 1% (1)

**Questions 10: Between CHIP and Medicaid, would you prefer one more than the other for your children? (n=146)**

- Yes 29% (42)
- No 40% (59)
- Not sure 31% (45)

**10A: Which [did you prefer]? (n=42)**

- CHIP 55% (23)
- Medicaid 45% (19)

**10B: Why?**

- Prefer CHIP (n=23):
  - Medicaid process and/or paperwork 78% (18)
  - Medicaid social stigma 9% (2)
  - Doctors' attitude towards those on Medicaid 4% (1)
  - No response 9% (2)
- Medicaid (n=19)
  - More coverage 100% (19)

(See Appendix F for a complete listing of the responses to this question.)

**Question 13: What caused you not to apply yet? (n=51)**

(Follow-up to “No” answers, Question 2)

- Paperwork 58% (29)
- No immediate need 20% (10)
- Other priorities 12% (6)
- Too busy .7% (1)
- Other 9% (5)
  - Change in income
  - Waiting on other insurance
  - Didn't want to go three months without insurance
  - Foreign status
  - Moving

*Note:* A summary of barriers to application reported in this question and in Question 3A can be found in Table 6 on page 28. The relationship of barriers to sociodemographic factors can be found in Table 7 on page 33.

**Question 22: Have you requested an application? (n=6)**

(Follow-up to “no” answers, Question #1; had not received an application.)

- Yes 17% (1)
- No 83% (5)

**22A: What caused you not to request an application? (n=5)**

- Other insurance 33% (2)
- Qualified Medicaid 17% (1)
- On Caring Program 17% (1)
- Not sure 17% (1)



**22B: Are you still considering requesting an application? (n=5)**

- Yes 20% (1)
- No 80% (4)

**22C: Do you have other insurance available? (n=6)**

(Participants who had not received an application were asked this question.)

- Yes 67% (4)
- No 33% (2)

**22D: Have you applied [for other insurance available]? (n=4)**

- Yes 100% (4)

**Question 23: What in particular prompted you to request an application? (n=1)**

- Sick Child 100% (1)

**Question 11, 20 & 29: (Sociodemographics – see above)**

**Question 12, 21 & 30: Is there anything you would like to add – any comment or suggestion about either CHIP or Medicaid? (n=148)**

Eleven participants responded to this question:

- ◆ Three participants who had been ineligible for CHIP suggested higher income limits.
- ◆ “I would like CHIP to cover periodontists.”
- ◆ “CHIP is slow on getting bills paid.”
- ◆ “. . . enrolled in Medicaid, it’s hard to keep on it.”
- ◆ “Need more PR work with dentists” (both programs).
- ◆ “Three-months uninsured is ridiculous, and the paperwork is too much.”
- ◆ “Both are good programs; CHIP is a nice alternative or option.”
- ◆ “. . . glad to have CHIP as an option, makes it easier for fluctuating incomes.”
- ◆ “Good program, everyone is helpful.”
- ◆ “Medicaid is for people who do nothing, CHIP is wonderful because it is for those who are working and trying hard.”

The relationship between sociodemographic factors and barriers to application were explored using Chi Square tests of significance. A series of planned comparisons were performed to determine the existence of statistically significant relationships between barriers and each of the demographic variables; gender, age, education, number of children, and SES. A statistically significant relationship was found between the number of children and paperwork; participants with two children were more likely to report paperwork as a barrier,  $P < .04$ . No other statistically significant relationships were found (see Table 7 below).

**Table 7**  
**Relationships Between Barriers and Sociodemographic Factors**

Primary Barriers	Gender	Age	Education	# Children	SES
Paperwork	0.10	0.44	0.29	0.04*	0.50
No Immediate Need	0.18	0.37	0.85	0.18	0.17

\* $P < .05$ .

## **CHAPTER V: Discussion**

The importance of health insurance to children's health and long term prospects in life is well documented (Perloff, 1999; Szilagyi et al., 2000; CDF, 1997, 2001; ITF, 1999; Byck, 2000), as is the continuing high number of uninsured children in the nation (Avruch et al., 1998; CBPP, 2000). It is estimated that 66% – 90% of the uninsured children are either CHIP or Medicaid-eligible; yet most remain uninsured because parents do not apply (CBPP, 2000; Selden et al., 1999). Many of those who work with CHIP in Montana assume that – in addition to paperwork and application process barriers – the Medicaid screen and enroll requirement creates a barrier to CHIP application for parents due to a Medicaid stigma (HMHB, 2000). Though no prior research was identified that could support or dispel this assumption, staff time and energy, and program funds have been expended in an effort to overcome the perceived barrier. However, to effectively combat barriers it is important to know first if the barrier exists, and what contributes to the barrier.

The purpose of this study, as reflected in the research questions, was to determine whether the Medicaid screen and enroll requirement is a barrier to CHIP application and enrollment and, if so, what contributes to the barrier – a social stigma attached to Medicaid, or other factors associated with Medicaid. Additionally, if Medicaid is not a barrier, to determine what are the barriers, and to determine if there is a relationship between sociodemographic factors including the parents' age, gender, education, number of children, and SES and the barriers.

## **Theoretical Framework**

The Health Belief Model provided the theoretical framework for this study. According to the Health Belief Model, an individual will take action to protect their health if they believe themselves to be susceptible to potentially severe consequences by not taking action, and if they believe the benefits of taking action outweigh the perceived barriers.

Responses to Question 1 on the questionnaire showed the large majority of participants (98%) had obtained applications for CHIP (n=146). Four of the five who had not requested an application were either ineligible or had other insurance, and one participant was not sure why he had not requested an application, but was still considering doing so. Therefore, participants took preliminary action to obtain health insurance. According to the Health Belief Model, this would suggest the participants perceived themselves susceptible to negative consequences due to lack of health insurance, and the potential benefit of obtaining health insurance outweighed the barriers to obtaining an application.

Responses to Question 2 regarding the participants' application status support this interpretation. Almost two-thirds (65%) of the participants had applied for CHIP, and three-fourths of those (76%) had done so immediately after receiving the application. Reported prompts to action were a change of income (48%), a sick child (35%), or stress and/or worry (16%) (n=91). The majority (75%) were enrolled in either CHIP or Medicaid (n=91). Of the 23 participants not enrolled (25%), one had other insurance available so had declined CHIP enrollment, and the rest had been determined ineligible.

Question 9 asked participants to rate the importance of health insurance on a scale of one to five, five being the highest. Almost all, 99.3%, rated it a “5,” of highest importance; only one participant rated it a “3,” or moderately important (n=145). Clearly, participants perceived the benefits of health insurance as significant.

The remainder of this discussion will focus on the results of the study as they pertain to each research question. Finally, a conclusion and recommendation for further research will be given.

### **Research Questions**

**1) Is the Medicaid screen and enroll requirement a barrier to applying for the CHIP program and, if so, what contributes to the barrier – a social stigma or other factors associated with Medicaid?**

The Medicaid screen and enroll requirement was not found to be a barrier to CHIP application for the large majority (84-88%) of participants (n=146). The majority of the remaining respondents (78%) said the Medicaid paperwork and procedures were the cause of their concern. Only three participants (2%) attributed their concern to a Medicaid stigma.

Questions 5 – 7 asked participants if they knew of the Medicaid screen and enroll requirement, if it affected their decision to apply, and if so, what about Medicaid affected their decision. Of the participants who knew of the Medicaid screening requirement the large majority, 88%, reported it had no affect on their decision to apply or not apply (n=57). In fact, only seven participants (12%) said that Medicaid affected their decision either “some” (5 participants), or “a lot” (2 participants), and five of the seven had

applied for CHIP by the time of the interview – including the two who responded that Medicaid affected their decision to apply “a lot.”

Questions 10, 10A and 10B asked participants if they would prefer either CHIP or Medicaid for their children. Again, the large majority of participants (84%) had either no preference, were not sure, or actually preferred Medicaid (n=146). Of those who had a preference, 23 participants (55%) preferred CHIP, and almost as many – 19 (45%) – preferred Medicaid (n=42). Participants who preferred Medicaid all gave the same reason: Medicaid offers more coverage than CHIP.

Of the 23 participants who preferred CHIP, the majority (78%) attributed their preference to the Medicaid paperwork and procedures (n=23). Answers included “less hassle,” “don’t have to keep up as much,” “not as time-consuming,” “less intrusive,” and “easier to manage” (see Appendix F). One respondent commented that CHIP was a good option for those with in-between incomes. Six of the seven participants who reported Medicaid had affected their decision to apply either “a lot” or “some” in Question 5 were among those who preferred CHIP (26%). However, the remaining participants who preferred CHIP reported the screen and enroll requirement had either not affected their decision at all, or they were not aware of it.

Only three participants (2% of the total 146 respondents, and 13% of the 23 who preferred CHIP) cited Medicaid stigma as the reason they preferred CHIP; two due to social stigma and one to treatment stigma. Of the three, one was a 60 year old grandmother who said Medicaid affected her decision to apply “a lot,” and that she had waited to apply due to “social implications” (Question 7); she felt strongly that Medicaid

was for those who are poor because they “do nothing.” Another was a man in his early 30’s who preferred CHIP because he thought Medicaid had a social stigma as it indicated low income, however he replied “not at all” when asked if Medicaid had affected his decision to apply. The third was a woman in her early 30’s with a college education who felt people with Medicaid are treated differently by the doctors. She also replied “not at all” when asked if Medicaid affected her decision to apply for CHIP.

In summary, findings indicated that Medicaid did not appear to be a barrier to application, even for the large majority of participants who preferred CHIP insurance. Moreover, concerns about Medicaid centered on the paperwork and procedures rather than a Medicaid stigma.

## **2) If Medicaid is not a barrier, what are the barriers?**

Questions 3A and 13 asked participants what caused them to either wait to apply or not apply. Two primary barriers to application were identified in the responses to both questions: paperwork (50% and 58% respectively), and no immediate need (27% and 20% respectively) (n=72). A summary of the responses to these two questions can be found in Table 6, page 29.

Paperwork as a barrier to enrollment for Medicaid has been well documented by numerous research studies (Byck, 2000; Perloff, 1999, ITF, 1999), and has been cited as a barrier to CHIP enrollment in CHIP progress reports and other publications (Davidoff et al, 2000; CBPP, 2000). The same studies and reports include numerous suggestions and recommendations for paperwork reduction and simplification strategies. Some states

who have adopted CHIP as a Medicaid expansion program have successfully reduced their application forms to one or two pages (CDF, 2000).

Montana has two combined CHIP/ Medicaid applications that can be used: the older form is 7 pages long, the more recent is 14 pages long. Application forms for separate CHIP programs, such as the Montana program, generally tend to be longer than those for Medicaid expansion programs because they must include eligibility screening for Medicaid as well as CHIP (CDF, 2000). Moreover, Montana is one of the few states in the nation that still has a resource limit for Medicaid eligibility. Because of the Medicaid screen and enroll requirement, questions pertaining to personal resources and assets must be included in the application although they add considerable length. The recent increase in length from 7 to 14 pages on the Montana application form, however, was due simply to graphic design preferences and choices made by CHIP and Medicaid officials. Clearly, results of this study indicate a need to simplify and reduce the complexity – and length – of the application form as much as possible.

The second barrier, no immediate need, is likely the more difficult barrier to address. “No immediate need” means the participant waited to apply, or did not apply, because their children were currently healthy and not in need of critical care. This barrier was reflected in the responses to Questions 4 and 23 that asked what prompted participants to apply (or request an application). “Change in income” (48%) and a “sick child” (36%) accounted for 84% of the responses (n=92); stress or worry accounted for only 16% of the responses. In other words, applying the Health Belief Model, findings suggest the large majority of participants took action – applied – when the consequences



of no insurance, and the benefits of CHIP, were *apparent* due to a change in income or an urgent health need. Relatively few participants, the 16% who were prompted to apply due to “stress or worry,” reported taking action because they *anticipated* the benefits of insurance outweighing any barriers to applying (though it is possible that some who reported “change in income” also applied in advance of an urgent health need).

A barrier to Medicaid enrollment frequently cited in the literature is that parents are unaware of their potential eligibility (Byck, 2000; Perloff, 1999). It is possible the “no immediate need” barrier identified in this study may be, in some respects, similar to the Medicaid barrier – for example, participants may be unaware of the value of preventive care, or the benefits health insurance can provide. If so, more outreach and education would be helpful in overcoming the barrier. However, further research is needed to identify the factors that contribute to the barrier; once the contributing factors are known effective strategies to overcome the barrier can be developed.

### **3) Is there a relationship between sociodemographic factors and barriers?**

A series of Chi Square Eta tests, designed for data that includes an interval data variable and categorical data variables, were used to explore relationships between sociodemographic factors and variables associated with the barriers identified through frequency count analysis. Only one statistically significant relationship was found between the number of children and paperwork; participants with two children were more likely to report paperwork as a barrier,  $P < .05$ . No other statistically significant differences were found (see Table 7, page 33).

## **Conclusion and Recommendations**

Results of this study clearly suggest that Medicaid was not a barrier to CHIP application and enrollment for the large majority of the target population. Further, the concerns that were reported regarding Medicaid centered on the Medicaid paperwork and procedures; Medicaid stigma was of concern to just three respondents out of 146 (2%).

Many staff members and family advocates who work with CHIP share an assumption that the Medicaid link with CHIP due to the screen and enroll requirement is a barrier to CHIP application (CK, 2000). Time, energy, and program funding has been expended on efforts to minimize the effects of this assumed barrier. Results of this study clearly suggest such efforts and expenditures have been unnecessary. These findings, therefore, will be useful in promoting efforts and policy decisions to overcome the barriers that do exist: paperwork and “no immediate need.” For instance, the combined application form needs to be simplified and shortened to make it more “user friendly.” Policy changes regarding Medicaid eligibility requirements, such as the resources and assets limit, would facilitate such simplification. Further research is needed to identify the contributing factors to the barrier “no immediate need” so that effective strategies to reduce the barrier can be found.

Findings of this study will also be useful in promoting discussion regarding the advantages of CHIP being incorporated as a Medicaid expansion program, rather than a separate program as it is now. Such a change would likely reduce administrative costs created by dual CHIP and Medicaid infrastructures and thus provide funding to insure additional children. This is of utmost importance: the number of CHIP-eligible children

on the waiting list for enrollment currently stands at approximately 1000 children, and the number increases every month.

Finally, further research is needed in addition to that mentioned above regarding the barrier “no immediate need.” First, participants for this study had called for information on CHIP; research is needed that will access those in the general population who have not called for information. Second, participants for this study resided in Missoula and other western Montana counties; similar studies are needed in other areas of the state to determine whether barriers vary from one area to another.

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## **Appendix A**

### **CHIP Printed Materials Sample**

# CHIP

Montana

## Children's Health Insurance Plan

CHIP is a low-cost, private health insurance plan that provides health insurance coverage to eligible Montana children through age 18. Financial eligibility is based on a family's adjusted gross income. There are no asset or resource tests.

Parents are in charge of the health care their children receive, and are partners with the state and federal governments in providing health insurance coverage for their children. Some parents share in the cost of their children's health by making a co-payment for each service used.

Applications for CHIP are available in all Montana communities, at county health departments, health care facilities, WIC offices, Head Start facilities, Indian Health Services, and many more community locations. Applications are available by mail by calling 1-877-KidsNow (1-877-543-7669).

### Eligibility

- Children through age 18
- Montana residents
- US citizens or qualified aliens
- Not currently insured or covered by health insurance in the past 3 months (some employment-related exceptions apply)
- Not eligible for Medicaid
- Parents not employed by the State of Montana
- Household meets income guidelines (see chart on back)

*There are no asset or resource tests.*

There is no longer an enrollment fee required.

### Copayments

Some families will pay a small copayment when services are used.

- No copayment for well-baby or well-child care, including age-appropriate immunizations
- No copayment for dental services
- \$25 each inpatient hospital visit
- \$5 each emergency room visit
- \$5 each outpatient hospital visit
- \$3 each physician visit
- \$3 each generic prescription drug
- \$5 each brand-name prescription drug

*The maximum copayment for any family is \$215 per family per benefit year (Oct. 1 through Sept. 30).*

### Services Covered

- Physician and advance practice registered nurses
- Inpatient and outpatient hospital services
- Routine sports or employment physicals
- General anesthesia services
- Surgical services
- Clinic and ambulatory health care services
- Prescription drugs
- Laboratory and radiological services
- Inpatient, outpatient, and residential mental health services
- Inpatient, outpatient, and residential substance abuse treatment services
- Dental services
- Vision exams
- Eyeglasses
- Hearing exams

*There are no pre-existing condition limitations.*



The state CHIP office will notify a family when benefits will begin. CHIP will pay for services on and after the date of enrollment but will not pay for services incurred before enrollment begins.

Montana's Department of Public Health and Human Services contracts with private insurance companies to provide health insurance to children enrolled in CHIP and pays a premium for each child every month. CHIP enrollees receive an insurance identification card, an enrollee handbook describing how to use the insurance, and a list of doctors and other health providers.

Dental services and eyeglasses are covered under CHIP. The Montana Department of Public Health and Human Services pays dentists or the eyeglass supplier directly for those services. More detailed information is provided when children are enrolled in CHIP.

As of January 2001, CHIP enrolled all children for whom funds were available (9700 children). Children determined eligible for CHIP are placed on a waiting list. However, children become disenrolled every month and spaces become available. Children may wait only a month or two before they are enrolled in CHIP. To find out how many children are currently on the waiting list or to find out the position of a family on the waiting list, call CHIP at 1-877-KidsNow (1-877-543-7669).

### CHIP Income Chart

#### Annual Adjusted Gross Income

This is the maximum amount a family may earn.

*Not all families at these income levels will be eligible,  
determination is made considering earned income and child care paid.*

Family Size (children and adults)	If your income is equal to or less than this amount, your children may be eligible for CHIP.
2	\$ 21,255
3	\$ 28,185
4	\$ 34,155
5	\$ 41,085

**Appendix B**  
**IRB Consent Form**

For Internal Use Only

RECEIVED (Rev. 7/00)

The University of Montana # 3701 INSTITUTIONAL REVIEW BOARD (IRB) CHECKLIST

MAR 16 2001

UNIVERSITY OF MONTANA ASSISTANT PRESIDENT FOR RESEARCH

Submit one completed copy of this Checklist, including any required attachments, for each course involving human subjects. The IRB meets monthly to evaluate proposals, and approval is granted for one academic year. See IRB Guidelines and Procedures for details.

Project Director: Bonnie Leifer Dept.: HRP Phone: 777-3811

Signature: [Signature] Date: 3-13-01

Co-Director(s): Dept.: Phone:

Project Title: Medicaid Screening on the Coattails of the Children's Health Insurance Plan (CHIP): is it a barrier to CHIP enrollment?

Project Description: The purpose of this project is to determine whether a federally mandated requirement that all CHIP applications be screened for potential Medicaid eligibility creates a barrier to CHIP enrollment for parents, and if so, why that is the case.

All investigators on this project must complete the NIH self-study course on protection of human research subjects.

Certification: I/We have completed the course - (Use additional page if necessary)

Table with 4 columns: Signature, Date, Signature, Date. Row 1: [Signature], 3-13-01, [Signature], [Date]

Students Only:

Faculty Supervisor: L. Ann Sondag Dept.: HHI? Phone: 5215

Signature: [Signature] (My signature confirms that I have read the IRB Checklist and attachments and agree that it accurately represents the planned research and that I will supervise this research project.)

For IRB Use Only

IRB Determination:

\_\_\_ Approved Exemption from Review

[X] Approved by Administrative Review

\_\_\_ Full IRB Determination:

- \_\_\_ Approved
\_\_\_ Conditional Approval (see attached memo)
\_\_\_ Resubmit Proposal (see attached memo)
\_\_\_ Disapproved (see attached memo)

Signature IRB Chair: [Signature] Date: 3/16/01 (over)

**Project Information**

1. Is Exemption from Review requested?  Yes  No  
(See outline in Section B of the IRB Guidelines and Procedures)

2. Human Subjects. Describe briefly (include age/gender): Subjects will be older than age 18, both male and female who live in Missoula, Mineral, Sanders, or Lake County, and have inquired about the Children's Health Insurance Plan.

Are any of the following included? Check all that apply.

Minors (under age 18) If YES, specify age range(s): \_\_\_\_\_

Members of physically, psychologically or socially vulnerable population? Explain why: \_\_\_\_\_

3. How are subjects selected/recruited? Explain briefly: Subjects will be contacted by telephone and asked to volunteer.

4. Identification of subjects in data.

Anonymous, no identification  Identified by name and/or address or other  Confidentiality Plan

5. Subject matter or kind(s) of information to be compiled from/about subjects.

Describe briefly: Subject's perceptions and knowledge about the Children's Health Insurance Plan application and enrollment process.

Is information on any of the following included? Check all that apply.

Sexual behavior  Illegal conduct  
 Alcohol use/abuse  Drug use/abuse  
 Information about the subject that, if it became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability.

6. Means of obtaining the information. Check all that apply.

Field/Laboratory observation  Mail survey (Attach questionnaire/instrument)  
 Tissue/Blood sampling  On-site survey (Attach questionnaire/instrument)  
 Measurement of motions/actions  Examine public documents, records, data, etc.  
 In-person interviews/survey (Attach questionnaire/instrument)  Examine private documents, records, data, etc.  
 Telephone interviews/survey (Attach questionnaire/instrument)  Use of standard educational tests, etc.  
 Other means (specify): \_\_\_\_\_  
Will subjects be videotaped, audiotaped or photographed? \_\_\_\_\_

7. Is a written consent form being used?  Yes (attach copy)  No

8. Will subject(s) receive an explanation of the research before and/or after the project?

Yes (attach copy)  No

9. Is this part of your thesis or dissertation?  Yes  No

If YES, date you successfully presented your proposal to your committee: \_\_\_\_\_

10. Are you applying for funding for this project?  Yes  No

If YES, please name the sponsor: \_\_\_\_\_

## **Appendix C**

### **CHIP Telephone Survey Protocol**

**CHIP Telephone Survey Protocol  
Spring 2001**

1. All interviews will be conducted from the Missoula City-County Health Department (MCCD) located at 301 W. Alder, Missoula, MT 59802.
2. All survey supplies and records will remain at the MCCHD office at all times.
3. All interviews will be conducted by the same interviewer.
4. The interviewer will be trained in standard telephone survey procedures. Training will be based on guidelines and training materials presented by Frey and Oishi (1995).
5. The interviewer will possess the necessary ability, knowledge, and skill to administer the survey questionnaire in a consistent, professional, and neutral manner.
6. The interviewer will always read the survey questions verbatim when administering the questionnaire.
7. The trained interviewer will apply and follow standard interviewing procedures to enhance the collection of reliable and valid data. In so doing the interviewer will perform three major roles:
  - Maximize the number of completed interviews by keeping refusals and early terminations of interviews to a minimum
  - Motivate respondents to participate thoughtfully by delivering the introductory statement, answering respondent questions, and engaging the respondent in the interview process
  - Administer the questionnaire by asking questions, recording answers, and probing incomplete responses.
8. Confidentiality for all survey participants will be strictly maintained, and the participants' name and phone number will not appear on the completed questionnaire.
9. Participants with questions about CHIP, or a pending application, are to be referred to the MCCHD CHIP Program Coordinator, Bonnie Leifer, 523-4750.

(Adapted from Frey & Oishi, 1995, p. 110)

## **Appendix D**

### **Interviewer Training Material**

**CHIP Survey Interviewer Training Material**  
**Spring 2001**

**General Interviewing Techniques Guidelines**

**A. NEUTRAL ROLE OF THE INTERVIEWER**

The interviewer is a neutral medium through which questions and answers are transmitted.

Therefore:

- 1) Avoid interjecting your own opinions.
- 2) Avoid being “clever.”
- 3) Avoid any unnecessary or overly enthusiastic reinforcement, such as “DY-NO-MITE!!”
- 4) Be an “active” listener but only give the minimum of reinforcement, such as “OK,” “I see,” . . . [and] “uh-huh.”
- 5) Never suggest an answer.

**B. GENERAL TASKS OF THE INTERVIEWER**

- 1) Communicate questions accurately.
- 2) Maximize the respondent’s ability and willingness to answer.
- 3) Listen actively to determine what is relevant.
- 4) Probe to increase the validity, clarity, and completeness of the response.

**C. HOW MUCH INFORMATION TO GIVE**

- 1) Read questions precisely as written.
- 2) I repeat, read them precisely as written. It is extremely important that everyone be asked the same question in the same way. Even a difference in one word could drastically change the meaning and thus the response.
- 3) Information that you can provide to the respondent is listed below. Do not go beyond this information to interpret questions from the respondent. Key phrases you might use to answer questions are:
  - “This is all the information available to us.”
  - “We would like you to answer the question in terms of the way it is stated. Could I read it again for you?”
  - “I’m sorry, I don’t have that information.”
  - “I will write on the questionnaire the qualifications to your answer you have just mentioned.”



4) If the respondent still requires more information, call on the operations supervisor for assistance.

**E. WHOSE OPINION TO ACCEPT**

Everything should be in terms of what the RESPONDENT thinks – not the respondent’s kids, friends, boss, bartender, etc. Therefore, you might need to say:

“I see. Now, is that what you think?”

“It’s your opinion that we really want.”

**ALSO, DON’T GIVE RESPONDENT YOUR OPINION.**

**F. RECORD EVERY CALL YOU MAKE**, even though the number was not working, No answer was received, or the interview was not completed.

**G. DO NOT TAKE ANYTHING HOME WITH YOU.** All questionnaires, code sheets, instruction sheets, etc. must be left in the survey center.

**H. AFTER YOU HAVE LEFT THE SURVEY CENTER**

We are adamant about the following:

The only way to be successful is to establish and maintain a reputation for confidentiality.

Therefore, please:

- 1) Do not tell anyone the names or locations of people you interviewed.
- 2) Do not tell anyone the substance of an interview or part of an interview no matter how fascinating or interesting it was. We find it rather disturbing to hear from other faculty members or students details of an interview two weeks after a study is completed. Confidentiality is essential!

## **What NOT to do as an Interviewer**

### **NEVER**

- Get involved in long explanations of the study.
- Try to explain sampling in detail.
- Deviate from the study introduction, sequence of questions, or question wording.
- Try to justify or defend what you are doing.
- Suggest an answer or agree or disagree with an answer.
- Interpret the meaning of a question.
- Try to ask questions from memory.
- Rush the respondent.
- Patronize the respondent.
- Dominate the interview.
- Let another person answer for the intended respondent.
- Interview someone you know.
- Falsify interviews.
- Improvise.
- Add response categories.
- Turn in a questionnaire without checking it over to be sure every question has been asked and its answer recorded.

## **Other Interviewing Tips**

### **Possible Responses to Refusal Attempts**

- |                   |   |
|-------------------|---|
| Too busy          | This should only take a few minutes. Sorry to have caught you at a bad time. I would be happy to call back. When would be a good time to call in the next day or two? |
| Bad health        | I'm sorry to hear that. I would be happy to call back in a day or two. Would that be ok?  |
| Not Interested    | It's very important that we get the opinions of everyone in the sample. Otherwise, the results won't be very useful. So, I'd really like to talk to you.              |
| No one's business | I can certainly understand. That's why all of our interviews are  |

confidential. Protecting people's privacy is one of our major concerns, so we do not put people's names on the interview forms. All the results are reported in such a way that no individual can be linked with any answers.

**Objects to phone** We are doing this survey by phone because we can reach a lot more people for a lot less cost.

### **Interview Probes**

**Show Interest** An expression of interest and understanding, such as "uh-huh," "I see," and "yes," conveys the message that the response has been heard and more is expected.

**Pause** Silence can tell a respondent that you are waiting to hear more.

**Repeat the question** This can help a respondent who has not understood, misinterpreted, or strayed from the question to get back on track.

**Repeat the reply** This can stimulate the respondent to say more, or recognize an inaccuracy.

### **Ask a neutral question:**

For clarification: "What do you mean exactly?"  
"Could you please explain that?"

For specificity: "Could you be more specific about that?"  
"Tell me about that. What, who, how, why?"

For relevance: "I see. Well, let me ask you again" (Repeat the question Verbatim.)  
"Would you tell me how you mean that?"

For completeness: "What else?"  
"Can you think of an example?"

### **Improper Probing**

Question: "About how many hours of television would you say you watch in a 24-hour period?"

Answer: "Oh, I watch TV all day."

Improper probe: "So you mean about 12 hours?"

Better probe: "Could you be more specific?"

## **Appendix E**

### **Telephone Survey Introduction and Questionnaire**

**CHIP Survey Telephone Introduction**  
**April 2001**

**Introduction**

Hello. Is this \_\_\_\_\_ OR, May I speak to \_\_\_\_\_?

(IF PERSON NOT HOME: find out when best to call and advise will call again.)

(IF NOT PERSON'S RESIDENCE: verify number, ask if they know the subject and get contact information or, if not known, thank them for their time and excuse the call.)

This is Karen Elliott from the CHIP Program at the Missoula Health Department. We are conducting a very brief survey of parents in Missoula and surrounding areas for their views on the CHIP application and enrollment process.

Your name was selected at random from a list of those who have requested CHIP information or a CHIP application. The survey will only take 5-7 minutes, and is completely voluntary and confidential; your name will not be reported. At any time you may choose not to answer a question, or may stop the survey just by telling me.

Your participation will be very helpful in determining how the CHIP program can be improved for families. Your answers will not affect any benefits to which you would normally be entitled. At the end of the survey if you have any questions I would be glad to answer them for you. May I begin asking some questions?

(Adapted from Frey & Oishi, 1995, pp. 47-61)



7. What was it about Medicaid that affected your decision?

- Social implications
- application process
- access to care
- other \_\_\_\_\_
- paperwork
- bad experience (self / other)
- not sure

8. Are your children enrolled in CHIP or Medicaid now?

Yes ⇒ 8A.  CHIP  
 Medicaid

No ⇒ 8B. Were they ineligible or did you choose not to enroll?

ineligible ↓  declined ⇒ 8C.  CHIP  
 Medicaid

8D. Why? \_\_\_\_\_

↓  
\_\_\_\_\_

9. On a scale of 1-5, one being lowest and 5 highest, how would you rate the importance of having health insurance for your children?

1      2      3      4      5

10. Between CHIP and Medicaid, do you feel one could better meet the needs of your children?

Yes ⇒ 10A.  CHIP  
 Medicaid

No ⇒ Go to # 11

↓ 10B. Why? \_\_\_\_\_

NOW I'D LIKE TO GET A LITTLE INFORMATION ABOUT YOU AND YOUR FAMILY.

11. Sociodemographics:

- 11A. \_\_\_\_\_ Age
- 11B. \_\_\_\_\_ Education (highest grade completed)
- 11C. \_\_\_\_\_ # children
- 11D. annual SES  <\$10,000  
 10 – 20,000  
 20 – 30,000  
 30 – 40,000  
 40 – 50,000  
 >50,000

12. Is there anything you would like to add – any comment or suggestion about either CHIP or Medicaid?

**Barriers to CHIP Enrollment Questionnaire**  
**April 2001**

Questionnaire # \_\_\_\_\_  
Date Completed \_\_\_\_\_

**Page 2: HAVE NOT APPLIED**

( from Page 1, #1)

13. What caused you not to apply yet?
- too busy
  - forgot
  - paperwork
  - no immediate need
  - other priorities
  - ⇓  other \_\_\_\_\_
- Medicaid ⇒ Go to # 16

14. When did you realize your application might be referred to Medicaid for eligibility screening?

- Didn't ⇒ Go to # 17
- Before requested application
  - When called for info/application
  - ⇓  Other \_\_\_\_\_
  - When received application
  - When referred to Medicaid

15. How did this affect your decision not to apply yet?

- A lot ⇓       some ⇓       Not at all ⇒ Go to # 17

16. What was it about Medicaid that affected your decision?

- Social implications
- application process
- access to care
- ⇓  other \_\_\_\_\_
- paperwork
- bad experience (self / other)
- not sure



17. Are you still considering applying for CHIP?

Yes ↓  No ⇒ 17A. Do you have other insurance options available?

Yes ⇒ 17B. Have you applied?  No ⇒ Go to # 18

\_\_ Yes \_\_ No ↓

18. On a scale of 1-5, one being lowest and 5 highest, how would you rate the importance of having health insurance for your children?

1 2 3 4 5

19. Between CHIP and Medicaid, do you feel one could better meet the needs of your children?

Yes ⇒ 19A. \_\_ CHIP  No ⇒ Go to # 20  
\_\_ Medicaid

↓ 19B. Why? \_\_\_\_\_

NOW I'D LIKE TO GET A LITTLE INFORMATION ABOUT YOU AND YOUR FAMILY.

20. Sociodemographics:
- 20A. \_\_\_ Age
  - 20B. \_\_\_ Education (highest grade completed)
  - 20C. \_\_\_ # children
  - 20D. annual SES
    - \_\_\_ <\$10,000
    - \_\_\_ 10 – 20,000
    - \_\_\_ 20 – 30,000
    - \_\_\_ 30 – 40,000
    - \_\_\_ 40 – 50,000
    - \_\_\_ >50,000

21. Is there anything you would like to add – any comment or suggestion about either CHIP or Medicaid?

**Barriers to CHIP Enrollment Questionnaire  
April 2001**

Questionnaire # \_\_\_\_\_  
Date Completed \_\_\_\_\_

**Page 3: HAVE NOT RECEIVED APPLICATION**

( from Page 1, #1)

22. Have you requested an application?

Yes ⇒ Go to # 23

No ⇒ 22A. What caused you not to request an application?

Medicaid ⇒ Go to # 26

↓ Other \_\_\_\_\_

22B. Are you still considering requesting an application?

Yes ⇒ Go to # 24

No ⇒ 22C. Do you have other insurance options available?

Yes ⇒ 22D. Have you applied?

\_\_\_ Yes \_\_\_ No

No ⇒ Go to # 27

23. What prompted you to request an application?

\_\_\_ Sick child \_\_\_ injury  
\_\_\_ stress/worry \_\_\_ income change  
\_\_\_ other persons experience  
\_\_\_ other \_\_\_\_\_

24. When did you realize your application might be referred to Medicaid for eligibility screening?

Didn't ⇒ Go to # 27

\_\_\_ Before requested application  
\_\_\_ When called for info/application

↓ Other \_\_\_\_\_



## **Appendix F**

### **Raw Data Compilation: Question 10B**

**CHIP Survey Questionnaire**  
**Raw Data Compilation: Question 10B**

**Question 10:** Between CHIP and Medicaid, would you prefer one more than the other for your children?

**10A:** Which?

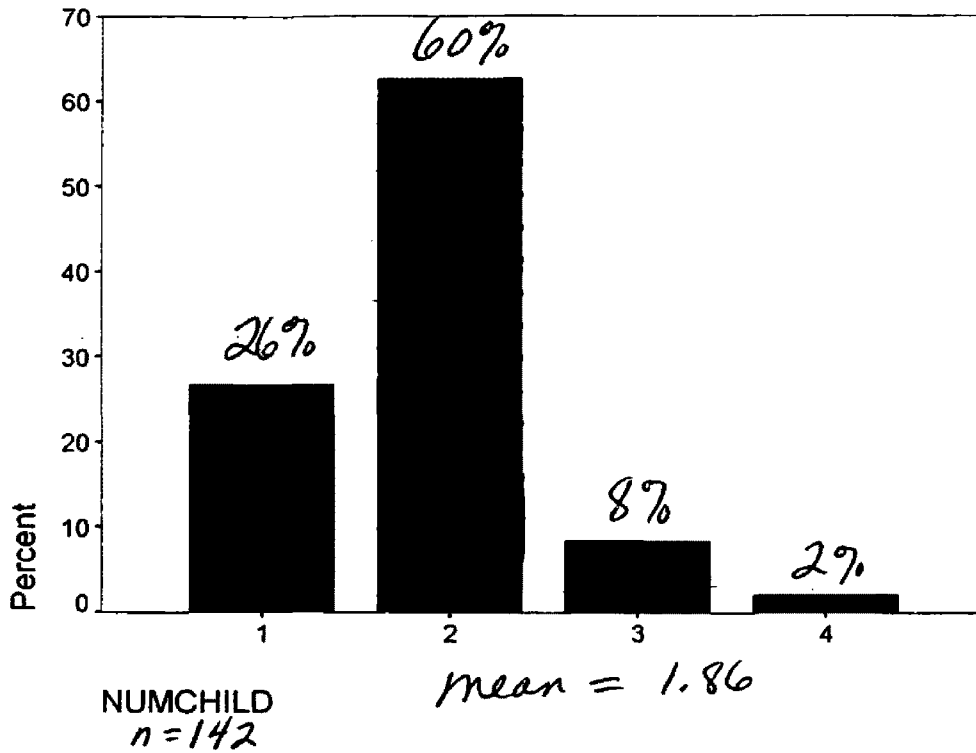
**10B:** Why?

<b>CHIP</b>	<b>MEDICAID</b>
Less hassle	Covers all bills
Not as much to do – less work than Medicaid	Covers all expenses
Less hassle	Pays for more
Don't have to keep up as much	Covers more
Less bother	More coverage
Medicaid requires more proof of income – treated differently with doctors when on Medicaid	Pays for more
Social stigma of Medicaid – low income	Pays for more
Good coverage – good option for those in-between incomes	Covers more
Easier to manage	Covers more on doctor's bills
Less to do	Pays for more
Less work	Covers more
Not as time consuming	Pays for more than CHIP
Less hassle	More coverage
Medicaid is for the poor	Covers more
	Medicaid covers more
 <u>Page 2 (those who waited to apply)</u>	
Not as intrusive	Covers more
Not as time consuming to keep up on	Better coverage
Less hassle	
Not as much work	
Less hassle	
Medicaid is a hassle-too much to do and keep up on	
 <u>Page 3 (those who did not request an application)</u>	
Medicaid is too much hassle	Medicaid covers more

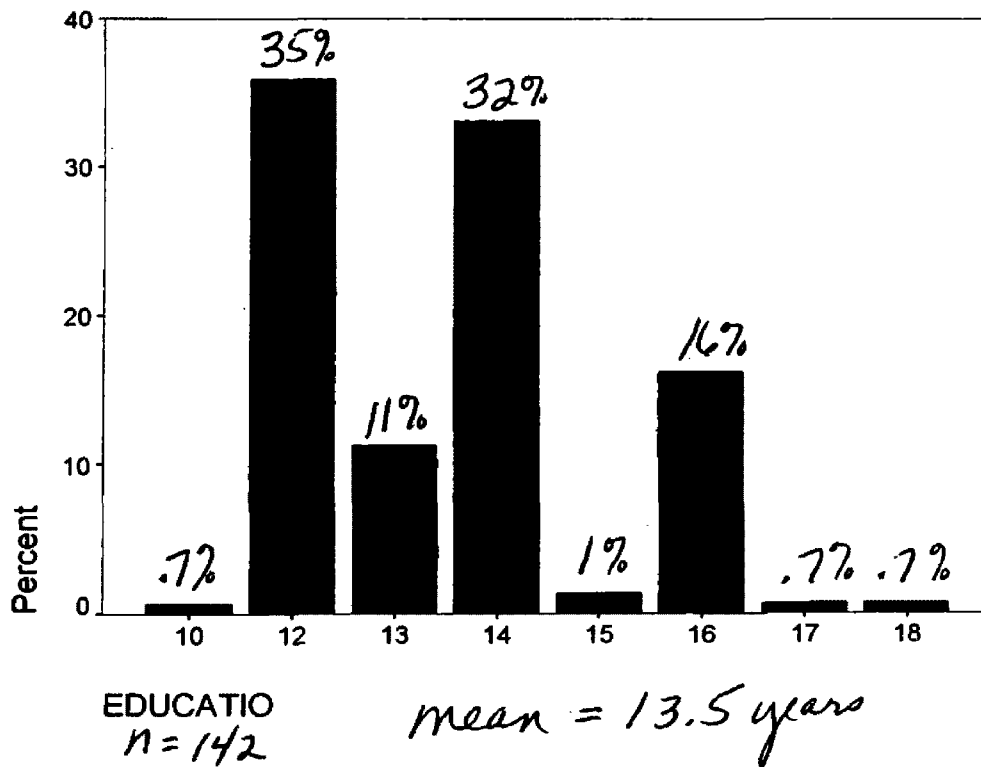
## **Appendix G**

### **Bar Graphs: Sociodemographic Data**

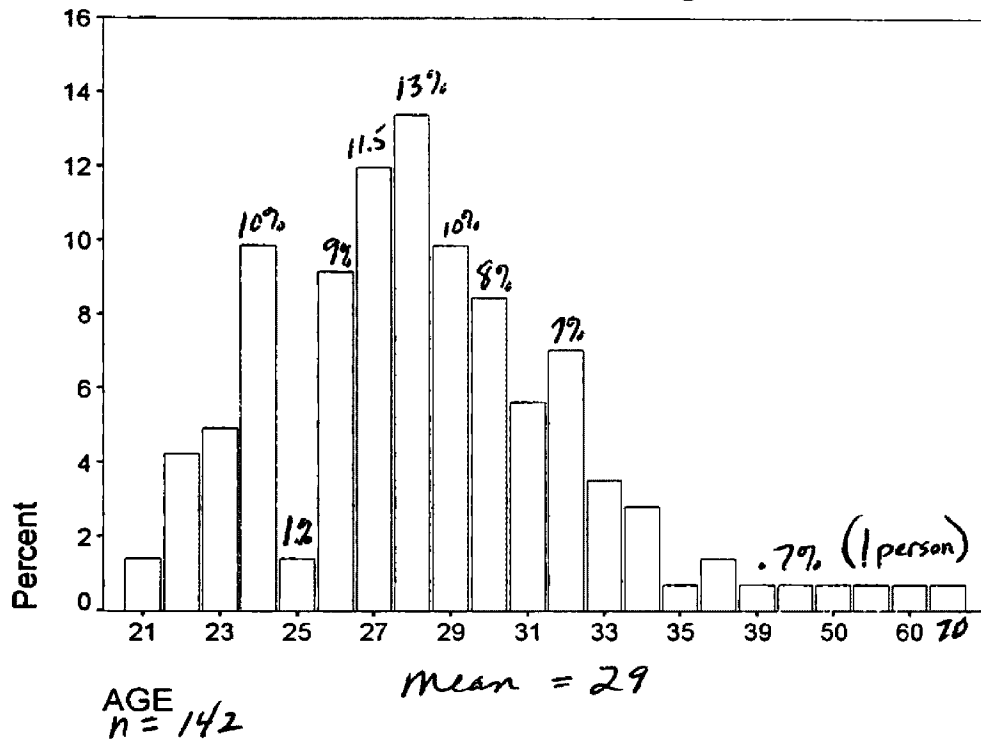
### Number of Children-Distribution in Percentage



### Level of Education-Distribution in Percentage



### Age Distribution in Percentages



### Income Distribution in Percentages

