Contract No.: 07685-009-01-MPR-01
MPR Reference No.: 6092-290

MATHEMATICA
Policy Research, Inc.

Evaluation of the Los Angeles Healthy Kids Program: Special Study of Children Who Left the Program

April 30, 2008

Ann Bagchi
Martha Kovac
Kathleen Paganelli
Matt Jacobus

Submitted to:

The Urban Institute
2100 M St., NW, Suite 500
Washington, DC 20037

Project Officer:
Ian Hill

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
Telephone: (609) 799-3535
Facsimile: (609) 799-0005

Project Director:
Martha Kovac

CONTENTS

CHAPTER I

BACKGROUND TO LOS ANGELES' HEALTHY KIDS PROGRAM

The Los Angeles Healthy Kids Program was conceived in July 2002 when the County's Proposition 10 Commission, called First 5 LA, set aside $100 million to establish the new health insurance program.[1] Modeled after California's Healthy Families program, Healthy Kids covers a comprehensive set of preventative, primary, acute, and specialty care services, including dental and vision care; imposes income-based premiums upon families with incomes above 133 percent of the federal poverty level (FPL); and delivers care through a managed care network managed by the LA Care Health Plan, a not-for-profit community health plan. Healthy Kids provides coverage to children in families with incomes below 300 percent of FPL who are not eligible for other public health insurance programs due to their immigration status or their family income.[2] Enrollment began in July 2003 and was initially limited to children through age 5. In May 2004, enrollment was expanded to children ages 6 through 18 after an infusion of $86 million in funds raised by the Children's Health Initiative (CHI) of Greater Los Angeles. However, rapid enrollment growth led to rapid depletion of funds, and program administrators were forced to cap enrollment of older children starting in June 2005. At the time, enrollment had peaked at nearly 45,000 children. A year later, as a result of steady attrition, enrollment had slipped to a little over 42,000 (Sommers et al. 2005, Wada et al. 2006).

[1] California voters approved the California Children and Families First Act (Proposition 10) in 1998. This statewide ballot initiative added a 50-cent tax on cigarettes and other tobacco products to fund programs to promote the health and social and educational development of children up to age 5. Eighty percent of Proposition 10 revenues were allocated at the county level to ensure that funds would be used to meet the local needs of state residents.

[2] Eligibility for Medi-Cal and Healthy Families (California's Medicaid and State Children's Health Insurance Program [SCHIP] plans, respectively) is restricted to citizens and immigrants who have legally resided in the United States for at least five years. Income limits are 100 percent of the FPL under Medi-Cal and 250 percent of the FPL under Healthy Families. Therefore, children enrolled in LA Healthy Kids are primarily undocumented children with family incomes less than 300 percent of the FPL, but the program also serves citizens and some legal residents with family incomes between 250 and 300 percent of the FPL.

First 5 LA contracted with the Urban Institute and its partners (Mathematica Policy Research, Inc. [MPR], the University of Southern California, the University of California at Los Angeles, and Castillo & Associates) to conduct a comprehensive evaluation of the Healthy Kids program. Since May 2004, the evaluation has generated a series of reports documenting the implementation of the program, as well as its impacts on access to care, use of services, health status, and parents' attitudes toward the program.[3]

One element of the evaluation is a longitudinal household survey of parents with children enrolled in Healthy Kids, administered by MPR.[4] The baseline survey was completed from April through December 2005 and a followup survey occurred from May 2006 to January 2007. Both waves of the survey achieved very high response rates. At baseline, of the 1,480 sampled children, 1,087 surveys were successfully completed – a response rate of 86 percent, after excluding 168 sampled children who were ineligible.[5] At follow up, surveys were completed with 975 of the 1,087 families who completed a baseline survey (90 percent of eligible respondents), an overall response rate of 77 percent of the original sample.[6,7] The survey found that the Healthy Kids program had significant positive impacts on a large number of critical outcomes. For example, among children newly enrolled in the program, the percent with a usual source of medical care increased by 14.7 percentage points while the percent with a usual source of dental care increased by 27.5 percentage points (Howell, Dubay, and Palmer 2007). The children also had higher rates of dental and specialist care and their parents expressed greater satisfaction with their child's health care quality (Howell, Dubay, and Palmer 2007). Improvements in access to and use of services led to a 4.7 percentage point reduction in emergency room use after enrollment in Healthy Kids (Howell, Dubay, and Palmer 2007).

Healthy Kids has been very successful in retaining children in the program, as evidenced by high renewal rates and low disenrollment rates. Since May 2005, the monthly renewal rate in Healthy Kids has consistently remained at over 75 percent and reached an all-time high of 88 percent in June 2007 (Farias et al. 2007, Wada et al. 2007). Combining children who voluntarily disenrolled from the program during the year with those who disenrolled at

[3] See the web sites of The Urban Institute (www.urban.org) and First 5 LA (www.first5la.org) for associated reports and briefs.

[4] Respondents to the telephone survey included parents, guardians, or other adults with knowledge of the enrolled child's health care. Ninety-nine percent of respondents were parents (92 percent were mothers and 7 percent were fathers); for the sake of simplicity, we use "parents" and "respondents" interchangeably throughout the remainder of the report.

[5] A brief screening interview determined if they were either the wrong age or were no longer enrolled in Healthy Kids.

[6]Calculated by dividing the number of completed follow-up surveys by the number of eligible baseline cases (or 975/1,262).

[7] In both interview waves, response rates were lower for parents of new enrollees than for those of established enrollees (82 and 91 percent, respectively, for the baseline survey and 88 and 92 percent for the followup survey).

renewal time, quarterly disenrollment as a proportion of monthly membership has been steady at about 5 percent for children ages 0-5 and for children ages 6-18. After excluding children that age out of Healthy Kids, the quarterly disenrollment as a proportion of monthly membership is about 2 percent. Non-response at renewal represented the biggest reason for disenrollment in 2006 and the first half of 2007; it was the reason for disenrollment for around 80 percent of disenrollees ages 0-5 and about 85 percent of disenrollees ages 6-18 in the first half of 2007 (Wada et al. 2006, Farias et al. 2007, Wada et al. 2007). Efforts to increase renewal and retention should focus on this factor, since almost no children disenrolled due to other factors affected by the program, such as dissatisfaction with the plan or provider or inability to pay premiums.

In order to learn more about children and families who disenrolled from Healthy Kids, Mathematica undertook a descriptive analysis of a sample of the disenrollee population. It includes 65 families with children who were enrolled in Healthy Kids during the baseline period but were no longer enrolled at the time of the followup survey. The report compares the characteristics and experiences of disenrollees with those of families whose children remained enrolled in the program between the two survey waves. Findings from this analysis provide a basis for recommendations on how the Healthy Kids program might further enhance its retention rate among its members.

Chapter II presents a more detailed description of the study sample and summarizes the demographic background of the sampled disenrollees compared with children who remained enrolled. Chapter III compares access to and use of health care between disenrollees and continuously enrolled children. Chapter IV discusses the reasons disenrolled families left the program and examines the health insurance coverage of children after they left Healthy Kids. Finally, Chapter V presents conclusions and discusses the policy implications of the study's findings.

CHAPTER II

STUDY SAMPLE: HEALTHY KIDS DISENROLLEES VERSUS ENROLLEES

LA Care Health Plan (LA Care), the prepaid managed care organization that manages the network that serves Healthy Kids enrollees, provided MPR with five monthly enrollment files, from March through July 2005, as a sampling frame for the study. MPR drew a two-stage stratified random sample of 1,480 children aged 1 to 5 from this frame.[8] The first stage of stratification distinguished between "new" and "established" enrollees, with the sample approximately evenly split between these two groups. New enrollees were defined as children who had enrolled in Healthy Kids between March and July 2005, shortly before their parents were interviewed for the baseline survey. Established enrollees were children who had enrolled in Healthy Kids between March and July 2004, at least one year before their parents were first interviewed. The second stage of stratification was among established enrollees; it distinguished enrollees who had completed the renewal process from those who had not. The former were oversampled to have more up-to-date contact information for potential respondents.

Sampled disenrollees were identified from the followup survey as children whose parents reported that they were no longer enrolled in Healthy Kids at the time of the second interview. Analyses for this report, therefore, exclude baseline respondents who were lost to followup but whose children may have disenrolled from the program. Analysis of final status reports indicates that the majority (95 percent) of the 112 respondents lost to followup could not be located by the survey calling center; the remainder were classified as refusals or non-completes. Given the fact that the Healthy Kids program serves a very mobile population, it is likely that many of these families moved from Los Angeles County between survey waves. If we assume this to be the case, a large percentage of individuals lost to followup would not have qualified for Healthy Kids due to the residency requirement

[8] Funding for the client survey is provided solely by First 5 LA. Since Proposition 10 funds could only be used for programs targeting children during their first five years of life, our survey was restricted to parents of children enrolled in Healthy Kids who were under age 6. However, the sample excluded infants under age 1 because there are few infants enrolled in Healthy Kids and because their health care is very different from that of older children.

and would, therefore, have ended up in the disenrollee sample. Analyses of the characteristics of respondents lost to followup versus sampled disenrollees suggest that those lost to followup were less likely to have children ages 2 and 3, were more likely to report some college education, and were more likely to have family incomes less than $10,000 per year (Table II.1).[9] Nonresponse weights were not calculated for the followup survey so we cannot be certain how representative the sample of disenrollees is of the full population of children who disenrolled from Healthy Kids.

We identified 65 disenrolled children from the followup survey; the remaining 910 children were continuously enrolled in Healthy Kids. Both the disenrolled and continuously enrolled groups include new enrollees and established enrollees. Demographic characteristics were collected for all children and their parents (regardless of the child's time on the program) during the baseline interview.[10] Baseline interviews also explored issues of health care coverage, health status, access to and use of services, and unmet health care needs; parents of new enrollees were asked about their child's experience during the six months prior to enrolling in Healthy Kids and established enrollees were asked about their experiences on Healthy Kids in the past six months. The follow-up survey covered similar survey topics, but questions regarding access to care and use of services focused on the most recent six months of Healthy Kids coverage, regardless of whether the child was a new or established enrollee at baseline. Therefore, for continuously enrolled children, the reference period for access to care and use variables was for the six months prior to the followup survey, whereas for disenrollees the period covered their last six months of enrollment in Healthy Kids. On average, disenrolled children had been off the program for 5.7 months by the time of the followup survey, so for the average disenrollee the followup survey referred to a period from between nearly six to twelve months in the past.

Although the following chapters focus on the disenrollee sample, comparisons between disenrollees and enrollees are included for sake of reference. Statistical significance was assessed using the chi-squared statistic but the small disenrollee sample size limits the ability to detect significant differences, particularly within subgroups of disenrollees.

SAMPLE CHARACTERISTICS

Across most demographic characteristics, disenrollees were similar to continuously enrolled children. Ninety-nine percent of sampled children were living with at least one parent in both the baseline and followup periods. As Figure II.1 shows, the majority (82 percent) of children were living in two-parent households; in most cases (78 percent among disenrollees and 85 percent among enrollees) both parents were working (data not presented). Overall, only around 8 percent of children were living in a household with no

[9] Self-reported educational background may be unreliable since evidence suggests that many respondents may have reported technical training programs as college-level course work.

[10] Thirty-three of the disenrolled children were new enrollees at the baseline survey; the remaining 32 were established enrollees. Analyses (not reported) found no significant differences between new and established enrollees with respect to their demographic characteristics.

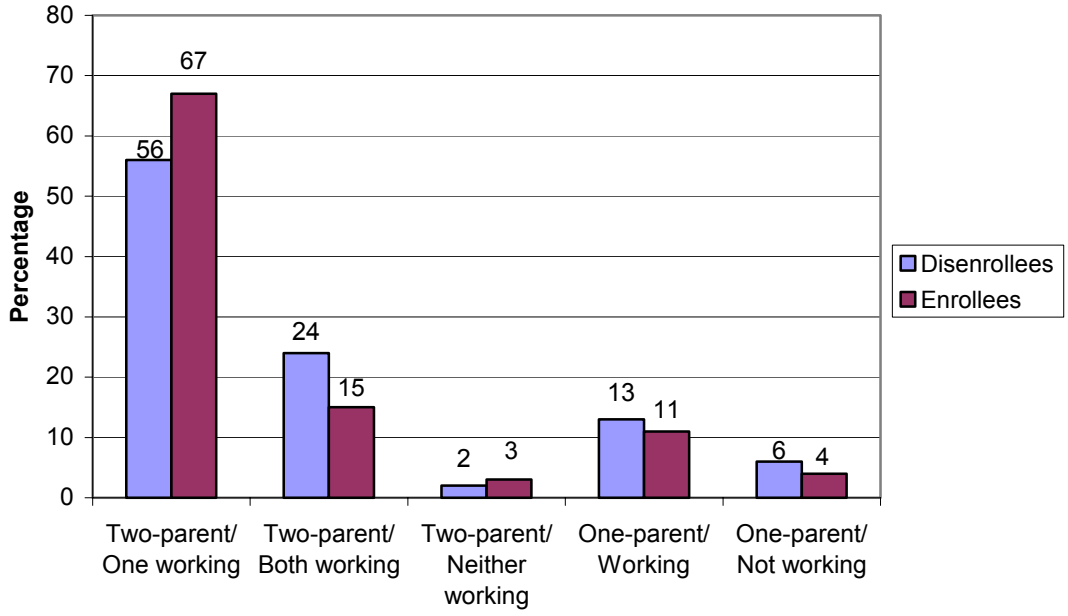
Table II.1 Comparison of Baseline Characteristics of Children Who Were Lost to Followup with Those Who Disenrolled from Healthy Kids[a] (Percentages, Unless Otherwise Indicated)

	Lost to Followup	Disenrollees
Number of Enrollees	112	65
Child's Age		
1 or younger	11**	11
2	10	20
3	19	9
4	23	28
5 or older	38	32
Child's race/ethnicity		
Mexican	76	82
Other Latino	10	12
Korean	11	6
Other	3	0
Child's country of birth		
United States	7	18
Mexico	73	68
Other Latin American	4	8
Korea	4	3
Other	11	3
Child's citizenship status		
United States citizen	8	22
Non-citizen	91	78
Citizenship application pending	1	0
Parent's age		
Less than 25 years	32	40
25 to 39 years	63	54
40 years or older	5	6
Parent's education level		
Less than a high school degree	31*	48
High school degree or equivalent	46	43
Some college	22	9
Parent's country of birth		
United States	2	5
Mexico	76	78
Other Latin American	5	8
Korea	7	3
Other	10	6
Parent's citizenship status		
United States citizen	4	6
Non-citizen	96	94
Household income		
Less than $10,000	53*	45
$10,000 to $19,999	20	29
$20,000 or more	27	27

Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Baseline Survey.*

[a]Percentages may not sum to 100 due to rounding. * - Difference between respondents lost to followup and disenrollees is significant at $p < 0.05$. ** - Difference between respondents lost to followup and disenrollees is significant at $p < 0.01$.

Figure II.1 Household Structure and Parental Employment Status Among Disenrollees at Baseline



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Baseline Survey*

Differences in the distributions between disenrollees and enrollees are insigificant, based on a Chi-squared test

parent working during the baseline period (differences between disenrollees and enrollees were insignificant).

Children ranged in age from 1 to 6 years old, with the majority of children at the higher end of the age distribution of eligibility for Healthy Kids; more than half of the children in each of the two groups were age 4 or older at the time of the baseline survey (Table II.2). The majority of children were of Mexican ethnicity; including other Latin American populations (such as Guatemalans and Ecuadorians), Latinos comprised around 90 percent of the population across each of the two enrollment groups. Koreans were the only other predominant ethnic group, representing 6 percent of all disenrollees and 13 percent of enrollees. Reflecting this ethnic distribution, the majority of children resided in Spanish-speaking households (72 percent) but a large percentage (25 percent) lived in households where multiple languages were spoken. In addition, the data on country of birth and U.S. citizenship status reflect the fact that the program primarily serves low-income, undocumented children; between 82 and 94 percent were born in a country other than the United States and more than three-quarters of the children in both groups were non-citizens

at the time of the baseline interview.[11] However, disenrolled children were significantly less likely that continuously enrolled children to be non-citizens (78 percent versus 92 percent, $p < 0.01$).

Table II.2 Baseline Demographic Characteristics of Disenrolled and Continuously Enrolled Children (Percentages, Unless Otherwise Indicated)

	Disenrollees	Continuously Enrolled
Sample Size (Number of Children)	65	910
Age		
1 or younger	11	6
2	20	13
3	9	21
4	28	27
5 or older	32	33
Race/ethnicity		
Mexican	82	76
Other Latino	12	11
Korean	6	13
Language(s) spoken in the home		
English	2	3
Spanish	72	73
Other	1	2
Multiple languages	25	23
Country of birth		
United States	18	6
Mexico	68	73
Other Latin American	8	8
Korea	3	5
Other	3	8
Child's citizenship status		
United States citizen	22**	7
Non-citizen	78	92
Citizenship application pending	0	<1

Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Baseline Survey.*

[a]Percentages may not sum to 100 due to rounding.

** - Difference between disenrollees and enrollees is significant at $p < 0.01$, based on the Chi-squared statistic.

As shown in Table II.3, parents of disenrolled children had significantly lower educational levels then continuously enrolled children. Whereas nearly half (48 percent) of parents of disenrolled children terminated formal education in the primary grades, the same was true of only 32 percent of enrolled children ($p < 0.05$). Similarly, while only 9 percent of parents of disenrollees had attended college, the same was true of 21 percent of parents of

[11] Some of these non-citizen children could have been legal residents who had not yet met the residency requirements to qualify for Medi-Cal or Healthy Families; the survey questionnaire did not ask specifically about the child's immigration status.

enrollees. However, this was the only significant difference between parents of the two groups of children. Respondents were relatively young at the time of the baseline survey; the median age was around 27 years old and between 32 and 40 percent were less than 25 years old (among enrollees and disenrollees, respectively). An even larger percentage of parents than children appeared to be undocumented immigrants. Ninety-five percent of respondents were born outside the United States and 94 percent reported that they were non-citizens. Although the survey did not ask the relationships of all of the family members living with the respondents, the vast majority were living with three or more family members at the time of the baseline survey (86 percent).

Table II.3 Baseline Characteristics of Parents of Disenrolled and Continuously Enrolled Children[a] (Percentages, Unless Otherwise Indicated)

	Disenrollees	Continuously Enrolled
Sample Size (Number of Respondents)	65	910
Age		
Less than 25 years	40	32
25 to 39 years	54	62
40 years or older	6	5
Median age	26	28
Education level		
Less than a high school degree	48*	32
High school degree or equivalent	43	47
Some college	9	21
Parent's country of birth		
United States	5	2
Mexico	78	76
Other Latin American	8	8
Korea	3	6
Other	6	8
Parent's citizenship status		
United States citizen	6	4
Non-citizen	94	95
Citizenship application pending	0	<1
Number of family members living with respondent		
Two or fewer	14	15
Three	28	30
Four	23	26
Five or more	35	30

Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Baseline Survey.*

[a]Percentages may not sum to 100 due to rounding.

* - Difference between disenrollees and enrollees is significant at $p < 0.05$, based on the Chi-squared statistic.

CHAPTER III

COMPARING ACCESS TO AND USE OF HEALTH CARE AMONG DISENROLLEES AND ENROLLEES

There were a number of significant differences between enrollees and disenrollees in terms of their access to and use of health care services while enrolled in Healthy Kids (as reported at the time of the followup survey). In short, we found that disenrolled children were less likely to have a usual source of care and had fewer doctor's visits than continuously enrolled children. Similarly, twice as many disenrollees as continuously enrolled children lacked a usual source of dental care. Disenrollees expressed less confidence that their children could get the care they needed and these parents were more likely to report an unmet health need.

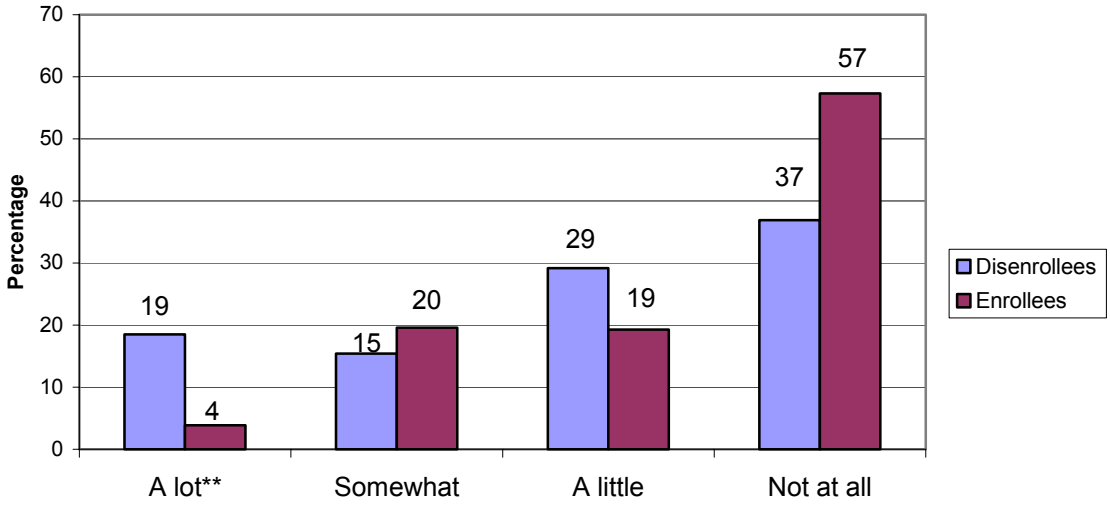
These findings were surprising in light of the fact that the questions on access and use pertained to a period of time when members of both groups had Healthy Kids coverage.[12] For example, 63 percent of parents with a disenrolled child reported some financial difficulties (either "a lot," "somewhat," or "a little" difficulty) as a result of their child's health care during the most recent six months of Healthy Kids coverage, compared with 43 percent of parents with enrolled children ($p < 0.01$, see Figure III.1). At the extremes, 19 percent of parents of disenrolled children said that their child's health caused "a lot" of financial difficulties and 37 percent said they had not experienced any difficulties; only 4 percent of parents with enrolled children reported "a lot" of difficulties and 57 percent reported none.

These reported financial difficulties could not be due to a lack of health insurance coverage, since all of the children were enrolled in Healthy Kids during the reference period. Difference also did not appear to be associated with the children's health status; there were no significant differences in reported health status between the enrollees and disenrollees either in the baseline or followup periods (results not presented). At baseline, around 17 percent of respondents said their child's health was "poor" or "fair" and the remainder rated

[12] As noted earlier, the reference period for these questions was the most recent six-month period of Healthy Kids coverage.

their child's health as "good," "very good," or "excellent." By the time of the followup survey, the percentage of children reported to be in fair or poor health had decreased to 13 percent, but the change was not significant.

Figure III.1 Extent to Which Child's Health Care Caused Financial Difficulties During the Most Recent 6 Months of Healthy Kids Coverage

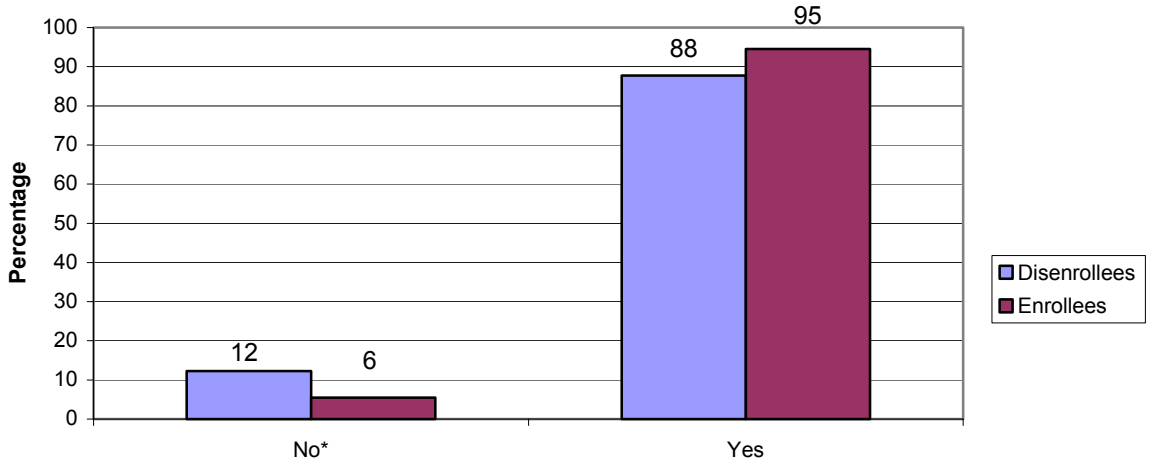


Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*

** Difference in distributions between disenrollees and enrollees is statistically significant at $p < 0.01$, based on a Chi-squared test

The financial difficulties parents of disenrollees reported may have been associated with their greater likelihood of reporting barriers in access to care during the time their children were enrolled in Healthy Kids. For example, disenrolled children were significantly more likely than continuously enrolled children to lack a usual source for medical care when they were enrolled in the program (12 percent versus 6 percent, respectively [$p < 0.05$], see Figure III.2). However, the source that respondents used to obtain medical care did not differ significantly between the two groups. Community clinics and health centers were the most common sources of care (at around 75 percent), followed by private physician offices (about 22 percent, see Figure III.3). Less than 7 percent of each group used the emergency room or some other source for care. Access to dental care was even more problematic for disenrolled children; while enrolled, they were twice as likely as children who remained enrolled to lack a usual source of dental care (52 percent versus 26 percent, respectively [$p < 0.01$], Figure III.4).

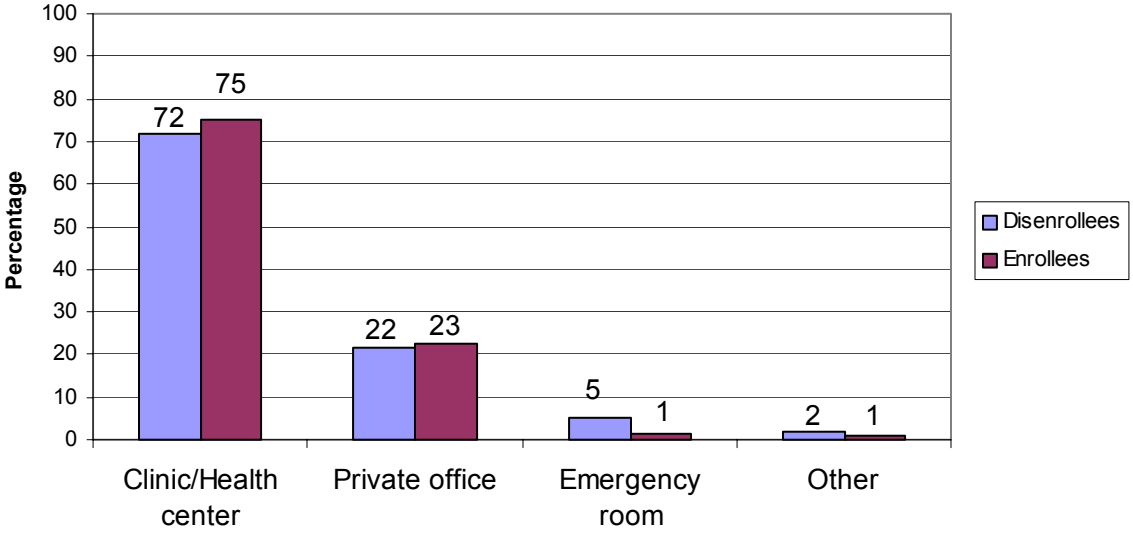
Figure III.2 Usual Source for Medical Care During the Most Recent 6 Months of Healthy Kids Coverage



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*

* Difference in distribution between disenrollees and enrollees is statistically significant at $p < 0.05$, based on a Chi-squared test

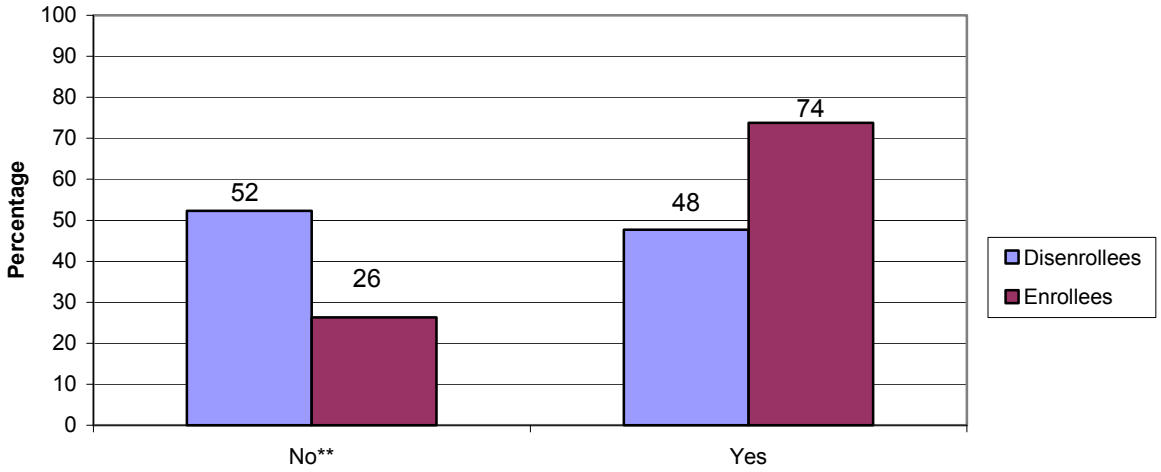
Figure III.3 Type of Place Went for Care During Most Recent 6 Months of Healthy Kids Coverage



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*
Note: Based on 58 disenrollees and 758 enrollees who reported a usual place of care

Difference in distribution between disenrollees and enrollees is not statistically significant, based on a Chi-squared test

Figure III.4 Usual Source of Dental Care During Most Recent 6 Months of Healthy Kids Coverage



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*

** Difference in distribution between disenrollees and enrollees is statistically significant at $p < 0.01$, based on a Chi-squared test

On several measures, parents of disenrolled children were more likely than parents of continuously enrolled children to report an unmet health need during their child's most recent period of Healthy Kids enrollment (Table III.1). Disenrollees were significantly more likely to have an unmet need for preventative care, vision care, and medical treatment following illness, accident, or injury, but there were no significant differences between the two groups on the need for specialist care, dental care, or prescription drugs. However, these findings were based on very small sample sizes; only 103 respondents reported an unmet need for preventative care and 121 respondents reported unmet dental care needs. On the remaining measures, there were no more than 35 respondents (in the two groups combined) who reported an unmet need.

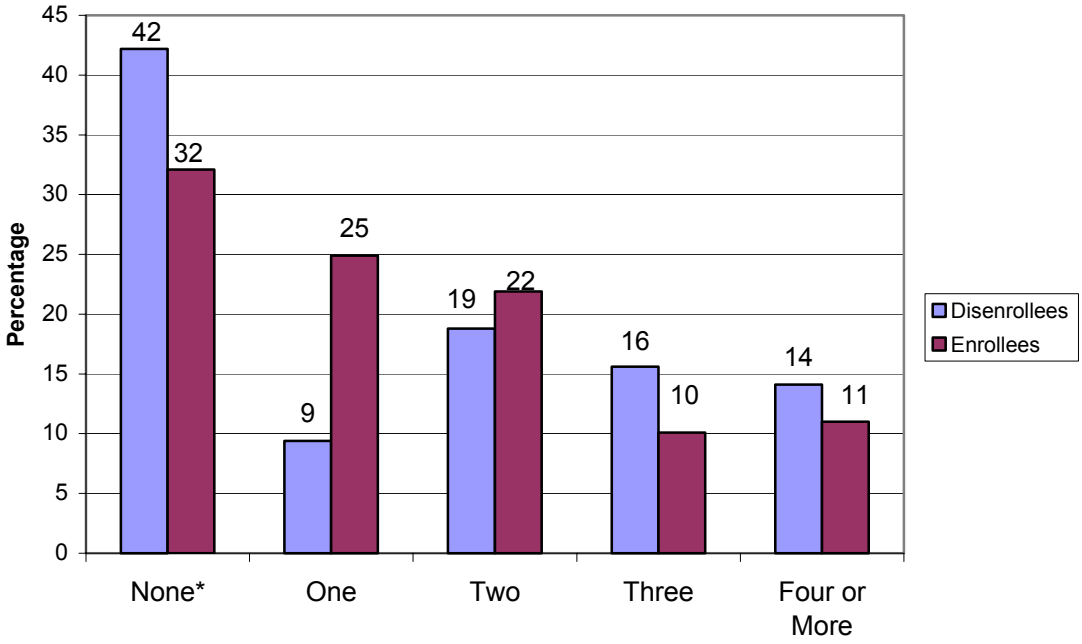
Table III.1 Parents Reporting an Unmet Health Need, by Enrollment Status[a] (Percentage, Unless Otherwise Indicated)

	Disenrollees	Enrollees
Number of Enrollees	65	910
Preventative medical care	19*	10
Vision care	5*	1
Medical care for illness, accident, or injury	6**	1
Specialist care	6	3
Dental care	17	12
Prescription drug	5	2

Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey.*
* - Difference between disenrollees and enrollees is significant at $p < 0.05$, based on a Chi-squared test. ** - Difference between disenrollees and enrollees is significant at $p < 0.01$, based on a Chi-squared test.

In addition to these apparent access barriers, disenrolled children were also significantly less likely to make use of health care services while enrolled in Healthy Kids than children who remained enrolled. Forty-two percent of disenrollees had no doctors' visits during their most recent six months of coverage, compared with 32 percent of children continuously enrolled ($p < 0.05$, see Figure III.5). Similarly, 65 percent of disenrolled children did not have a dental visit during the reference period, compared with 51 percent of enrollees ($p < 0.05$, Figure III.6).

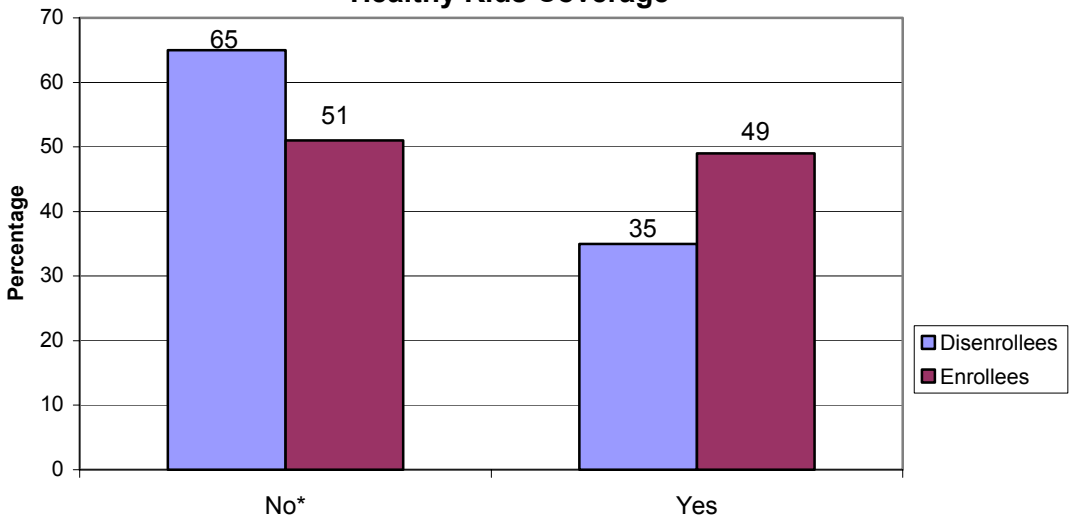
Figure III.5 Number of Doctor Visits During Most Recent 6 Months of Healthy Kids Coverage



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*

* Difference in distribution between disenrollees and enrollees is statistically significant at $p < 0.05$, based on a Chi-squared test

Figure III.6 Dental Visit During the Most Recent 6 Months of Healthy Kids Coverage

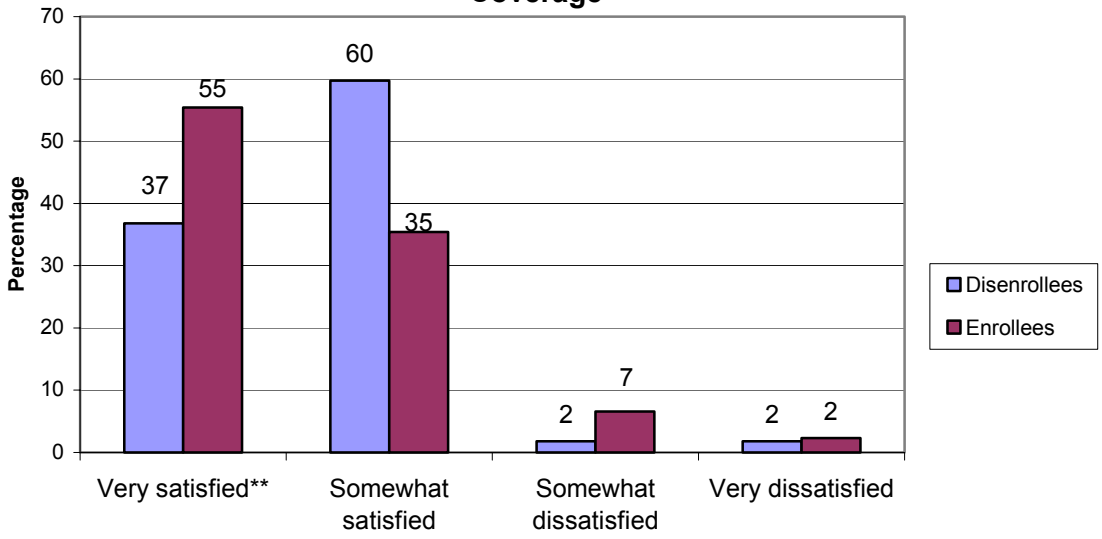


Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*
Note: Based on a total sample size of 655 (40 disenrollees and 615 enrollees)

* Difference in distribution between disenrollees and enrollees is statistically significant at $p < 0.05$, based on a Chi-squared test

While the majority of parents in both groups were satisfied with the amount of time they spent with doctors while enrolled in Healthy Kids, only 37 percent of parents with a disenrolled child said that they were "very satisfied" with the time they spent with doctors, compared with 55 percent of parents of enrolled children ($p < 0.01$, see Figure III.7). In contrast, nearly 60 percent of respondents with disenrolled children said they were only "somewhat satisfied" versus 35 percent of respondents with enrolled children. Overall, however, parents of disenrolled children were less likely to be dissatisfied with their child's care than parents of enrolled children; only 4 percent of parents of disenrolled children reported feeling "somewhat" or "very" dissatisfied with the time they spent with physicians, versus 9 percent of respondents with enrolled children.

Figure III.7 Satisfaction with the Amount of Time Spent with Doctors During Most Recent 6 Months of Healthy Kids Coverage

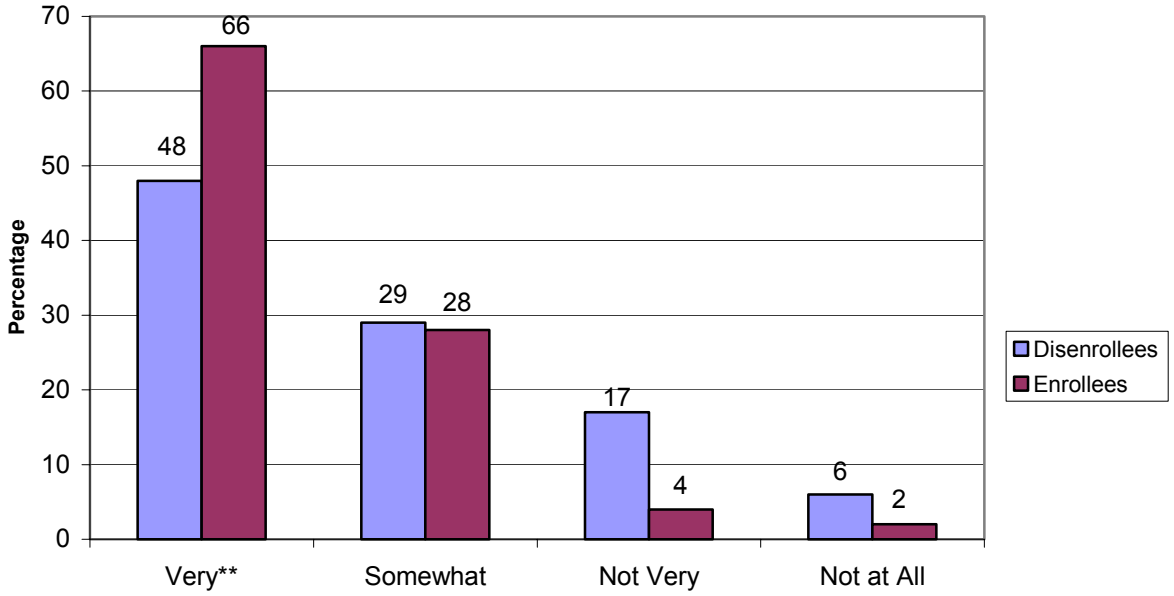


Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*
Note: Based on a sample size of 811 (58 disenrollees and 753 enrollees)

** Difference in distribution between disenrollees and enrollees is statistically significant at $p < 0.01$, based on a Chi-squared test

The problems disenrollees' parents reported with regard to access and usual source of care may explain why they were significantly more likely to lack confidence that they could get care for their child when it was needed while they were enrolled in Healthy Kids ($p < 0.01$, see Figure III.8). Only 48 percent of parents with a disenrolled child said they were "very confident" that their child could get care when it was needed, compared with 66 percent of those whose child remained enrolled in Healthy Kids. Alternatively, 6 percent of those with disenrolled children were "not at all confident" of their ability to obtain care for their child while enrolled, versus 2 percent of those with a continuously enrolled child.

Figure III.8 Respondent Confidence Level that Child Can Get Care When Needed, Most Recent 6 Months of Healthy Kids Coverage



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*

** Difference in distribution between disenrollees and enrollees is statistically significant at $p < 0.01$, based on a Chi-squared test

CHAPTER IV

WHY DO CHILDREN LEAVE HEALTHY KIDS AND HOW MANY REMAIN INSURED?

Respondents of disenrolled children gave a wide variety of explanations for why enrollment had lapsed. Interviewers asked these respondents to name the main reason their child's Healthy Kids coverage had ended; Table IV.1 provides a summary of the most commonly reported reasons. As seen in the top panel of the table, about one-third (35 percent) of respondents with a disenrolled child lost that child's coverage for reasons related to eligibility requirements (that is, moving outside the coverage area or obtaining coverage through another source). Addressing the problems these families face in obtaining health insurance for their children would require program expansions that either cannot be supported under current funding limits or would require action in areas outside LA County. For example, 23 percent of families lost coverage because they moved out of LA County.[13] Some of these families may have moved to areas without Healthy Kids or other similar children's health insurance programs (that is, out of state or to another California county that does not offer Healthy Kids). Although the survey did not ask about the respondent's current place of residence, 71 percent of the children who were disenrolled because they moved from LA County were without health insurance at the time of the followup survey.

Among the other 65 percent of disenrollees, coverage lapsed despite the fact that the child may still have been eligible for Healthy Kids (though there is no way to determine this from the available data). Twenty-three percent of these respondents reported that they either lost or never received the renewal application; another 17 percent said they chose not to reapply but gave no further explanation. In 5 percent of cases, the family moved and either lost the paperwork or never received their new card. Six percent of respondents said they did not know why their child's coverage ended. Only one person (2 percent) reported disenrolling because of problems with the quality of care, a finding very consistent with that of a study of a Florida child health insurance program which found that few disenrollees

[13] As noted in Chapter II, this likely underestimates the percentage of children who lost coverage due to a change in residence. Without nonresponse weights, it is impossible to accurately estimate the percentage of children who disenrolled as the result of a move.

reported dissatisfaction as the primary reason for leaving the program (Shenkman et al, 2002). Similarly, all of the other reasons for disenrollment were reported for only respondent (for example, forgetting to pay the premium and feeling that there was too much paperwork). Other reasons for disenrollment included misperceptions of the eligibility requirements (for example, the child was born in the United States and, therefore, not eligible), uncertainty of enrollment status ("I don't know if she has Healthy Kids because I haven't got any information from Healthy Kids, just from LA Health Care), and failure to keep appointments ("Perhaps because I did not take her in June of last year to a dentist appointment?").

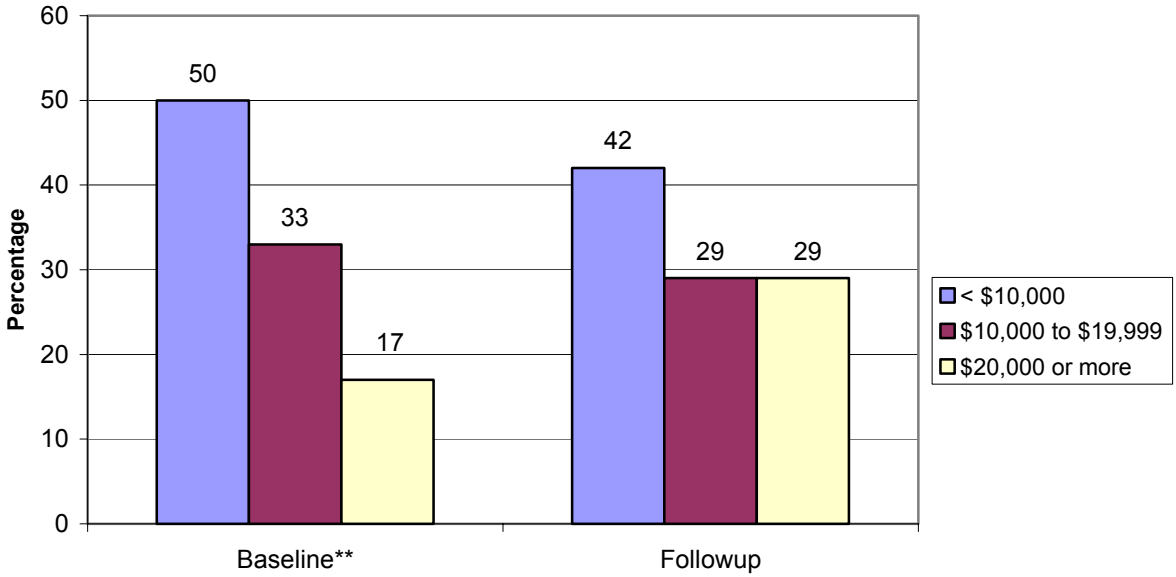
Table IV.1 Main Reasons for Disenrollment from Healthy Kids[a] (Percentages, Unless Otherwise Indicated)

Sample Size (Number of Respondents)	65
Unavoidable factors related to program eligibility	*35*
Family moved out of Los Angeles county	22
Child obtained coverage from Medi-Cal or Healthy Families	3
Child obtained other insurance coverage	5
Child aged out of program	3
Household income increased, child no longer eligible	3
Potentially avoidable factors related to family behavior/attitude	*65*
Did not receive (or lost) application	22
Did not reapply (no other reason given)	17
Family moved and lost paperwork	5
Too much paperwork	2
Forgot to pay premium	2
Did not like the quality of care	2
"Don't know"	6
Other	11

Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Baseline Survey.*
[a]Percentages may not sum to 100 due to rounding.

The annual income distributions for the parents of disenrollees showed a significant increase at the higher income categories between the baseline and followup interviews ($p < 0.01$, see Figure IV.1). In the baseline period, 50 percent of families with a disenrolled child had incomes less than $10,000, another 33 percent of families were in the middle income group ($10,000-$19,999), and the remaining 17 percent had incomes of $20,000 or more. By the time of the followup survey, the percentage of families in the lowest income group had declined to around 42 percent and that for the middle income group had fallen to 29 percent. In turn, the percentage of families in the highest income bracket had increased 12 percentage points from 17 to 29 percent. However, only two respondents report an increase in income as the primary reason for their child's disenrollment.

Figure IV.1 Income Distribution of Disenrollees at Baseline and Followup

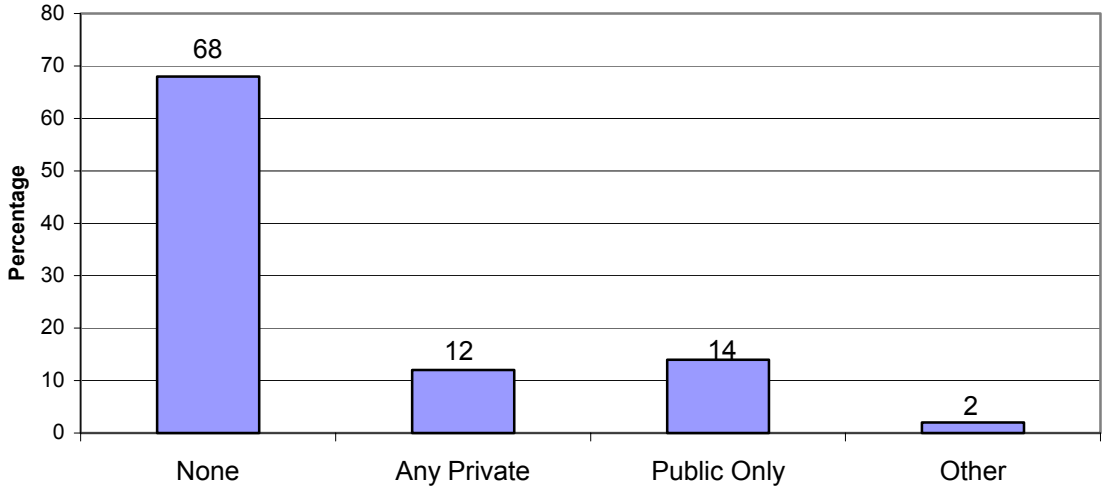


Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Baseline and Followup Surveys*
Note: Based on 58 respondents

** Difference in the distributions between baseline and followup is statistically significant at $p < 0.01$, based on a Chi-squared test

Despite the rise in average incomes for families with disenrolled children, the majority of disenrollees had no health insurance at the time of the follow-up survey (68 percent, see Figure IV.2). Another 12 percent of respondents said their child had health insurance through some type of private coverage (including employer- or union-sponsored coverage) and 14 percent had switched to some other type of public insurance (either Medi-Cal, emergency Medi-Cal, Healthy Families, or California Kids). Only one respondent (2 percent) reported having some other type of insurance and the remaining three cases (5 percent of the sample) were missing data on this variable.

Figure IV.2 Current Source of Health Insurance Among Disenrollees



Source: *Evaluation of the Children's Health Initiative of Los Angeles County, Followup Survey*

CHAPTER V

DISCUSSION AND POLICY IMPLICATIONS

Results of this descriptive analysis suggest two principal findings regarding the characteristics and health outcomes for children who disenrolled from the LA Healthy Kids program. First, many children are left uninsured after losing Healthy Kids coverage, despite the fact that most remain eligible for the program. Second, disenrolled children were more likely than continuously enrolled children to experience barriers in access to care, despite identical health insurance coverage, which may help explain their parents' willingness to let their coverage lapse.

Many Who Disenrolled from Healthy Kids Were Uninsured at Followup

The majority (68 percent) of sampled children who disenrolled from Healthy Kids were without health insurance coverage at the time of the followup survey. While LA Care retains the large majority of children in the Healthy Kids program, these findings suggest that many disenrollees remain eligible for the program and lose coverage out of a failure to reapply or due to a lost application.

LA Care is responsible for administering the eligibility renewal process and uses a variety of methods to facilitate program renewal and maximize retention rates. Once enrolled in Healthy Kids, a child is entitled to 12 months of continuous coverage. Families receive a pre-populated renewal form 45 to 60 days prior to their renewal date. After reviewing the forms, families must contact LA Care with any changes in their situation and mail back the form to maintain eligibility. If forms are not received within 30 days, LA Care will place at least three followup calls and give nonrespondents 30 days' notice before disenrolling children from the program. "Application assistors" are also available in the same community-based outreach settings that provide support to families applying for public insurance programs. Available data indicate that families that have been through the renewal process find it very easy (Hill et al. 2006).

A recent analysis of the procedures for enrollment and renewal in Medi-Cal, Healthy Families, and Healthy Kids suggested that greater integration of procedures across these three programs could substantially improve coverage and retention rates, particularly since many of the families participating in Healthy Kids include children of mixed immigration status (Kattlove and Maral 2005). The assumption is that parents in these households may

be confused about application and renewal requirements because they have to deal with two or three distinct programs. However, this does not appear to explain the problem of disenrollment for this study sample. Overall, around 71 percent of children included in the baseline survey had a sibling in the household (there was no significant difference between disenrollees and continuously enrolled children, results not presented). Among families with a sibling present, disenrollees from Healthy Kids were significantly *less* likely than enrollees to have a sibling enrolled in either Medi-Cal or Healthy Families (40 percent versus 55 percent, respectively, $p < 0.10$, results not presented).

In their analysis of the renewal process, the Program Integration Workgroup identified two likely stages at which children enrolled in Healthy Kids could experience a coverage gap. One stage was at the point of completing and returning the renewal form; the other was after the determination of eligibility, when the family would be required to pay their premium or apply for premium assistance. In both cases, the gap would occur after LA Care had tried to contact the families through followup calls. To the extent that it is not already doing so, LA Care may improve retention rates through face-to-face outreach involving partnerships with the same community groups that participate in enrollment activities or by mailing postcards seeking address updates from members at interim points in time (such as 3 and 9 months post enrollment).

Parents of Disenrolled Children Reported More Negative Experiences

The access to care and health care utilization measures examined in Chapter III pertain to a period of time when all of the survey's target children were still enrolled in Healthy Kids. Differences in access and use between the two groups of children cannot, therefore, be attributed to differences in health insurance coverage. A few follow-up questions asked about reasons for access barriers. For example, for parents who reported an unmet health need, interviewers asked parents about the main cause for the delay or failure to receive care. Responses to these questions included time to schedule an appointment, transportation problems, and the place of care not accepting Healthy Kids coverage. Few respondents reported unmet needs, so responses to these followup questions could not be used to discern potential differences in the causes of access barriers.

There are at least two reasons for caution in interpreting the findings from Chapter III. First, comparisons are based on very small sample sizes. This is particularly evident with respect to the analyses of unmet needs. Only 13 respondents (including both enrollees and disenrollees) said their children did not get medical attention after an illness, accident, or injury and only 15 said their child did not receive needed dental care. A larger number of respondents (103) said that their child did not get needed preventative medical care over the targeted six-month time frame, but this included only 12 disenrollees.

Second, there may be some recall bias on the part of parents of disenrolled children and they may have projected a more negative view of their experience on the program due to their child's current disenrolled status. These parents were asked to evaluate their experiences during the last six months that their child was enrolled in Healthy Kids, which may have referred to a period several months prior (as noted earlier, disenrolled children had

been off Healthy Kids for an average of 5.7 months by the time of the followup survey). The fact that only one respondent reported disenrolling his or her child because of dissatisfaction with the quality of care received on the program suggests that other factors played a more important role in disenrollment. Given the small sample size of the study, it is difficult to draw clear conclusions regarding the extent to which access barriers exist and contribute to patterns of disenrollment.

It is possible that access barriers contributed to parents' decisions not to re-enroll their children in Healthy Kids or to let their children's coverage lapse. As reported in Chapter IV, 23 percent of parents did not report specific reasons for their child's disenrollment (17 percent said they did not reapply and 6 percent said they did not know why coverage ended). It is possible that, for some of these parents, access barriers affected their decisions about program renewal. However, the data do not permit causal analysis.

Conclusions

Ninety-two percent of sampled children who were disenrolled from the LA Healthy Kids program between the two waves of the client survey were living in households with at least one working parent. Despite some evidence of increasing household income over the study period, disenrolled children remained in economically vulnerable situations. Healthy Kids fills a critical need, as evidenced by the fact that the majority of disenrolled children (68 percent) were uninsured at the time of the followup survey. Given that many of these children are undocumented immigrants, they have few alternatives for health care coverage in the absence of Healthy Kids. Thus, it is important that program administrators continue to refine processes to ensure that every child eligible for the program remains enrolled. Despite policies that entail extensive outreach efforts through community-based programs and numerous attempts to contact parents, 42 percent of the parents with disenrolled children cited specific factors amenable to improved outreach (such as forgetting to pay the premium, not reapplying, and losing the renewal application). Much of the outreach effort has focused on enrolling children in the Healthy Kids program. This study suggests that many children who disenroll remain eligible for Healthy Kids and may benefit from additional retention-focused outreach activities.

REFERENCES

Farias, Albert, Michael Cousineau, Moira Inkelas, Patricia Barreto, Brigette Courtot, and Ian Hill. "Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: First and Second Quarter 2007." The Urban Institute, University of Southern California, and University of California at Los Angeles, Washington, DC: The Urban Institute, September, 2007.

Hill, Ian, Brigette Courtot, Patricia Barreto, Eriko Wada, and Enrique Castillo. "What Do Parents Say About the Los Angeles Healthy Kids Program?" The Urban Institute, The University of California at Los Angeles, The University of Southern California, and Castillo & Associates. Washington, DC: The Urban Institute, March 2006.

Howell, Embry, Lisa Dubay, Genevieve Kenney, Louise Palmer, Ian Hill, Moira Inkelas, and Martha Kovac. "A Profile of Young Children in the Los Angeles Healthy Kids Program: Who Are They and What Are Their Experiences on the Program?" Mathematica Policy Research, Inc., The Urban Institute, and University of California, Washington, DC: The Urban Institute, October, 2006.

Howell, Embry, Lisa Dubay, and Louise Palmer. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Health Services, and Health Status." Washington, DC: The Urban Institute, October 2006.

Kattlove, Jenny, and Maral Farsi. "Mapping Children's Health Coverage Enrollment: Recommendations for Improvement." Los Angeles: Program Integration Workgroup, Children's Health Initiative of Greater Los Angeles, July 2005.

Shenkman Elizabeth, Bruce Vogel, James Boyett, and Rose Naff. "Disenrollment and Reenrollment Patterns in a SCHIP." Health Care Financing Review, vol. 23, no. 3, pp. 47-63, Spring 2002.

Sommers, Anna, Joshua McFeeters, Ian Hill, Eriko Wada, Michael Cousineau, Erin Cox, Moira Inkelas, Patricia Barreto, and Tom Rice. "Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: Second Quarter 2005." The Urban Institute, University of Southern California, and University of California at Los Angeles, Washington, DC: The Urban Institute, October, 2005.

Wada, Eriko, Michael Cousineau, Moira Inkelas, Patricia Barreto, Joshua McFeeters, Anna Sommers, and Ian Hill. "Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: Third and Fourth Quarter 2006." The Urban Institute, University of Southern California, and University of California at Los Angeles, Washington, DC: The Urban Institute, May, 2007.

Wada, Eriko, Michael Cousineau, Moira Inkelas, Patricia Barreto, Joshua McFeeters, Ian Hill, and Anna Sommers. "Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: First and Second Quarter 2006." The Urban Institute, University of Southern California, and University of California at Los Angeles, Washington, DC: The Urban Institute, October, 2006.