



**New Hampshire Healthy Kids Program Evaluation:  
Gold Fee-for-Service, Gold Managed Care, and Silver**

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## SECTION 1: EXECUTIVE SUMMARY

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### BACKGROUND

The purpose of this report is to describe the findings obtained from the 2000-2001 Healthy Kids Program evaluation. This program evaluation included the State's Medicaid programs, both fee-for-service (Healthy Kids Gold FFS) and managed care (Healthy Kids Gold MC) and the State Title XXI-Children's Health Insurance Program (Healthy Kids Silver). The evaluation addressed children's enrollment and disenrollment patterns, the quality of care that they received while in the program, and their experiences after they disenrolled. To learn more about the enrollees' and disenrollees' experiences, three data sources were used: 1) program enrollment files, 2) person-level health care use data, and 3) telephone survey data.

### NEW ENROLLEE SURVEY RESULTS

Families whose children were enrolled in the Healthy Kids Gold FFS, Gold MC, or Silver for two months or less were asked to participate in a telephone survey about their experiences with the application process. Information also was obtained from families about their children's health care experiences prior to enrolling in the program.

Families were almost exclusively white and non-Hispanic for each of the program components. However, 6% were black and 3% were Hispanic. Overall, about 4% of the state population is considered minorities. Therefore the program serves a higher percentage of minorities than might be expected based on the state's demographic characteristics.

Over 90% of families in all of the program components, Gold FFS, Gold MC, and Silver, enrolled all of the children. Of those who only enrolled one child in the family (10% or less of the families), approximately 90% indicated that the other children in the family had coverage from some other source. The remaining 10% indicated they chose the children with the greatest health care needs to insure.

Families were asked several questions about how they learned about the Healthy Kids Program. First, they were asked to name all of the different ways they learned about the program, then they were asked to name the primary way they learned about Healthy Kids. Families predominantly learned about the program through brochures (over 50%), health care providers (about 50%), family and friends (about 40%) and the schools (about 45%). However, other sources of information were important such as community health centers and hospitals.

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The majority of families felt that they were kept informed during the application process. Sixty-eight percent of Healthy Kids Silver enrollees, 60% of Healthy Kids Gold FFS enrollees, and 64% of Healthy Kids Gold MC enrollees said they were kept informed. The majority of families also strongly agreed or agreed that the application form was easy to understand and convenient.

#### **CROWD OUT**

Throughout the development of the Title XXI legislation at the Federal level, many policy analysts expressed concern about a phenomenon called “crowd out.” Crowd out can occur when employees either opt out of or not take employer-based coverage if there are less expensive alternatives. This scenario can result in a decrease in private sector coverage and an increase in public sector spending. Only 11% of Gold FFS, 11% of Gold MC, and 7% of Silver enrollees had employer-based coverage in the 12 months preceding their enrollment into the Healthy Kids Program. Thus crowd out of employer-based coverage was not a large issue.

#### **ENROLLMENT AND DISENROLLMENT**

The Title XXI Program was intended to improve children’s access to health care by providing affordable insurance coverage to low-income families. However, access to care and the quality of the children’s health care may be hampered if they are covered for short periods of time. Unfortunately, very little information is available about the factors influencing disenrollment and re-enrollment patterns in subsidized children’s health insurance programs.

Several analyses were conducted to analyze New Hampshire’s enrollment and disenrollment experiences. First, New Hampshire was compared to the enrollment and disenrollment experiences in four other states: New York, Florida, Kansas, and Oregon. Next disenrollment experiences for those with and without special health care needs in New Hampshire were analyzed.

Although New Hampshire has an active renewal process for their Healthy Kids Programs, the state does not experience the markedly increased disenrollment seen in other states with active renewal processes. Examining the renewal practices in New Hampshire was not a component of this evaluation. Therefore the reasons contributing to successful renewal in New Hampshire vis-à-vis other states are not known.

While some increase in attrition is seen in New Hampshire at approximately 12 and 18 months, there are not large disenrollments as seen in New York, Oregon, and Kansas. For example at 12 months of enrollment, around 10% of Program enrollees in New Hampshire disenroll compared to about 50% of enrollees in Kansas.

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A similar analysis as described above was completed for Healthy Kids Silver and Gold (FFS and MC combined) examining the patterns for children with and without chronic conditions. The health status characteristics of those that disenroll compared to those that remain enrolled have important implications for the organization and financing of the program. Over time, the premium may increase due to the adverse retention of children with increased health care needs and the loss of healthier children. In addition, the size and composition of the provider network may need to change to accommodate sicker children, perhaps in need of more specialty care.

There is steady program attrition, regardless of the child's health status (chronic conditions versus not). However the probability of remaining in the program is higher for those with chronic conditions than for children who are healthy for both program components (Healthy Kids Silver and Healthy Kids Gold FFS/MC). The differences are not large. However, the New Hampshire programs are retaining more children with special needs when compared to those without special needs. This phenomenon has been observed and documented in Florida.<sup>1</sup>

**PARENTAL  
REPORT OF UNMET  
NEED**

Parents of New Enrollees and Established Enrollees were asked if their children needed any of the following services: routine medical care, surgical procedures, specialty care, mental health care or counseling, prescriptions, and dental care. If the respondent indicated the child needed any of the services, he or she was then asked if the child received the needed care, and if not, why not. New Enrollees were asked to think about the 12 months prior to the children enrolling in the program. Established Enrollees were asked to think about their children's past 12 months in the program.

In general, there was little unmet need reported among new enrollees. The greatest area of unmet need was found among Gold Program recipients, particularly in the areas of mental health counseling and dental care. Established enrollees demonstrated almost no unmet health care needs when compared to new enrollees.

**FAMILY  
SATISFACTION  
WITH CARE**

The Consumer Assessment of Health Plans Survey (CAHPS) was used to assess family satisfaction with care after enrollment in the programs. This instrument was selected because it is being used nationally in many of the State Title XXI evaluations. Overall families report excellent access to care and satisfaction with the programs.

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For some of the items, statistically significant differences were noted between Healthy Kids Silver, Gold FFS, and Gold MC. For example, a significantly higher percentage of Healthy Kids Silver families were able to get an appointment for routine care and illness or injury care as soon as they wanted when compared to Gold FFS and MC. For example, 69% of Healthy Kids Silver families compared to 62% of Gold FFS and MC families reported they got appointments for routine care as soon as they wanted them. Eighty percent of Healthy Kids Silver families were seen for emergency care as soon as they wanted compared with only about 74% of Gold FFS and MC enrollees. In addition, a significantly higher percentage of Healthy Kids Silver families reported that the doctors talked to the children in ways the children could understand when compared to Gold FFS and MC. No other significant differences were noted.

**COMPLIANCE  
WITH WELL  
CHILD CARE  
VISITS**

We estimated compliance with American Academy of Pediatrics (AAP) guidelines for well child visits for children in the Healthy Kids Gold FFS, Gold MC, and Silver Programs (both users and non-users of the health care system) continuously enrolled for at least 12 months. The percentages of children in compliance with recommended guidelines were very good for Healthy Kids Silver for ages 5 and under with 85% of children in compliance. For Gold FFS and MC only 65% and 67% of the children age 2 and under, respectively, were in compliance. For those 3 to 5 in Gold FFS and MC only 69% and 66% were in compliance. For Gold FFS, MC, and Silver, less than 70% of those between the ages of 6 and 19 years were in compliance with well child visit guidelines.

**INCIDENCE OF  
INPATIENT  
ADMISSIONS FOR  
AMBULATORY  
CARE SENSITIVE  
CONDITIONS**

Ambulatory care sensitive conditions (ACSC) are those conditions that should be treated on an outpatient basis. Inpatient stays for such conditions often indicate poor access to care or a potential problem with the quality of care provided. Examples of such conditions include asthma, dehydration, gastroenteritis, otitis media, cellulitis, urinary tract infections, epilepsy, and diabetes. The claims and encounter data were searched for inpatient admissions with these primary diagnoses. In the Gold FFS Program, 1.7% of the children hospitalized had a diagnosis that was considered an ACSC. The occurrence was 1.2% for Gold MC and 1.2% for Silver.

**BENEFIT PACKAGE  
LIMITATIONS**

There are some limitations to the Healthy Kids Silver benefit package. For example, mental health benefits include 20 outpatient visits in 12 months. No children exceeded this number of visits. There also is a 15-day maximum for inpatient mental health care. No children exceeded this benefit limit

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**PHARMACY USE**

A software program that groups prescription drugs from various manufacturers into major drug and drug classes was used to categorize pharmacy use in the Healthy Kids Program. As expected, medications for the respiratory tract and antimicrobials were the most common major drug classes identified for both Silver and Gold FFS program components. Central nervous system drugs also were common.

**DISENROLLEE  
SURVEY RESULTS**

The most common reason for disenrollment was that the families' incomes were too high. About one-third of the disenrollees in each program indicated that their incomes had increased beyond the eligibility limits. About 20% in each program reported some difficulty with the renewal process and staying enrolled.

Only 11% of the Healthy Kids Silver disenrollee families reported dissatisfaction with the premium amount. Thirteen percent of Healthy Kids Silver families reported that they were cancelled due to non-payment of premium. Of the 11% of families who reported dissatisfaction with the premium, 5% of them also reported they were cancelled due to non-payment of premium.

Most children were uninsured after leaving the program. Only 22% of Healthy Kids Silver families, 13% of Gold FFS families, and 12% of Gold MC families obtained other health insurance coverage for their children. However this coverage often reflected movement between the Healthy Kids Program components.

## SECTION 2: BACKGROUND AND METHODOLOGY

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### BACKGROUND

The purpose of this report is to describe the findings obtained from the 2000-2001 Healthy Kids Program evaluation. This program evaluation included the State's Medicaid programs, both fee-for-service (Healthy Kids Gold FFS) and managed care (Healthy Kids Gold MC) and the State Title XXI-Children's Health Insurance Program (Healthy Kids Silver). The evaluation addressed children's enrollment and disenrollment patterns, the quality of care that they received while in the program, and their experiences after they disenrolled.

The purpose of this report is to present the following:

1. Methods used to conduct the evaluation,
2. Enrollees' experiences with the application process,
3. New enrollees health insurance status prior to enrollment or incidence of crowd out,
4. Children's disenrollment patterns,
5. Experiences of children with special health care needs (CSHCN) in the program,
6. Parents' reports of program satisfaction and quality of care, and
7. Children's use of health care services.

### METHODOLOGY

**Data Sources:** To learn more about the enrollees' and disenrollees' experiences, three data sources were used: 1) program enrollment files, 2) person-level health care use data, and 3) telephone survey data. Each of these data sources is described in the following paragraphs. All three program components, Gold FFS, Gold MC, and Silver provided person-level enrollment and claims and encounter information for 1999 and 2000. The enrollment files contain basic demographic information such as family income, enrollee age, and enrollee gender. In addition, the enrollment files contain important information about the children's enrollment in each of the programs from month to month.

The claims and encounter data contain rich information about the children's diagnoses, the types of health care services they used, and the location where the services were received. Information was provided for outpatient, inpatient, and emergency room (ER) services. In addition, pharmacy information was provided for each child including the number and type of prescriptions the child received.

These data were supplemented with in-depth telephone survey data. Telephone surveys were conducted with 1) New Enrollees – those enrolled in the program for 2 months or less, 2) Established Enrollees – those enrolled in the program for 6 months or longer, and 3) Disenrollees – those who were enrolled in the program for at least 3 months followed by

a disenrollment.

These surveys were administered to Healthy Kids Silver, Healthy Kids Gold FFS, and Healthy Kids Gold MC Program families. The interviews were approximately 30 minutes in length and addressed several areas that are described in Table 1.

**Table 1. Telephone Survey Content**

<b>Content Area</b>	<b>New Enrollee</b>	<b>Established Enrollees</b>	<b>Disenrollee</b>
Relationship of Respondent to enrollee (child)	Y	Y	Y
The CSHCN Screener to assess for the presence of special health care needs	Y	Y	Y
Experience with application and enrollment process	Y		
Health insurance coverage prior to enrollment	Y		
Usual Source of Care	Y	Y	Y
Satisfaction with care as measured by the Consumer Assessment of Health Plans Survey (CAHPS)		Y	
Assessment of Unmet Need	Y	Y	
Reasons for disenrollment			Y
Insurance status after disenrollment			Y
Demographic Information	Y	Y	Y

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**METHODOLOGY**

***Telephone Survey Sample:*** A target of 200 completed survey for each survey type for each program component was established. That is, there were 200 New Enrollee Surveys completed for Healthy Kids Silver, Healthy Kids Gold FFS, and Healthy Kids MC for a total of 600 completed New Enrollee Surveys. Likewise there were a total of 600 completed Established Enrollee Surveys and Disenrollee Surveys. Table 2 contains information about the response rates for the surveys.

Response rates were very good for the New Enrollee and Established Enrollee survey. Families whose children were disenrolled from the program were harder to locate than new enrollees or established enrollees and once located, a higher percentage refused to participate.

The survey respondent was selected by asking to speak to a person in the household 18 years or older who knew the most about the child's health care. In 97% of the cases, this person was the child's mother and in 3% of the cases, the respondent was the child's father or some other guardian.

**Table 2. Telephone Survey Response Rates**

<b>Program Component</b>	<b>New Enrollee</b>		<b>Established Enrollees</b>		<b>Disenrollee</b>	
	<b>Not Located</b>	<b>Refused</b>	<b>Not Located</b>	<b>Refused</b>	<b>Not Located</b>	<b>Refused</b>
Gold FFS	24%	15%	24%	17%	25%	24%
Gold MC	23%	17%	22%	19%	23%	26%
Silver	21%	16%	20%	16%	25%	24%

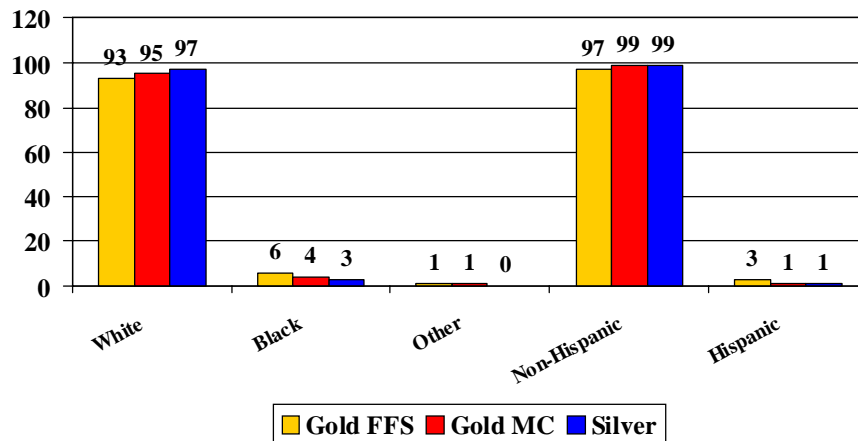
## SECTION 3: NEW ENROLLEE SURVEY RESULTS

### DEMOGRAPHIC AND HEALTH CHARACTERISTICS

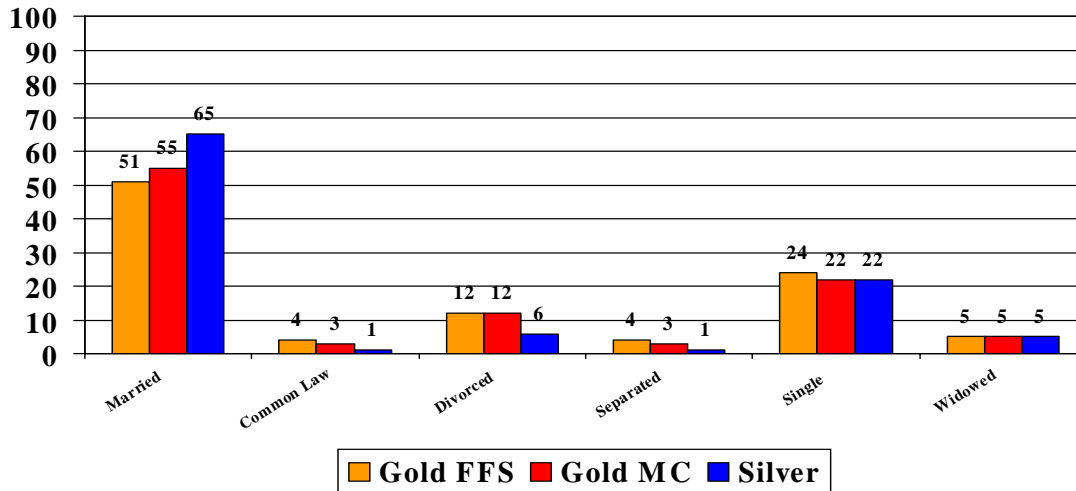
Families whose children were enrolled in the New Hampshire Healthy Kids Program for two months or less were contacted and asked to participate in a New Enrollee Survey. This survey included questions about the families' demographic characteristics, whether the child had a special health care need (as measured by the CSHCN Screener), how the family heard about the program, satisfaction with the application and enrollment process, the child's usual source of care pre and post enrollment, and an assessment of unmet health care needs. The results from those surveys are summarized in this section.

Families were almost exclusively white and non-Hispanic for each of the program components (Figure 1). Only 6% were black, 3% were Hispanic and 1% were of some other racial/ethnic group. However, the program is serving a higher percentage of minority children than might be expected based on the state's demographic characteristics. Overall, New Hampshire has a 4% minority population. Depending on the program component, 50% to 65% of respondents were married and over 60% of children resided in two parent families (Figures 2 and 3).

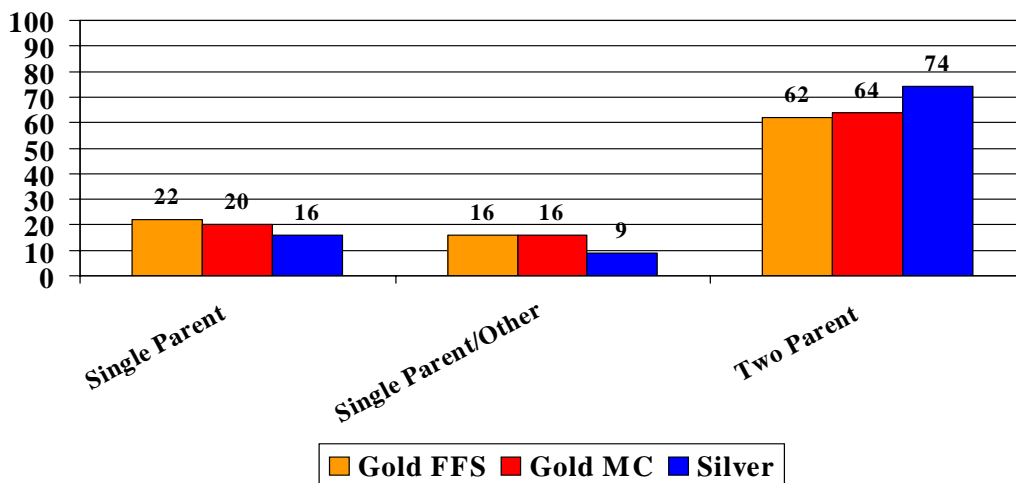
Figure 1: New Enrollee Demographic Characteristics



## Figure 2: New Enrollee Respondent Marital Status



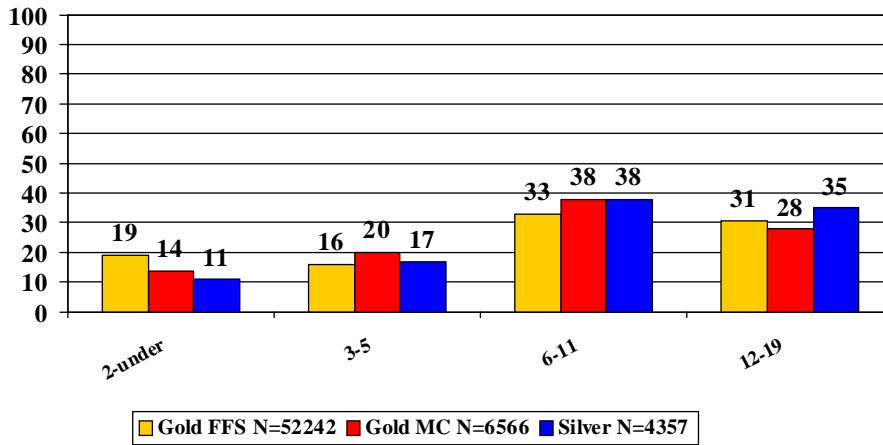
## Figure 3: New Enrollee Household Type



**FAMILIES’  
DECISIONS ABOUT  
WHO TO ENROLL**

There was interest in learning about whether families enroll all of their children in one of the Healthy Kids Program components (i.e., Silver, Gold FFS, Gold MC). Families first were asked how many children age 18 and younger resided in their families. For Healthy Kids Silver, there was a mean number of 1.98 ±1.13 children in the family with a mean age of 9.14 years (±5.08). Both Healthy Kids Gold FFS and Gold MC had somewhat larger families. There was an average of 2.23 children (±1.25) in Gold FFS and an average of 2.21 children (±1.01) in Gold MC. Their mean ages were 9.12 years (±4.73) and 9.11 years (±4.99) respectively. Figure 4 shows the age breakdowns of the children for each program.

Figure 4: Children’s Ages



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Almost all of the children in the families were enrolled in Healthy Kids. Ninety-two percent of Healthy Kids Silver families, 94% of Healthy Kids Gold FFS families, and 94% of Healthy Kids Gold MC families had all children enrolled. The 6% to 8% of families who did not have all children enrolled were asked how they chose which children to enroll. Of those who enrolled only one of their children, 10% of Healthy Kids Silver families, 8% of Healthy Kids Gold FFS, and 9% of Healthy Kids Gold MC reported that they chose the child that had a chronic medical problem or ongoing health care needs. The remaining families in all three programs who did not cover all children reported that the other children in the family had coverage from another source. Thus, for each of the programs overall, Gold FFS, Gold, MC, and Silver, less than 1% of the total sample enrolled only one child in the family because he or she had a chronic medical problem.

**HOW FAMILIES  
HEARD ABOUT THE  
PROGRAM**

Families were asked several questions about how they learned about the Healthy Kids Program. First, they were asked to name all of the different ways they learned about the program, then they were asked to name the primary way they learned about Healthy Kids. Certain responses led to a series of questions designed to gather more information about that response. For example, families who said they learned about Healthy Kids through their children's school were then asked if they heard about the program through the school nurse, the guidance counselor, the special education teacher and so on. Figure 5 contains a summary of the different ways that families learned about the program. For this question, families could provide more than one response.

Families predominantly learned about the program through brochures, health care providers, family and friends, and schools. However, other sources of information were important such as community health centers and hospitals.

Figure 5. Learned About the Program

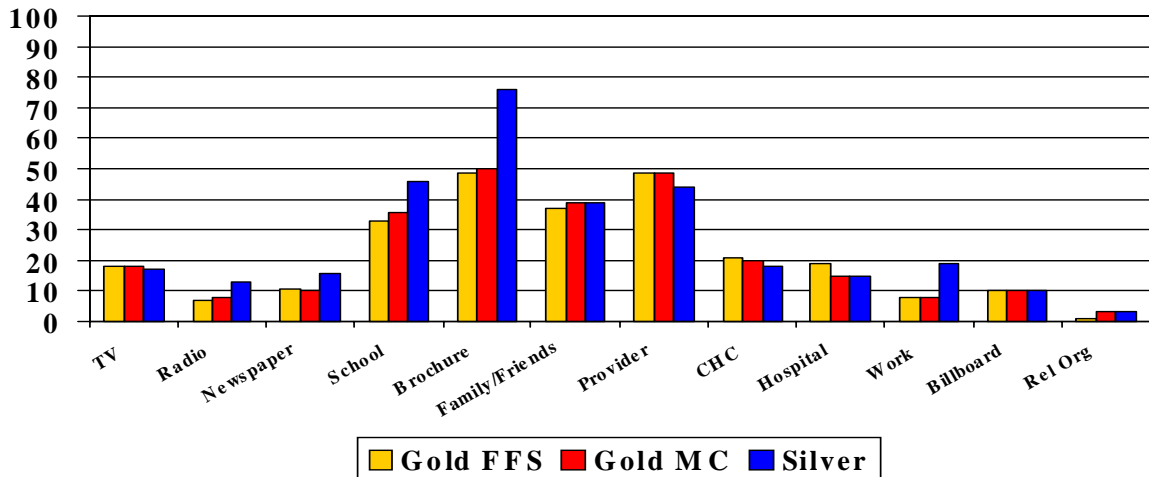


Table 3 summarizes the responses about the particular source of information for those families who learned about the program from the school, a health care provider, a community health center, and/or a hospital. In the school setting, teachers and the postcard campaign were the most frequently mentioned sources of information.

In providers' offices, the front office staff and the doctor were important sources of information for all of the groups. Nurses were an important source of information for Healthy Kids Gold FFS and MC enrollees but not Silver enrollees. In community health centers, nurses, social workers, and doctors were all important sources of information. Finally, in hospitals, admissions staff played an important role in getting information to families.

**Table 3. Particular Sources of Information**

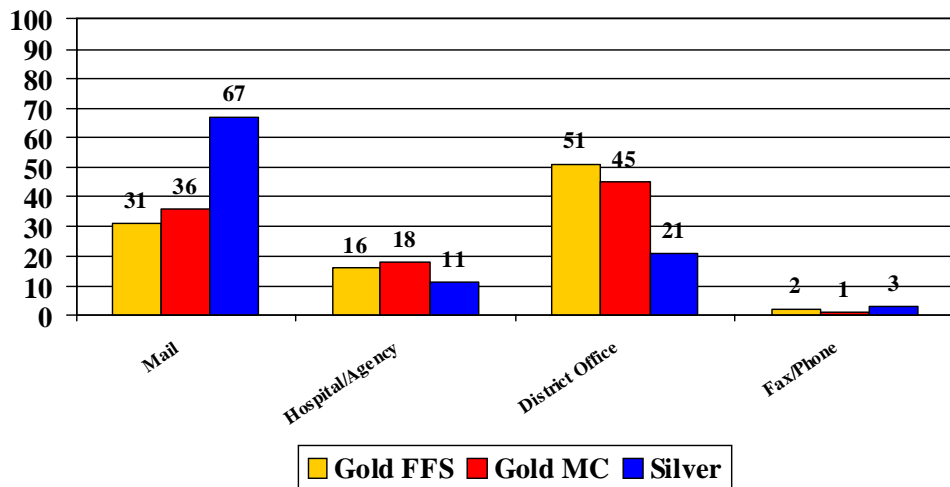
<b>Category</b>	<b>Healthy Kids Gold FFS (%)</b>	<b>Healthy Kids Gold MC (%)</b>	<b>Healthy Kids Silver (%)</b>
<b>Schools</b>	<b>N=66</b>	<b>N=76</b>	<b>N=92</b>
School nurse	29%	25%	15%
Guidance counselor	5%	5%	5%
Special education	10%	9%	5%
School lunch program	11%	10%	10%
Postcard campaign	26%	26%	27%
Poster in school	10%	11%	14%
Teacher	24%	24%	31%
<b>Provider</b>	<b>N=98</b>	<b>N=98</b>	<b>N=88</b>
Front office staff	36%	33%	36%
Nurse	21%	15%	2%
Doctor	33%	34%	27%
<b>Community Health Center</b>	<b>N=42</b>	<b>N=40</b>	<b>N=36</b>
Nurse	16%	16%	16%
Social Worker	39%	37%	20%
Doctor	12%	15%	20%
<b>Hospital</b>	<b>N=38</b>	<b>N=30</b>	<b>N=30</b>
Admissions staff	19%	19%	19%
Social worker	28%	24%	14%
Nurse	19%	20%	23%

**EXPERIENCES WITH THE APPLICATION PROCESS**

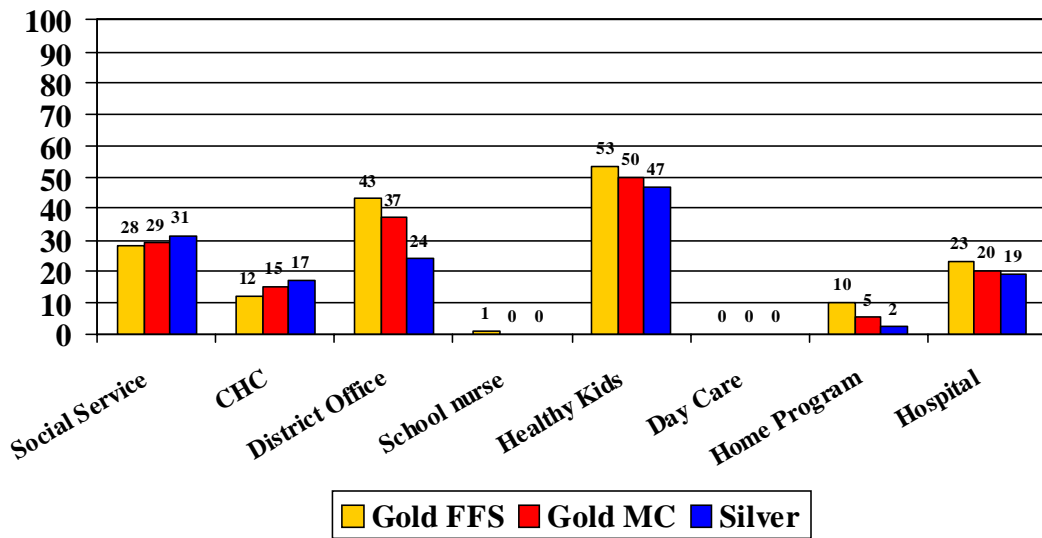
Families were asked a series of questions about their experiences with the application and enrollment process beginning with questions about how they applied. Sixty-seven percent of Healthy Kids Silver families applied for the program by mail. Fifty-one percent of Healthy Kids Gold FFS and 45% of Healthy Kids Gold MC applied through district offices. These results are summarized in Figure 6.

Thirty-one percent of Healthy Kids Silver enrollees, 43% of Healthy Kids Gold FFS, and 38% of Healthy Kids Gold MC received help from another person. Those receiving help were asked to respond to a series of questions about all of the places where they may have received help with the application process (Figure 7). Families were allowed to choose more than one response so the responses will not total 100%. The highest percentage of families named the Healthy Kids Office as the place where they received assistance with the application followed by the district office.

### Figure 6. How Applied



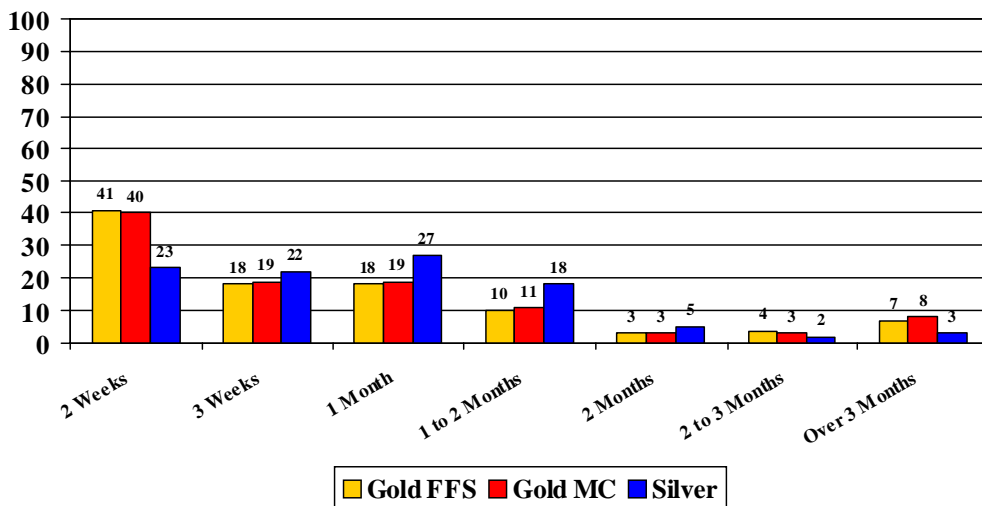
## Figure 7. Sources of Application Assistance



Families were also asked about their perceptions of how long it took from application to notification of insurance coverage. These results are summarized in Figure 8. Forty-one percent of Healthy Kids Gold FFS and 40% of Healthy Kids Gold MC reported waiting only 2 weeks or less. In contrast, only 23% of Healthy Kids Silver enrollees waited two weeks or less. Less than 10% of families in all programs reported waiting two months or longer.

It is important to reiterate that the waiting times reported above and in Figure 8 represent families' perceptions of the waiting time from application to notification and coverage. Based on Healthy Kids Silver administrative data, the actual time for determining Healthy Kids Silver eligibility is 12 days, on average. However, the children's actual coverage in the program typically begins a few weeks after the eligibility determination has occurred.

### Figure 8. Time From Application to Notification/Coverage



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The majority of families felt that they were kept informed during the application process. Sixty-eight percent of Healthy Kids Silver enrollees, 60% of Healthy Kids Gold FFS enrollees, and 64% of Healthy Kids Gold MC enrollees said they were kept informed. The majority of families also strongly agreed or agreed that the application form was easy to understand.

- 52% of Healthy Kids Silver enrollees strongly agreed that the application form was easy to understand compared to 38% of Healthy Kids Gold FFS and 40% of Healthy Kids Gold MC families.
- 43% of Healthy Kids Silver enrollees agreed that the form was easy to understand compared to 51% of Healthy Kids Gold FFS and 49% of Healthy Kids Gold MC families.
- Only 5% of Healthy Kids Silver families disagreed or strongly disagreed that the form was easy to understand compared with 10% of Healthy Kids Gold FFS and 10% of Healthy Kids Gold MC families.

The documentation required for the application process seemed to be a concern for families with 68% of Healthy Kids Silver, 59% of Healthy Kids Gold FFS, and 62% of Healthy Kids Gold MC families reporting that it was somewhat difficult to difficult to get the required documentation. Despite their concerns about the documentation the vast majority of families agreed or strongly agreed that the application process was convenient. The following results were obtained:

- 36% of Healthy Kids Silver enrollees strongly agreed that the application process was convenient compared to 28% of Healthy Kids Gold FFS and 30% of Healthy Kids Gold MC families.
- 56% of Healthy Kids Silver enrollees agreed that the application process was convenient compared to 52% of Healthy Kids Gold FFS and 49% of Healthy Kids Gold MC families.
- Only 9% of Healthy Kids Silver families disagreed or strongly disagreed that the application process was convenient compared with 19% of Healthy Kids Gold FFS and 18% of Healthy Kids Gold MC families.

Interestingly, more Healthy Kids Silver families called to ask someone questions about their children’s applications when compared to Healthy Kids Gold FFS of MC families (65% versus 46% and 50% respectively). Table 4 contains a summary of the people or places that families contacted with questions. Families could choose more than one response. Therefore the results will not total 100%. Ninety-four percent of Healthy Kids Silver families, 83% of Healthy Kids Gold FFS and 88% of Healthy Kids Gold MC were able to reach the person or place they attempted to contact.

Once they reached the person or place, the majority of families rated their contact as helpful or very helpful. They also reported being treated with courtesy and respect. These results are summarized in Table 5.

**Table 4. Persons or Places Families Contacted with Questions**

Category	Healthy Kids Gold FFS (%)	Healthy Kids Gold MC (%)	Healthy Kids Silver (%)
	<b>N=92</b>	<b>N=100</b>	<b>N=130</b>
Social Service Agency	32%	30%	14%
Community Health Center	3%	5%	0%
District Office	49%	53%	18%
School Nurse	0%	0%	0%
Healthy Kids Office	29%	34%	72%
Day Care	0%	0%	0%
Visiting Nurse Program	0%	0%	0%
Hospital	1%	0%	0%

**Table 5. Satisfaction with Person or Place Contacted**

Category	Healthy Kids Gold FFS (%)	Healthy Kids Gold MC (%)	Healthy Kids Silver (%)
<b>Would you say they were..</b>	<b>N=92</b>	<b>N=100</b>	<b>N=130</b>
Very Helpful	51%	50%	63%
Helpful	21%	24%	18%
Somewhat Helpful	21%	18%	15%
Not Helpful At All	7%	6%	4%
<b>Treated With Courtesy?</b>			
Strongly Agree	37%	40%	57%
Agree	55%	53%	41%
Disagree	5%	3%	2%
Strongly Disagree	3%	4%	0%

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Families were asked if they received any written information explaining the Healthy Kids Program after their children were enrolled. Ninety-Five percent of Healthy Kids Silver, 88% of Healthy Kids Gold FFS, and 90% of Healthy Kids Gold MC received written information.

- 56% of Healthy Kids Silver enrollees strongly agreed that the information was easy to understand compared to 39% of Healthy Kids Gold FFS and 39% of Healthy Kids Gold MC families.
- 42% of Healthy Kids Silver enrollees agreed that the information was easy to understand compared to 54% of Healthy Kids Gold FFS and 56% of Healthy Kids Gold MC families.
- Only 2% of Healthy Kids Silver families disagreed or strongly disagreed that the information was easy to understand compared with 6% of Healthy Kids Gold FFS and 4% of Healthy Kids Gold MC families.

Most families reported that no one explained the information in the written material to them. However, given the strongly positive responses about the ease of understanding the material this particular response is not surprising. Twenty-four percent of Healthy Kids Silver families, and 33% and 30% of Healthy Kids Gold FFS and MC respectively reported that someone explained the information to them. The person or place cited most frequently as explaining information to Healthy Kids Silver families were (responses will not total 100%):

- 10% - social service agency
- 23% - District Office
- 57% - Healthy Kids Office

Healthy Kids Gold FFS received explanations from the following:

- 24% - social service agency
- 38% - District Office
- 21% - Healthy Kids Office

Finally, Healthy Kids Gold MC received explanations about the written materials from the following:

- 26% - social service agency
- 42% - District Office
- 25% - Healthy Kids Office

## SECTION 4: CROWD OUT

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### CROWD OUT

Throughout the development of the Title XXI legislation at the Federal level, many policy analysts expressed concern about a phenomenon called “crowd out.” Crowd out can occur when employers, knowing that other insurance alternatives exist for their employees, drop dependent coverage, resulting in a shift of children from private to public programs. Alternatively, employees may either opt out of or not take employer-based coverage if there are less expensive alternatives. Each of these scenarios result in a decrease in private sector coverage and an increase in public sector spending. Moreover, substitution of employer-based coverage with a subsidized state plan may result in fewer improvements in access to care and health status than anticipated because families who are already covered are simply moving to a different form of health insurance.

Because substitution can blunt the impact of health insurance expansions, Federal Title XXI legislation requires states to assess the degree to which the states’ programs are contributing to crowd out of employer-based dependent coverage.<sup>2</sup> The Title XXI legislation does include elements that may contribute to crowd out. For example, states may elect to provide coverage for children residing in families with incomes up to 200% of the federal poverty level (FPL). Earlier studies have demonstrated that access to employer-based coverage varies significantly by income with families above 185% FPL reporting increased access when compared to those with lower incomes.<sup>3</sup> Thus, families at the upper end of the income cutoff for government subsidized insurance coverage may have greater access to employer-based dependent coverage than families at the lower end of the income range. If families at the higher range of the income scale elect a Title XXI option as opposed to their employer-based coverage, these families are then contributing to crowd out. The Title XXI benefit package may be richer than those typically offered by many employers and available at a substantially reduced premium to families, thereby potentially contributing to the substitution of public for private coverage. The New Hampshire Title XXI Program is the premium-based Healthy Kids Silver Program.

Thus, as part of the New Enrollee Telephone Survey, respondents were asked detailed questions about the following:

- Whether their children had insurance coverage in the 12 months preceding their enrollment in the CHIP, and
- If so the type of insurance coverage they had.

Only 17% of the Healthy Kids Silver enrollees, 22% of the Healthy Kids Gold FFS enrollees, and 21% of the Healthy Kids Gold MC enrollees had any health insurance coverage in the 12 months preceding program entry. Table 6 shows the type of coverage that these children had.

For those children with coverage in the 12 months preceding program entry, the majority had private insurance from an employer or Healthy Kids Gold. Thus, the large majority of children had no health insurance coverage prior to program entry. The percentage with any insurance and the percentage of children with employer-based coverage is similar to that seen in Florida. For example, 11% of Florida Healthy Kids enrollees and 17% of Florida Medicaid enrollees had employer-based coverage at some time during the 12 months preceding Title XXI or Title XIX enrollment.<sup>4</sup>

**Table 6. Type of Coverage Children Had in 12 Months Preceding Healthy Kids Program Entry**

Type of Coverage	Healthy Kids Gold FFS	Healthy Kids Gold MC	Healthy Kids Silver
Private from employer	11%	11%	7%
Private purchased by self	1%	1%	1%
Healthy Kids Gold	6%	6%	8%
Matthew Thornton	4%	4%	1%
Healthy Kids Silver	<1%	<1%	<1%

## SECTION 5: DISENROLLMENT PATTERNS

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### INTRODUCTION

The Title XXI Program was intended to improve children's access to health care by providing affordable insurance coverage to low-income families. However, access to care and the quality of the children's health care may be hampered if they are covered for short periods of time. Unfortunately, very little information is available about the factors influencing disenrollment and re-enrollment patterns in subsidized children's health insurance programs.

In Federal Fiscal Year (FFY)-1999, 1.96 million different children were enrolled in Title XXI Programs. However, at minimum, an estimated 18 percent of children enrolled at some time during FFY 1999 disenrolled from the program at least one time. In some states, disenrollment is more substantial, with as many as 50% of the children leaving.<sup>5</sup>

The disenrollment phenomenon is not limited to Title XXI Programs. Children in Medicaid frequently remain enrolled for very short periods of time and then disenroll. For example, in 1991 only 38 percent of new Medicaid enrollees were enrolled in the program a year later.

Several analyses were conducted to analyze New Hampshire's enrollment and disenrollment experiences. First, we compare New Hampshire to the enrollment and disenrollment experiences in four other states: New York, Florida, Kansas, and Oregon.<sup>1</sup> Next we analyzed disenrollment experiences for those with and without special health care needs in New Hampshire. Each of these analyses is described in the following paragraphs.

### FIVE STATE COMPARISON

In the analyses comparing the five states, the following basic questions were asked:

1. How long are children enrolled in Title XXI in New Hampshire likely to remain enrolled?
2. How does this pattern compare to that of other states?

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<sup>1</sup> Dr. Andrew Dick at the University of Rochester conducted the analyses of the enrollment and disenrollment patterns in Title XXI in New York, Florida, Kansas, and Oregon. The New Hampshire analyses were conducted following the guidelines that Dr. Dick established to the extent possible. The investigators in New York, Florida, Kansas, and Oregon had enrollment files spanning longer time periods than were made available in New Hampshire. Modifications were made to accommodate the different time periods.

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To conduct this analysis enrollment files were used from each of five states. In New Hampshire, Healthy Kids is characterized as Healthy Kids Silver and as Gold FFS/MC. Gold FFS/MC was not separated because the program eligibility requirements are identical for those two programs. However, the eligibility requirements differ between Silver and Gold FFS/MC. Therefore, the disenrollment patterns were analyzed separately.

To begin the analysis, “new” enrollment spells were identified for each enrollee in the data sets. A “new” enrollment is defined as one that was preceded by at least 12 months during which there was no Title XXI enrollment for New York, Florida, Kansas, and Oregon. In New Hampshire, due to the time period for which we had data, a “new” enrollment was defined as one that was preceded by at least 6 months during which there was no Title XXI enrollment.

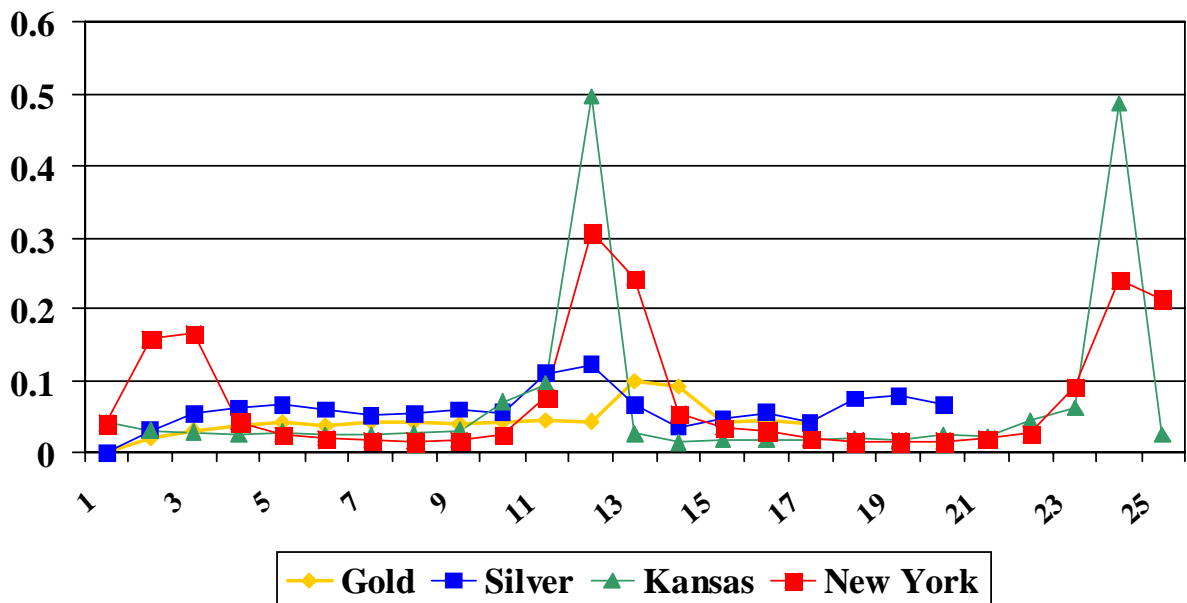
From the enrollment histories, Title XXI enrollment spells, or episodes of continuous enrollment, were created for each child. The analytical data set includes information on whether the enrollment episode is new, the number of continuous months of enrollment, the calendar month during which the enrollment began, and whether the outcome of the enrollment is known. That is, some children disenrolled from the program during the time period for which we had data. However, for other children, we do not know if they remained enrolled beyond the last month for which we have data. Statistically, this issue is called “censoring.”

To assess new enrollment, Kaplan-Meier (empirical) hazard functions and the corresponding non-parametric survivor functions for enrollment episodes, both incorporating censoring, were calculated. In addition, we wanted to examine not only how long a child stays on Title XXI during his or her initial enrollment episode, but also the length of time a child stays disenrolled. Disenrollment durations were analyzed by calculating Kaplan-Meier hazard functions and the corresponding non-parametric survivor functions for these episodes.

Very large numbers of enrollees were available (N = 177,615 in Florida, 40,572 in Kansas, 792,111 in New York, 44,243 in Oregon, N= 5,323 for Healthy Kids Silver and N= 63,165 for Healthy Kids Gold FFS and MC combined). Figure 8 contains the results for the “new” enrollment episodes for each state. The following points can be made about Figure 9:

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1. New York has a much higher hazard rate for disenrollment during months two and three because this is the time frame in which presumptive eligibility is resolved. Oregon has a high hazard rate for disenrollment at month six, which is the end of their continuous eligibility period and renewal time. The same phenomenon is seen in Kansas and New York at 12 months at the end of their continuous eligibility periods (and again for Oregon).
  2. In contrast, Florida does not have spikes of disenrollment due to their passive renewal process. Families are sent letters annually asking them to update their family information. Families do not need to respond to continue their enrollment. Because Florida requires a premium payment from all Title XXI enrollees, families that do not want to remain in the program can simply stop paying their premiums.
  3. New Hampshire Healthy Kids Silver shows an increased hazard for disenrollment at months 11 and 12 and again at months 18 and 19. However, the hazard rates for disenrollment are relatively smooth compared to New York, Kansas, and Oregon. In months 13 and 14, there is an increased hazard rate for disenrollment from Healthy Kids Gold FFS/MC. As is the case with Healthy Kids Silver, disenrollment rates are relatively smooth in comparison to three of the other states included in the analysis.
  4. Although New Hampshire has an active renewal process for their Healthy Kids Programs, the state does not experience the markedly increased disenrollment seen in other states with active renewal processes. Examining the renewal practices in New Hampshire was not a component of this evaluation. Therefore the reasons contributing to successful renewal in New Hampshire vis-à-vis other states are not known.

# Figure 9: Disenrollment Patterns: Probability of Disenrollment



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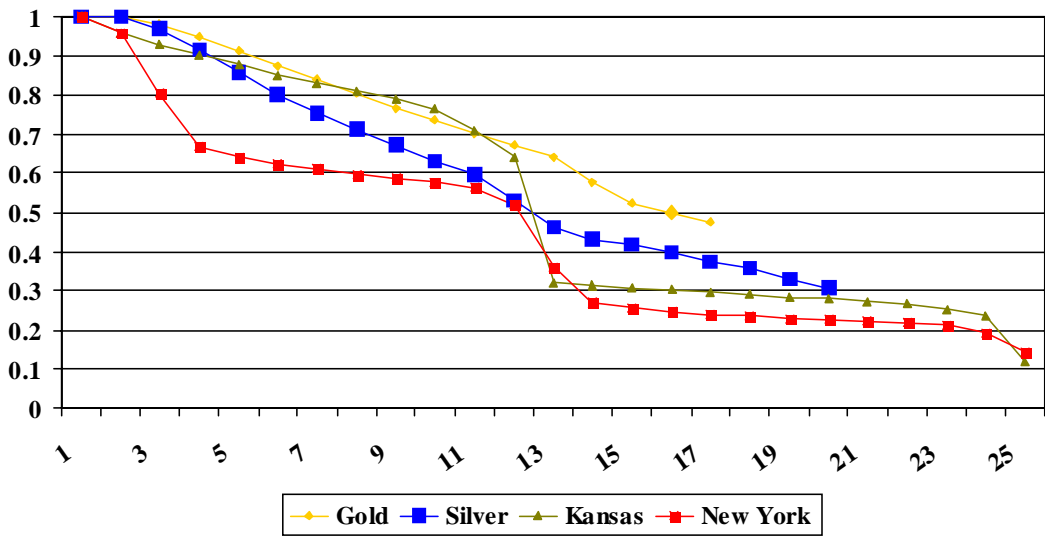
Figure 10 presents estimates, by state, of the probability that a child will be enrolled in each month following a “new” enrollment, regardless of disenrollment experiences prior to that month. So for example, in New Hampshire, the probability is 0.44 that a child will be enrolled in Healthy Kids Silver 21 months after the initial enrollment in the program. Thus, for some children, the program provides a relatively long-term source of health insurance coverage. New Hampshire Healthy Kids Gold FFS and MC seem to be sources of longer-term coverage for the children with higher probabilities of enrollment during the second year for these programs in comparison to Healthy Kids Silver.

New Hampshire Healthy Kids enrollees (both Silver and Gold FFS/MC) experience higher probability of program enrollment during Year 2 than seen in New York, Oregon, or Kansas. Only Florida has a higher probability of enrollment during year 2 in comparison to New Hampshire.

Figure 10 also illustrates the steady program attrition that all states experience. New York, Oregon, and Kansas experience the most dramatic attrition at their renewal periods at the end of continuous eligibility. In contrast, Florida and New Hampshire (Healthy Kids Silver and Healthy Kids Gold FFS/MC) show steady attrition but no dramatic spikes.

To summarize, program retention is important. There is increasing evidence that renewal periods can result in significant program disenrollment. Both New Hampshire (Silver and Gold Programs) and Florida experience relatively smooth attrition. While some increase in attrition is seen in New Hampshire at approximately 12 and 18 months, there are not large disenrollments as seen in New York, Oregon, and Kansas. In addition, both New Hampshire Healthy Kids Silver and Gold FFS/MC serve as a source of long-term insurance coverage for children relative to three of the other states in the analysis (New York, Oregon, and Kansas).

# Figure 10: Probability of Enrollment By Month



## SECTION 6: CHRONIC CONDITIONS, ENROLLMENT, DISENROLLMENT, TYPES OF DIAGNOSES

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### ENROLLMENT AND DISENROLLMENT FOR THOSE WITH AND WITHOUT CHRONIC CONDITIONS

A similar analysis as described above was completed for Healthy Kids Silver and Gold (FFS and MC combined) examining the patterns for children with and without chronic conditions. The health status characteristics of those that disenroll compared to those that remain enrolled have important implications for the organization and financing of the program. Over time, the premium may increase due to the adverse retention of children with increased health care needs and the loss of healthier children. In addition, the size and composition of the provider network may need to change to accommodate sicker children, perhaps in need of more specialty care.

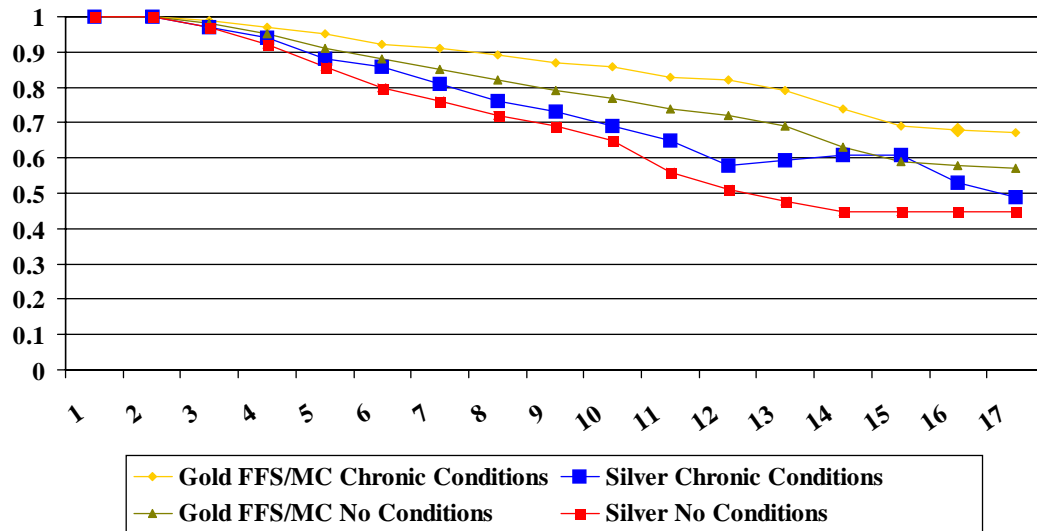
For this part of the analysis, children with chronic conditions were identified using a list of over 2,000 diagnoses that might indicate the presence of a chronic condition. Three pediatricians at an academic health center reviewed diagnoses listed in the *International Classification of Diseases, 9<sup>th</sup> Revision* (ICD-9). They developed a list of diagnoses representing high prevalence and generally low severity conditions like asthma and low prevalence and high severity conditions like childhood cancers. The Vice President for Classification Research at the National Association of Children's Hospitals and Related Institutions (NACHRI) reviewed the list before it was finalized.

The claims and encounter data provided for the analyses were searched for the presence of any of these diagnoses. Two occurrences of asthma and attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) were required before the child was considered to have a chronic condition. This was done to limit the potential of including children with tentative diagnoses for those conditions. All other conditions on the list required the occurrence of the diagnosis only once in the claims and encounter records.

Four percent of children in Healthy Kids Gold FFS/MC were identified with chronic conditions and 5% were identified with these conditions in Silver. It is important to note that the list used to identify these children is broad and includes children with mild to moderate chronic conditions.

Figure 11 shows the probability that children with and without chronic conditions will be enrolled in the program by month. There is steady program attrition, regardless of the child's health status (chronic conditions versus not). However the probability of remaining in the program is higher for those with chronic conditions than for children who are healthy for both program components (Healthy Kids Silver and Healthy Kids Gold FFS/MC). The differences are not large. However, the New Hampshire programs are retaining more children with special needs when compared to those without special needs. This phenomenon has been observed and documented in Florida.<sup>6</sup>

Figure 11. Probability of Enrollment By Month For Children With and Without Chronic Conditions



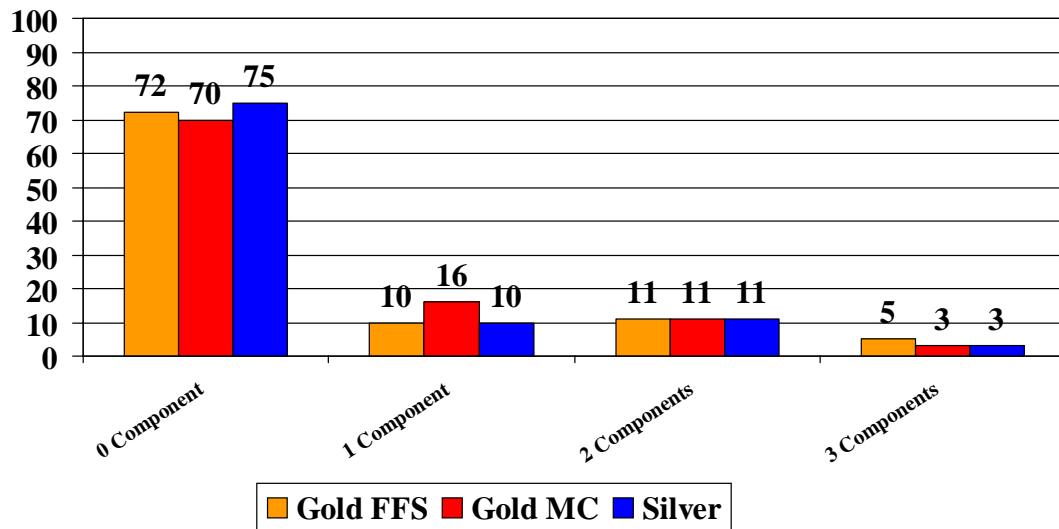
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**PARENT REPORT  
OF THE PRESENCE  
OF CHRONIC  
CONDITIONS**

In addition to identifying children with chronic conditions using diagnoses found in claims and encounter files, parent report was used. Parent report to identify children with chronic conditions is a common approach used by several state Title XXI Programs. For example, both Texas and Florida use parent report as part of their initial screening to determine if a child has a chronic condition that may require referral to special programs or providers. A survey called the Children with Special Health Care Needs (CSHCN) Screener or a variation of that survey is used. The CSHCN Screener contains five items that capture three components related to children's health: 1) limitations in functioning, 2) dependency on compensatory devices, and 3) service use or need that is higher than would be expected for other children of the same age. The child could be identified as having a chronic condition based on a positive screen for only one of the three components, three combinations of any two components or all three components.<sup>7</sup> The CSHCN Screener has been tested on several populations of children and the testing supports the components included in the instrument.

The majority of children in Healthy Kids Silver, Healthy Kids Gold FFS, and Gold MC did not have special health care needs according to the CSHCN Screener criteria. Over 70% of the children in all three programs did not have any identified chronic condition. About 27% of the children were identified with chronic conditions using the CSHCN Screener. This figure is comparable to that seen in Texas (28%), Indiana (26%), and Florida (26%). Most of the children with chronic conditions in New Hampshire were identified based on only one or two of the components described above. Only 3% to 4% of the children screened positively for all three domains measured by the CSHCN Screener. Different states are using different criteria to identify children with chronic conditions. For example, Texas is using a version of the CSHCN Screener to identify these children, but they are requiring the child to screen positively on all three domains measured by the screener. Using this criterion, 5% of children in the Texas Title XXI Program have special needs. Figure 12 contains a summary of the New Hampshire findings.

Figure 12: Children With Chronic Conditions Self-Reported in Surveys



## SECTION 7: PARENTS' REPORTED SATISFACTION WITH HEALTH CARE QUALITY

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### PARENTAL REPORT OF UNMET NEED

Parents of New Enrollees and Established Enrollees were asked if their children needed any of the following services: routine medical care, surgical procedures, specialty care, mental health care or counseling, prescriptions, and dental care. If the respondent indicated the child needed any of the services, he or she was then asked if the child received the needed care, and if not, why not. New Enrollees were asked to think about the 12 months prior to the children enrolling in the program. Established Enrollees were asked to think about their children's past 12 months in the program.

In Figures 13, 14, and 15 we compare the percentage of new enrollees who received needed care *prior to* enrollment in the program to the percentage of established enrollees who reported their children received needed care *while in* the program. In general, there was little unmet need reported among new enrollees. The greatest area of unmet need was found among Gold Program recipients, particularly in the areas of mental health counseling and dental care. Established enrollees demonstrated almost no unmet health care needs when compared to new enrollees.

It is important to note that assessing unmet need is very difficult. Diminished access to care may affect perceived need for health care. For example, in a study of Hispanic families' responses to questions about unmet health care needs, investigators noted that the perception of need is based, in part, on experience with the health care system.<sup>8</sup> If an individual does not use the health care system, he or she may not realize that certain health care needs exist. Perceived need is an important component of the questions asked on the New Hampshire telephone surveys. Families must first identify that the child needed the particular health care service before reporting whether the child received that service. To the extent that families face restricted access to care, they may not have enough health care knowledge or experience to know what their children needed. Thus unmet health care need based on parental report, particularly among new enrollees, may greatly underestimate the extent of the children's unmet need. Thus, our comparison of new and established enrollees may underestimate the change families experienced in having their children's health care needs addressed.

Figure 13: Gold FFS, Received Needed Care: Comparison of New Enrollees to Established Enrollees

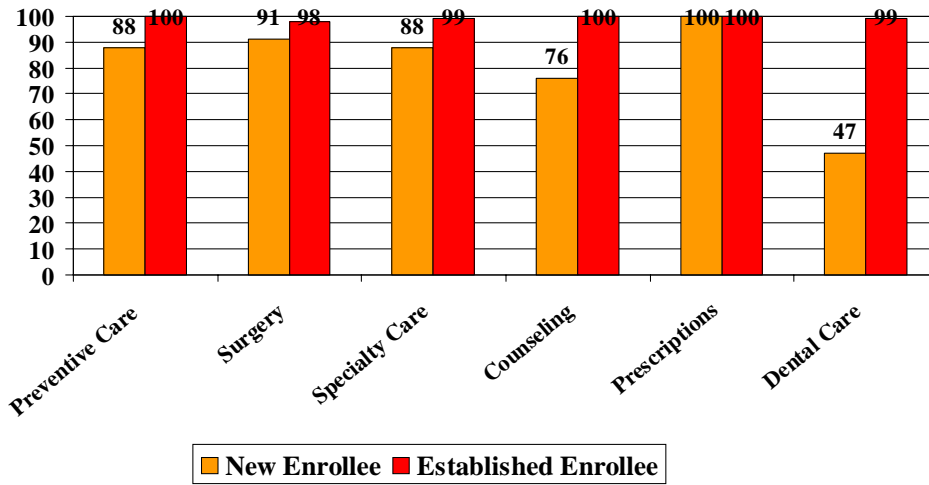


Figure 14: Gold MC, Received Needed Care: Comparison of New Enrollees to Established Enrollees

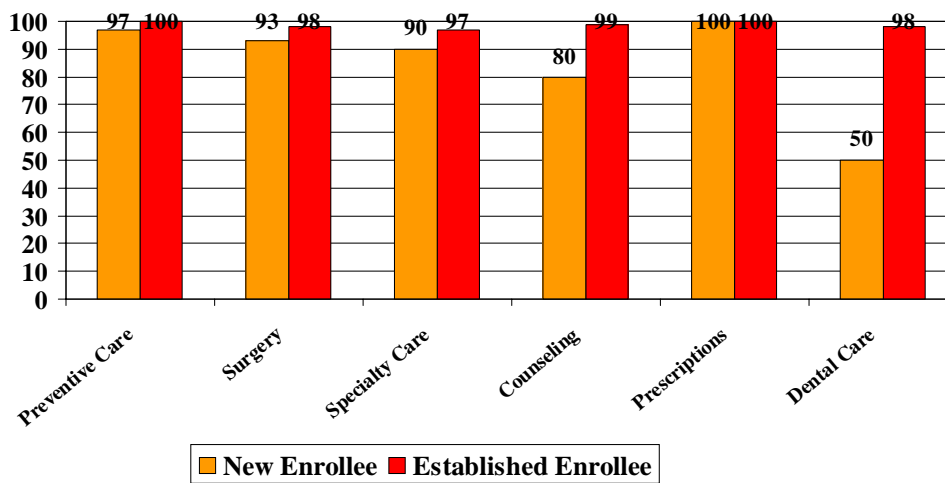
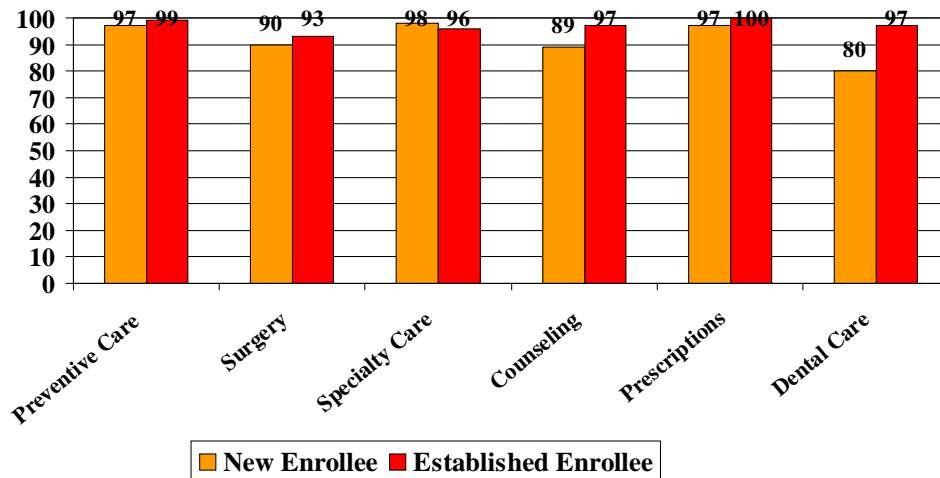


Figure 15: Silver, Received Needed Care: Comparison of New Enrollees to Established Enrollees

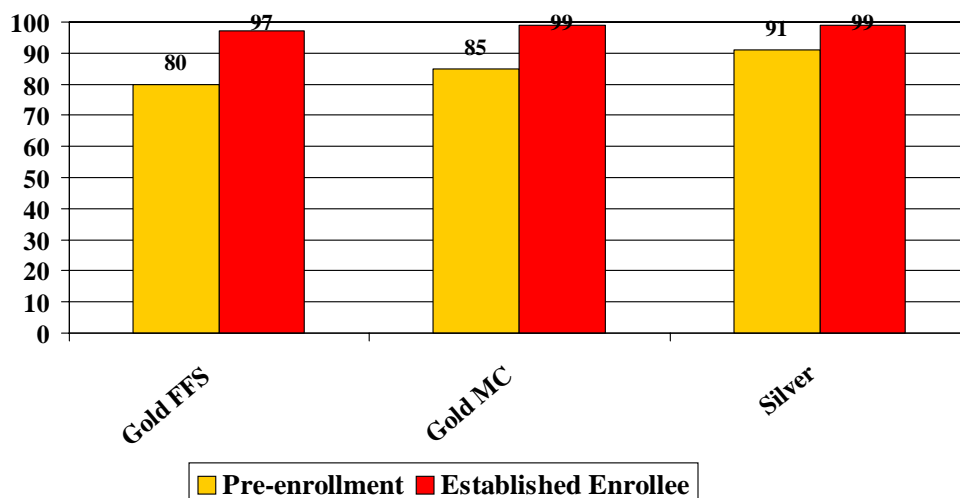


**CHILDREN’S  
USUAL SOURCE OF  
CARE**

Assessing whether children have a usual source of health care is an important component of quality monitoring. A usual source of care implies that the child and his or her family have personal relationship with their health care provider over time. The benefits associated with a usual source of care are well documented and include early detection of health care problems and reduced costs of care.<sup>9</sup> Uninsured children are less likely than insured children to have a usual source of care.

The percentage of families with a usual source of care was high pre-enrollment – 80% of Healthy Kids Gold FFS, 91% of Healthy Kids Silver, and 85% of Healthy Kids Gold MC reported a usual source of care for their children before enrolling in the programs. The percentage of children with a usual source of care increased for all program components to 97% to 99% (Figure 16).

Figure 16. Percent with Usual Source of Care



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Seventy-three percent of Healthy Kids Gold FFS families chose to and were able to keep their children’s same usual source of care pre and post enrollment. Eighty-two percent of Healthy Kids Silver families kept their children’s usual source of care, as did 72% of Healthy Kids Gold MC enrollees. Families in all three programs also enjoyed long-term relationships with their children’s providers. Over 40% of families in all three programs had the same provider for five or more years, and an additional 35% had the same provider for 2 to 5 years (Figure 17).

The majority of families reported that it was “not a problem” to find a personal doctor or nurse for their children after enrolling in one of the Healthy Kids Programs. These results are contained in Figure 18.

Figure 17. Length of Time With Provider

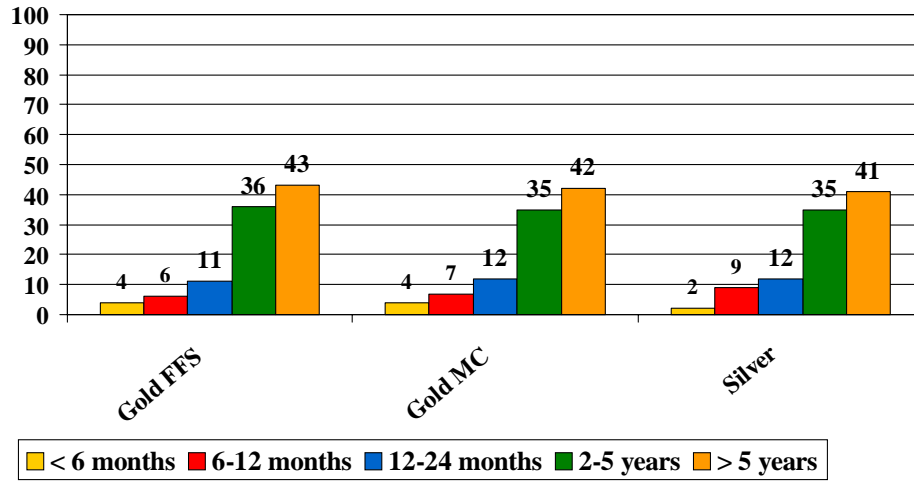
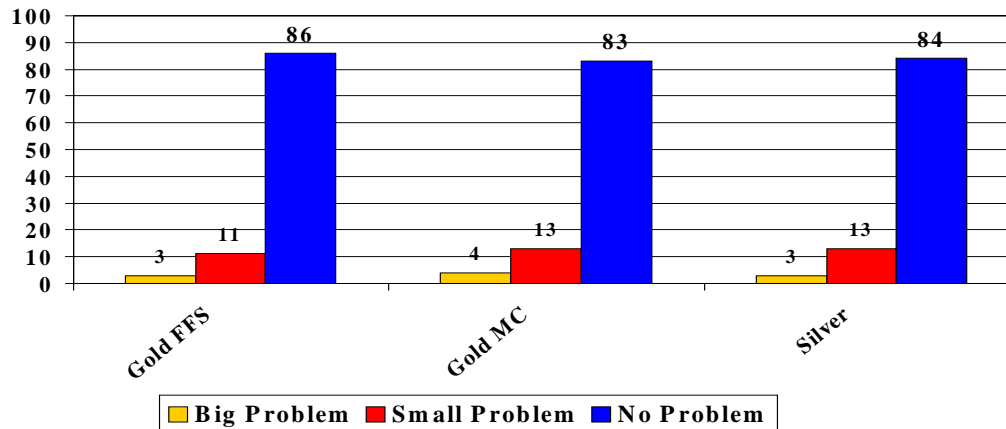


Figure 18. Problem Getting A Personal Doctor or Nurse



Families were also asked questions about the person or place who served as their children’s usual sources of care. Table 7 contains information about families’ usual source of care pre and post enrollment in the Healthy Kids Programs. Prior to enrollment the majority of children in all three program components saw a provider in either a pediatric or family practitioner practice setting. Only 2% of children in all programs used the emergency room (ER) as a usual source of care. Post-enrollment, no children used the ER as a usual source of care. Of those who switched from an ER to another source of care, 75% across all programs chose a pediatric group practice and 25% chose a family practitioner.

The percent of families using community health centers (CHC) as their usual source of care also declined somewhat pre and post enrollment. Across all programs, among those who switched from a CHC to another source of care, 33% of families switched to a pediatric group practice and 67% switched to a family practitioner.

**Table 7. Type of Usual Source of Care Pre and Post Program Enrollment**

Type	Healthy Kids Gold FFS		Healthy Kids Gold MC		Healthy Kids Silver	
	Pre-Enroll	Post-Enroll	Pre-Enroll	Post-Enroll	Pre-Enroll	Post-Enroll
Hospital ER	2%	0%	3%	0%	2%	0%
Clinic at Hospital	9%	12%	8%	10%	11%	7%
Pediatric Group Practice	34%	40%	32%	41%	46%	53%
Family Practitioner Practice	35%	31%	35%	30%	29%	30%
HMO Clinic	4%	6%	6%	8%	5%	4%
CHC	15%	10%	15%	11%	6%	5%
School Clinic	0%	0%	0%	0%	0%	0%
Health Department	0%	0%	0%	0%	1%	<1%
Immunization Clinic	1%	<1%	1%	0%	0%	0%

**FAMILY  
SATISFACTION  
WITH CARE**

The Consumer Assessment of Health Plans Survey (CAHPS) was used to assess family satisfaction with care after enrollment in the programs. This instrument was selected because it is being used nationally in many of the State Title XXI evaluations. Thus, New Hampshire will have the opportunity to compare their findings to those of other states in the future. Table 8 contains a summary of these findings for each program. Overall families report excellent access to care and satisfaction with the programs.

These findings are descriptive and do not take into account factors that may influence satisfaction with care such as enrollee health status, respondent education, or family income. Regression models were developed examining the relationship between the child’s health and sociodemographic characteristics and responses to CAHPS items. None of the variables in the models were significant. However, it is important to note that the sample sizes are small. The CAHPS developers recommend including 300 surveys per health plan to ensure an adequate sample size for comparisons on all of the items. There was adequate sample size for many of the CAHPS items to conduct our analyses. However, the health and demographic variables were not significant.

For some of the items, statistically significant differences were noted between Healthy Kids Silver, Gold FFS, and Gold MC. For example, a significantly higher percentage of Healthy Kids Silver families were able to get an appointment for routine care and illness or injury care as soon as they wanted when compared to Gold FFS and MC. In addition, a significantly higher percentage of Healthy Kids Silver families reported that the doctors talked to the children in ways the children could understand when compared to Gold FFS and MC. No other significant differences were noted.

**Table 8. Satisfaction with Care**

Item	Healthy Kids Gold FFS	Healthy Kids Gold MC	Healthy Kids Silver
<b>How often did doctor or nurse talk to you about how your child is feeling, behaving, growing?</b>			
Never	5%	3%	3%
Sometimes	11%	11%	10%
Usually	15%	17%	18%
Always	69%	69%	69%
<b>In the last 6 months did you think your child needed to see a specialist?</b>			
Yes	34%	34%	30%
No	66%	66%	70%

**Table 8 continued. Satisfaction with Care**

Item	Healthy Kids Gold FFS	Healthy Kids Gold MC	Healthy Kids Silver
<b>In the last 6 months how much of a problem was it to get a referral to a specialist?</b>	<b>N=68</b>	<b>N=68</b>	<b>N=60</b>
A big problem	6%	6%	6%
A small problem	9%	7%	9%
Not a problem at all	85%	87%	85%
<b>In the last 6 months was the specialist your child saw the same as your child's personal doctor or nurse?</b>			
Yes	9%	6%	4%
No	91%	94%	96%
<b>Did you make any appointments for routine care?</b>			
Yes	82%	87%	88%
No	18%	13%	12%
<b>How often did you get that appointment as quickly as you wanted?*</b>			
Never	2%	2%	1%
Sometimes	7%	8%	6%
Usually	29%	28%	23%
Always	62%	62%	69%
<b>Did your child have an illness or injury where you needed care right away?</b>			
Yes	50%	51%	47%
No	50%	49%	53%
<b>Did you get that care as soon as you wanted?*</b>	<b>N=100</b>	<b>N=96</b>	<b>N=94</b>
Never	2%	2%	1%
Sometimes	9%	10%	3%
Usually	15%	14%	16%
Always	74%	74%	80%
<b>How much of a problem was it for you to get the care you believed was necessary for your child?</b>			
A big problem	3%	3%	2%
A small problem	10%	12%	4%
Not a problem at all	87%	85%	93%
<b>How much of a problem, if any, were delays in your child's health care while you waited for plan approval?</b>			
A big problem	4%	3%	2%
A small problem	5%	4%	4%
Not a problem at all	91%	91%	94%
<b>How often did you wait more than 15 minutes?</b>			
Never	43%	48%	50%
Sometimes	42%	37%	36%
Usually	7%	7%	7%
Always	7%	7%	8%

\*Statistically significant difference in responses at the  $p < .05$  level.

**Table 8 continued. Satisfaction with Care**

Item	Healthy Kids Gold FFS	Healthy Kids Gold MC	Healthy Kids Silver
<b>How often were you treated with courtesy and respect?</b>			
Never	0%	1%	1%
Sometimes	3%	3%	2%
Usually	12%	10%	10%
Always	86%	87%	87%
<b>How often were staff in the doctor's office as helpful as you thought they should be?</b>			
Never	0%	0%	1%
Sometimes	6%	7%	3%
Usually	18%	17%	20%
Always	75%	75%	75%
<b>How often did providers listen carefully to you?</b>			
Never	<1%	0%	0%
Sometimes	5%	5%	5%
Usually	16%	18%	16%
Always	78%	76%	79%
<b>How often did providers explain things in a way you could understand?</b>			
Never	<1%	0%	0%
Sometimes	2%	1%	1%
Usually	13%	14%	13%
Always	85%	85%	86%
<b>How often did the doctor show respect for what you had to say?</b>			
Never	<1%	1%	2%
Sometimes	6%	5%	4%
Usually	14%	14%	14%
Always	79%	79%	80%
<b>Is your child old enough to talk to the doctor?</b>			
Yes	50%	50%	50%
No	50%	50%	50%
<b>Did the doctor explain things in a way your child could understand?*</b>	<b>N=100</b>	<b>N=100</b>	<b>N=100</b>
Never	1%	1%	2%
Sometimes	8%	6%	3%
Usually	25%	27%	16%
Always	66%	66%	79%
<b>How often did the doctor spend enough time with your child?</b>			
Never	<1%	<1%	<1%
Sometimes	11%	12%	3%
Usually	17%	16%	22%
Always	71%	71%	74%

\*Statistically significant difference in responses at the  $p < .05$  level.

**Table 8 continued. Satisfaction with Care**

<b>Item</b>	<b>Healthy Kids Gold FFS</b>	<b>Healthy Kids Gold MC</b>	<b>Healthy Kids Silver</b>
<b>Does your child have special health care needs that require help in school?</b>			
Yes	15%	33%	10%
No	85%	67%	90%
<b>Did your child's doctor talk to the school about these needs?</b>	<b>N=30</b>	<b>N=66</b>	<b>N=20</b>
Yes	78%	76%	77%
No	22%	24%	23%
<b>Does your child receive counseling....?</b>			
Yes	12%	27%	14%
<b>How much of a problem was it for you to get this counseling?</b>	<b>N=54</b>	<b>N=28</b>	<b>N=24</b>
A big problem	11%	13%	23%
A small problem	7%	17%	14%
Not a problem at all	82%	70%	63%
<b>Since you joined the program how difficult was it for you to get a dentist?</b>			
Very difficult	37%	30%	8%
Somewhat difficult	13%	20%	11%
Not at all difficult	39%	39%	68%
<b>How long do you wait for a dental appointment?</b>			
Less than 1 week	12%	15%	20%
1 to 2 weeks	17%	14%	17%
3 to 4 weeks	19%	20%	24%
More than 4 weeks	52%	51%	39%
<b>Does the dentist's office treat you with courtesy and respect?</b>			
Never	9%	8%	3%
Sometimes	6%	6%	2%
Usually	41%	36%	34%
Always	45%	50%	62%

## SECTION 8: HEALTH CARE USE AND PHARMACY RESULTS

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Figure 19 contains descriptive information on the amount of health care the children are using. As expected based on the analyses using the CDPS, the amount of health care use is similar in the Healthy Kids Gold FFS, Healthy Kids Gold MC, and Healthy Kids Silver Programs. The majority of the children's care is in the outpatient setting. Information about the health care use of children enrolled in Florida's Healthy Kids Program is provided for comparison purposes. The use rates for inpatient care were significantly higher for Gold FFS when compared to Gold MC and Silver.

In addition to assessing the amount of health care that the children used, the percentage of children enrolled but not using health care also was calculated. A high percentage of children enrolled and not using health care may indicate potential problems with access to care. Figure 20 illustrates the findings. The amount enrolled and not using health care in Florida is shown for comparison purposes. A significantly higher percentage of children in the Gold MC are non-users of the health care system when compared to Gold FFS and Silver (37% compared to 26% and 27%, respectively in 2000).

Figure 19. Health Care Use  
Annual Visit Rates - 2000

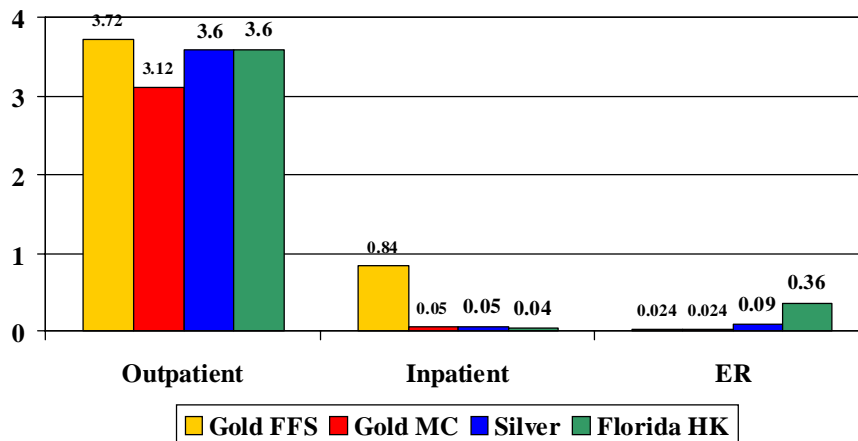
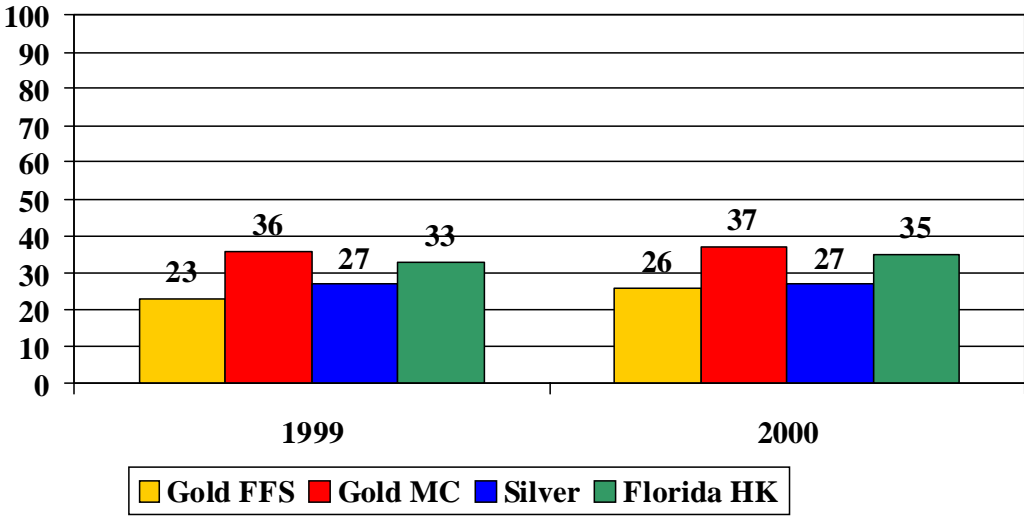


Figure 20. Percent Not Using the Health Care System - 1999 and 2000

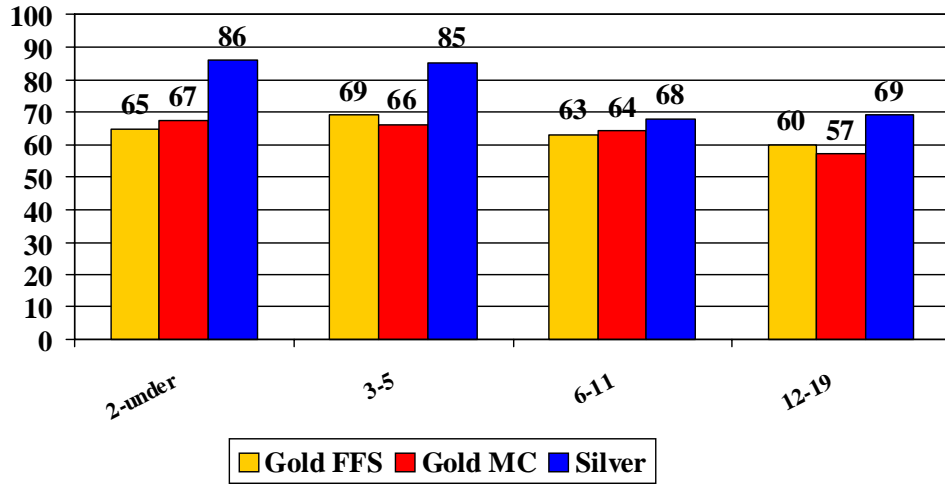


**COMPLIANCE WITH WELL CHILD CARE VISITS**

We estimated compliance with American Academy of Pediatrics (AAP) guidelines for well child visits for children in the Healthy Kids Gold FFS, Gold MC, and Silver Programs (both users and non-users of the health care system) continuously enrolled for at least 12 months. The percentages of children in compliance with recommended guidelines by age cohort are shown in Figure 21.

It was not possible to calculate compliance with immunizations due to missing codes in the claims and encounter data. New Hampshire has a universal immunization program. As a result, providers do not have to bill for immunizations and therefore the immunizations given cannot be calculated reliably from claims data. However, high percentage of children in compliance with well child visit guidelines suggests that immunization compliance might also be very good.

Figure 21. Well Child Care Visit Compliance



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**INCIDENCE OF  
INPATIENT  
ADMISSIONS FOR  
AMBULATORY  
CARE SENSITIVE  
CONDITIONS**

Ambulatory care sensitive conditions (ACSC) are those conditions that should be treated on an outpatient basis. Inpatient stays for such conditions often indicate poor access to care or a potential problem with the quality of care provided. Examples of such conditions include asthma, dehydration, gastroenteritis, otitis media, cellulitis, urinary tract infections, epilepsy, and diabetes. The claims and encounter data were searched for inpatient admissions with these primary diagnoses. In the Gold FFS Program, 1.7% of the children hospitalized had a diagnosis that was considered an ACSC. The occurrence was 1.2% for Gold MC and 1.2% for Silver.

For each of the three programs, approximately 50% of the admissions for ACSC were for asthma. An additional 9% of the admissions were for urinary tract infections and 8% were for diabetes with ketoacidosis. The remaining admissions were for a variety of other conditions such as epilepsy (1%), cellulitis (3%), varicella (1%), and others.

**BENEFIT PACKAGE  
LIMITATIONS**

There are some limitations to the Healthy Kids Silver benefit package. For example, mental health benefits include 20 outpatient visits in 12 months. No children exceeded this number of visits. There also is a 15-day maximum for inpatient mental health care. No children exceeded this benefit limit. It is important to note that based on the claims and encounter data, unusually low percentages of children have special health care needs of any type (5% or less of those who use health care services). Thus, it is possible that mental health diagnoses simply were not recorded for the visits. If the visit did not have an ICD-9 CM code indicating a mental health diagnosis, we did not count that visit toward the benefit package limit. Thus, the information we are providing may be an underestimate.

**PHARMACY USE**

A software program that groups prescription drugs from various manufacturers into major drug and drug classes was used to categorize pharmacy use in the Healthy Kids Program. Further analyses are being conducted to identify generic versus name-brand prescriptions. In addition, additional review is occurring for the Healthy Kids Gold MC pharmacy information. These results are not included in this report and will be provided as a supplement. Table 9 contains a summary of the filled prescriptions by major drug classes for each of the program components.

As expected, medications for the respiratory tract and antimicrobials were the most common major drug classes identified for both Silver and Gold FFS program components. Central nervous system drugs also were common.

**Table 9. Percentage of Filled Prescriptions By Major Drug Classes 2000**

Major Class	Healthy Kids Gold FFS N=465,046 Prescriptions	Healthy Kids Gold MC N=65,032 Prescriptions	Healthy Kids Silver N=15,504 Prescriptions
Antidotes	0.10	0.13	0.15
Antimicrobials	24.80	26.99	26.48
Antiparasitics	0.64	0.72	0.27
Cardiovascular-Renal	5.05	4.80	2.57
Central Nervous System	23.63	20.98	20.63
Contrast Media, Radiopharmaceuticals	0.00	0.01	0.89
Gastrointestinals	1.87	1.01	0.27
Hematologies	0.18	0.13	8.64
Hormones/Hormonal Mechanisms	5.71	6.10	0.23
Immunologies	0.19	0.06	2.48
Metabolics/Nutrients	3.14	3.70	3.07
Neurologics	6.95	3.96	0.05
Oncolytics	0.11	0.02	2.53
Ophthalmics	2.54	2.88	1.27
Otics	1.02	1.38	3.82
Relief of Pain	4.14	4.22	20.77
Respiratory Tract	14.66	16.92	4.62
Skin/Mucous Membranes	3.69	4.12	1.25
Unclassified/Misc	1.59	1.87	0.15

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To provide further detail, we further categorized the same prescriptions listed in Table 9 into drug classes. Table 10 summarizes these findings.

**Table 10. Percentage of Filled Prescriptions By Drug Classes**

Major Class	Healthy Kids Gold FFS	Healthy Kids Gold MC	Healthy Kids Silver
Ace Inhibitors	0.13	0.09	0.11
Acne Products	0.38	0.27	0.88
Adrenal Corticosteroids	2.25	2.85	3.36
Alpha Agonists/Alpha Blockers	1.53	1.24	0
Aminoglycosides	0.12	0.17	0.07
Analgesics, General	0.88	0.65	0.73
Analgesics-Narcotic	1.64	1.62	1.74
Analgesics-Non-Narcotic	0.04	0.01	0
Anaphylaxis Treatment Kit	0.06	0.09	0.04
Androgens/Anabolic Steroids	0.00	0	0
Anesthesia, Adjuncts To/Analeptics	0.04	0.05	0.04
Anesthetics, General	0.00	0	0
Anesthetics, Local	0.03	0.01	0.07
Anesthetics, Topical	0.03	0.04	0.04
Anorectal Products	0	0.00	0
Anorexiant/Cns Stimulants	5.90	6.86	7.56
*Antacids	0.00	0	0
*Anterior Pituitary/Hypothalamic Function	0.10	0.05	0
Anthelmintics	0.12	0.14	0.33
Antianginals	0.06	0.02	0.13
Antianxiety	0.92	0.53	0.48
Antiarrhythmics	0.04	0	0.04
Antiarthritics	0.22	0.10	0.20
Antiasthmatics/Broncodilators	6.68	8.88	8.97
Antibacterials, Miscellaneous	0.18	0.11	0.07
Anticoagulants/Thrombolytics	0.12	0	0.07
Anticonvulsants	6.00	3.48	1.82
Antidepressants	7.89	5.22	6.07
Antidiarrheals	0.04	0.04	0.02
Antidiuretics	0.62	0.48	0.92
Antidotes, General	0.01	0.00	0
Antidotes, Specific	0.02	0.00	0
Antiemetics	0.11	0.10	0.02
Antifungals	1.64	1.60	0.75
Antigout	0.00	0.00	0
Antihistamines	3.68	3.39	7.70
Antihypertensives	2.32	2.81	0.84

**Table 10 continued. Percentage of Filled Prescriptions By Drug Classes**

Major Class	Healthy Kids Gold FFS N=465,046 Prescriptions	Healthy Kids Gold MC	Healthy Kids Silver N=15,504 Prescriptions
Antimalarials	0.01	0	0
Antimetabolites	0.02	0	0
Antimigraine/Other Headaches	0.21	0.11	0.35
Antimycobacterials (Incl Anti Leprosy)	0.07	0.05	0
Antineoplastics	0.07	0.05	0
Antiprotozoals	0.10	0.11	0
Antipsychotics/Antimaniacs	3.15	2.02	0.73
Antiseptics,Urinary Tract	0.20	0.17	0.35
Antiseptics/Disinfectants	0.02	0	0.02
Antispasmodics/Anticholinergics	0.04	0.02	0.04
Antitoxins/Antivenins	0.00	0.01	0
Antitussives/Expectorants/Mucolytics	0.87	0.95	1.06
Antivirals	0.30	0.62	0.20
Beta Blockers	0.13	0.03	0
Blood Components/Substitutes	0	0	0
Blood Glucose Regulators	0.61	0.77	2.48
Calcium Channel Blockers	0.04	0	0.11
Calcium Metabolism	0.06	0.01	0.26
Cardiac Glycosides	0.15	0.06	0.11
Central Nervous System	0.03	0	0
Cephalosporins	2.77	3.31	2.59
Cns, Miscellaneous	3.43	2.74	3.78
Cold Remedies	0.99	1.50	1.36
Contraceptives	0.17	0.14	0.40
Coronary Vasodilators	0	0.02	0
Corticosteroids-Inhalation/Nasal	1.40	1.47	2.86
Cycloplegics/Mydriatics	0.03	0.04	0.02
Deficiency Anemias	0.07	0.05	0
Dental Preparations	1.60	2.53	1.25
Dentifrice/Denture Products	0.06	0.15	0.02
Dermatitis/Antipuretics	0.01	0	0
Dermatologics	2.29	1.98	3.01
*Diagnostics, Radiopaque & Nonradioactive	0.00	0.01	0
Disorders, Acid/Peptic	1.35	0.61	0.46
Diuretics	0.17	0.12	0.04
Drugs Used In Disorders Of Growth Hormone Secretion	0.11	0.08	0
Estrogens/Progestins	1.61	1.32	2.13
Extrapyramidal Movement Disorders	0.25	0.11	0
Gastrointestinal, Miscellaneous	0.30	0.22	0.07
Glaucoma	0.03	0	0
*Hematologics	0.00	0	0

**Table 10 continued. Percentage of Filled Prescriptions By Drug Classes**

Major Class	Healthy Kids Gold FFS	Healthy Kids Gold MC	Healthy Kids Silver
Hemostatics	0.04	0	0
Hormonal/Biological Response Modifiers	0.01	0	0
Hormones/Hormonal Mechanisms	0.01	0.04	0
Hyperlipidemia	0.04	0.01	0.02
Hypotension/Shock	0.00	0	0
Immune Serums	0.01	0	0
Immunologics	0.05	0.00	0
Immunomodulators	0.11	0.06	0.18
Keratolytics	0.00	0	0
Laxatives	0.05	0.01	0
Lincosamides/Macrolides	4.91	5.06	5.96
*Myasthenia Gravis	0	0.02	0
Nasal Decongestants	0.46	0.28	0.90
Nsaid	1.06	1.01	0.51
*Nutrition, Enteral/Parenteral	0.00	0	0
Ocular Anti-Infective/Anti-Inflammatory	2.53	2.95	2.11
*Ophthalmics	0.00	0	0
Ophthalmics, Miscellaneous	0.03	0.02	0.07
Ophthalmics-Decongestants/Antiallergy Agents	0.10	0.05	0.11
Otics	0.01	0.00	0
Otics, Topical	1.07	1.65	1.45
Penicillins	13.07	15.46	13.13
Personal Care Products (Vaginal)	0.03	0.01	0
Pharmaceutical Aids	0.02	0.04	0
Polymyxins	0.01	0	0
Quinolones/Derivatives	0.08	0.05	0.02
Relaxants/Stimulants, Urinary Tract	0.22	0.12	0.15
Relaxants/Stimulants,Uterine	0.00	0.01	0
Repl/Regs Of Electrolytes/Water Balance	0.26	0.14	0.13
Scabicides/Pediculicides	0.46	0.43	0.02
Sedatives/Hypnotics	0.64	0.34	0.18
Skeletal Muscle Hyperactivity	0.28	0.20	0.18
Sulfonamides/Related Compounds	2.06	2.32	2.07
*Surgical Aids	0.00	0	0
Tetracyclines	0.41	0.41	1.36
Thyroid/Antithyroid	0.32	0.23	0.02
Topical Anti-Infectives	0.64	0.63	0.57
Topical Steroids	0.44	0.72	0.46
Unclassified	0.43	0.23	0.24
Vaccines/Antisera	0.01	0.01	0
*Vascular Disorders, Cerebral/Peripheral	0	0	0
Vertigo/Motion Sickness/Vomiting	0.21	0.27	0.09
Vitamins/Minerals	3.40	4.91	3.28

## SECTION 9: DISENROLLEE SURVEY RESULTS

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### **DISENROLLEE SURVEY RESULTS**

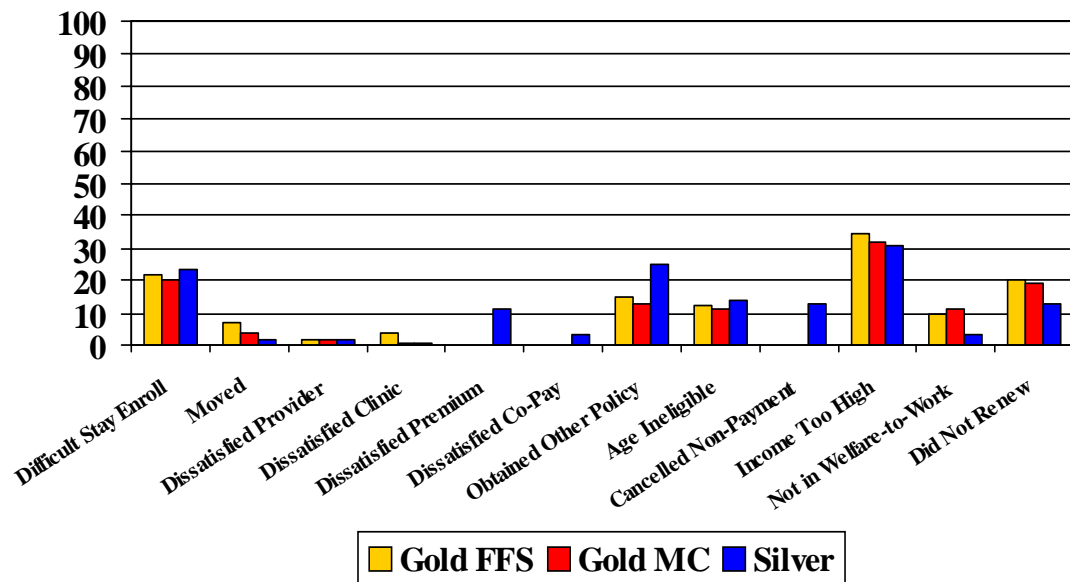
Figure 22 shows the reasons that families gave for disenrolling their children from the Healthy Kids Program. The most common reason for disenrollment was that the families' incomes were too high. About one-third of the disenrollees in each program indicated that their incomes had increased beyond the eligibility limits. About 20% in each program reported some difficulty with the renewal process and staying enrolled.

Only 11% of the Healthy Kids Silver disenrollee families reported dissatisfaction with the premium amount. Thirteen percent of Healthy Kids Silver families reported that they were cancelled due to non-payment of premium. Of the 11% of families who reported dissatisfaction with the premium, 5% of them also reported they were cancelled due to non-payment of premium.

Most children were uninsured after leaving the program. Only 22% of Healthy Kids Silver families, 13% of Gold FFS families, and 12% of Gold MC families obtained other health insurance coverage for their children. However this coverage often reflected movement between the Healthy Kids Program components.

Only 55% of Silver families whose children were insured, 54% of Gold FFS families, and 53% of Gold MC families reported that their children had employer-based coverage. The rest of those with insurance coverage moved to another Healthy Kids Program component. That is, 45% of Silver families with coverage moved to either Gold MC or FFS. Thirty-six percent of Gold FFS families with coverage moved to Silver and 10% moved to Gold MC. Twenty-five percent of Gold MC families with coverage moved to Gold FFS and twenty-two percent moved to Silver.

## Figure 22. Reasons for Disenrollment



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Families whose children disenrolled from the programs also were asked questions about their usual source of care while enrolled. Ninety-five percent of Healthy Kids Silver, 92% of Healthy Kids Gold FFS, and 94% of Healthy Kids Gold MC enrollees had a usual source of care while enrolled. After disenrolling, 91% of Healthy Kids Silver enrollees reported that their children still had a usual source of care compared to only 84% of Healthy Kids Gold FFS enrollees and 85% of Healthy Kids Gold MC enrollees. For those with a usual source of care, 93% of Healthy Kids Silver enrollees, 89% of Healthy Kids Gold FFS enrollees, and 90% of Healthy Kids Gold MC enrollees kept the same usual source of care post-enrollment.

Ninety-four percent of Healthy Kids Silver enrollees indicated they were very satisfied to satisfied with their usual source of care while enrolled. The same high level of satisfaction was expressed by 96% of Healthy Kids Gold FFS enrollees and 95% of Healthy Kids Gold MC enrollees.

Families were very satisfied with the program while their children were enrolled. Eighty percent of Healthy Kids Silver disenrollees said the care their children received while enrolled was very good to excellent; while 20% said it was fair to good. No Healthy Kids Silver disenrollees thought the care was poor. Sixty-six percent of Healthy Kids Gold FFS disenrollees reported that the care was very good to excellent, 25% said it was good, and 9% said it was fair to poor. Similarly 65% of Healthy Kids Gold MC disenrollees reported that the care was very good to excellent, 26% said it was good and 9% said it was fair to poor.

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