Addressing the Barriers to Covering Kids:

A Values-based Strategic Framework

Final Report ▼ Wave 1 ▼ April 2001

WIRTHLIN WORLDWIDE

THE ROBERT WOOD JOHNSON FOUNDATION

covering kids™

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TABLE OF CONTENTS

INTRODUCTION TO THE REPORT

This report describes the research component of a comprehensive, multi-year communications effort in support of the **Covering Kids Initiative** (CKI) and funded by the **Robert Wood Johnson Foundation** (RWJF). The purpose of this campaign is to help enroll eligible children in Medicaid and the new Federal-State Children's Health Insurance Programs (SCHIP). Wirthlin Worldwide conducted this research in cooperation with RWJF, the GMMB advertising agency team, and the Covering Kids Initiative national program office director and staff (this group will be referred to as the CKI Communication Team throughout this report).

A national population survey conducted by Wirthlin Worldwide in early 2000 found that 16% of parents with children under 21 years of age in their household indicated they did not have health insurance coverage for their child(ren) that covers regular trips to the doctor as well as emergency care. National estimates at the onset of this effort reported as many as 10 million children without health insurance, and of these, approximately seven million uninsured kids are eligible for either SCHIP or Medicaid insurance coverage by virtue of their age, family size, and total household income. Overall, this campaign is designed to reduce this large pool of uninsured children who are eligible for low-cost or free health insurance by motivating their parents to call, apply, and enroll their children in Medicaid or SCHIP.

This comprehensive report details the formative and evaluative research conducted in support of the campaign. This research was the basis for the strategic communications used in various components of the program including community outreach efforts, earned media events, and paid advertisements. This report is presented in the following sections:

A. Executive Summary
B. Chapter 1: Detailed Findings (includes Research Goals and Objectives and Theoretical Framework)
C. Chapter 2: Challenges and Barriers Identified
D. Chapter 3: Solutions Found
E. Chapter 4: Campaign Shows Measurable Progress
F. Appendices: Questionnaires Guides, Ad Scripts, and Sampling Approach

The research team at Wirthlin Worldwide for this effort was directed by David Richardson, Executive Vice President; Jean Statler, Senior Vice President; and Maury Giles, Senior Research Executive. Additional research staff involved in this effort included Bill Johnson, Account Associate; Andrew Cober, Research Manager; Barbara Openshaw, Research Manager; Eleesha Lewis, Senior Project Director; Cara Boxer, Project Director; and Chris Sibbett, Research Assistant.

EXECUTIVE SUMMARY

Around the globe, parents inherently want to provide a loving, safe home where their children can grow and flourish. Often, families in America are faced with tough choices based on financial pressures, which they know can jeopardize their strong desire to raise healthy, thriving children. For working families, one such decision is related to health insurance for their children; especially if their employer does not provide such insurance or they cannot afford it. The only option is to not cover their children and then hope that something tragic will not befall them. Yet, one primary concern parents have, across all ethnic groups, is how to keep their children healthy and prevent serious illness and accidents.

It is this desire to protect their children **coupled** with the fact that there is help in the form of the Medicaid and Federal-State Children's Health Insurance Programs (SCHIP) that provided a catalyst for this multi-year communications effort to motivate parents with uninsured children to seek health care coverage. This campaign, in support of the Covering Kids Initiative, is built on the foundation of formative, strategic research conducted by Wirthlin Worldwide to:

- Uncover the decision-making process parents with insured children and parents with uninsured children go through;
- Identify the barriers to enrolling in government-sponsored health care programs;
- Develop messages that will tap into motivational drivers to encourage enrollment;
- Craft the communications strategy;
- Assess all communications' effectiveness in delivering on the strategy; and
- Evaluate progress or track results.

Simply stated, the research showed that the way to make this issue personally relevant is to tap into the emotional connections parents make when caring for their children, which centers on their desire to be a good parent and to make smart decisions for their children. Both of these touchstones cause them to feel less stress and worry about doing a good job, which ultimately drives to the terminal value that motivates them as a parent—a sense of peace of mind.

This is fundamentally good news in that the parents with children who are eligible for SCHIP, but are not currently enrolled, would accomplish their goal as good parents if they found an outlet to provide health care coverage for their children. The single biggest barrier, however, to getting through to parents of eligible uninsured children, is that they do not know the SCHIP program is for their children. Because they work, earn a living, probably pay taxes, and equate government programs with welfare only, they tune out messages promoting SCHIP or Medicaid. Thus, the most significant challenge that emerged from this research was to figure out the most effective way to say: "We're talking to you."

Other hurdles identified by the research included:

- The SCHIP programs are not yet well known or understood by most parents with eligible children;
- The perception that Medicaid is linked to welfare, thus the parents of eligible uninsured children did not understand the program's value and questioned its quality;

- The stigma associated with the treatment the newly enrolled would expect to receive, primarily from those encountered during the application process and at the front desk of the doctor's office; and
- The stress created in having to make difficult choices pitting financial constraints against health concerns.

Wirthlin Worldwide and the CKI Communication Team believed that the lack of SCHIP program awareness could be overcome through a comprehensive advertising and public relations campaign. Further, the treatment stigma could be addressed by communicating the specific and comprehensive coverage provided. This would tap into the powerful emotional considerations that motivate parents of uninsured children to give it a try. To address the challenge of making the connection to the parents of eligible uninsured children that this program is for them, key phrases were successfully tested. They were: *working families*, *earning (a specified income level*), and *low-cost or free health care coverage.*

Based Wirthlin Worldwide's formative, strategic research and the challenges identified, the advertising agency, GMMB, developed a series of television, radio, and print advertisements, along with collateral materials. This phase of the program involved earned media, enrollment events, and testing the advertisements and collateral materials in six medium-sized cities, while selecting two comparison markets to watch where no activity for the program was initiated. Wirthlin Worldwide then evaluated the effectiveness of the campaign in each of these markets by comparing results in the test markets to the comparison markets.

The campaign, which consisted of three to four weeks of enrollment events and paid and earned media in six mid-sized media markets, generated a significant increase in hotline callers in every market. Initial reports showed calls to the national hotline increased from an average of 15,000 calls per month to 58,000 in August (campaign started August 9). In addition, calls in the targeted markets saw an increase ranging from 77% on the low end (in Baltimore, MD where many calls were directed to the national hotline) to an increase of 645% on the high end (in Greenville, NC).

Most importantly, Wirthlin Worldwide's post-campaign research demonstrated that this increase in calls was a direct result of the television advertising, which consisted of four tested and refined television executions. The television ads scored significantly higher than Wirthlin Worldwide's established internal normative data for advertising testing on core attributes. Six out of ten (58%) parents of eligible uninsured children within the media markets included in the campaign reported having seen the advertisements. And one out of four (24%) of those people who saw the advertisements said they called the hotline number—an overall direct response rate considerably higher than expected norms for this type of campaign and target audience.

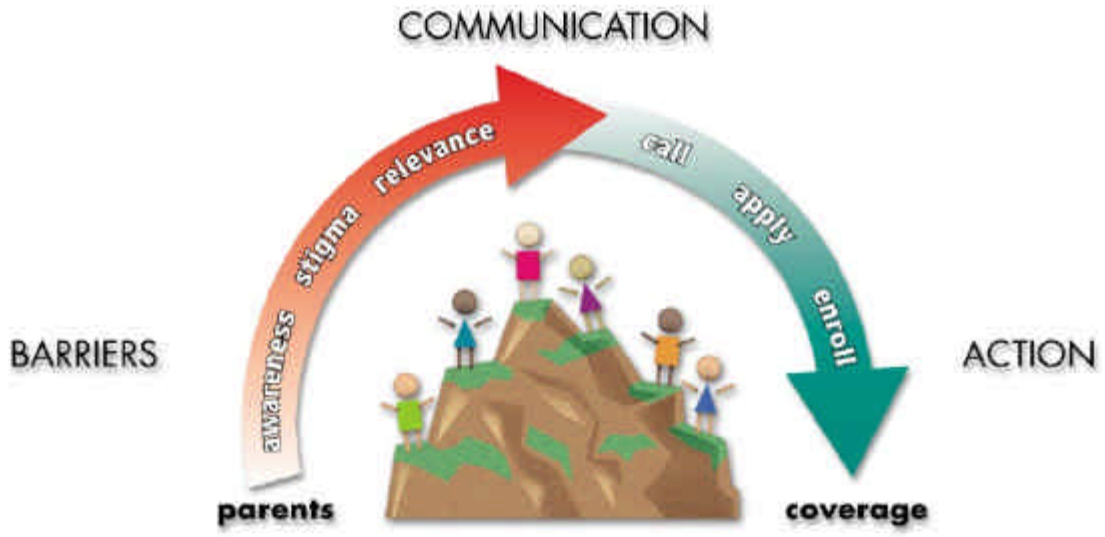
As a result of the formative research and campaign success in the test markets, Wirthlin Worldwide recommended four action steps or Strategic Imperatives for the campaign to follow as it moved forward; namely:

- Show how low-cost or free health care coverage yields the emotional payoff of being a good parent and making smart decisions that will reduce stress and bring peace of mind;
- Generate awareness broadly among the target audience;
- Help eligible families understand that these programs apply to them; and

- Establish SCHIP and Medicaid as valued products/services by showing the comprehensive and specific coverage.

An imperative not directly under the purview of this campaign is improving the enrollment process—eligibility, paperwork, convenience, insurance card, how to do it, and how it works. As important as it is for the target audience to recognize that they are eligible, once they make the telephone call then enrollment will depend on how they are treated and how bureaucratic the process is. Findings from Wirthlin Worldwide's benchmark research reveal the most frequently cited concern about enrollment in the programs was *too much paperwork* (23%). Of least concern was *how long it takes to enroll* and the *desire for the process to be streamlined*. Other studies have shown there is still significant room for improving the enrollment process applicants must go through to obtain health care coverage/treatment for their children. Therefore, efforts to improve the enrollment process must continue to be addressed.

The illustration below captures the continuum of the campaign to motivate parents to call, apply, and enroll their children in government health care programs. This icon will be used as a guide throughout this report.



CHAPTER 1: DETAILED FINDINGS

Research Objectives

The issues keeping parents of eligible uninsured children from calling for information about how to enroll their children in Medicaid or SCHIP are complex. Given this complexity and the need to identify a values-based strategy, Wirthlin Worldwide was enlisted to join the CKI Communication Team to provide strategic research in support of this effort. The Wirthlin Worldwide research had three primary objectives:

1. Conduct research among the target audience and influencers that helps guide the development of a communications strategy aimed at motivating parents of eligible uninsured children to call for more information.

2. Use that strategy as a framework for assessing specific communications approaches and identifying the most effective execution(s) for paid advertising.

3. Assess the progress of the program in penetrating the consciousness of the target audience and influencing them to take action (i.e., call the their state's Medicaid and SCHIP toll-free hotline to get information, apply, and enroll in either Medicaid or SCHIP coverage for their children).

The research program provided the strategic underpinning for the campaign; the components included:

- VISTA™ : a proprietary research methodology to identify linkages between rational and emotional considerations related to health and insurance issues in the minds of parents of eligible uninsured children;

- A Quantitative Benchmark Survey: to examine other aspects of knowledge and attitudes about health insurance as well as to identify barriers to enrollment;

    - Insights from these pieces of research helped guide campaign strategy.
    - This strategy, in turn, shaped GMMB's development of TV and radio advertisements.

- Pulseline ™: advertising assessment using a technique generically described as dial-testing, which provides detailed feedback on what works best about the advertising and was it on strategy;

    - GMMB finalized advertising executions and presented them in specific markets.

- Tracking: Tracking study conducted in the target markets after the first round of advertising and related communications activities to measure the impact of both the advertising and related activities; and

- Other research with specific audiences, such as opinion leaders, to provide additional perspectives and context on some of the issues. These research components were:

  - A national survey of the general public;
  - In-depth interviews with opinion leaders at the state level;
  - A survey of policy makers on Capitol Hill; and
  - Focus group research among caseworkers and others directly involved in the administration of Medicaid and SCHIP programs.

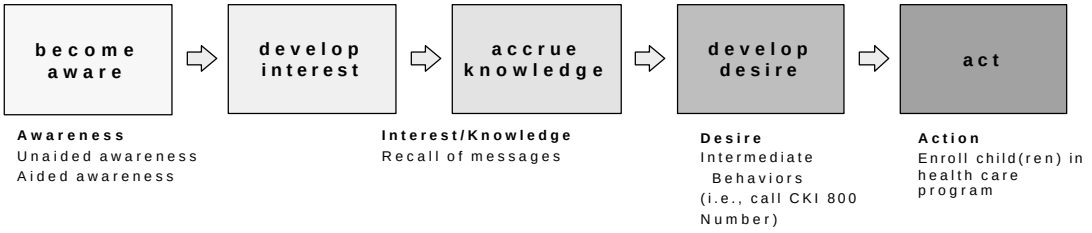
Theoretical Framework for Research Program

There are two primary research models that have shaped the questioning process employed in this research. Both draw from communications development theory.

The picture below illustrates the first model, which is often called the Hierarchy of Effects Model.[1] This is a model of how individuals cognitively move from understanding to action. The notion is that people generally have to move through each of the steps from left to right in order to take an action. For example, it is difficult to take an action if one is not even aware of the context or situation. In most situations, people act only after gathering enough information to become knowledgeable and interested. This progression from awareness to action is illustrated in Figure 1 below:

FIGURE 1

HIERARCHY OF EFFECTS MODEL



Survey questions were developed based on this broad framework in order to determine where the target audience is along the continuum. This is important from a communications standpoint because it helps determine whether the emphasis needs to be on creating awareness or on addressing a specific concern.

[1] Lavidge, R.J. and G.A. Steiner, "A Model for Predictive Measurements of Advertising Effectiveness," Journal of Marketing (October 1961), pp.59-62.

Within this framework, questions were built around two government health care programs; namely, Medicaid and SCHIP. Wirthlin Worldwide also examined the larger health context and probed, in some detail, the specifics of these programs as to how they affect individuals, including the range of barriers to enrollment. At the action end of the spectrum, several gradations were measured. The primary purpose of the communications effort was to stimulate parents of eligible uninsured children to at least inquire, via telephone or in-person, about the programs and their eligibility for them. That initial inquiry, in turn, is expected to lead to more serious efforts to apply or re-apply and, ultimately, to enroll.

The second model Wirthlin Worldwide employed draws from Means-End Theory[2, 3]. It builds on the principle that people do things for a reason. Whatever the action, or the perception of programs such as SCHIP and Medicaid, people will be *motivated* to act if communications help them link the tangible dimensions to the underlying emotions associated with them. The nexus of these rational/emotional elements is called the strategic hinge. The research technique that activates this hinge is known as VISTA™ (Values in Strategy Assessment) research.

VISTA™ is a research methodology that employs a laddering question process in a two-hour, one-on-one, in-person interview designed to elicit emotions associated with particular stimuli. From these ladders, Wirthlin Worldwide created maps that plot the way people think about the issues. Using these maps as thinking tools, Wirthlin Worldwide sought to identify the strategic hinge that might be used to link perceptions and concerns about child health care to the action of obtaining insurance coverage. Identifying the best means of activating this hinge is the purpose of this form of strategic research and lies at the foundation of all subsequent research components in this initiative. Essentially, this research has focused on helping to craft communications that *persuade* people by reason and *motivate* them through emotion.

When Wirthlin Worldwide approaches this type of research, a process called the "4 L's" is used. The "4L's" are:

- **Level**: in what context are people most likely to consider this?
- **Location**: where in the overall scheme of thoughts do the critical issues fall?
- **Linkages**: what are the key elements that connect with one another?
- **Language**: what is the language that people use?

A brief word about each of these L's. For this initiative, Wirthlin Worldwide approached the **Level** question by probing four possible points of entry under consideration:

1. Concerns about raising a child.
2. Caring for the health needs of a child.
3. Obtaining health care coverage.

[2] Gutman, Jonathan, and Thomas J. Reynolds. "An Investigation of the Levels of Cognitive Abstraction Utilized by Consumers in Product Differentiation." In *Attitude Research Under the Sun*, J. Eighmey, ed. Chicago: American Marketing Association, 1979.

[3] Reynolds, Thomas J., and Jonathan Gutman. "Laddering: Extending the Repertory Grid Methodology to Construct Attribute-Consequence-Value Hierarchies." In *Personal Values and Consumer Psychology*, R. Pitts and A Woodside, eds. Lexington, MA: Lexington Books, 1984.

4. Stigma associated with government health care coverage programs.

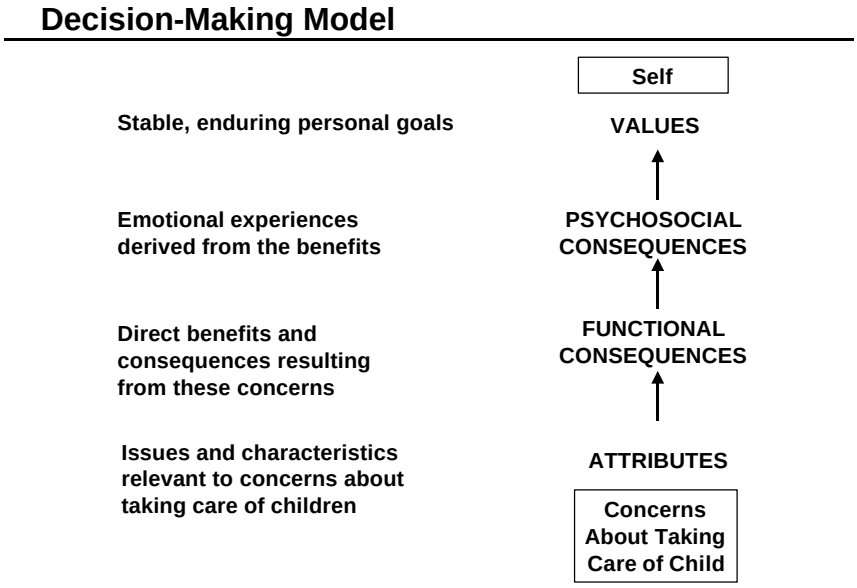
In other words, what is the best point of entry for talking about these issues? To talk generally about the concerns that parents have for their children (i.e., what do you worry about most as they grow up)? To talk specifically about their health needs (i.e., what do you need to do to keep them healthy)? To focus directly on the issue of insurance? Or, to address at least one of the issues that many people highlighted as an impediment to more people enrolling; namely, the concern about being stigmatized or otherwise looked down upon? In addressing each of these **Level** dimensions, Wirthlin Worldwide gained insight into the most effective hooks for capturing people's attention.

The **Location** question recognizes that, when probed, people disclose there are actually many elements that factor into their decision-making processes. Which of these are most likely to be effective? In general, and confirmed in this case, Wirthlin Worldwide found that the core element most likely to be the strategic hinge is what is often referred to as a *psycho-social consequence*, or an emotional dimension that has a link to the tangible factors: concern about helping a child grow up safely, being a good parent, worrying less, and supporting one's family (see Figure 2).

Linkage analysis captures the critical strategy development dimension that underlies Means-End Theory. Emotional messages are substantially more effective if they are linked to the appropriate tangible dimensions. An emotional message with the wrong link, or left floating by itself, is less likely to stimulate the appropriate action.

The following graphic in Figure 2 illustrates the various steps in the decision-making process that Wirthlin Worldwide maps and links through this type of qualitative research:

FIGURE 2



By uncovering these "mind maps" among parents of eligible uninsured children and understanding the linkages, Wirthlin Worldwide and the CKI Communication Team was able to identify the positive and personally relevant messages most likely to motivate people to act. Communication is most effective if it uses language that people understand and use themselves. The nature of this research process elicited that language from respondents. With this insight, Wirthlin Worldwide and the CKI Communication Team was able to understand what parents meant when talking about these issues (i.e., did they refer to "insurance", "insurance coverage" and/or "health coverage", etc.).

Summary of Research Components: Objectives and Key Findings

The following provides a summary of the key objectives and findings from each of the eight primary research components for this overall program.

National Quorum™

Questions to be Answered:

1. What is the incidence of U.S. households with uninsured children?
2. How many Americans know someone who is uninsured?
3. How aware are Americans of Medicaid and SCHIP options for children's health care coverage?

Methodology:

- Fielded from April 7 to April 12, 2000.
- National telephone survey of 1,006 randomly selected adults with a subsample of 409 parents with children under 21 years of age living in the household.

Key Findings:

- Nationally, 16% of parents with children under 21 years of age in the household indicated they do not have health insurance coverage for their children that covers regular trips to the doctor as well as emergency care (this translates into 6% of the total sample of U.S. households).
- Another 14% said they have Medicaid or coverage through another government program, while 60% have employer-sponsored health plans, 9% have other private health coverage, and 1% either do not know or refused to give an answer.
- More than one out of four (27%) U.S. adults said they know someone "whose children, for any reason at all, do not have health insurance coverage for regular doctor visits or emergency care." The people they know tend to be close friends (50%), relatives (40%), neighbors (24%), co-workers (24%), or "other people you know" (41%).
- Four out of ten (42%) Americans said they are aware of "options for someone to get free or low cost health insurance coverage for their children if they cannot afford it on their own or through their employer" and 36% were able to tell us what specific option of which they were aware.

How Used In Campaign:

- Starting point for designing the national benchmark survey among parents of uninsured children.

- Benchmark numbers for program name recognition and percent without coverage for later national tracking.

VISTA™

Questions to be Answered:

1. What are the primary concerns parents have in raising their children?
2. What are they currently doing to provide for the health needs of their children?
3. How do parents of eligible uninsured children react to health care coverage options of Medicaid and SCHIP?
4. What stigma is associated with government health care coverage programs?

Methodology:

- Conducted in April/May 2000 in Los Angeles, CA and Chicago, IL.
- In-person, one-on-one, 2-hour interviews.
- Stratified sample of 114 adults whose children are eligible for Medicaid or SCHIP.
- Designed to focus on contrasting parents of eligible enrolled children (n=56) and parents of eligible uninsured children (n=58).
- Targeted four ethnic groups (Caucasian n=26, African American n=30, Hispanic/Latino n=32, and Native American n=26).

Key Findings:

- In the context of raising their children, parents focused on the issues of protection, education / guidance, and having the resources to meet basic needs. The words *health care* or *insurance* were seldom used, though clearly the language parents use regarding *protecting* or *taking care of* their children has a strong, though not articulated, link to the health insurance concept.
- There were two key perceptual pathways most parents follow. One led through the higher-order emotional gateway of being a good parent, while the other passed through a realm of considerations summarized as less stress/worry.
- The end value most parents seek when thinking about their children in a variety of contexts is peace of mind, often reached through a state of personal happiness. At considerably lower frequencies, the values of pride, accomplishment, and self-esteem come into play – particularly when parents focus on themselves.
- Focusing attention on health decisions fleshes out the parental thought pattern in the key linkage between the protect and good parent/less worry factors: with access to knowledgeable professionals, helping children get the help they need, and thus staying healthy.
- When parents considered the merits of Medicaid/SCHIP, they concentrated most on the dual forces of insurance benefits (which ties to both access and care) and low cost (which ladders primarily to the idea of *saving money/less worry*).
- Finally, focusing on the feedback parents would expect, by far the dominant idea was reinforcement of the happiness that their children have adequate coverage, though a segment of parents were more sensitive to a sense of stigma.

How Used In Campaign:

- Probed the links between the tangible dimensions that characterize these programs, and the thoughts and emotions that they evoke among potential participants.
- Used to generate the communications framework for messages that motivate action.

Pre-Test Benchmark Survey

Questions to be Answered:

1. Quantitatively answer the same primary questions from the VISTA study.
2. How serious of a problem is stigma – social and treatment?
3. How do parents of eligible uninsured children react to the primary messages derived from the VISTA study?

Methodology:

- Fielded from June 8 to July 6, 2000.
- National telephone survey of 829 low-income, parents of eligible children.
- Oversample of 1,949 interviews among low-income, parents of eligible children under the age of 19 residing in the six states targeted for the wave one advertising campaign as well as in two comparison markets.

CKI Pre-Test Markets	
Test Markets	**Sample Size**
Fresno, CA	247
Albuquerque, NM	197
Springfield, IL	247
Baltimore, MD	274
Boise, ID	242
Greenville, NC	255
Comparison Markets	**Sample Size**
Idaho Falls, ID	247
Wilmington, NC	240

- To participate in the survey, parents had to fit into one of two categories: (1) parents whose children were already enrolled in Medicaid or SCHIP; or (2) parents of uninsured children who were eligible for coverage through either program according to current state eligibility requirements.
- Spanish-speaking respondents were given the option of participating in Spanish.

Key Findings:

- Only one out of five parents of eligible uninsured children (22%) was readily aware of the SCHIP program in their state. And most (72%) of those who had heard of it believed they would not be eligible to get coverage for their kids.
- More than half (58%) of parents of SCHIP-eligible uninsured children had either NEVER had coverage for their children or had been without coverage for more than a year – they had no reason to believe they would qualify for coverage.
- Among the uninsured, 69% of those eligible for SCHIP and 75% of those eligible for Medicaid said they would be EXTREMELY likely to enroll, if they knew they were eligible.
- The most frequently mentioned hesitations among parents of SCHIP-eligible uninsured children were an admitted lack of information (27%) and a firm belief they would not be eligible (24%).
- These parents strongly believed having health care coverage is "part of being a good parent" (78%) and with it, they would be "less stressed" (72%) about making ends meet for their family living expenses.
- Seventy-five percent of parents of eligible children believed government health programs based on financial need are a *good thing to help people take care of their families*, while only 25% said these programs are a *public symbol that I cannot make it on my own*.

How Used In Campaign:

- Quantitatively tested the communications framework resulting from the VISTA study.
- Tested specific message elements to be used in paid advertisements.
- Generated findings to be used for earned media coverage.
- Provided benchmark measurements for pre/post comparison of the impact of the campaign.

Pulseline™

Questions to be Answered:

1. How do parents of eligible uninsured children respond to various communication executions?
2. What message elements are most effective and why?
3. What is confusing or missing in the rough cut communication executions?
4. What themelines, logos, and phrases are most effective in a campaign for this effort?

Methodology:

- Conducted on July 6 and 10, 2000 in Baltimore, MD and Fresno, CA, respectively.
- Two groups in Baltimore and two groups in Fresno, for a total of 101 parents of eligible uninsured children.
- Nine different advertisement executions were tested, although one spot (*Worry*) was eliminated after Baltimore due to receiving particularly low scores from participants.
- Participants used a small hand-held device to record their reactions, moment-by-moment, to each advertisement execution.

- After viewing the advertisement executions, participants were separated into smaller groups to answer more detailed questions about each spot.

Key Findings:

- *Hard Choices* was the most effective at linking the parenting/worrying elements and, as such, scored the highest. The other spots that came out on top by ethnicity included:
  - Caucasian → *Care Giver* and *What If*?
  - African American → *Breathe* and *One In A Million*
  - Hispanics → *Cash Register* and *Recovery Time*
- The most positive themeline: "The health care they need. A health plan you can afford."
- Use of the SCHIP state-specific program logo was most effective by itself – it performed twice as well on its own, compared to the Medicaid, CKI, and RWJF logos.
- The phrases "for working families" and "even if you work" were very powerful – but could be more powerful with an income amount added.
- The addition of a dollar figure was an effective way to catch the attention of parents of SCHIP-eligible uninsured children and to motivate them to call by overcoming the misperception that "I would not be eligible."

How Used In Campaign:

- Identified the most effective advertising executions.
- Pointed out specific changes to make the final advertisement executions more effective.

State Medicaid and SCHIP Toll-free Hotline Follow-up Research

Questions to be Answered:

1. Who called the hotline number during the time the campaign was underway?
2. What motivated parents to make the call?
3. How much of a role did the earned media and paid media efforts play in motivating hotline calls?
4. How many callers intended to apply for SCHIP for their children?

Methodology:

- Fielded from August 24, 2000 to September 16, 2000.
- Telephone survey among 503 adults who called the hotline number specified in the advertisements in the Albuquerque, NM (n=359) and Greenville, NC (n=129) media markets.
- Respondents were callers who agreed to a follow-up phone interview at the time of their original call to the toll-free number. Respondents were contacted within 48 hours of making the call.

Key Findings:

- Most callers to the hotline numbers were doing so for the first time for a child living in their household, showing the effectiveness of the advertisements in reaching the target parents.
- Almost all those who made the call said they learned of the telephone number from the advertisements—mostly from television advertisements.
- Callers were most likely to say they remember the ads talking about *insurance for children* and that an income figure was provided
- *Breathe* was the most effective in leaving a specific memorable impression.
- Intent to apply for coverage among those who called was very high in both markets.

How Used In Campaign:

- Evaluated how effective the advertisements were in motivating parents of eligible uninsured children to call.
- Identified any refinements in the message and/or communications for future waves.

Post-Test Evaluation Survey

Questions to be Answered:

1. What is the level of recall of the advertisements in each of the test markets?
2. What effect did the campaign have in each of the following areas?
   - ✓ Recall of advertising efforts …*leading to…*
   - ✓ Increased awareness of free or low-cost health care coverage for children …*leading to…*
   - ✓ Higher recognition of the SCHIP program (Medicaid name recognition universal) …*leading to…*
   - ✓ Belief that "my child" may be eligible for coverage …*leading to…*
   - ✓ Action taken to call the state Medicaid and SCHIP toll-free hotline numbers …*leading to…*
   - ✓ Intent to apply for coverage.
3. How are these measurements different in the test versus the comparison markets?

Methodology:

- Fielded from September 16, 2000 to October 17, 2000. Interviewing began in each of the markets (6 test markets, 2 comparison markets) the day following the end of the ad runs in that market.
- Telephone survey with 3,014 adults with a child under the age of 19 in the household. These interviews were divided across the markets as follows:

CKI Post-Test Markets	
Test Markets	**Sample Size**
Fresno, CA	383
Albuquerque, NM	305
Springfield, IL	383
Baltimore, MD	419
Boise, ID	374
Greenville, NC	395
Comparison Markets	**Sample Size**
Idaho Falls, ID	383
Wilmington, NC	372

- To participate in the survey, parents had to fit into one of two categories: (1) parents whose children were already enrolled in Medicaid or SCHIP; or (2) parents of unenrolled children who were eligible for coverage through either program according to current state eligibility requirements.
- 645 individuals, across all 8 media markets, completed both the pre-test benchmark survey and the post-test evaluation survey, providing a panel of respondents with which to compare changes during the campaign.
- Spanish-speaking respondents were given the option of participating in Spanish.

Key Findings:

- Overall, there was much higher recall of campaign advertising and other efforts in the test markets versus the comparison markets. Specifically, 58% of the parents of eligible uninsured children across all test markets remembered seeing the advertisements (up from 13% before the campaign who said they recalled having seen advertisements about these programs). In the comparison markets, 37% of the parents of eligible uninsured children remembered seeing the advertisements (up from 9% before the campaign).
- Parents of eligible children who live in urban (58%) and suburban (59%) locales are significantly more likely to recall seeing campaign advertising than parents in rural areas (48%).[4]
- Name recognition of government programs for health care coverage increased by 15 percentage points among the target audience from 51% to 66%.
- SCHIP program name recognition increased by 13 percentage points to 68%.
- Advertisements appear to have been effective in helping more parents of eligible uninsured children realize their child may be eligible for coverage, compared to benchmark levels (from 37% to 63%).
- Overall, 14% of the parents of eligible uninsured children across all test markets said they called the hotline number for more information after having seen the advertisements. This translates into one out of every four of the parents of eligible uninsured children who saw the advertisement actually made the call—a high rate.

[4] Urban, rural, and suburban areas are defined according to Census data that designates the Central Cities within a Metropolitan Statistical Area (MSA) ("urban"), non-Central City portions of an MSA ("suburban"), and non-MSA counties ("rural").

- Additionally, the brief campaign resulted in one out of every ten parents of eligible uninsured children saying they now plan to apply for coverage. This translates into two-thirds of parents of eligible uninsured children who made the call saying they now plan to follow through and apply.
- Parents of eligible uninsured children in the test markets were three times as likely to call the hotline number for information than those in the comparison markets, and nearly five times more likely to say they plan to enroll their children.
- The percentage who believes "my child" is eligible for Medicaid or SCHIP has increased to 63% as a result of the campaign. Awareness of eligibility increased to 54% among the eligible-uninsured in the comparison markets.
- Parents of eligible children who live in rural areas (21%) are significantly more likely to believe government health programs are a symbol that they cannot make it on their own compared to parents in suburban (16%) and urban (14%) areas.

How Used In Campaign:

- Evaluation of the effect of the campaign.
- Identified any refinements in the message and/or communications for future waves.

Opinion Leader Interviews

Questions to be Answered:

1. How aware are these opinion leaders and policy makers of SCHIP programs?
2. How important do they consider these programs to be?
3. What perceptions do they have of those who currently receive government aid?
4. How do they define success for these programs?

Methodology:

- Fielded from June 2, 2000 to July 31, 2000.
- 20 in-depth interviews with opinion leaders across the country in positions with responsibility or involvement with government health care programs for children.
- Respondents included state and local elected officials (including one governor), legislative or administrative staff members, state and local government employees, and staff members at foundations or universities.
- Eight interviews were conducted with respondents at the state level, eight with those at the local level, and four with those representing foundations or universities.
- Respondents represented the following states: Alabama, Idaho, Massachusetts, New Jersey, Ohio, Pennsylvania, Texas, Vermont, and Virginia, as well as the District of Columbia.

Key Findings:

- Awareness of SCHIP and state-branded SCHIP programs by name was high, but clearly was not at the same level as Medicaid, even among this opinion leader / policy maker audience.
- Respondents perceived Medicaid and SCHIP as serving very different clientele. Medicaid was seen as providing health care coverage for those at the bottom of the economic ladder—welfare

recipients, single mothers, the unemployed, people with spotty work histories, minority group members, and/or the poorly educated. SCHIP was viewed as serving the children of low income, working families.
- Respondents suggested that publicity about SCHIP be broadened beyond traditional media delivery channels. They encouraged outreach efforts that will reach people in places in the community that they frequent—churches, grocery stores, schools, daycare centers, etc.

How Used in Campaign:

- Guided communications and other efforts to interact with policy makers about these programs.
- Gained an understanding of the opinions of a key level of individuals who influence the funding and management of these programs.

Congressional Omnibus™

Questions to be Answered:

1. How high of a priority is reducing the number of uninsured among congressional staffers?
2. How effective do they see Medicaid and SCHIP in reaching their objectives?

Methodology:

- Fielded from April 26, 2000 to June 16, 2000.
- Telephone interviews with 150 senior congressional staff on Capitol Hill.

Key Findings:

- The issues of access/coverage (29%) and cost (19%) emerged as top health care priorities on an unaided basis among staffers.
- Most staffers (78%) said reducing the number of uninsured Americans should be a top priority (ratings of 4 and 5 on a 5-point scale). Interestingly though, few saw this goal as attainable. Only 35% rated the goal similarly on attainability. (Average scores are 4.2 and 3.2, respectively, on the same scale).
- Thirty percent (30%) of staffers were not able to rate the SCHIP program for its effectiveness. Of those who were able to rate it, 27% rated it a 50 or below (on a 100-point scale). The average rating of the program was a modest 60.2. In general, effectiveness or favorability scores in the 51-60 range imply that perceptions are at best slightly above average. For context, a very good rating is typically in the 65-70 range. A poor rating is 50 or below.
- Staffers gave Medicaid a slightly higher average effectiveness rating of 65 (on a 100-point scale). Four out of ten (40%) staffers rated Medicaid between 71 and 100 in effectiveness.

How Used in Campaign:

- Established benchmarks of Congressional attitudes.

Caseworker Focus Groups

Questions to be Answered:

1. How do caseworkers view those who receive Medicaid and/or SCHIP coverage?
2. How familiar are caseworkers with the SCHIP program?
3. What motivates someone to start and keep this job over time?

Methodology:

- Conducted in June, 2000 in Chicago, IL and Los Angeles, CA.
- Two focus groups with a total of 22 caseworkers and other public employees who work with state Medicaid and/or SCHIP programs.

Key Findings:

- Most social workers in the groups enjoyed being able to help people with their problems. When these public employees were able to help others, they felt happy that they had been able to make a difference in someone else's life. Higher-level values that are triggered by this process include *self-esteem*, *satisfaction*, *accomplishment,* and *pride*.
- There was another set of caseworkers, however, who were driven by the sense of control and power they felt in having people come to them for help and relying heavily on them, individually, to find solutions to their problems.
- There was universal understanding of state Medicaid programs—typically referred to as public aid or a medical card (in Illinois) among caseworkers. Awareness of state-branded SCHIP programs was far lower, however. There was a strong need to build awareness among front-line workers of the SCHIP program, eligibility requirements, and how it works in tandem with the Medicaid program.
- Social workers provided the following explanations for why people do not seek coverage:
  - ✓ ***A lack of awareness about the programs among potential clients.*** This was seen as the biggest barrier for SCHIP programs at present. Probably a majority of those who are eligible for the program are unaware of its existence, according to those on the front line.
  - ✓ ***The nature of the potential client pool.*** Many of the problems associated with lower socio-economic status, such as language barriers, low education, and a high percentage of transients, make it more difficult to enroll people in government programs.
  - ✓ ***A fear of deportation.*** Potential clients who are in the United States illegally have a fear of being deported if they register for government benefits of any kind.
  - ✓ ***A lack of understanding about the importance of health care.*** A common theme among social workers was the perception that potential clients do not value the need for regular, non-emergency health care and/or preventive health care programs such as immunizations. Both cultural and socio-economic factors are involved here. However, based on research findings, this perception is, in fact, not true—parents do value this type of care more than many expect.

- ✓ ***A social stigma attached to government programs.*** Another perception among social workers was that a significant number of those who are eligible for SCHIP hesitate to sign up for it because they feel it indicates they are receiving public assistance, an indication they cannot make it on their own. Many caseworkers said having to visit the welfare office to sign up is a negative for many potential SCHIP recipients who want to avoid the impression they need public assistance. The reality, based on the research findings, is this perceived social stigma is not a significant barrier.
- ✓ ***A desire to avoid sharing personal information.*** Social workers reported that some potential clients do not want to share this information with the government and thus avoid enrolling.
- ✓ ***A lack of awareness and/or training about the SCHIP program among public employees.*** Employees who are not aware of the program or who do not understand how to enroll people present an obvious barrier to efforts to increase enrollment. Even among those who are aware of SCHIP, only a few have received specific training about the enrollment process for this program.
- ✓ ***An inconvenient registration process.*** Because most potential participants in the SCHIP program are employed, social workers said these parents have difficulty taking time off from work to wait for what may be hours at the welfare office in order to enroll.
- ✓ ***Difficulty with the enrollment process.*** While participants said that the SCHIP enrollment process is far simpler than it used to be, the red tape involved still presents a barrier for some. Medicaid enrollment was also seen as involving a lot of red tape.

- Once a person is enrolled, from the social workers' perspective, the major barrier to continuing enrollment in the program is ineligibility as parents enter a higher income bracket.

How Used in Campaign:

- Gained an understanding of the behaviors and attitudes of those most directly involved in the enrollment process. Even though the campaign does not cover or affect their behavior, it is an important component to successfully enrolling more people.

Post-Campaign Ad Testing Focus Groups

Questions to be Answered:

- How powerful are the final public service announcement (PSA) executions with respect to delivering on the core communication strategy?
- What value do the words "working families" add to the advertisements?
- Is there added value in having the dollar figure included in the advertisements, or not?
- How does the target audience react to various phrases describing eligibility?
- How would the eligible uninsured react if they were to call and find out they were not eligible?

Methodology:

- Two groups conducted on January 31, 2001 in Miami, FL and two groups conducted on February 1, 2001 in New Orleans, LA.
- Participants were parents of uninsured children who would qualify for Medicaid or SCHIP.

Key Findings:

- The PSA executions were very effective at motivating people to call. In fact, the scores for the ads on the key measurements increased considerably since the rough cut tests in July 2000.
- The phrase "working families" helped communicate to parents of uninsured children who are employed that the program is for them. At a bare minimum, either this phrase or visuals showing working families must be included.
- Including the dollar figure is one additional "silver bullet" that brings in that last group of people who are sitting on the fence because they do not believe they are eligible.
- The approach of catching attention to create a feeling that "I might be eligible" was effective in motivating someone to call. Attempts to define parameters of eligibility were confusing.
- Most participants said they would feel frustrated if they called the toll-free number and found out they were not eligible. However, they would be glad that they took the time to try. In fact, almost all said they would tell others about it with the hope that maybe others would qualify.
- There are elements of each of the three brochure concepts that appealed to this audience. Most preferred pictures of children who vary in age and ethnicity. Bright colors, such as red, yellow, and green were eye-catching. Finally, the words "low-cost or free health care coverage" immediately captured the audience's attention and made them want to pick up the brochure to learn more.
- Most participants did not mention lack of health care coverage when asked about the biggest challenges they face as a parent. However, when probed further, they revealed that the lack of health care coverage is, in fact, the source of their day-to-day worry about finances and keeping their children safe and healthy.

How Used in Campaign:

- Identified any refinements in the message and/or communications for future waves.

CHAPTER 2: CHALLENGES AND BARRIERS IDENTIFIED

This chapter reviews the child health care coverage landscape from the perspective of parents of uninsured children eligible for coverage through Medicaid or SCHIP. Specifically, this chapter addresses the following challenges identified through the formative research that impede parental action toward receiving health care coverage for their children:

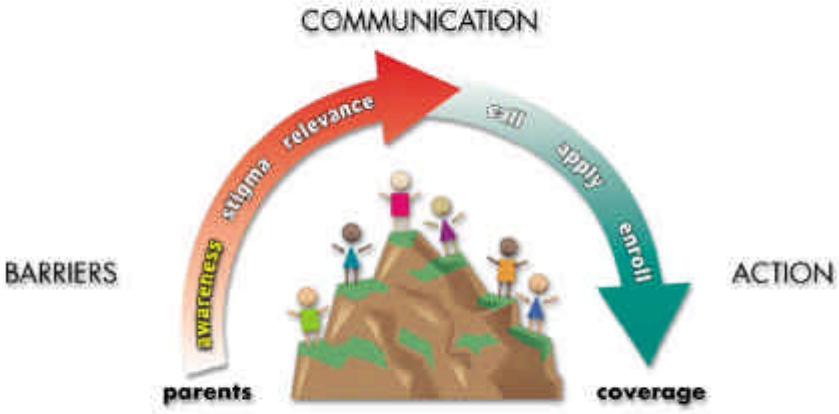
- **Awareness** – how aware are parents of insurance opportunities for their children? How does awareness differ by eligibility? Where do parents most frequently learn about coverage options?

- **Stigma** – what is the relative importance of social stigma versus treatment stigma? How might treatment expectations influence the decision to pursue coverage? What affect does enrollment status have on perceptions of the programs?

- **Relevance** – what do people understand about who these programs are designed for? What is the difference among those who are eligible and those who are not? What is the relative importance of insurance coverage compared to other health care related issues?

By understanding these barriers, the CKI Communications Team was able to craft the most effective communication strategy designed to eliminate or reduce these barriers thus motivating the parent to call, apply, and enroll.

Barrier One: Awareness



Referring to the previously discussed "hierarchy of effects model," the initial step is to generate awareness of Medicaid and SCHIP in order to motivate parents of eligible uninsured children to enroll. The research shows that there is a need to increase awareness of specific SCHIP government health care programs among parents of eligible uninsured children. However, the good news is that awareness (name recognition) is much higher than had been expected and, therefore, is a relatively small barrier to overcome.

National Quorum™ Results

Our national population survey showed 42% of Americans claimed they are aware of "options for someone to get free or low cost health insurance coverage for their children if they cannot afford it on their own or through their employer" and 36% could tell us a specific program of which they are aware. When asked to name the option, collectively, one out of five adults (21%) cited a specific program, either Medicaid (6%), SCHIP (5%), or government programs in general (10%). The other 15% of total mentions said WIC, welfare, private insurance, Blue Cross/Blue Shield, or a hospital emergency room.

Looking across demographics, name recognition among the general public was generally highest among those who did not need Medicaid or SCHIP coverage for their children—i.e., higher educated, higher income, and those who already have insurance. However, working women were among those most likely to be aware of Medicaid or SCHIP programs (57% said they are aware and 33% could volunteer a program name).

This initial national population research showed only 35% of those who said they currently do not have health care coverage for their children were aware of options available for free or low-cost insurance. And only 15% of these parents volunteered either Medicaid or SCHIP programs as options available to the uninsured who cannot afford private insurance.

Pre-test Benchmark Results

Our quantitative benchmark study among a national sample of parents of eligible uninsured children showed general name recognition of these programs was slightly higher than what Wirthlin Worldwide found among the general public. Specifically, more than half (55%) of parents of eligible uninsured children said they know of options to get "free or low cost health insurance coverage for their children if they cannot afford it on their own or through their employer."

However, although specific name recognition of Medicaid was almost universal among the parents of eligible uninsured children, only 42% of those eligible for SCHIP but currently not enrolled had heard of the program when asked directly about the program name in their state. Prior to the national benchmark study and in the initial qualitative VISTA interviews, Wirthlin Worldwide heard many parents of eligible uninsured children express a lack of awareness and understanding of SCHIP. The national study quantified this fact.

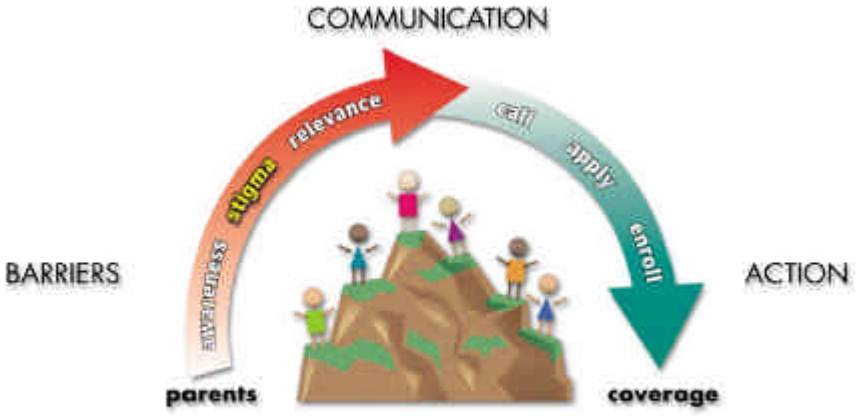
Those who had heard of Medicaid were most likely to say they learned of it through the welfare office (23%), family (16%), friends (15%), or a doctor/nurse (12%). In comparison, those aware of SCHIP by program name were more likely to say they had learned of it on TV (16%) or from the welfare office (11%), doctor/nurse (11%), friends (9%), or their children's school (9%). This would suggest more

memorable advertising of SCHIP had been aired since its inception just three years ago than had been used to promote Medicaid.

Conversations with family, close friends, and doctors were the key avenues of increasing awareness of these programs. In fact, parents of eligible uninsured children were most likely to say they talk "regularly or quite often" to their relatives (33%), close friends (27%), or doctor (23%) about what to do to acquire health care coverage for their children. And more than one out of four Americans (27%) said they know someone who does not have health insurance coverage for their children.

In summary, the awareness barrier is more specifically tied to a lack of awareness of eligibility. That is, many parents of eligible uninsured children are not aware that their children might qualify for SCHIP. However, the barrier is not as high as had been expected; nonetheless, it is a critical first step in moving parents of uninsured children toward the desired action.

Barrier Two: Stigma



The hypothesis that social stigma is the most significant barrier preventing parents of uninsured children from enrolling in Medicaid and/or SCHIP received little support from this research. Instead, the primary barrier related to stigma is with respect to how parents of eligible uninsured children believe they will be treated by social workers and those at the front desk in a doctor's office if they have Medicaid or SCHIP coverage for their children or *treatment stigma*. This is not to say social stigma is non-existent—in fact, it is a more significant issue among parents of SCHIP-eligible uninsured children than among parents of Medicaid-eligible uninsured children. But, generally speaking, most parents of eligible uninsured children were not worried about how they will be looked upon by family, friends, or co-workers if they were to have Medicaid or SCHIP coverage for their children.

VISTA™ Results

Evidence of this assertion was found in many facets of the research. First, when the issue of stigma was explored in the VISTA interviews, parents of eligible children said those closest to them would see their enrollment in Medicaid or SCHIP as a smart decision to ensure their children receive the help they need to remain healthy. Instead of being concerned about social stigma, parents expressed concern about how they would be treated when they took their children to a doctor's office. The following are concerns cited most frequently:

- People on Medicaid are Treated Like Second Class Citizens (43%)
  "I've been treated like a number and not a person."
  "There is a difference made between Medicaid patients and those on private insurance – the medical professionals look down on those with a medical card."

- The Medical Staff is Rude / Uncaring (23%)
  "The doctor's attitude, uncaring the way he talks to me and my daughter."
  "There are doctors and nurses that don't like kids or they treat them badly."

- People on Medicaid are Made to Wait Longer (20%)
  "I speak from experience. My son was bleeding all over when we were on the [State Medicaid program] card and they made us wait. When my son had a skin problem and we were on HMO, they took us right in."
  "It's a big difference, we have to wait, it doesn't matter how sick the person is."

As evident above, many of these comments were made in reference to Medicaid. For most of the parents of eligible uninsured children, Medicaid was their only prior frame of reference for government health care programs since many were not very familiar with the SCHIP program. It was clear these concerns dominate their perceptions of government health care programs in general.

Pre-Test Benchmark Results

The quantitative benchmark survey confirmed the concern parents of eligible uninsured children have about the slowness of treatment is prevalent across the country for those on Medicaid or SCHIP. On a 5-point scale in which a 1 means *slow* and a 5 means *quick*, parents of eligible, enrolled children gave treatment when enrolling in the program an average rating of 3.5, clearly the most negative rating given across all attributes tested. However, the score is still higher than the midpoint of 3 (on the 5-point scale).

Looking at the various treatment measurements assessed in the benchmark survey, the most positive ratings were given to actual and expected treatment by the doctors and nurses, while the most negative assessments were given to expected treatment of parents of eligible uninsured children by front office personnel AND by those with whom parents of eligible uninsured children would interact when applying for Medicaid or SCHIP. Tables 1 – 3 below show these ratings.

TABLE 1

TREATMENT BY DOCTORS AND NURSES

	Medicaid Experience n=539*	SCHIP Experience n=323*	Unenrolled Expectation n=504
Ignored Questions (1) – Answered Questions (5)	4.6	4.6	4.4
Difficult (1) – Helpful (5)	4.6	4.5	4.4
Rude (1) – Friendly (5)	4.6	4.5	4.3
Angry (1) – Happy (5)	4.5	4.5	4.3
Not interested in me (1) – Cared about me (5)	4.5	4.5	4.2
Slow (1) – Quick (5)	3.9	3.9	3.8

***Questions were asked of half of the sample.**

CKI Pre-Test Benchmark Survey June 8, 2000-July 6, 2000, n=2,888

TABLE 2

TREATMENT BY FRONT OFFICE

	Medicaid Experience n=567*	SCHIP Experience n=307*	Unenrolled Expectation n=504
Ignored Questions (1) – Answered Questions (5)	4.5	4.6	4.2
Difficult (1) – Helpful (5)	4.5	4.5	4.1
Rude (1) – Friendly (5)	4.6	4.5	4.1
Angry (1) – Happy (5)	4.3	4.4	4.0
Not interested in me (1) – Cared about me (5)	4.4	4.4	4.0
Slow (1) – Quick (5)	4	3.9	3.5

***Questions were asked of half of the sample.**

CKI Benchmark Survey June 8, 2000-July 6, 2000, n=2,888

TABLE 3

TREATMENT WHEN ENROLLING IN PROGRAM

	Medicaid/SCHIP Experience n=2456*	Unenrolled Expectation n=432
Ignored Questions (1) – Answered Questions (5)	4.1	4
Difficult (1) – Helpful (5)	3.8	3.8
Rude (1) – Friendly (5)	3.8	3.8
Angry (1) – Happy (5)	3.8	3.8
Not interested in me (1) – Cared about me (5)	3.7	3.7
Slow (1) – Quick (5)	3.5	3.5

***Questions were asked of those currently enrolled, those who had been enrolled in the past, and those who had applied for coverage.**

CKI Benchmark Survey June 8, 2000-July 6, 2000, n=2,888

As evident above, parents of eligible uninsured children were as positive about the expected helpfulness and caring of medical professionals as were their enrolled counterparts who were speaking from their experience. But parents of eligible uninsured children were more apprehensive about the treatment from non-professional medical gatekeepers.

Unfortunately, both experience with and expectations of treatment by Medicaid/SCHIP contacts during the enrollment process were more negative than comparable figures for treatment by other professionals in the medical system (medical offices). And those who speak from experience in the system were more negative than those who can only describe their expectations. Specifically, 13% of parents of eligible children who have enrolled in either program said poor treatment was the biggest problem they encountered in the enrollment process. Although nearly a third (30%) said they *did not have any problem* at all when enrolling, the most frequently mentioned problem was *too much paperwork* (23%).

None of the assessments above, however, are extremely negative. In fact, satisfaction with coverage was very high among those enrolled in either program. Almost nine out of ten (88%) Medicaid recipients said they were extremely or very satisfied with the coverage they have for their children. Seventy-nine percent (79%) of SCHIP enrollees expressed a similar level of satisfaction.

The most important finding from the benchmark study with respect to evaluating the barrier of stigma, however, was how parents of eligible children told us they felt about both programs. Those who are enrolled in Medicaid gave the program a very high favorability rating of 84 on a 100-point scale. Similarly, those enrolled in SCHIP gave the program a rating of 86. Those eligible for Medicaid but not enrolled gave the program a high rating of 69, exactly the same rating given to SCHIP by those eligible for SCHIP but not currently enrolled. Therefore, parents of eligible children did not feel negative toward these programs, and tended to have even more positive feelings toward both programs once they are actually enrolled.

Wirthlin Worldwide also discovered that parents of eligible uninsured children would gladly enroll for coverage if they knew they were eligible. Specifically, 85% of those eligible for Medicaid said they would be extremely or very likely to enroll in the program. Three out of four (78%) parents of SCHIP-eligible uninsured children also said they would be extremely or very likely to enroll their children. Of those who said they would not enroll in Medicaid, only 10% volunteered it was because they did not want to depend on the government, and just 7% said it was because of a social stigma associated with the program. Only 9% of those who would not enroll in SCHIP volunteered a similar reason.

In the most direct measure of the influence of social stigma on enrollment, respondents were presented with two different opinions of government health programs based on financial need and were asked to report which opinion came closer to their own. The statements presented to respondents were:

> *Some people say government health programs based on financial needs are embarrassing because they are a public symbol that I cannot make it on my own.*
>
> *Other people say government health programs based on financial needs are simply a good thing to help people take care of their families.*

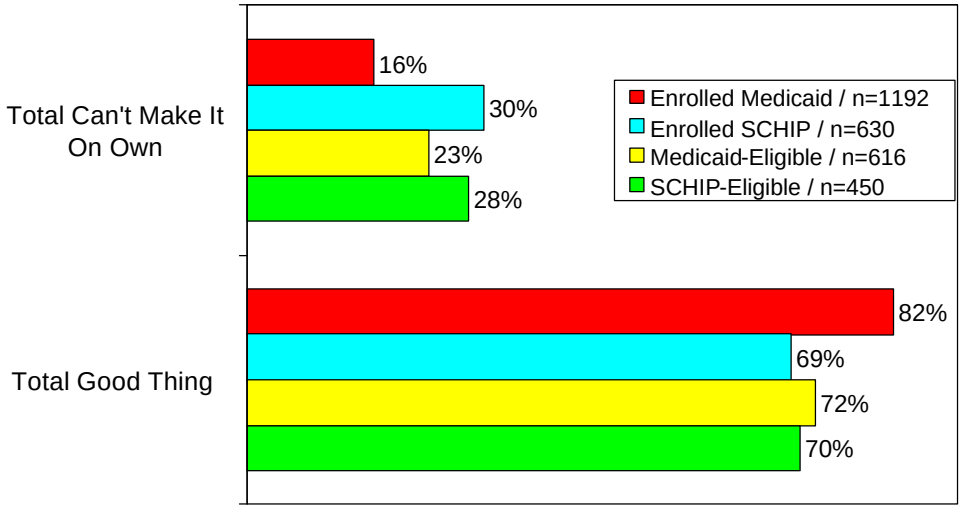
The findings confirm that social stigma was not a significant barrier among most parents. That is, a clear majority of parents (75%) believed that enrollment in such programs is simply a good thing. Even among those who are eligible for the programs, but whose children are not currently enrolled, 69% reported such programs are a good thing, and only 27% said that such programs mean that is a public sign they cannot make it on their own.

Social stigma was also examined looking at parents who live in urban, suburban, and rural areas.[5] The data show that parents of eligible children who live in rural areas (25%) are significantly more likely to believe that enrollment in government health programs are a public symbol that they cannot make it on their own compared to their counterparts who live in suburban areas (19%). There is no significant difference between rural and urban areas (22%).

As illustrated in Figure 3, parents of SCHIP-eligible uninsured children were the target audience most likely to express a higher level of social stigma as a barrier to enrolling their child in these programs.

FIGURE 3

SCHIP Target Parents Feel More Embarrassed About Program Participation Than Medicaid Parents

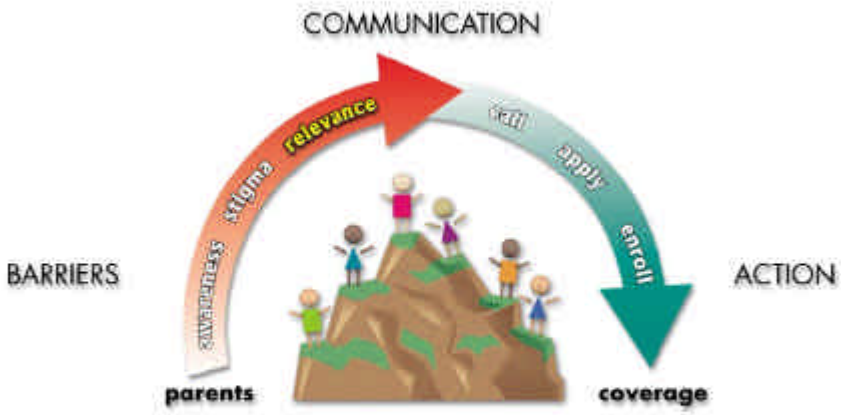


CKI Benchmark Survey June 8, 2000-July 6, 2000; n=2,888

[5] Urban, rural, and suburban areas are defined according to Census data that designates the Central Cities within a Metropolitan Statistical Area (MSA) ("urban"), non-Central City portions of an MSA ("suburban"), and non-MSA counties ("rural").

In summary, treatment stigma is a greater barrier to enrollment than is social stigma. However, neither aspects of stigma associated with these programs present an insurmountable barrier. In fact, data suggest the stigma barrier is not extremely high and is greatest with respect to those parents of eligible uninsured children.

Barrier Three: Relevance



Again following the Hierarchy of Effects Model, parents of eligible uninsured children will not express a desire to take action to enroll in Medicaid or SCHIP until they learn of the program and begin to develop an interest in it. A unique and significant obstacle in this effort is that most parents of eligible uninsured children stop short of demonstrating a specific interest in these health care coverage programs because they mistakenly write them off as programs intended for someone else—someone who is on welfare or is unemployed. As a result, exploring the issue of relevance became a vital component of the research because it represents the single greatest barrier keeping parents of eligible uninsured children from even starting the inquiry process for enrollment.

In short, this barrier is the misperception that these programs DO NOT apply to their family because they are employed and/or they make too much money to qualify. Thus, the programs are not perceived as relevant to many of these parents of eligible uninsured children. Wirthlin Worldwide found this early on in the VISTA™ interviews when parents of eligible uninsured children, after being told about Medicaid and SCHIP programs, responded with conviction that although they felt these programs are good for other families they are, in fact, "not for someone like me." This was especially true among those parents of SCHIP-eligible uninsured children. The magnitude of the problem emerged in the benchmark.

Wirthlin Worldwide saw further evidence of this barrier in the Pulseline™ advertisement testing phase. After watching multiple rough-cut television commercials promoting Medicaid and SCHIP during a two

and a half hour session, many parents of eligible uninsured children participating in the sessions said they enjoyed the spots but did not believe the programs were relevant to them since they work or make too much money. Once again, this feedback confirmed the necessity of finding ways to get the attention of parents of eligible uninsured children and make them think, "I might qualify for this."

Pre-Test Benchmark Results

In the national benchmark survey, this trend of relevancy was quantified. Specifically, six out of ten (57%) parents of eligible uninsured children who had heard of SCHIP or Medicaid said they did not believe or did not know whether their child(ren) is eligible for either program. This number was even higher when looking at parents of SCHIP-eligible uninsured children (66% did not believe they are eligible), Caucasians (67% did not believe they are eligible), and households in which both parents work (71% did not believe they are eligible). The significance of this barrier was magnified in light of the finding that 85% of those eligible for Medicaid and 78% of those eligible for SCHIP said they would be extremely or very likely to enroll their children if they knew they were eligible.

Another facet of relevance tested by Wirthlin Worldwide was the hypothesis that the parents of eligible uninsured children simply do not value health care coverage and, therefore, these programs are not personally relevant to them. This was not confirmed. In fact, these parents of eligible uninsured children indicated they do value health care for their children, but they struggle financially with how to afford it.

When asked to rate the importance (on a scale of 1 to 5) of several things parents may do to take care of their children, *taking your child to the doctor when it is necessary* (4.9), *taking your child to the doctor for wellness check-ups, immunizations, and preventive care* (4.7) and *providing health insurance coverage for your child* (4.7) were all rated extremely important. Wirthlin Worldwide found that 40% of the parents of eligible uninsured children were working and had health plans offered to them but turned the plans down; the other 60% were in jobs that did not offer health care coverage benefits. Most (67%) of those who turned the coverage down said they did so because it was not affordable.

Notably, while the importance of *taking a child to the doctor* received consistently high ratings across all ethnic subgroups, the importance of *check-ups* and *providing insurance coverage* was rated slightly lower by Caucasians than by African Americans or Hispanics. This difference increased even more when eligibility and enrollment status were factored in. Table 4 below shows these results:

TABLE 4

	Eligible – not yet enrolled (Importance Ratings 1-5)		
	Caucasian n=563	African American n=220	Hispanic n=217
Taking child to doctor when necessary	4.9	4.9	4.9
Taking child for check-ups/immunizations	4.4	4.8	4.7
Providing health insurance coverage for child	4.3	4.7	4.6

CKI Benchmark Survey June 8, 2000-July 6, 2000, n=2,888

As evident, *having insurance* and *taking their child to the doctor* was very important across ethnic groups. Caucasians tended to rate the importance of *having insurance coverage* lowest compared to other ethnic groups.

In summary, the most significant barrier to enrollment among the parents of eligible uninsured children is the mistaken notion that they would not be eligible for Medicaid or SCHIP coverage for their children. This is the key barrier to making these programs relevant. Parents of eligible uninsured children value health care coverage and preventive care, but are forced into choices of how to pay for it.

Chapter Summary

This research identified and measured barriers that must be overcome through the CKI campaign's strategic communications to motivate parents to action. Specifically, generating awareness of SCHIP by program name, increasing the value of Medicaid and SCHIP as products and services in order to overcome the treatment stigma associated with coverage, and raising the notion that these programs are designed for working families are the barriers preventing parents of eligible uninsured children from enjoying the benefits of this coverage.

The second objective of this research was to identify the most effective strategy to reduce these barriers and motivate parents of eligible uninsured children to take three key actions:

1) Call the state's Medicaid and SCHIP toll-free hotline number displayed to obtain information about the programs;
2) Apply for coverage; and
3) Enroll their child(ren) in the program.

The next chapter of this report reviews the communication framework developed for this campaign through Wirthlin Worldwide's formative research. It is important to note that this framework is designed to motivate the initial action of calling the toll-free number for more information. This strategy did not focus on the additional communications needed to increase the likelihood that the application and enrollment steps would be taken by parents of eligible uninsured children. Future research and exploration are needed to find ways to reduce barriers that impede parents whose children are eligible from completing the process.

CHAPTER 3: SOLUTIONS FOUND TO OVERCOME BARRIERS

This chapter reviews the framework for messages designed to motivate parents of eligible uninsured children to action, the strategic imperatives for addressing the barriers identified, and the assessment/refinement of specific executions produced by GMMB for the campaign.

Communications Framework

The research approach guiding the development of the CKI communications efforts is based on a conceptual foundation that Wirthlin Worldwide has found to hold true in all effective communications strategies. This foundation requires an understanding of personal values that are specific to the situation and context at hand.

VISTA™ Results

The VISTA™ methodology was designed primarily to probe the links between the tangible dimensions that characterize Medicaid and/or SCHIP and the thoughts and emotions that they evoke among potential recipients. The method relies on a *laddering* interview technique to help respondents verbalize the personal values that underlie these associations. As explained in the introduction, it begins by eliciting the most important rational factors associated with decision processes known as attributes and functional consequences, and then it *ladders* respondents to find the motivational aspects demonstrated by the psycho-social consequences and value level.

The rationale for this approach derives from Means-End Theory. From a communications standpoint, if one understands the ways in which people think about the issues, one can more effectively tap into the full range of tangible/emotional thought patterns. From experience, Wirthlin Worldwide also finds that the higher-order emotional motivators often are the most appropriate leverage points around which to build a campaign and can help serve as important gateways to the levels of entry outlined previously. The following section reviews the findings at each level of entry explored.

Concerns About Raising Child

Specific to the practices and concerns about raising a child, parents spoke predominantly about the components of being a good parent and protecting their child(ren). Key findings are as follows:

- Providing a loving and safe home;
- Protecting children from accidents, illness, bad friends, crime (bad friends being much more of a concern for African American parents);
- Helping a child to stay healthy (this would include actions such as providing proper food, immunizations, going to the doctor, providing insurance, and exercise);
- Emergency care (this was seen as more important than general wellness care);
- Spending time with a child—being a role model, a teacher, and providing emotional support;
- Providing a good education (this was viewed as most important by African Americans); and
- Child care/day care (this was generally rated low, particularly among Caucasian audiences).

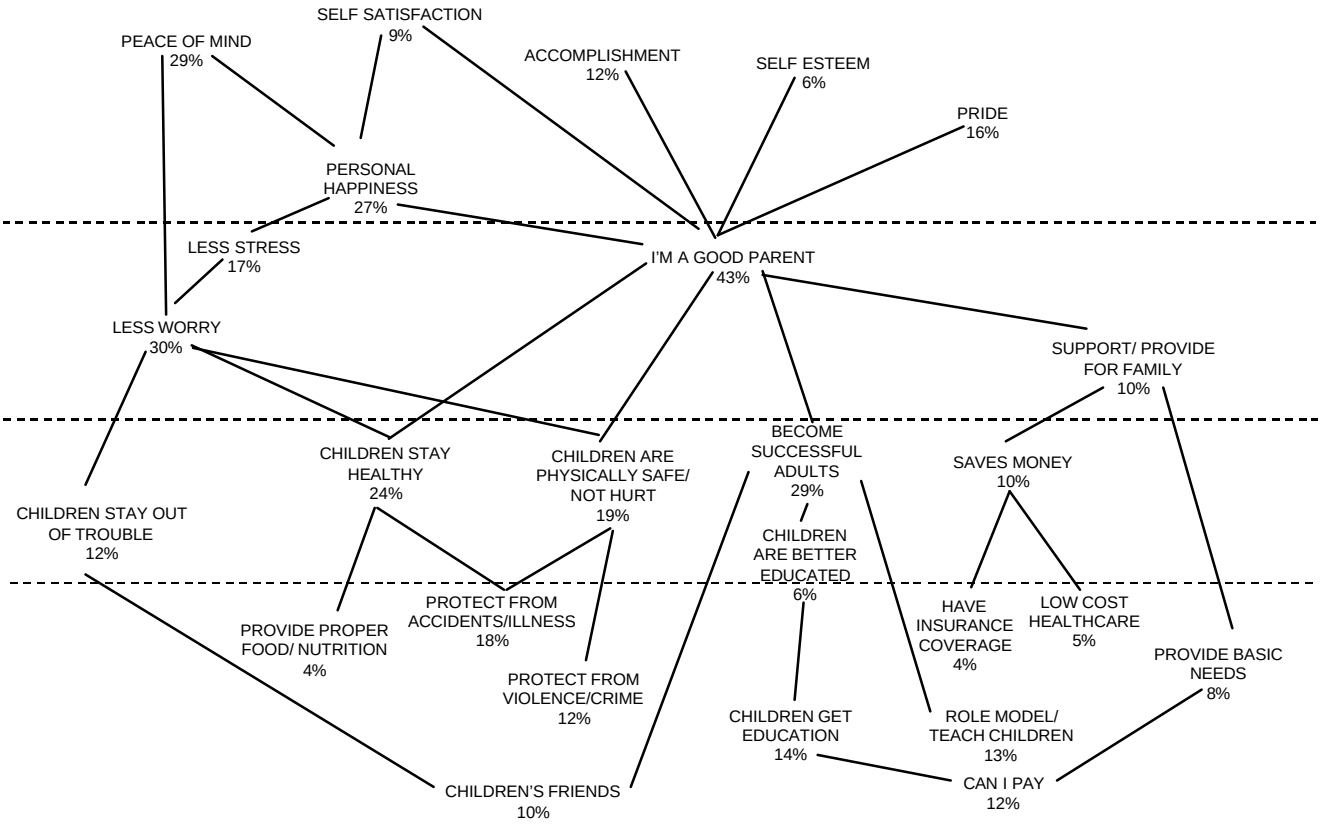
The importance of feeling like you are a good parent when it comes to caring for your child(ren) is clearly identified in the map shown below (Figure 4) that was developed from this portion of the VISTA™ interview. The map builds from the rational elements on the bottom to the functional and emotional benefits resulting from each specific behavior. Ultimately, the most important terminal values sought by parents of eligible children with respect to caring for their children are listed at the top of the map.

The VISTA™ maps provided in this chapter serve as a roadmap for the decision-making process parents go through with respect to making choices about their children. The map was assembled through the culmination of extensive two-hour, one-on-one interviews in which parents were probed on the rational and emotional elements associated with making a choice for their children. As shown in Figure 4, parents were probed on the most important concerns they had with respect to raising their children. At the lower levels, or rational levels, of the map, the most frequently mentioned concerns were *money* (can I pay), *education* (children get education) *protection from violence* (protect from crime/violence), and *protection from illness* (protect from accidents/illness). The percentages under each of the codes on the map refer to the percent of respondents who mentioned this theme at any given level of the map.

From these rational or tangible components of decision-making, respondents were probed during the interview as to why these issues are important to them as parents. This laddering (illustrated previously in Figure 2) ultimately led to more emotional dimensions of the decision-making process such as feelings of *self-esteem*, *pride*, and *peace of mind*. To the degree that different rational and emotional elements of choice were mentioned by respondents in connection with one another, lines are drawn between them to illustrate a decision-making pathway. Once the various decision-making pathways are placed together, a consumer decision-making map, like the one in Figure 4, is created.

FIGURE 4

Concerns In Taking Care of Children



CKI Vista™ Research April/May 2000, n=114

As seen above, whether it is most important to protect your child, provide an education, or ensure they have health care coverage, these actions predominantly fill the emotional need to feel like you're being a good parent (mentioned by 43% of respondents—a very high number is this type of qualitative methodology). Therefore, communications on this issue must demonstrate how Medicaid and SCHIP will deliver the feeling of being a good parent.

Caring for Child's Health Needs

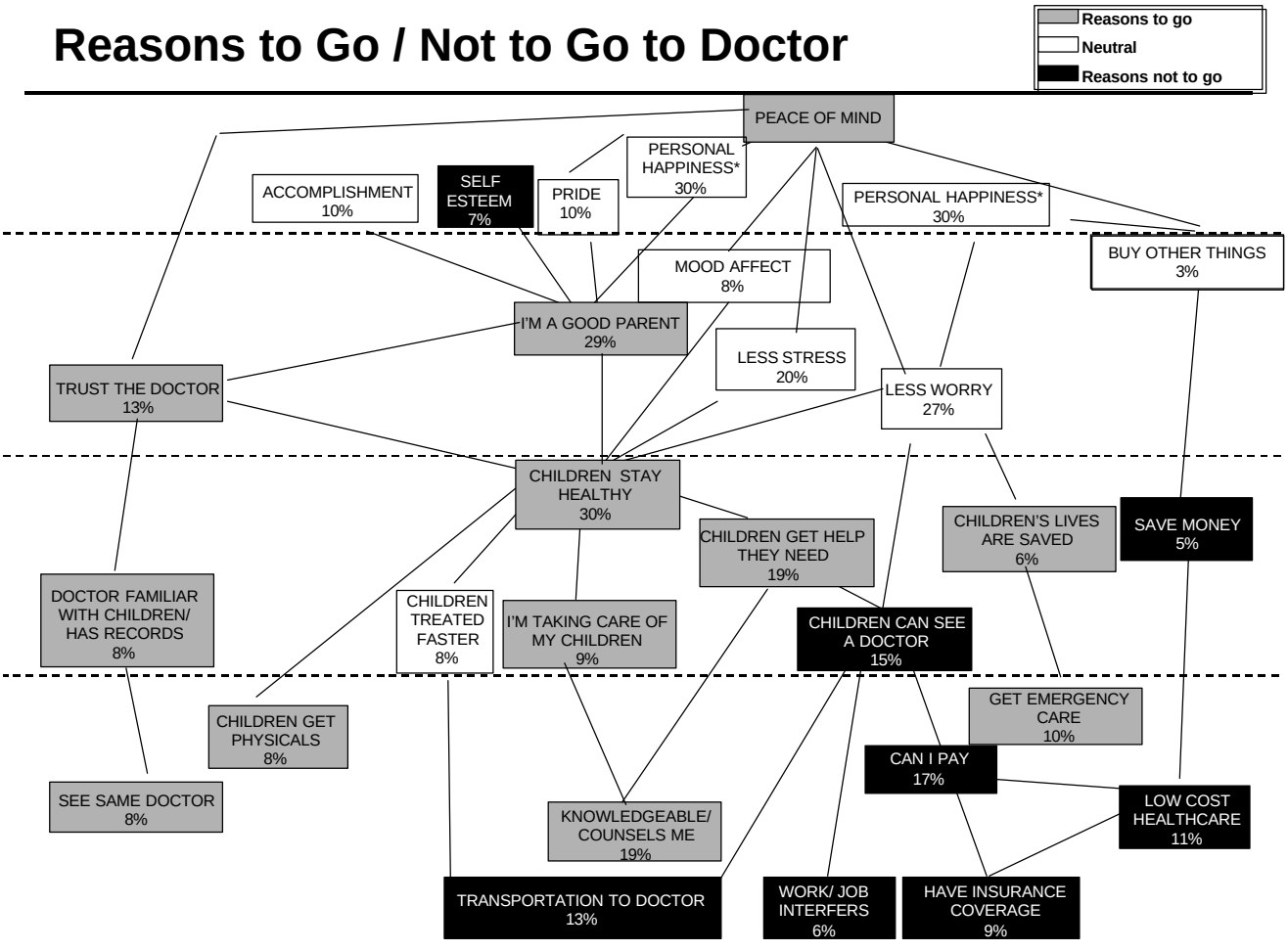
The second level of entry for parents focuses specifically on how parents address their child(ren)'s health care needs. Key findings are as follows:

- Illness and emergency are seen as the primary reasons to seek care;
- Most parents still use regular doctor's office for well-care;

- A regular immunization schedule is mentioned by Caucasians and Hispanics, but not as frequently by African Americans;
- Unenrolled households, especially Medicaid-eligible, as well as African Americans and Hispanics are more likely than others to rely on free clinics;
- Most SCHIP-eligible-unenrolled rely on a doctor despite the cost.

Whether it is a doctor's office or a clinic, parents of eligible children value the access to a doctor because it helps them as parents to ensure that their children will get the help they need to remain healthy. This important finding in the communication framework is evident in the VISTA map shown below. These ladders were generated through questioning respondents about reasons they choose to take or not take their children to the doctor. Again, the map provided in Figure 5 builds from the rational on the bottom to the emotional and values on top. Those items in the lighter colored boxes were primarily identified as reasons to go to the doctor, while the dark boxes are primarily identified as reasons not to go. The clear boxes were mentioned as both reasons to go and not to go (but all phrases are listed as positive statements).

FIGURE 5



CKI Vista™ Research April/May 2000, n=114

The two most important findings from this map are, first, that most people want to feel like they are doing a good job as a parent by helping their children get the help they need to remain healthy. This feeling is only important to the degree to which it delivers a sense of *peace of mind* to that parent. Second, parents want to *reduce the stress and worry* they have about their children. As the child stays healthy and is able to see a doctor, the parent's level of stress and worry is reduced. Therefore, communications must show how Medicaid and/or SCHIP coverage will deliver access to a quality doctor to ensure the children get the help they need to stay healthy so that the parents' stress is reduced, they feel confident about their parenting, and, ultimately, they feel *peace of mind*.

Health care Coverage for Kids

The third level of entry to consider in communications is the issue of providing health care coverage for children. Parents may define health care coverage in a variety of ways, but in the context of paying for doctor's visits, parents view health care coverage as derived from the following components: Medical care will be paid for, the ability to have doctor's visits, expense, and achieving *peace of mind*.

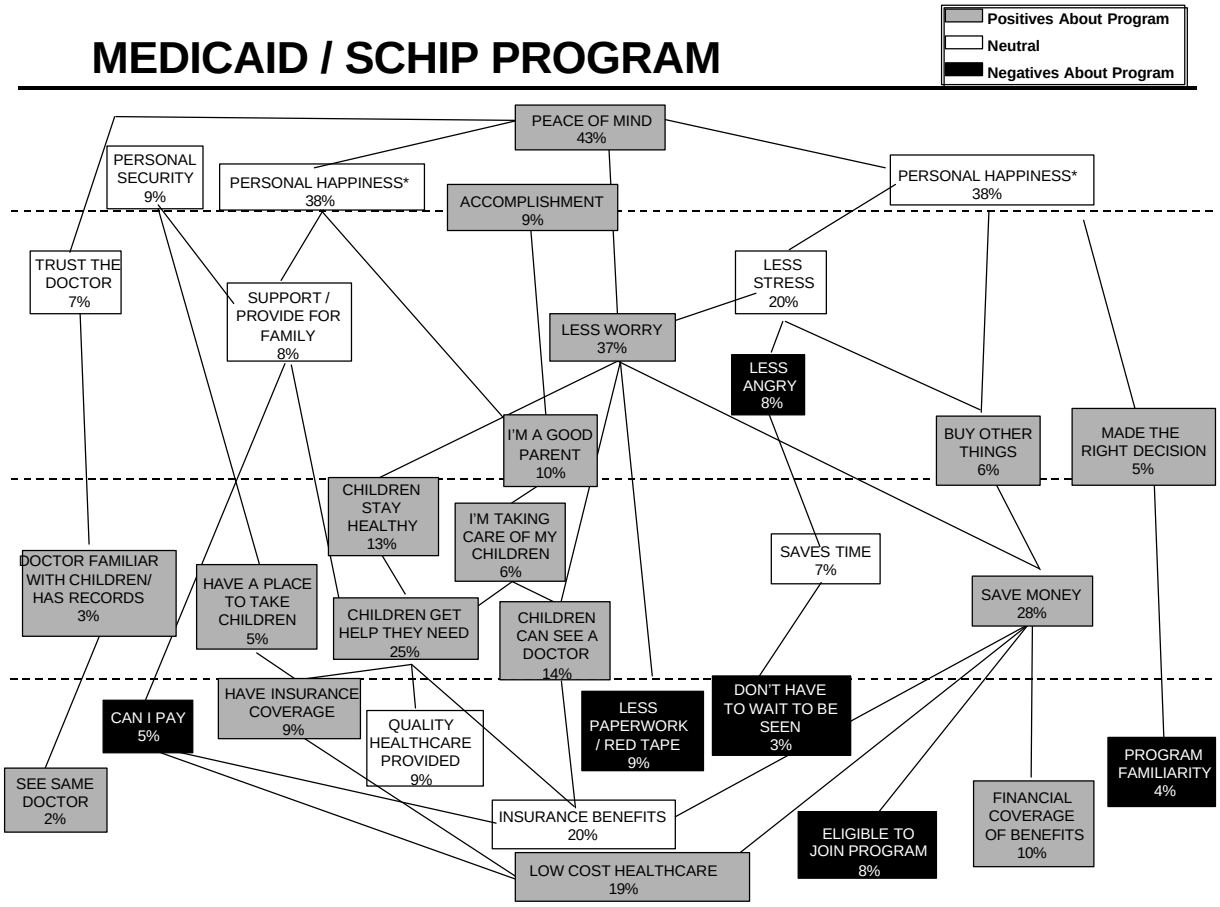
Thus, when talking about this issue, parents inevitably consider the financial stress associated with finding a way to pay for doctors' bills. In fact, when responding to the word *insurance*, parents were most likely to consider the cost and not the benefits of having their child(ren) covered. It is important to avoid using the word *insurance* when promoting these programs because of this—parents were not as likely to pay attention because they quickly wrote it off as something expensive.

Specific to information regarding health care coverage for children, parents:

- Want to know about the services covered, the cost (including co-pay or deductible), and where they can go;
- Are most likely to seek out information about health care coverage from family, close friends, and providers;
- Believe they would be most likely to receive information about government-sponsored health care coverage through television ads or even the Yellow Pages (referring to insurance companies); and
- Most frequently talk about coverage issues with family, close friends, and doctors.

When asked about the positive and negative aspects of having coverage through Medicaid or SCHIP, it became clear that having low-cost or free health care coverage connects the desire to save money and to ensure child(ren) get the help they need to stay healthy. Both of these benefits help reduce the stress the parents have about caring for their child(ren) and protecting their pocketbook, which in turn delivers the sense of *peace of mind*. The map in Figure 6 illustrates this.

FIGURE 6



CKI Vista™ Research April/May 2000, n=114

Therefore, communications on this issue must demonstrate how low-cost or free health care coverage will reduce stress associated with raising a child and managing a household budget. When probed as to reasons why parents do or do not have coverage for their children, parents offered the following:

- Having a child is the obvious motivator for getting coverage;
- The parent is typically incident/need-based driven, especially among minorities; and
- Loss of coverage or lack of coverage is caused by lack of money, not offered through job, or confusion over eligibility.

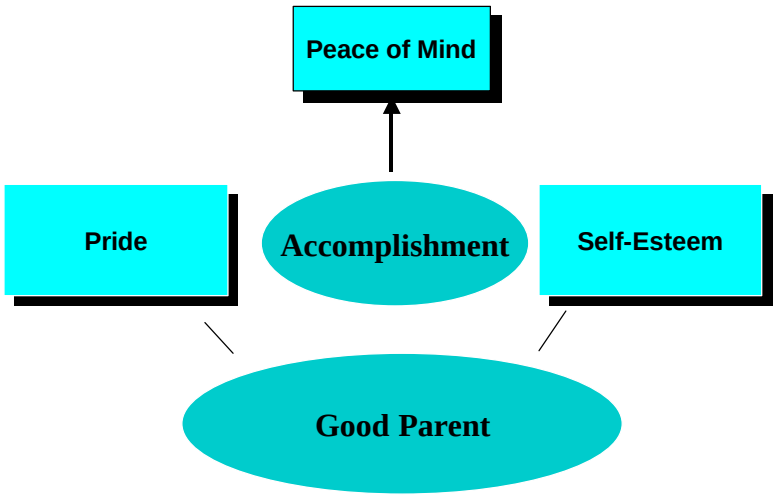
To this last point, in the quantitative benchmark survey Wirthlin Worldwide found that 40% of Caucasians and 53% of Hispanics who are eligible for coverage reported that they have reapplied for coverage more than one time over the past two years (32% among African Americans) and that 22% of Hispanics reported they have applied for government health insurance for their children and were rejected (18% for Caucasians and African Americans). This movement through the system causes confusion and/or frustration over eligibility issues.

Stigma
This stigma concern was an important area of inquiry for the VISTA™ research in terms of helping to craft effective communications that would motivate parents beyond the stigma concern. The study revealed that, in the context of raising their children, parents of eligible children focused mostly on the issues of protection, education/guidance, and having the resources to meet basic needs, not on how they look if they sign up for government assistance.

Summary of Framework Developed
There are two key "perceptual pathways" that most parents followed from their articulation of these important considerations in raising their children. One led through the higher-order emotional gateway of being a *good parent*, while the other passed through a realm of considerations summarized as *less stress/worry*. Importantly, one strong link to the *good parent* theme is the notion that this choice of enrollment represents the *right decision*. This is a somewhat more personal concept than the various kid-focused thoughts, and it is one of the stronger counters against the stigma/embarrassment of accepting public aid. This link is depicted in Figure 7 below.

FIGURE 7

Good Parent Communications Framework



As seen through these maps, the end value that most parents seek when thinking about their children in a variety of contexts is *peace of mind*, often reached through a state of *personal happiness*. At considerably lower frequencies, the values of *pride*, *accomplishment*, and *self-esteem* come into play – particularly when parents focus on themselves. To the degree that communications can effectively

communicate to parents on these emotional gateways, the barrier of social stigma becomes less of a factor in the decision whether or not to enroll their children in government health care.

Benchmark Study Results

This *good parent* theme, highlighted by enrollment as the *right decision* for children, was further validated in the quantitative benchmark study. Fully 86% of parents "strongly agreed" with the statement that *I feel part of being a good parent is making sure my kids have health insurance coverage*. Similar to earlier findings with respect to the importance of health care coverage for children, African Americans (95%) and Hispanics (91%) were more likely to report that they "strongly agree" with this statement than Caucasians (80%). This difference holds when crossed by current enrollment status as well. While 88% of African American parents of eligible uninsured children and 85% of Hispanic parents of eligible uninsured children "strongly agree" with the statement, a significantly lower proportion of Caucasian parents of eligible uninsured children (71%) reported strong agreement.

Strategic Imperatives Developed

Once the decision-making process was uncovered and the context understood, Wirthlin Worldwide, along with the CKI Communications Team, identified the key Strategic Imperatives that helped to form the earned media messages and the advertising messages. Five Strategic Imperatives—the key actions steps necessary to reach the campaign's communications objectives—emerge based on this research:

- **Strategic Imperative One**:
  Show/communicate how low-cost health care coverage yields the emotional payoff of being a good parent and making smart decisions that will reduce stress and bring peace of mind.
- **Strategic Imperative Two**:
  Generate awareness broadly among the target audience. Set the right context.
- **Strategic Imperative Three**:
  Help eligible families understand that these programs apply to them.
- **Strategic Imperative Four**:
  Establish SCHIP and Medicaid as valued products/services.

Support for Strategic Imperative One

Show/communicate how low-cost health care coverage yields the emotional payoff of being a good parent and making smart decisions that will reduce stress and bring peace of mind.

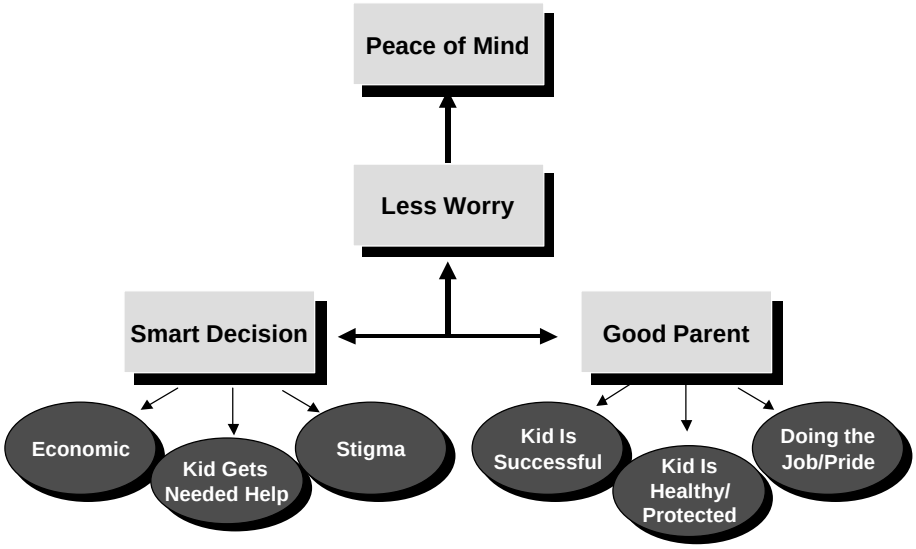
Parents want to protect their children. They also want the *peace of mind* that will come when they can *reduce financial stress* and *reduce worry* about their children so they feel like they are being a good parent. Underpinning this desire to be a good parent is the sense of *pride, accomplishment,* and *self-esteem* the person feels.

Caring for their children's health needs means having access to doctors so their children get the help needed to be healthy. Health insurance is considered to be a predominantly financial consideration and does not perceptually connect with the health of their children.

Health care coverage, as opposed to health insurance, was found to be the most effective term because it provides a link between financial stress and worry about the children. The words low cost or free were the most believable and enticing to parents. It is important that the message attracts attention with financial considerations, but also drives home the message that results in the *peace of mind* that is being sought, as shown in Figure 8**. It is imperative that the communication is personally relevant and taps into the emotional connections parents make when caring for their children**.

FIGURE 8

CKI Communications Framework



Parents realize they are making a smart choice by enrolling in the program when they consider what those people close to them will say about their choice to get coverage. Therefore, there is little stigma reported by parents participating in the program. Perceived value of the program will increase by focusing on what services are covered, the benefits received (i.e., insurance card like any other health insurance plan), and the ease of applying over the telephone.

Figures 9 and 10 present two examples of how this communication strategy can be implemented with respect to language and message.

FIGURE 9

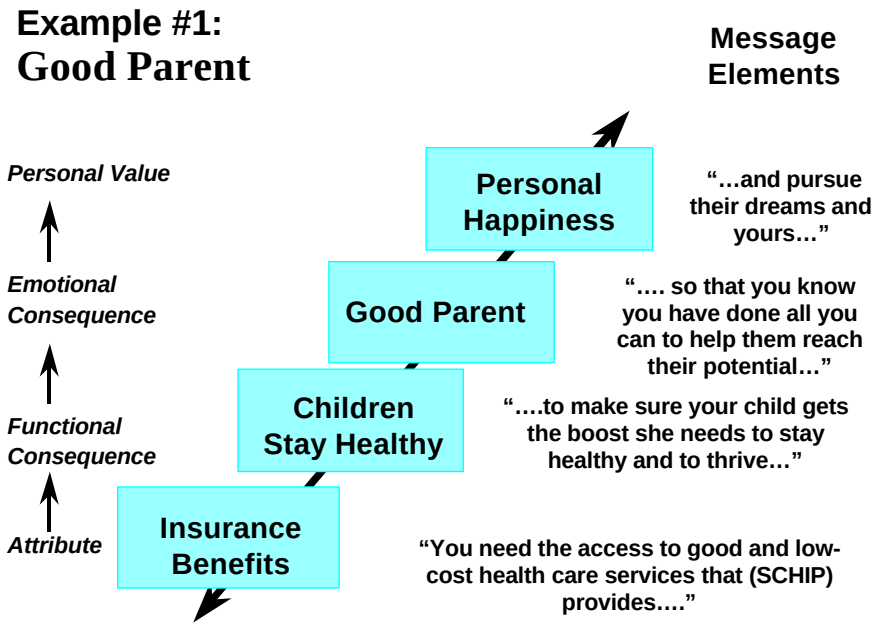
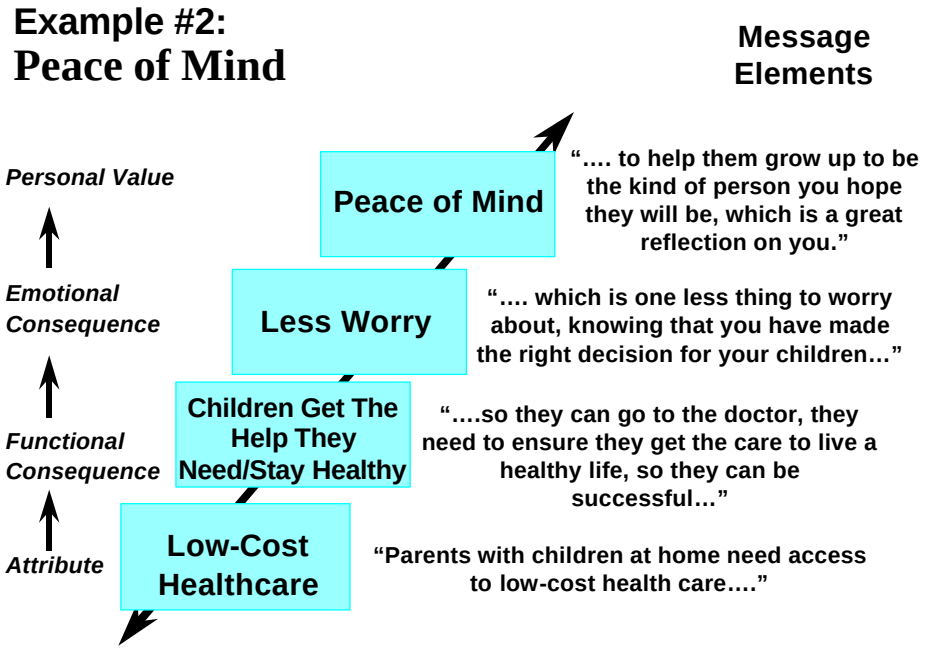


FIGURE 10



Support for Strategic Imperative Two

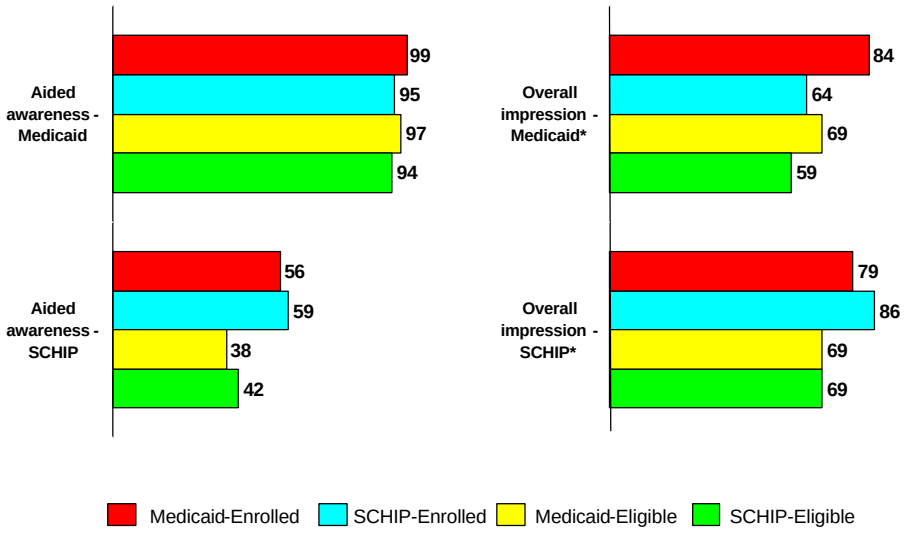
Generate awareness broadly among the target audience. Set the right context.

In reference to the Hierarchy of Effects Model explained earlier in this report, it is important to begin a communications campaign by building awareness among those audiences targeted. Without that foundation, that is if they are not aware of the context or situation, it is difficult for someone to take an action.

Throughout the initial phases of the research, it was very clear that there was a much higher name recognition of Medicaid than of SCHIP among the eligible-unenrolled. But the overall impressions for both programs among those aware of them were about the same, as illustrated below in Figure 11.

FIGURE 11

SCHIP Awareness is Low, Though Well-Regarded



*(*Base=Those aware of programs)*

CKI Benchmark Survey June 8, 2000-July 6, 2000, n=2,888

This situation called out for high levels of both paid and earned media activities in the test markets to raise the level of awareness; the research results highlighted the best way to raise awareness was to tap into parents' top-of-mind concern about their children, that is—protecting them from harm.

Support for Strategic Imperative Three

Help eligible families understand that these programs apply to them.

From the perspective of parents of eligible uninsured children, insurance coverage equals financial concerns. The research showed that six out of ten parents of eligible uninsured children did not believe that this program applied to them. But 82% would enroll if they knew they were eligible. What was discovered in the advertising assessment was that people responded well to language and visuals that represent working families and appropriate income levels. Also, "low-cost and/or free" were effective when describing the program and eligibility.

Support for Strategic Imperative Four

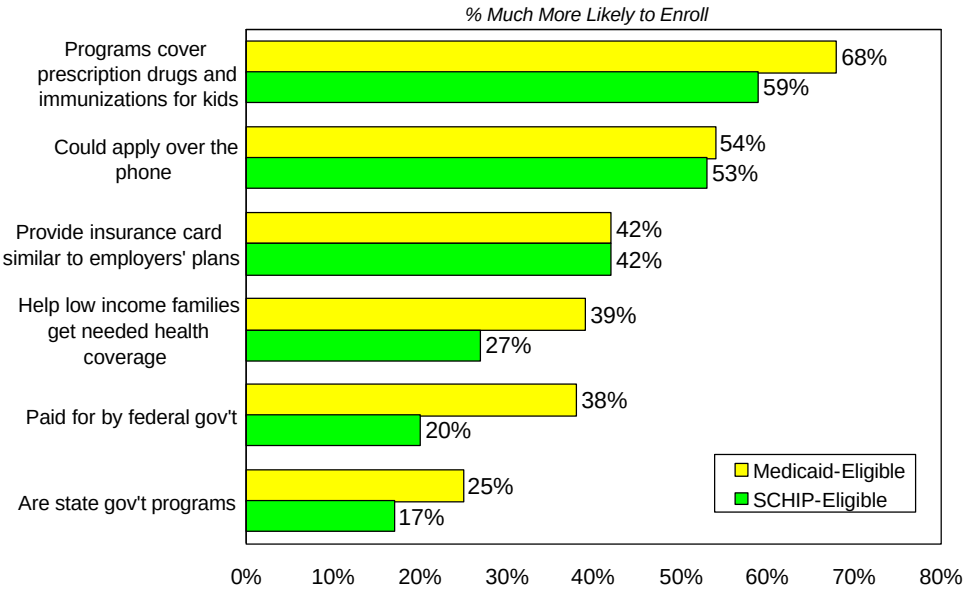
Establish SCHIP and Medicaid as valued products/services.

Three out of four current Medicaid and SCHIP insured were satisfied with the program, which showed that people who are personally familiar with the program are favorable. Thus, to attract the parents of eligible uninsured children, imagery must be created in the advertising that tells the story in value-laden ways how SCHIP made a difference in someone's life, so that the parents of eligible uninsured children say, "I want that."

Our benchmark research demonstrated the significant impact various attributes of these programs can have in motivating parents of eligible uninsured children to enroll. Figure 12 shows the percentage of parents of eligible uninsured children who said they would be much more likely to enroll knowing each of the following about Medicaid and/or SCHIP.

FIGURE 12

Impact of Other Messages on Likelihood to Enroll



CKI Benchmark Survey June 8, 2000-July 6, 2000, n=2,888

Enrollment is a smart economic decision and a smart decision for the child's health by a good parent. By participating in the program, one can receive the following benefits: comprehensive coverage, emergency coverage, prescriptions, immunizations, low-cost and free, convenience, and a state program. However, it is important to always connect those features of the program to why a parent should care about providing these things.

Ad Testing: Finding the Executions That Work

From the communications framework, GMMB produced nine different rough cut advertising executions. The nine ads were: *Hard Choices*, *Care Giver*, *What If*, *Breathe*, *One in a Million*, *Cash Register*, *Recovery Time*, *Be Ready*, and *Worry*. These executions were tested using Wirthlin Worldwide's proprietary research methodology called Pulseline™.

The initial objective of the ad testing was to determine how parents of eligible children respond to the general "feel" of the advertisement. Specifically, Wirthlin Worldwide looked for one of two advertising approaches: problem-solution, in which respondents reacted negatively to the initial problem presented but responded very favorably to the solution presented; or a continuous steady positive build in the feel of the spot. Using this test, Wirthlin Worldwide found that all executions except for *Worry* were

effective in one of these two types. *Worry* was too harsh, dramatic, and never delivered a favorable sense of solution to respondents; consequently, it was discarded.

All of the ads were also assessed on several attributes, including:

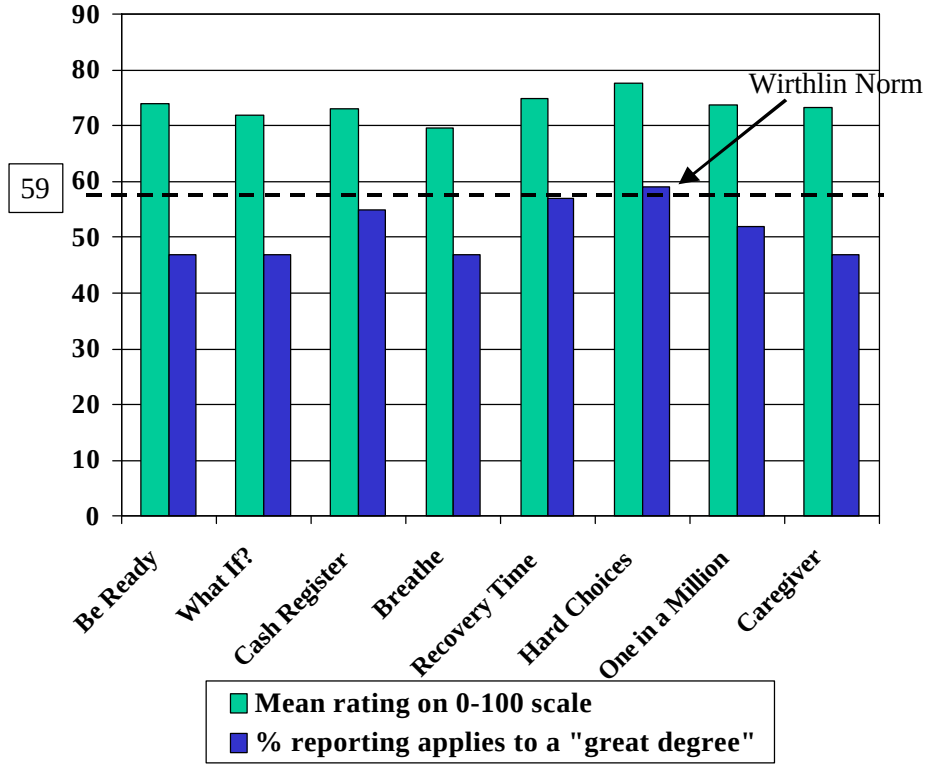
1) Really catches my attention,
2) Makes me want to call to get more information,
3) Makes me want to enroll, and
4) Seems like it is for a family like mine.

Respondents watched each spot twice, and then rated each one on these dimensions. The purpose was to determine the extent to which the advertisements generated the intended action.

Figures 13-16 show the average rating on a 100-point scale for each spot, the percentage of respondents who gave the highest rating for each spot on each respective attribute, and the Wirthlin Worldwide normative rating for each attribute. Wirthlin Worldwide has collected normative data from testing a wide variety of successful and unsuccessful public opinion commercials over the past ten years. Wirthlin Worldwide has found that advertising that exceeds these norms will successfully communicate key copy points in the marketplace given that it receives sufficient media weight. The higher the bar the more effective the ad was in communicating that specific attribute to the eligible audience. By reviewing these measurements, Wirthlin Worldwide was able to help the CKI Communication Team make decisions as to which spots best delivered the desired effect.

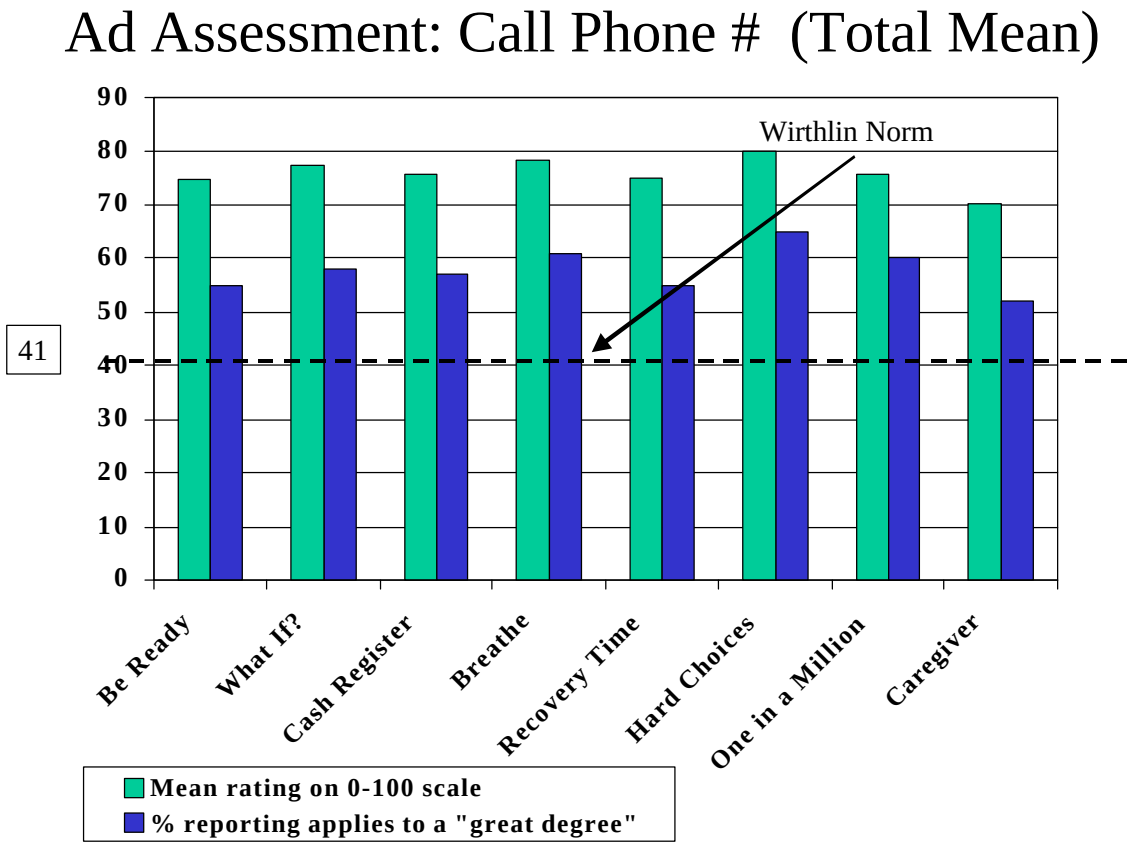
FIGURE 13

Ad Assessment: Attention (Total Mean)



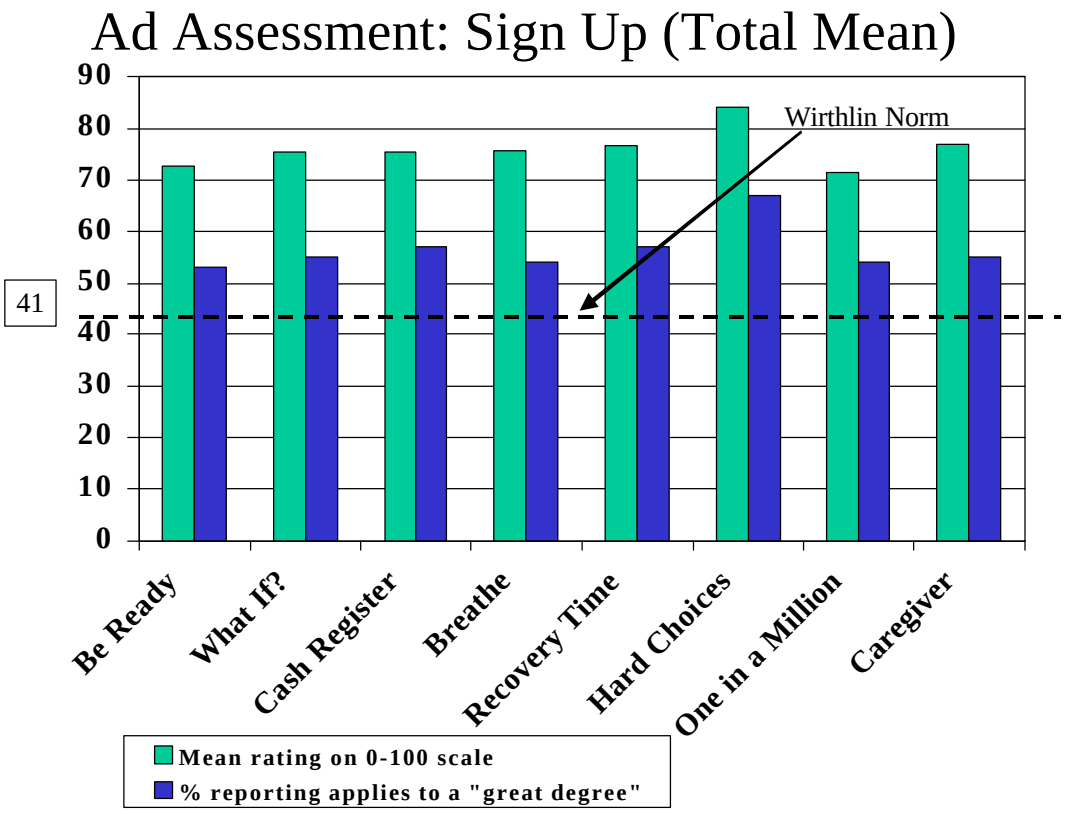
CKI Pulseline™ Field Dates July 6, 2000/July 10, 2000, n=101

FIGURE 14



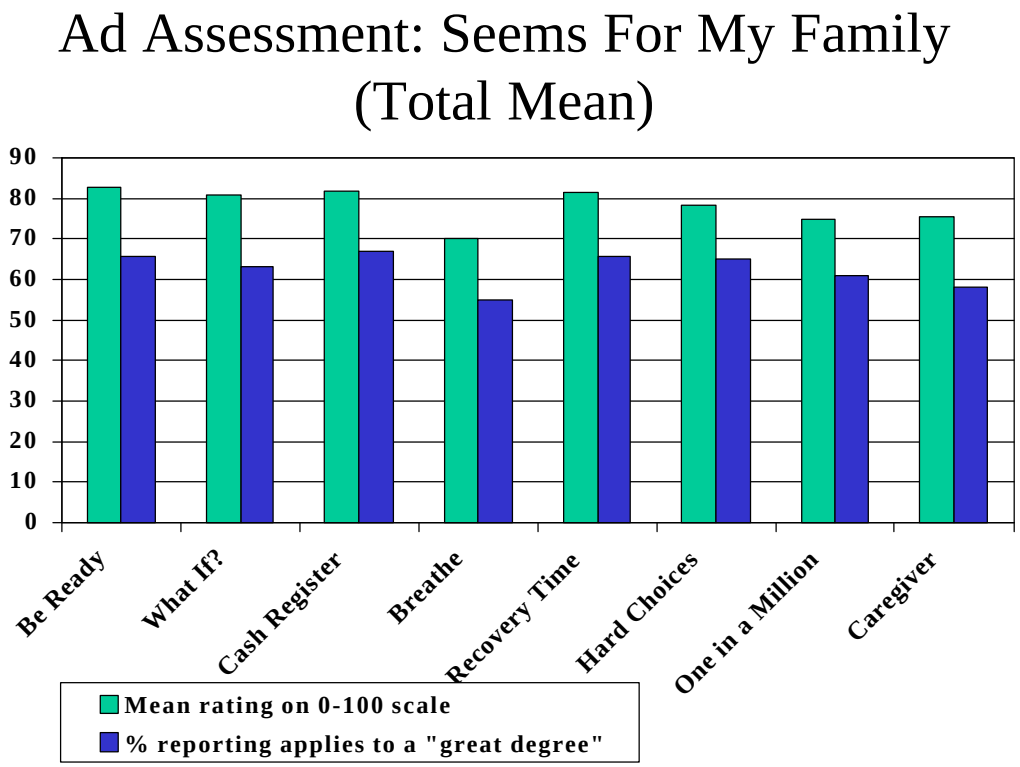
CKI Pulseline™ Field Dates July 6, 2000/July 10, 2000, n=101

FIGURE 15



CKI Pulseline™ Field Dates July 6, 2000/July 10, 2000, n=101

FIGURE 16



CKI Pulseline™ Field Dates July 6, 2000/July 10, 2000, n=101

The most obvious finding from these charts is that all of the spots were above the normative ratings in the key desired impacts. Therefore, the result of the Pulseline™ sessions effectively guided the identification of the best of the best and refining the executions per additional feedback received. In general, the most important findings guiding the decisions were as follows:

- Each of the executions tested performed well, especially among Hispanics.
- *Hard Choices* tops the list – this is the most effective at linking the parenting/worrying elements and, as such, scores the highest. Even though this spot performs well across ethnicities, African Americans clearly give lower ratings than others in being able to relate to the Caucasian family shown in the ad.
- Other spots that come out on top by ethnicity include:
  - Caucasian → *Care Giver* and *What If?*
  - African American → *Breathe* and *One In A Million*
  - Hispanics → *Cash Register* and *Recovery Time*
- *Be Ready* scored the lowest and is not nearly as effective as the others.

Based on the results of the ad testing, four ads were selected to air in six test markets. Table 5 provides the specific advertisements aired in each market (see Appendix B for ad scripts):

TABLE 5

Market	Date of Ad Campaign	Advertisement
Albuquerque (Latino target)	August 16 – September 19	*Hard Choices; Cash Register*
Fresno (Latino target)	August 21 – September 22	*Hard Choices; Cash Register*
Springfield (Caucasian target)	August 22 – September 23	*Hard Choices; Care Giver*
Boise (Caucasian target)	August 25 – September 28	*Hard Choices; Care Giver*
Baltimore (African Am. target)	August 14 – September 15	*Hard Choices; Breathe*
Greenville (African Am. target)	August 14 – September 15	*Hard Choices; Breathe*

The final advertising executions were modified based on the feedback received during the ad testing phase. The specific recommended changes based upon the research were as follows:

- ✓ *Make the telephone number more noticeable and on screen more often.* Although participants viewed the ad executions more than 30 times, recall of the telephone number was very low.

- ✓ *Add an income figure to create the idea that "I might be eligible."* Although all of the participants in the ad testing were eligible for the health care program, understanding that they were indeed eligible for the advertised health care program was very low.

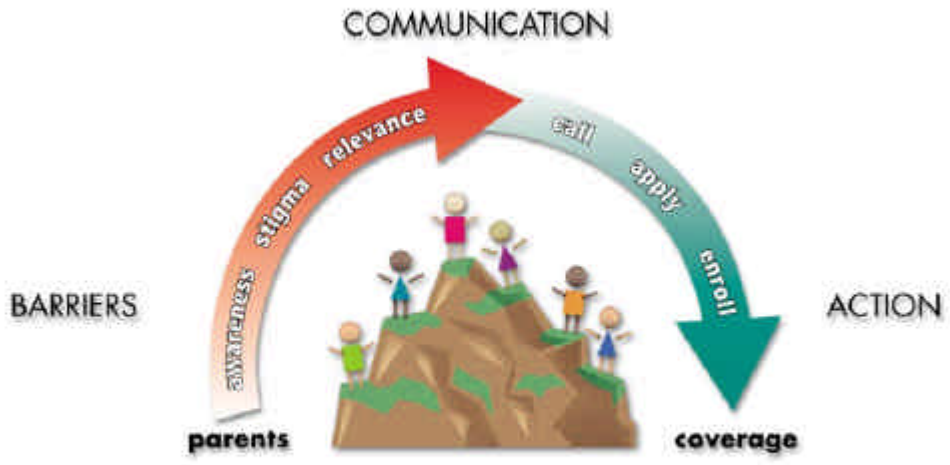
- ✓ *Shoot the spots in "working class" homes and neighborhoods and include more shots of teenagers.* Participants said they did not feel some of the visuals looked like areas in which they live. In addition, those with older kids got the impression that the program was designed for young children only.

- ✓ *Use the words "low-cost" or "free" in that order, and consistently demonstrate/show the concept of working families throughout the ads.* Participants told us free alone was not credible and low-cost was believable. Together, they are much stronger if you lead with low-cost. The word affordable was considered relative and, therefore, would not attract attention.

CHAPTER 4: CAMPAIGN SHOWS MEASURABLE PROGRESS

This chapter reviews the impact of the communication efforts in this campaign. Wirthlin Worldwide evaluated the impact of advertisements and earned media efforts through two telephone studies: 1) a survey of actual callers in the Albuquerque, Greenville, and Wilmington markets, and 2) a post-test survey in each of the six markets and the two comparison markets. This research shows the campaign was very effective in increasing awareness, creating interest, and lowering the barrier of relevance among the parents of eligible uninsured children. As stated in the outset of this report, the secondary data collected show significant increases in hotline calls during the time in which the campaign was underway. These data show why the calls were made.

Evaluative Analytical Plan



The primary objective of the CKI Back-to-School campaign was to generate calls to the hotline telephone number in each of the test markets as one step toward increasing enrollment of uninsured children in Medicaid or SCHIP programs in their state. The formative research Wirthlin Worldwide conducted demonstrated that the most effective communication strategy to reach this goal was to show how these programs deliver *peace of mind* by helping *reduce the worry parents feel about their children's health and their family's financial security*. The research also revealed that the most significant barrier preventing parents of eligible uninsured children from making the call was that most

do not realize such programs are designed for working families who are not offered or can not afford private insurance.

Therefore, the primary targets for progress through this campaign were to see measurable impact in each of the following areas:

1) Recall of advertising efforts …*leading to…*
2) Increased awareness of free or low-cost health care coverage for children …*leading to…*
3) Higher recognition of the SCHIP program name (Medicaid name recognition universal) …*leading to…*
4) Belief that "my child" may be eligible for coverage …*leading to…*
5) Action taken to call the 800 numbers …*leading to…*
6) Intent to apply for coverage.

Again, this follows the general Hierarchy of Effects Model in advertising: advertising will first impact awareness, followed by attitudes, and then behaviors. Hence, these measurements were used as the primary yardstick for progress over time among all respondents interviewed in the six test markets.

Post-Test Survey Findings

The post-test summary provides findings across all test and comparison markets. The primary findings are as follows:

1. Six out of ten (58%) parents of eligible children in the test markets had seen the advertisements, a 44-percentage-point increase over the benchmark measurement. In contrast, only 37% of parents of eligible children recalled seeing an advertisement in the comparison markets during the same time frame.

2. One out of four (24%) of those who saw the ads called the hotline phone number to get more information about Medicaid and/or SCHIP. Only 14% of those in comparison markets who saw an advertisement said they called the phone number.

3. Most (64%) of those who said they called the hotline number in the test markets indicated they planned to apply for coverage through Medicaid and/or SCHIP. This is better than the 40% of callers in the comparison markets who said they plan to apply.

4. Parents of eligible uninsured children in the test markets were three times as likely to call the hotline number for information than those in the comparison markets, and nearly five times more likely to say they plan to enroll their children.

5. Name recognition of SCHIP programs increased by 8 percentage points in the test markets to 60% after the campaign. In the Wilmington comparison market, recall of SCHIP dropped from 52% to 48% during the same time frame. But, SCHIP recognition increased in the Idaho Falls comparison market from 40% to 63% during that time frame—Wirthlin Worldwide has since been told advertising and outreach efforts were underway in Idaho Falls promoting the SCHIP

program.

6. The percentage who believe "my child" is eligible for Medicaid or SCHIP has increased from 37% to 63% in the test markets as a result of the campaign. This belief increased from 41% to 54% among the parents of eligible uninsured children in the comparison markets.

Historically, direct response marketing efforts (direct mail for example) have been deemed successful with responses of 1% and extremely successful with a response of up to 5% of the target audience. For comparison, the response to this campaign ranged from a low of 10% in Greenville among the target audience who saw the ad and made a call, to a high of 33% in Fresno among the target who saw the ad and made a call.

For a specific example, in a separate campaign, Sacramento was used as a test market and ads were run for a comparable time frame. Awareness of the ads reached 33% (half as much as what was measured for the CKI test wave one). In addition, there were only 172 calls to a hotline number promoted in the ads—the secondary information gathered from the CKI test markets demonstrates significant increase far beyond 172. The comparison is not direct because of different-sized markets and different audiences, but the point holds true.

Primary Measurements In Test Markets Combined

The post-test survey demonstrated that the campaign was effective in each of the primary measurements designated as yardsticks for progress. The following tables show the impact across these dimensions among the sample of all respondents from all six test markets combined as well as across the test and comparison markets in North Carolina and Idaho (significant changes marked *).

Overall, across all test markets, there was significant movement on key measurement dimensions from the pre-test to the post-test. As shown in Table 6, ad recall and the belief that "my child" is eligible showed dramatic increases between pre and post-tests.

TABLE 6

	TEST MARKETS ONLY		
	PRE-TEST n=1,462	**POST-TEST** n=2,259	**CHANGE**
Recall of advertisements	14%	58%	+44*
Name recognition of government insurance programs	66%	70%	+4*
Name recognition of SCHIP program	61%	69%	+8*
Believe "my child" is eligible *(uninsured ONLY)*	37%	63%	+26*
Called the phone number *(uninsured ONLY)*		14%	
Intend to apply *(uninsured ONLY)*		9%	

The primary measurements show significant progress with nearly one out of ten parents of eligible uninsured children in the test markets indicating they called and now intend to apply. Looked at in

another way, this indicates that one out of four (24%) who saw the ads called the phone number to get more information.

There is not as significant an impact shown in the secondary measurements. These trends are illustrated in Table 7, again among the combined test markets:

TABLE 7

	TEST MARKETS ONLY		
	PRE-TEST n=1,462	**POST-TEST n=2,249**	**CHANGE**
Thermometer Rating of Medicaid	70.6	68.6	-2.0
Thermometer Rating of SCHIP	77.7	74.3	-3.4*
Believe Programs A Good Thing to Help Families	76%	80%	+4*

*** Indicates significant change**

These perceptions of Medicaid and SCHIP are not easily improved upon in the course of a five-week campaign. And it is important to note that thermometer (favorability) ratings are already fairly high, making it even more difficult to measure improvement. Worthy of note, was the shift toward even less concern about the social stigma over the course of this initial wave of the campaign.

Primary Findings In Comparison Markets

The comparison markets help illustrate the significance of the shift in the test markets. However, there is evidence of the confirmed advertising and outreach efforts not part of CKI that took place in Idaho Falls, a comparison market to Boise. Therefore, much of the movement within the data from the combined comparison markets is attributable to efforts made in Idaho Falls (see Table 8).

TABLE 8

	COMPARISON MARKETS		
	PRE-TEST n=508	**POST-TEST n=938**	**CHANGE**
Recall of advertisements	9%	37%	+28*
Name recognition of government insurance programs	71%	69%	-2
Name recognition of SCHIP program	46%	56%	+10*
Believe "my child" is eligible *(uninsured ONLY)*	41%	54%	+13
Called the phone number *(uninsured ONLY)*		5%	
Intend to apply *(uninsured ONLY)*		2%	

*** Indicates significant change**

The affect of the Idaho Falls market on the combined comparison can be clearly seen if the test and comparison markets are broken out individually, as is shown in Tables 9 and 10.

TABLE 9

	IDAHO COMPARISON vs. TEST MARKET					
	Idaho Falls			Boise		
	PRE n=247	POST n=383	CHG	PRE n=242	POST n=374	CHG
Recall of advertisements	9%	53%	+44*	22%	68%	+46*
Name recognition of government insurance programs	72%	75%	+3	69%	82%	+13*
Name recognition of SCHIP program	40%	63%	+23*	66%	82%	+16*
Believe "my child" is eligible *(uninsured ONLY)*	40%	51%	+11	35%	57%	+22*
Called the phone number *(uninsured ONLY)*		8%			16%	
Intend to apply *(uninsured ONLY)*		3%			11%	

*** Indicates significant change**

TABLE 10

	NORTH CAROLINA COMPARISON vs. TEST MARKET					
	Greenville			Wilmington		
	PRE n=247	POST n=383	CHG	PRE n=242	POST n=374	CHG
Recall of advertisements	9%	47%	+38*	10%	21%	+11*
Name recognition of government insurance programs	63%	65%	+2	69%	63%	+6
Name recognition of SCHIP program	49%	54%	+5	52%	48%	+4
Believe "my child" is eligible *(uninsured ONLY)*	35%	65%	+30*	42%	57%	+15
Called the phone number *(uninsured ONLY)*		5%			1%	
Intend to apply *(uninsured ONLY)*		3%			1%	

*** Indicates significant change**

The primary measurements in the combined comparison markets did not show the same levels of movement in the key areas as in the test markets—only one out of 20 called the phone number and two out of 100 plan to apply (impact on enrollment is five times higher in the test markets). Importantly, with respect to the recall of advertisements AND the increased name recognition, almost all the increase was found in the Idaho Falls comparison market. Specifically, ad recall jumped by 44 points in Idaho Falls, from 9% to 53%, and name recognition of the SCHIP program increased by 23 points, from 40% to 63%. This is evidence of either spillover of the Boise CKI campaign into the Idaho Falls media market or the effect of the other efforts underway in the state at that time.

In the comparison markets, the measured change in perceptions of Medicaid and SCHIP as well as the change in social stigma was very similar to what was found in the test markets (see Table 11):

TABLE 11

	ALL COMPARISON MARKETS		
	PRE-TEST n=984	**POST-TEST n=1524**	**CHANGE**
Thermometer Rating of Medicaid	76.5	71.5	-5.0*
Thermometer Rating of SCHIP	81.3	75.7	-5.6*
Believe Programs Simply A Good Thing	74%	78%	+4*

*** Indicates significant change**

Primary Findings Among Eligible-Uninsured Only

The target audience of this campaign was parents whose children would qualify for Medicaid or SCHIP but are not currently enrolled in either program. Thus, assessing the impact of the campaign among this audience was critical. The results of the post-test survey demonstrated that the shifts/changes were greater for this audience than for all respondents, as shown in Table 12:

TABLE 12

	UNINSURED – TEST MARKETS ONLY		
	PRE-TEST n=492	**POST-TEST n=760**	**CHANGE**
Recall of advertisements	13%	58%	+45*
Name recognition of government insurance programs	51%	66%	+15*
Name recognition of SCHIP program	55%	68%	+13*
[1]Believe "my child" is eligible *(uninsured ONLY)*	37%	63%	+26*
[1]Called the phone number *(uninsured ONLY)*		14%	
[1]Intend to apply *(uninsured ONLY)*		9%	

*** Indicates significant change**

[1]The last three measurements shown above are the same figures reported in table 7 given that these questions are only pertinent among the eligible uninsured audience.

Again, looking at the comparison markets individually (Tables 13 and 14), there was evidence of the spillover from other campaigns into the Idaho Falls market. In addition, the largest increases among the parents of eligible uninsured children were found in the Boise market. There was no significant shift among this audience in the Greenville test market.

TABLE 13

	IDAHO - UNINSURED COMPARISON vs. TEST MARKET					
	Idaho Falls			Boise		
	PRE n=88	POST n=136	CHG	PRE n=93	POST n=142	CHG
Recall of advertisements	7%	43%	+36*	24%	65%	+41*
Name recognition of government insurance programs	55%	62%	+7	54%	74%	+20*
Name recognition of SCHIP program	33%	53%	+20*	60%	83%	+33*
Believe "my child" is eligible *(uninsured ONLY)*	40%	51%	+11	35%	57%	+22*
Called the phone number *(uninsured ONLY)*		8%			16%	
Intend to apply *(uninsured ONLY)*		3%			11%	

*** Indicates significant change**

TABLE 14

	NORTH CAROLINA - UNINSURED COMPARISON vs. TEST MARKET					
	Greenville			Wilmington		
	PRE n=73	POST n=115	CHG	PRE n=77	POST n=119	CHG
Recall of advertisements	11%	52%	+41*	17%	24%	+7
Name recognition of government insurance programs	49%	60%	+11	61%	59%	-2
Name recognition of SCHIP program	38%	52%	+14	43%	43%	--
Believe "my child" is eligible *(uninsured ONLY)*	35%	65%	+30*	42%	57%	+15
Called the phone number *(uninsured ONLY)*		5%			1%	
Intend to apply *(uninsured ONLY)*		3%			1%	

*** Indicates significant change**

Also among the parents of eligible uninsured children, there was a more significant increase in the percentage who believed these programs are simply a good thing to help people care for their families rather than a public sign they cannot make it on their own. These results are shown in Table 15:

TABLE 15

	UNINSURED – TEST MARKETS ONLY		
	PRE-TEST n=492	POST-TEST n=760	CHANGE
Thermometer Rating of Medicaid	59.9	57.9	-2.0
Thermometer Rating of SCHIP	68.7	64.9	-3.8
Believe Programs A Good Thing to Help Families	68%	76%	+8*

*** Indicates significant change**

Primary Measurements Near Equal Impact Across Ethnicity

The campaign was designed to target specific ethnic groups in each market. Specifically, Baltimore and Greenville were selected as African American markets, Fresno and Albuquerque were selected as Latino markets, and Springfield and Boise were selected as Caucasian markets. As such, the *Cash Register* advertisement was produced in Spanish and *Breathe* was designed to reach an African American audience. *Hard Choices* was designed to reach across ethnicities, and *Care Giver* was specifically targeted at Caucasian parents. In every case, these advertisements tested most effective for the target audience at which they are directed.

The post-test results showed very little difference in the impact on ethnic groups when data for the test markets were combined. The only significant difference was that Caucasians were more likely to have an increased recognition of the SCHIP program, whereas this name recognition did not change significantly among African Americans and Latinos interviewed. Table 16 shows the primary measurements among specific ethnic groups within the test markets:

TABLE 16

	TEST MARKETS ONLY								
	African Americans			Caucasians			Latinos		
	PRE n=320	POST n=495	CHGE	PRE n=833	POST n=1295	CHGE	PRE n=309	POST n=470	CHGE
Recall of ads	10%	54%	+44*	14%	54%	+44*	19%	64%	+45*
Recognition of programs	55%	60%	+5	69%	76%	+7*	69%	65%	-4
SCHIP recognition	53%	57%	+4	60%	73%	+13*	69%	70%	+1
Believe eligible	45%	83%	+38*	32%	61%	+29*	47%	76%	+29*
Called number		9%			12%			10%	
Intend to apply		7%			7%			8%	

*** Indicates significant change**

With respect to the secondary measurements, social stigma was further reduced among African Americans and Caucasians through the campaign, but there was no statistically significant change among

Latinos. In addition, perceptions of SCHIP actually became less favorable among Caucasians. These results are provided in Table 17:

TABLE 17

	TEST MARKETS ONLY								
	African Americans			Caucasians			Latinos		
	PRE n=320	POST n=495	CHGE	PRE n=833	POST n=1295	CHGE	PRE n=309	POST n=470	CHGE
Medicaid Therm.	73.3	70.5	-2.8	67.2	64.6	-2.6	76.9	77.4	+0.5
SCHIP Therm.	80.9	78.5	-2.4	75.9	71.9	-4.0*	79.6	77.7	-1.9
Believe Programs A Good Thing to Help	77%	83%	+6*	73%	78%	+5*	84%	81%	-3

*** Indicates significant change**

In summary, the data demonstrate almost equal impact across ethnicities on the primary evaluative measurements pertinent to the campaign.

Advertisement Specific Findings

Respondents who said they had seen advertisements were asked what they specifically recalled. Overall, in the six test markets, the most frequently mentioned details were:

- Program for working/low-income families (17%);
- Insurance for children (15%); and
- Mentions an income figure (14%).

However, since the combinations of ads varied by market, recall also varied by market. Two out of five respondents in Fresno recalled that the ads were about insurance for children. In Boise (35%), the most frequently mentioned detail was that the ads were about programs for working/low income families. In Baltimore (25%), Greenville (20%), and Springfield (19%) the mention of an income figure had the most memorable impact. Specific breakouts by market are provided in Table 18 below:

TABLE 18

Market (among those who recall seeing ads)	**Insurance for children**	**Program for working/low- income families**	**Mentions exact dollar figure**
Fresno (n=241)	40%	16%	6%
Albuquerque (n=187)	36%	14%	12%
Springfield (n=195)	12%	7%	19%
Boise (n=255)	31%	35%	5%
Baltimore (n=250)	25%	14%	25%
Greenville (n=187)	17%	14%	20%

When asked whether the advertisement made them believe that their child would be eligible, 77% of respondents in the test markets said yes (41% definitely, 36% probably). The primary reasons given for why the ad made them believe their child would be eligible was *the dollar amount shown in the ad* (30%) and *the ad showed or talked about things that seem like it is for a family like mine* (23%).

State Medicaid and SCHIP Toll-free Hotline Caller Assessment Findings

The callback study provides evidence from two of the test markets: Albuquerque and Greenville. These two markets were the only ones for which Wirthlin Worldwide was able to receive lists of actual callers from state officials during the course of the campaign. The primary findings are as follows:

1. The advertisements effectively drove the target audience in both test markets to call the toll free number in their area: 83% of those calling in these two markets learned of the number via recent advertisements and called for their first time.

2. More than eight out of ten parents (84%) who called the toll free number for a child living in their household said they plan to apply for the program.

3. Those who recall the ads were most likely to say they remember it talked about "insurance for children" and/or it gave an income figure for eligibility.

4. Respondents were more likely to remember specifics from the *Breathe* spot than from *Hard Choices* or *Cash Register*. However, there was no evidence in this study to suggest one execution is more effective in motivating people to call versus the other.

5. The ads effectively communicated to parents that their children might be eligible—mostly due to the inclusion of the dollar figure in the spot. And, the dollar figure was most effective with working families—other research reveals working families are least likely to believe they are eligible.

6. Only 9.3% of callers in Greenville and 8.6% of callers in Albuquerque were turned away because they learned they were not eligible after calling.

7. The average household income by family size was below eligibility requirements at each level—indicating most callers were the right households that would likely qualify for coverage.

Ad Impact on Callers

The advertisements effectively drove the target audience in both test markets to call the toll free number in their area. Specifically, 95% of callers in the Greenville market said they learned of the toll free number through an advertisement – in contrast, 64% (or 9 out of 14) of those interviewed from the Wilmington area (the comparison market) called the toll free number. Similarly, in Albuquerque results showed 86% of callers heard about this number from an advertisement.

Wirthlin Worldwide measured recall of advertisements in two ways: unaided and aided. The former shows the level of long-term impact in which the target audience is able to remember the message without prompting. The latter picks up the expanded reach of the ads among those who only recall the spots when prompted. Together, these two measurements demonstrate the total penetration of the advertisements among those who called the toll free number. Table 19 shows how the markets vary in aided and unaided recall of the advertisements.

TABLE 19

	Greenville (Test)	Wilmington (Comparison)	Albuquerque (Test)
Unaided Recall	91% (n=118)	57% (n=8)	70% (n=253)
Aided Recall	5% (n=6)	7% (n=1)	16% (n=59)
Total Recall	**95% (n=124)**	**64% (n=9)**	**86% (n=312)**

Clearly, the **advertising mix in Greenville was most effective in leaving a memorable impression**—the difference lies in TV advertisement recall (84% in Greenville versus 63% in Albuquerque). In both markets, 10% of callers reported having heard radio spots, while 9% in Albuquerque and 4% in Greenville refer to print advertisements.

Across the board, **recall of the advertisements was higher in Greenville than in Albuquerque** among toll-free hotline callers. It was obvious from the open-ended data collected that callers in Greenville were much more likely to be able to recall specific details of the *Breathe* television spot (28%). Specific mentions of the *Hard Choices* spot were much lower at 7% in Greenville and 6% in Albuquerque. But in both markets, the items most frequently cited by callers were: the income dollar figure and insurance for children. Importantly, the income figure was much more likely to be recalled by callers from working households (28%) than callers from unemployed households (7%)—clearly **the household income dollar figure was more effective at capturing the attention of the audience most likely to believe that such a program is not for them (as defined through earlier research)**.

The specific differences across markets in what callers remember about the advertisements are provided in Table 20:

TABLE 20

	Greenville (Test) n=123	Albuquerque (Test) n=311
Insurance for Children	25% (n=28)	43% (n=135)
Exact Dollar Figure	34% (n=39)	23% (n=73)
For Working/Low-Income	17% (n=19)	6% (n=22)
Specific to *Breathe*	29% (n=33)	--
Specific to *Hard Choices*	7% (n=8)	6% (n=19)
General Ad Details	4% (n=5)	15% (n=47)
Gave a Phone Number	13% (n=15)	16% (n=49)

The ads effectively communicated to parents that their children might be eligible—mostly due to the inclusion of the dollar figure in the spot. That is, 89% of callers said the advertisements made them believe their child would be eligible (46% definitely and 43% probably).

The following are specifics from the ads that made parents of eligible uninsured children believe their child was eligible:

- A dollar amount was shown in the ad (59%),
- It talked about health insurance for kids (11%),
- It showed or talked about things that seem like it is for a family like mine (10%), and
- It talked about ways to pay for health insurance or how to get low cost insurance (8%).

Again, **the dollar figure was most effective with working families.** Specifically, 62% of those from working households mentioned the dollar amount as the reason they believe their children would be eligible, whereas only 32% of unemployed households said it made them believe their children would be eligible.

Why Callers Took The Time to Call

The primary reasons cited for calling the toll free number were consistent in both test markets: **they lack insurance coverage for their kids (47%), they can't afford private insurance (24%), and they are curious to get further information (19%).** Overall, there were no statistically significant differences across the two markets as to why people called the phone number.

But there are a few significant differences by subgroups worth noting:

- Men were more likely than women to say they called out of curiosity to "check it out" (37% to 17%).

- Minorities were more likely than Caucasians to say they called to "see if I qualify."
- Those who said they DO NOT plan to apply were most likely to say they were calling out of curiosity to "check it out" (40%).
- Those who saw a newspaper or print advertisement were most likely to say they called simply because their child does not have health care coverage right now (58%).

Again, results show those calling from working households were most likely to voluntarily say the dollar amount in the advertisement motivated them to call (7%).

Intent to Apply Among Callers

One of the most promising findings from this evaluative research was that **more than eight out of ten parents (84%) who called the toll free number for a child living in their household said they plan to apply for the program.** These results were consistent in both Greenville (83%) and Albuquerque (84%). Therefore, the efforts in both markets were equally effective in motivating the right target audience to call and apply.

Only 11% of parents who called said they did not plan to apply, and 5% said they were not sure. The greatest level of uncertainty as to whether or not they would apply was generally among parents with infants and households with five or more children in the home. Additionally, 12% of those from working households who called the toll free number said they did not plan to apply; this compares to only 2% of those not employed.

As expected, "making too much money for their family size" was the primary reason parents gave for not planning to apply. Specifically, 45% of those not planning to apply in Greenville and 39% in Albuquerque indicated they make too much money to qualify and, therefore, will not be applying. This represents 7% of those who called in the Greenville market and 6% who called in the Albuquerque market who said they will not apply because they are not eligible due to family size and household income.

As a follow-up, those who did not volunteer income as the reason for not applying were asked directly if they are concerned their income was too high to be eligible. This follow-up question was asked in order to get a complete picture of the number of those who called the hotline number and were turned away because they were not eligible. The results of this question, combined with those who volunteered income as a reason, showed that **9.3% of callers in Greenville and 8.6% of callers in Albuquerque were turned away because they learned they were not eligible after calling**.

Profile of Callers

Table 21 reports the mean household income by family size. Data across all markets have been combined to provide a sufficient sample size to report the mean for each subgroup. This provides additional insight into the likelihood that callers may qualify for coverage based upon their income and family size:

TABLE 21

	HIGHEST INCOME CATEGORY	TOTAL MEAN INCOME
2-3 In Household (n=224)	Less than $20K (41%)	$21,700
4 In Household (n=161)	$30-$34K (20%) $35K+ (22%)	$27,500
5+ In Household (n=97)	$35K+ (27%)	$28,600

In short, the average household income of those who called the hotline was within the eligible income range based upon family size. This is important in that most of those who called were the right target that, in fact, were very likely to qualify for this coverage based upon their family size and household income.

Post-Wave One Ad Testing On Eligibility Language

After the results were in and reported, there emerged a need to specifically test the eligibility language used in the advertisements to evaluate if this expression generated calls from eligible families, while minimizing the sense of "false advertising" among those who might call and learn they are not eligible for coverage.

Wirthlin Worldwide conducted a total of four focus groups in Miami, Florida and New Orleans, Louisiana, with 35 parents of eligible uninsured children. Two groups were conducted in Miami on January 31, 2001, and two groups were conducted in New Orleans on February 1, 2001.

Background and Objectives

The formative research conducted in Wave One revealed that the most significant barrier preventing parents of eligible uninsured children from enrolling is the misperception that the SCHIP and/or Medicaid programs DO NOT apply to their family because they are employed and/or they make too much money to qualify. The idea of adding a dollar figure in the advertisements was initially tested during breakout sessions in Fresno as part of the original testing of rough cut executions. The result showed many of those least likely to believe they would be eligible quickly changed their opinion when they heard a dollar figure, and said they would likely call if a figure was included. As a result, the final ads referred to a specific income level in order to catch attention and generate a feeling of "I might be eligible" among this target group.

Wirthlin Worldwide's post-test surveys found the income figure was one of the items most frequently recalled by those who had seen or heard the advertisements. In fact, it was much more likely to be recalled by those in working households than among those callers in unemployed households. Again, this confirmed the ability of the added dollar figure to attract attention and motivate calls in a real market test and in a follow-up quantitative survey assessment.

However, there is a potential trade-off by adding the dollar figure to the advertisements: whether this would lead to an increased number of callers and an increased number of people disappointed and, perhaps, disaffected when they learn they are not eligible even though they saw the dollar figure in the ad. This concern, coupled with the fact the dollar figure had not been tested in a formal execution of the advertisements, led to the need for further testing before the next wave of advertising.

This Post-Wave One phase of research was specifically designed to answer the following questions:

- *How powerful are the final PSA executions with respect to delivering on the core communication strategy?*
- *What value do the words "working families" add to the advertisements?*
- *Is there added value in having the dollar figure included in the advertisements, or not?*
- *How does the target audience react to various phrases describing eligibility?*
- *How might the eligible uninsured react if they were to call and find out they were not eligible?*

The following summary reports the topline answers to these questions.

Key Findings

1) How powerful are the final PSA executions with respect to delivering on the core communication strategy?

ANSWER: *They are very effective at motivating people to call. In fact, the scores for the ads on the key measurements have increased considerably since the rough cut tests in July 2000.*

After viewing each of the PSAs, participants were asked to rate each execution on the following statements:

- This ad really caught my attention.
- This ad makes me want to call the phone number for more information.
- This ad makes me want to sign my children up for the health care coverage program in my state.
- This ad seems like it is about a program for families like mine.

These, too, were used in the July 2000 ad tests of the rough-cut spots. Table 22 below shows the initial rough cut and subsequent final execution scores on each PSA (rated on a 100-point scale).

TABLE 22

PSA 1: *Hard Choices*			
	Feb-01	**Jul-00**	**CHANGE**
Attention	88.8	77.6	**+11.2**
Call	94.7	80	**+14.7**
Sign up	83.0	84	-1.0
Families like mine	81.2	78.25	**+2.9**

PSA 2: *Care Giver*			
	Feb-01	**Jul-00**	**CHANGE**
Attention	86.5	73.4	**+13.1**
Call	88.8	70.2	**+18.6**
Sign up	87.1	76.8	**+10.3**
Families like mine	78.8	75.4	**+3.4**

PSA 3: *Breathe*			
	Feb-01	**Jul-00**	**CHANGE**
Attention	91.2	69.45	**+21.7**
Call	90.0	78.4	**+11.6**
Sign up	88.2	75.73	**+12.5**
Families like mine	87.1	70	**+17.1**

These scores are well above normative data Wirthlin Worldwide has measured with respect to advertisement testing in general. Additionally, it is important to note the higher scores of the final executions. These high scores were visibly apparent by the reaction of the focus group participants; each of whom was very excited to call the hotline number even after only the first PSA was shown.

In short, the final ad executions caught the audience's attention, motivated parents of eligible uninsured children to call and sign up, and communicated that the ads were talking to families like theirs. Anecdotally, several parents during the groups wanted the ads to be played again so they could write down the telephone number.

2) What value do the words "working families" add to the advertisements?

ANSWER: *This phrase helps communicate to parents who are employed that the program is for them. At a bare minimum, either the phrase "working families" or visuals showing working families must be included.*

When asked what they recalled from watching the PSAs, many parents of eligible uninsured children mentioned the fact that the program was for "working families." Almost everyone in the sessions said they would call because they fit in that category and believe they may actually be eligible for the

program. This was asked before the income figure was added, showing the power of the ads to motivate calls.

A note of caution, some participants who were not currently working believed they might not be eligible for the program because they were unemployed. This should not alter the design of the ads, but, instead, points to the need to include other language about eligibility in written material where more detail is provided.

3) Is there added value in having the dollar figure included in the advertisements, or not?

ANSWER: *Absolutely. Including the dollar figure is one additional "silver bullet" that brings in that last group of people who are sitting on the fence because they do not believe they are eligible.*

The addition of the dollar figure significantly attracts attention and motivates people to make the call who otherwise would not have done so. At the same time, lower income audiences were not as likely to even notice it was added. In the end, all participants in every group said they were more likely to call after viewing the ads with the income figure—specifically, those in the groups who made more money and were eligible for SCHIP but not for Medicaid. In fact, the few who said they would not call after the original ad said they definitely would call after seeing the income figure.

4) How does the target audience react to various phrases describing eligibility?

ANSWER: *In short, the approach of catching attention to create a feeling of "I might be eligible" was more effective in motivating someone to call. Attempts to define parameters of eligibility were confusing.*

For this test phase, the advertisements were designed to test two approaches to the eligibility issue:

1) Create a possibility that I may be eligible -OR-
2) Attempt to define specific parameters of eligibility.

The net result is that the former approach was more effective in motivating people to call without a serious downside if they called and found out they were not eligible for coverage. The latter approach was potentially confusing, lessening the "power" of the dollar figure, and of greater risk to offend people who found out they did not qualify after calling the number. Most respondents either took the language of "A Family of Four" as literally defining for whom the program is designed OR were left asking questions as to what it really means. In short, less is more when it comes to motivating a call.

Specifically, Wirthlin Worldwide saw the following trends in the groups:

- The dollar figure alone gave respondents the hope that they might be eligible.
- It is important to clearly state qualifiers such as "even families" and "making up to" and "can qualify to get the card."
- The use of "may" and "could" lessen the strength of the attention grabber, but do tend to communicate "the possibility" rather than defining qualifications. However, you gain more than you lose by using "can" in the copy.

- As more qualifiers were added, such as "family of four," the potential for confusion increased. Many participants questioned what a “family of four” meant—some inferred that both a mother and a father needed to be present in the household.
- Adding "or slightly more" caught more attention, but it was confusing when attached to the "family of four" language. "Or slightly more" linked to both family size and income was perceived as "defining eligibility" rather than "creating the possibility that I am eligible." Adding “even more” or “slightly more” to the dollar figure can generate more interest, but may lead to increased calls by people who do not qualify.

5) How might the eligible uninsured react if they were to call and find out they are not eligible?

ANSWER: *Most said they would feel frustrated, but glad that they took the time to try. In fact, almost all said they would tell others about it with the hope that maybe others would qualify.*

After viewing or listening to all of the ads, Wirthlin Worldwide asked participants how they would feel if they called the phone number based upon the income figure they saw or heard and were told they were ineligible. Almost all said they would feel frustrated, upset, and mad. And several said they would think that it was false advertising. However, when probed beyond the feeling of frustration, many said, "well at least I tried" because in that sense "it was worth my time and effort."

When probed directly, many said they would still be more likely to talk with other people about the program because now they know that a program exists to help people and perhaps others would qualify for it if they called to check—even though the participants themselves were not qualified. Very few (only one or two out of 35-40) people expressed serious offense at being told they were ineligible after seeing an ad with the dollar figure.

Net Recommended Actions

1. Use the language “even families making up to $XX,XXX can qualify to get the card.”
2. Negotiate the appropriate income figure with each state.
3. Consider using “even families making up to $XX,XXX or more can qualify to get the card.”
4. Find language to add ON SCREEN stating that eligibility is determined by family size and income level.

Future Research

Wirthlin Worldwide is currently working on two separate reports, which address specific findings from the studies discussed above for Native American and Latino parents.