Evaluation of the San Mateo County Children's Health Initiative: Second Annual Report

Embry Howell, Urban Institute
Dana Hughes, University of California San Francisco
Genevieve Kenney, Urban Institute
Jennifer Sullivan, Urban Institute
Jamie Rubenstein, Urban Institute

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San Mateo County
Children's Health Initiative Coalition
225 37th Ave.
San Mateo, CA 94403

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EXECUTIVE SUMMARY

This report, the second in a series of five annual reports from the Evaluation of the San Mateo County Children's Health Initiative (CHI), provides a new look at the initiative as it enters its third year of operation. Since the CHI began active outreach and enrollment in January 2003, the program has achieved several important milestones:

- Established a stable governance structure with broad input from key government agencies and several key private sector stakeholders;

- Developed a broad funding base for the initiative, raising over $7 million in 2004;

- Established 40 outreach and enrollment sites around the county where 26 full-time enrollment assistors work to enroll children in public health insurance;

- Developed a new insurance product, Healthy Kids, to cover children not eligible for other health insurance. This program had served 7,821 children as of March 2005. There has been some attrition over the course of the program, so the total number of children enrolled in March 2005 was about 5,400.

Using several data sources, the evaluation investigated the demographic and health status characteristics of children enrolled in Healthy Kids (comparing them with enrollees in the Healthy Families and Medi-Cal programs); their access to care; their use of services; their parents' satisfaction with the program; and the cost of their care. The data for the analysis come from an annual site visit conducted in October 2004; health plan administrative enrollment and utilization data; focus groups with parents of children enrolled in Healthy Kids conducted during late 2004 and early 2005; interviews with providers conducted during late 2004; aggregate data on hospital visits and costs from local hospitals; and a client survey conducted with a sample of 411 parents of Healthy Kids enrollees.

In addition, the evaluation explored several issues of particular concern to the CHI Coalition, including (1) the possibility of substituting Healthy Kids coverage for other forms of public or private health insurance; (2) reasons for limited private provider participation in the program; and (3) the impact of the program on the financial status of hospitals in the county. Key findings include:

- The Healthy Kids program has experienced sustained enrollment growth since the CHI began, and Healthy Families enrollment has also grown, in contrast to Medi-Cal enrollment for children. During 2004, Healthy Kids enrollment grew by 18 percent, Healthy Families by 5 percent, and Medi-Cal for children by only 1 percent.

- Healthy Kids enrollees are predominantly very low income, undocumented children in large, extended immigrant families who have resided in San Mateo County for some time. Based on administrative and client survey data, we estimate

that 78.3 percent of enrollees have family incomes at or below 150 percent of the federal poverty level (FPL); about 90 percent are undocumented; 48 percent live in households that include at least one nonparent adult; and 44 percent are from families that have been living in the county for four or more years. These enrollees are older than Healthy Families and Medi-Cal children on average, with 78 percent between the ages of 6 and 18, compared with 72 percent of Healthy Families enrollees and 59 percent of Medi-Cal enrollees.

- Although the health status of Healthy Kids enrollees is generally better than that of Medi-Cal children, about a third have medical problems, a third have dental problems, and a fifth have mental health problems.

- There is little evidence of "crowd-out" from private insurance. Only 14 percent of higher-income and 6 percent of all Healthy Kids enrollees have access to affordable private insurance.

- Many Healthy Kids (22 percent) participants were enrolled in Emergency Medi-Cal prior to Healthy Kids enrollment. However, Healthy Kids coverage is far more comprehensive.

- In the client survey and focus groups, parents report that access to care for Healthy Kids enrollees is generally good, but there are some areas where access could be improved. For example, although a large majority (88 percent) report a usual source of medical care, only 72 percent report a usual source of dental care and only 41 percent report access to their doctor when offices are closed.

- Still, 70 percent of parents are very satisfied with the care their children receive. There are several areas where they would like to see improvement, including better clarity of the program materials they receive.

- Use of services by Healthy Kids enrollees is lower than it is for Medi-Cal and national norms, particularly for preventive care. According to data from the Health Plan of San Mateo, only 33 percent of Healthy Kids enrollees had a preventive care visit, compared with 42 percent of Healthy Families enrollees and 38 percent of Medi-Cal enrollees.

- The average annual cost of care for Healthy Kids participants ($442) is substantially lower than that for Medi-Cal and below the reimbursement being provided for their care in premiums to the Health Plan of San Mateo.

- Many private providers are unaware of the Healthy Kids program, and many of those who are aware have experienced difficulties participating in other public programs and are therefore reluctant to participate in Healthy Kids.

- The CHI has had a positive though limited impact on the financial status of area hospitals. Between 2002 and 2004, the number of hospital stays, emergency room

visits, and outpatient visits for uninsured children declined by 23 percent, 2 percent, and 59 percent respectively, while the frequency of all three services increased for publicly insured children.

Based on these findings, areas requiring increased attention from the San Mateo CHI in the coming months include:

- A continued focus on the administrative barriers to enrollment and retention in each of the three public programs, particularly Medi-Cal.

- A consideration of options to recoup federal and state matching funds for children who could have services covered by Emergency Medi-Cal.

- An examination of why the anticipated growth in Medi-Cal did not occur.

- Development of new ways to assure parents that their immigration status will not be affected when they apply.

- An examination of use and cost of services from the Health Plan of San Mateo, to ensure that Healthy Kids enrollees are receiving adequate preventive services and that the premiums paid to the plan are fair in relationship to the cost of services received.

- Continued attention to the causes of low private-provider participation in Healthy Kids and other public programs, particularly among dentists.

- An examination of the areas in which parents were less satisfied with services, including limited after-hours care, limited access to dental care, and the need for improved clarity in the parents they receive.

During the coming year, the evaluation will continue monitoring the issues outlined above, using administrative data and in-depth interviews with stakeholders. In addition, the issue of substitution for private insurance coverage will be further explored through focus groups with employers in the county. Finally, a second round of the client survey will be used to study the impact of Healthy Kids on access to care, use of services, and health status**.** In this round, parents of young children age 0 through 5 will be over-sampled in order to analyze special issues for this population. Some of these data—such as extensive data on utilization and cost of care from encounter data for the three public programs—provide a unique data source for policymakers both within and outside San Mateo County.

INTRODUCTION

In February 2003, San Mateo County launched its Children's Health Initiative (CHI), the goal of which is to make certain that all children in the county have health insurance. To fill gaps in other public program coverage (i.e., for undocumented children and for children whose family income is above 250 percent of the federal poverty level), the county created a new insurance product called "Healthy Kids." In addition to administering Healthy Kids, the CHI conducts outreach and enrollment for two other public insurance programs, Medi-Cal (Medicaid) and Healthy Families (State Child Health Insurance Program-SCHIP). This initiative is one of several similar initiatives being implemented in California counties, including Los Angeles, Santa Clara, and San Francisco counties, among others.

In conjunction with CHI's implementation, the architects and major stakeholders elected to evaluate the initiative. The evaluation is being conducted under contract with the Urban Institute, consultant Dana Hughes of the University of California San Francisco (UCSF), and subcontractors Mathematica Policy Research and the Aguirre Group. The evaluation spans five years. Each year, the evaluation team produces an annual report, designed to answer a subset of the evaluation's research questions. This second annual report provides new information that is designed to answer the following questions:

- Which children are served by the CHI and what are their demographic and health status characteristics?
- What was the children's health insurance coverage before enrolling in Healthy Kids, and what access do enrollees have to employer-sponsored coverage?
- How well are Healthy Kids enrollees able to access health services?

- What services do Healthy Kids enrollees receive, and how does their use compare with Medi-Cal and Healthy Families children's use?
- What is the cost of care for Healthy Kids enrollees and how does it compare with the cost for Medi-Cal and Healthy Families children?
- What were parents' experiences with the Healthy Kids program, and are they satisfied with the services their children receive?
- Are providers satisfied with the program?
- How does the CHI affect the financial status of San Mateo County providers?

The answers to these questions come from the annual site visit, health plan administrative data, focus groups with parents, interviews with providers, and aggregate data from local hospitals. A particularly important additional data source for this report is a client survey. Between February and April of 2004, interviews were conducted with parents of a sample of Healthy Kids participants. A total of 411 telephone interviews were conducted—314 with parents of enrollees with incomes below 250 percent of the federal poverty level and 97 with parents of enrollees in families with higher incomes.[1] The survey response rate was 77 percent. Interviews were conducted in both English and Spanish, though more than 90 percent of the interviews were in Spanish. As the evaluation proceeds over the five-year period, different data collection activities will occur each year, allowing for different types of analyses.

The first annual report[2] from the evaluation of the San Mateo CHI provided extensive contextual information about the CHI. Before addressing each of the research questions, we provide a brief update of this contextual information, highlighting the major changes since the first annual report.

[1] As of January 2004, just 367 children were enrolled in the higher-income group. A random sample would have yielded too few higher-income children to study, so a stratified sample was drawn. Sample weights account for unequal selection probabilities, and standard errors are computed in STATA.
[2] The first annual report can be accessed at http://www.urban.org/url.cfm?ID=411003.

THE CONTEXT AND IMPLEMENTATION OF THE CHILDREN'S HEALTH INITIATIVE (CHI) IN 2004

Economy of the County and State[3]*:* The economic health of San Mateo is improving, albeit slowly. The unemployment rate rose from 1.6 percent in FY 2000 to 4.7 percent by the end of 2001. This was the first increase in unemployment in 10 years. Unemployment averaged 4.5 percent in 2004, down from 5.2 percent in 2003. Amazingly, home prices continued to rise in the county, and home ownership currently remains out of reach for many working families. In 2004, the median cost of a single-family house was more than $700,000, up from $640,000 in 2002. Affordable rentals are also difficult to find, with occupancy rates for rentals averaging 93 percent.

San Mateo County has experienced a net migration out of its borders, with a net decrease of 4,053 residents between 2002 and 2003. This situation is likely the result of the high cost of living and the high unemployment rate.

The Health Plan of San Mateo: At the time of the first annual report, the fate of the Health Plan of San Mateo (HPSM)—the plan that covers all Medi-Cal and Healthy Kids recipients, as well as those Healthy Families children whose parents elect this option—was immersed in significant financial problems. While financial problems continue, particularly because of inadequate Medi-Cal capitation rates, the current state government's support for the expansion of Medi-Cal managed care promises to improve the financial stability of existing plans. The Healthy Kids program was profitable in the first year, and some of the profits (about $1 million) were used to cover plan losses in other

[3] Data from this section are taken from selected editions of *Financial Highlights*, a publication of the San Mateo County Controller, http://www.co.sanmateo.ca.us/smc/department/controller/home/0,2151,4666323_40755844,00.html and the California Department of Finance http://www.dof.ca.gov/HTML/FINBULL/Fb_home.htm February 2005.

business lines. After the first year, the CHI and Health Plan leadership decided that 80 percent of any CHI program savings would be returned to the CHI program in order to forestall the implementation of an enrollment cap.

Local Government Budget Issues: One of the county's persisting major budget issues is the "structural deficit" of the county public hospital, the San Mateo Medical Center. This situation comes, in part, from the fact that the hospital does not receive federal Medicaid supplemental funds (known as SB 1255, from the state Senate bill authorizing the funds in California).[4] When San Mateo received its waiver to operate a County Organized Health System[5], the SB 1255 program was not in place. When the capitation rates were set for the Health Plan of San Mateo (HPSM), they were considered adequately "generous," so at the time that the state's supplemental payment for fee-for-service hospital reimbursement went into effect—which other counties with public hospitals could take advantage of—it was decided that the HPSM and the San Mateo Medical Center needed no extra SB 1255 payments.

The Health Plan of San Mateo covers the Medi-Cal aged and disabled population, a circumstance that creates additional financial difficulties. Other County Organized Health System plans like the HPSM have an average of 27 percent of their Medi-Cal membership from the Aged, Blind, and Disabled (ABD) category, but HPSM's ABD population made up 42 percent of its total Medi-Cal membership in 2003. Consequently, the San Mateo publicly insured hospital population is disproportionately composed of the elderly and

[4] SB 1255, the federal Medicaid supplemental funding process for California, provides public hospitals extra funds over and above regular Medi-Cal reimbursement to address the inability of most public hospitals to "cost-shift" because the bulk of patients are Medicaid-covered or uninsured.

[5] In 1986, San Mateo County was the second California county to establish a County Organized Health System (COHS) to provide and manage health care to Medicaid beneficiaries on a capitated basis. The county established a non-profit entity, the Health Plan of San Mateo (HPSM), to administer the program.

disabled, compared with most counties with Medicaid managed care. Capitation rates for these groups have not kept up with hospital cost inflation. This case mix—combined with the lack of SB 1255 funds—creates the hospital's "structural deficit." Efforts are underway to permit the county to receive SB 1255 funds.

Children's Health Initiative Changes: There have been few changes in CHI policies and procedures over the past year. The staff has also remained relatively stable, with a few important exceptions.[6]

The enrollment process continues as described in last year's report, except for the adoption of the One-e-App, an online application software designed to process all applications for the Healthy Kids, Medi-Cal, and Healthy Families programs. By fall 2004, virtually all application assistors, and some benefits analysts employed by the Human Services Agency (HAS), used One-e-App. One-e-App's purpose is to streamline application preparation and processing and to provide a single application for all three programs. However, at the time of our second site visit in October 2004, One-e-App was not yet operating as a streamlined alternative to paper applications for Medi-Cal and Healthy Families. At the same time, One-e-App was working very well for Healthy Kids applications. For example, some application assistors found it necessary to complete the Medi-Cal or Healthy Families applications online, print them, and then fax or mail them. This resulted from staff turnover at the single point of entry contractor, where applications

[6] Margaret Taylor, one of the key leaders of the CHI effort, is no longer director of the San Mateo County Health Services Agency, effective April 2004. She continues to work as a consultant for the county and state on children's insurance issues, and she also sits on the state First 5 Commission. Toby Douglas is gradually taking on more policy and planning/public health functions, while Marmi Bermudez is taking on more day-to-day operational responsibilities related to the CHI. Charlene Silva is the interim director of the agency and is reportedly supportive of the CHI. In addition, Sam Tobin left the HPSM for a position in Alameda County at the end of October 2004, and Vicki Shih assumed his data responsibilities. Michael Murray has tended his resignation as the CEO of the HPSM effective July 1, 2005.

for Medi-Cal and Healthy Families are transmitted by One-e-App. We also witnessed one certified application assistor (CAA) instruct a parent to go directly to a Human Services office because the CAA perceived this to be the most reliable way to obtain Medi-Cal coverage. When Medi-Cal applications are sent to the single point of entry, some time elapses before they are returned to the county for Medi-Cal eligibility determination. The effort to document these problems for Healthy Family and Medi-Cal applications is leading to smoother operations over time.

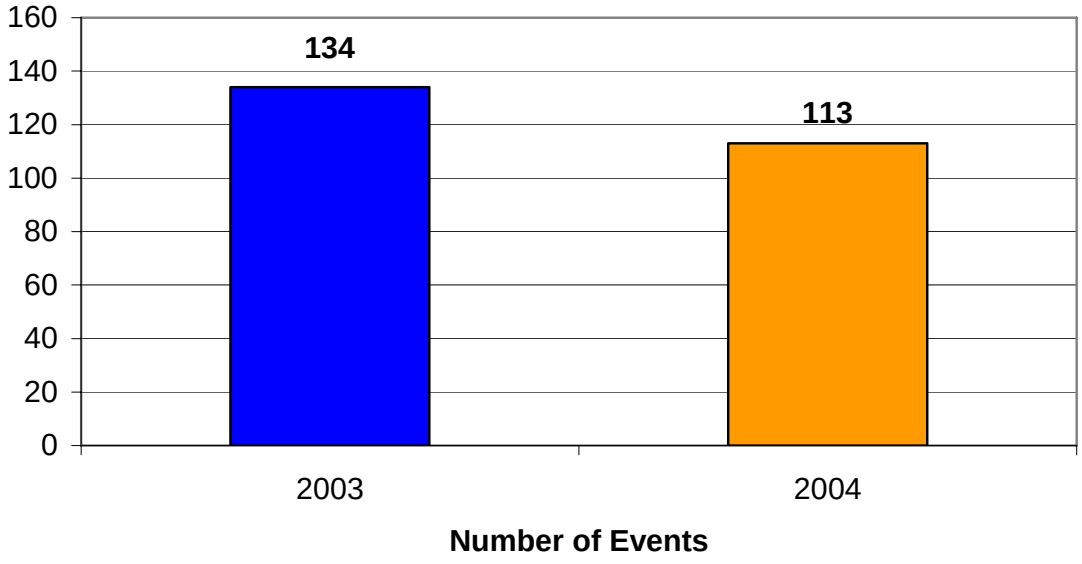
High numbers of terminations from the Healthy Kids program have become a major focus of the CHI coalition. As of March 2005, 2,448 children (of the 7,821 who have ever enrolled) had left Healthy Kids. Reasons for termination are varied: failure to pay the premium (22 percent), child "aged out" (12 percent), family moved out of the county (7 percent), or the child obtained other insurance (4 percent). The largest share of terminations (54 percent) occur at annual enrollment anniversaries and accompanying eligibility redeterminations, and result primarily from a loss of contact with families who have moved away. In response, the CHI Oversight Coalition has adopted a number of strategies to reverse these trends. Specifically, staff members:

- Assist families with the renewal process via telephone using the One-e-App;
- Send address reminder notices on a quarterly basis to increase contact with current members and decrease funder payments for those members who are no longer living in the county;
- Inform families of the availability of "hardship assistance," and include a screen for this in the One-e-App;
- Offer $30 Target gift certificates to families that complete their renewals 30 days before their Healthy Kid members' termination date as an incentive to complete the process early;
- Call families at least 3 times to remind them about the need to renew, including a night/weekend call;
- Hold weekend enrollment events with appointments to assist families with renewal.

Though implementation of these strategies is still new, they appear to hold considerable promise for success. For example, the HPSM has received about 200 change-of-address reply cards from each of the two address change reminder mailings. This effort has produced better tracking of disenrolled members who have moved out of county. Also, after the first batch of incentive information was mailed in December 2004 to the Healthy Kids members soon up for renewal, 177 families renewed early and received the $30 incentive.

Outreach continues as an intensive effort, with 26 full-time enrollment assistors working around the county. Outreach/enrollment events are held regularly throughout the county, although frequency declined from 2003 to 2004 (figure 1). A large number of fixed outreach sites exist, 40 around the county, concentrated primarily near the areas with the largest number of poor children (figure 2).

Figure 1
San Mateo Children's Health Initiative
Outreach Events
2003-2004



Source: CHI outreach data, San Mateo County Health Services Agency.

Figure 2
San Mateo County CHI Outreach Sites
2004

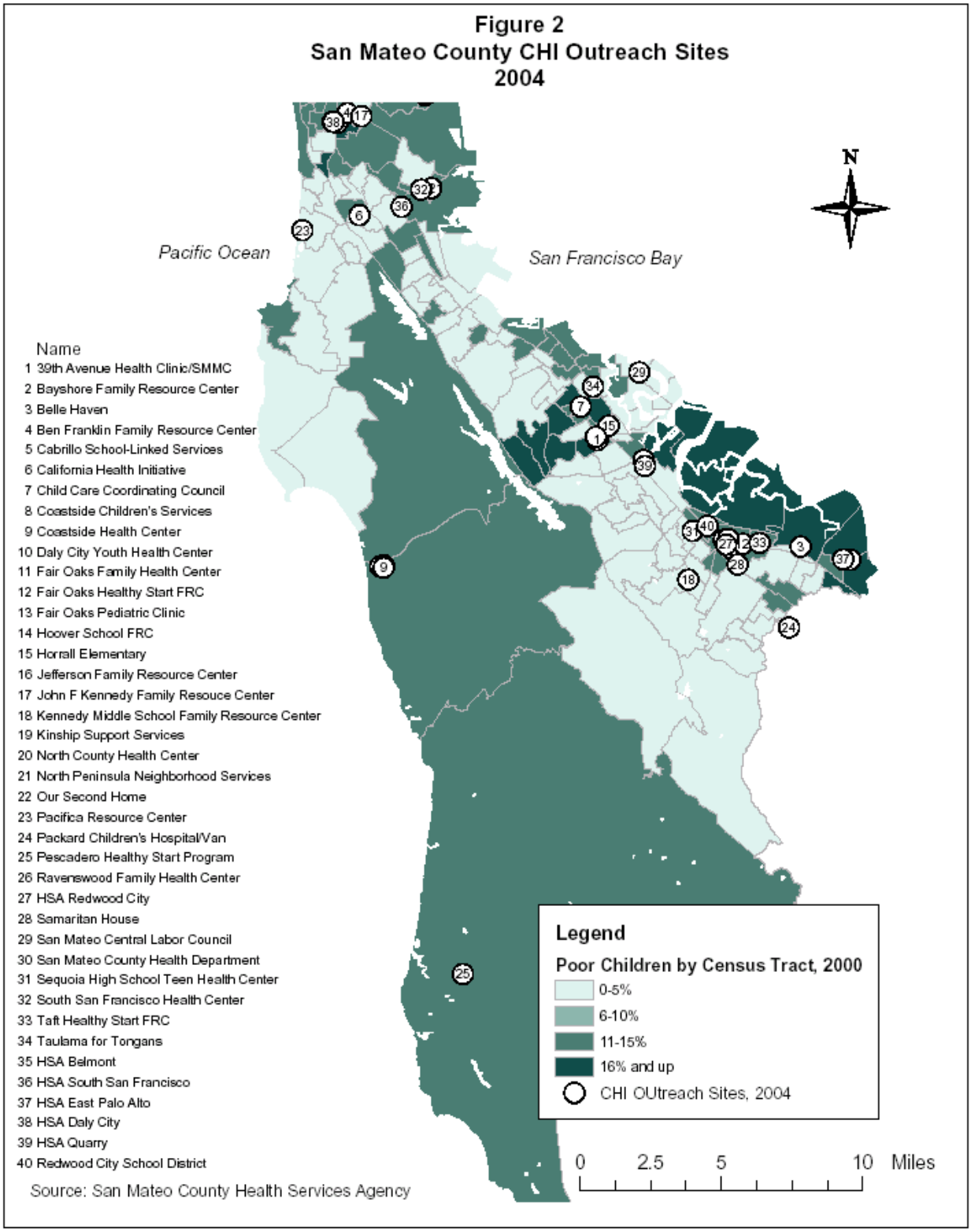
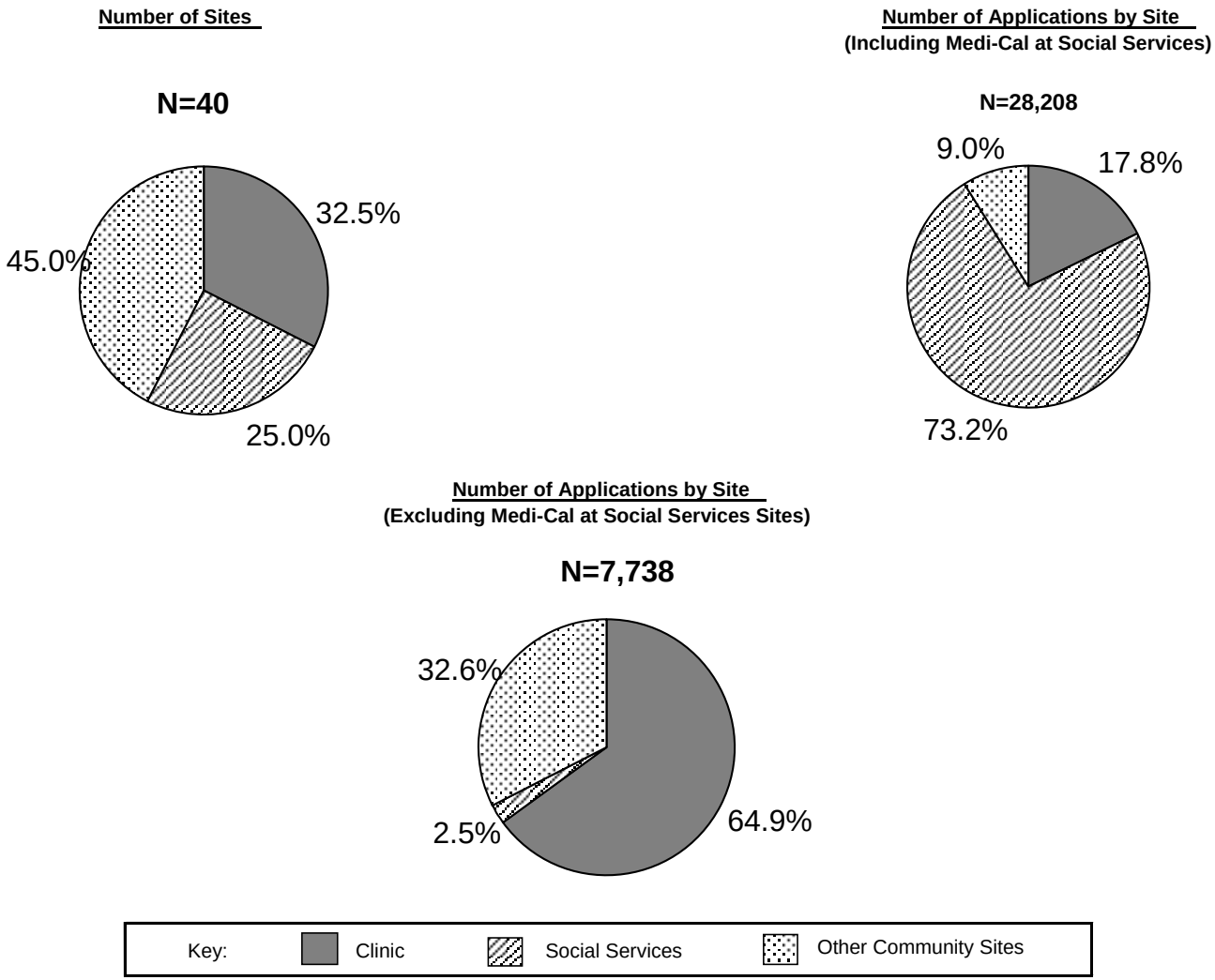


Figure 3 illustrates the number of outreach/application assistance sites by type (clinic, social services, and other community sites) and the number of applications completed at these sites. If Medi-Cal applications completed at Human Services Agency sites are included in the figures, about three-fourths of applications for the three public programs are completed at those sites. It is perhaps a better measure of the CHI activity to exclude the Medi-Cal applications completed at HSA sites, since those activities predated the CHI activities. The picture is quite different when such applications are excluded, as shown in the figure. Using that calculation (the third pie chart in figure 3), a majority of applications are completed in clinics (64.9 percent). In contrast, 32.6 percent of applications in 2004 were completed at other community sites, including schools and community-based organizations (CBOs).

Table 1 shows data from the client survey as to how parents heard about Healthy Kids, where they applied, and how easy they found it to apply. About a third of parents heard about Healthy Kids in health care settings, about a third from other community sites (such as Human Services or schools), and the rest from family or friends, media, or more than one source. About two-thirds said they applied for Healthy Kids at a health care site, with 10.1 percent applying at Human Services offices, 17.3 percent applying at schools, and the remainder applying in other locations (e.g., CBOs). Almost all (93.4 percent) found the application process for Healthy Kids to be either very or somewhat easy.

Enrollment trends for children in the three public health insurance programs during 2003 and 2004 are shown in figure 4, along with trends in Food Stamps enrollment. Food Stamps enrollment climbed steadily, reflecting the county's economic circumstances. Somewhat surprisingly, Medi-Cal enrollment for children did not grow during the period.

Figure 3
Number of Outreach/Enrollment Sites and Volume of Applications, by Type of Site
2004



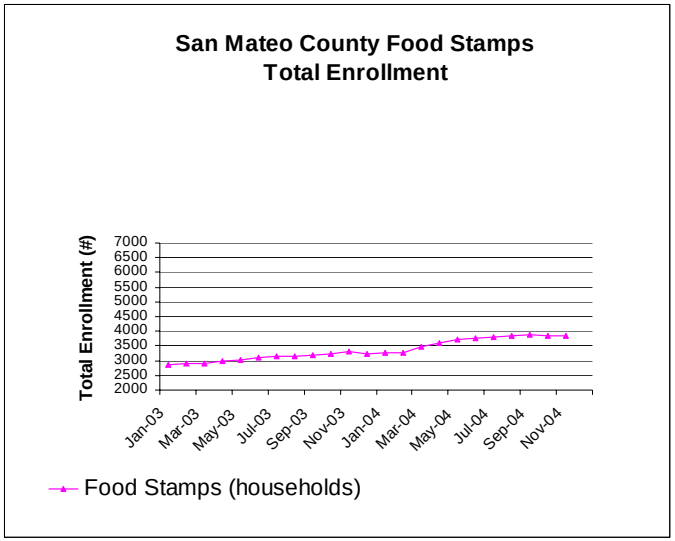
Source: CHI outreach data, San Mateo Health Services Agency and San Mateo Human Services Agency.

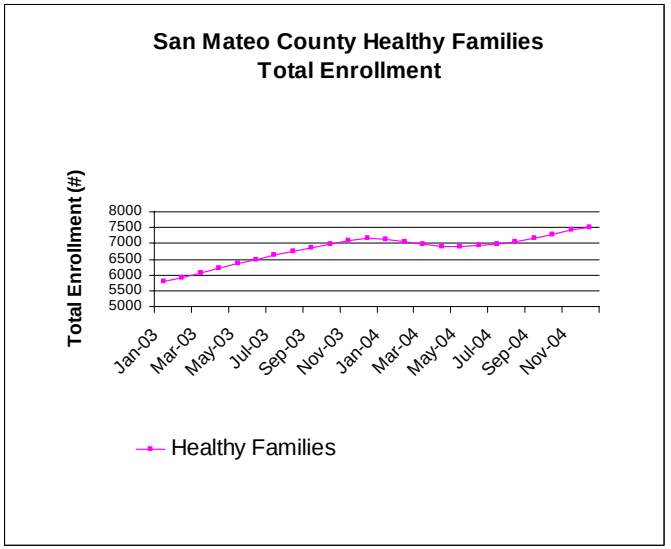
Table 1
Enrollment Process for
Healthy Kids Children
January 2004

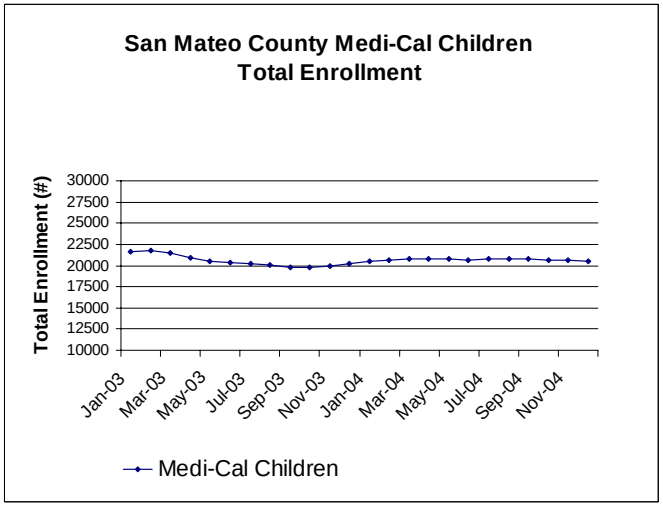
		%
How Parent Heard about Healthy Kids		
Clinic/Hospital/ER		34.0
Media (Radio, TV)		2.3
Family/Friends		19.8
Other (Schools, Human Services)		38.2
More Than One Source		8.7
	Total	**100**
Where Applied?		
Clinic/Hospital/ER		65.5
Human Services		10.1
School		17.3
Other		7.1
	Total	**100**
How Easy to Apply		
Very Easy		43.2
Somewhat Easy		50.2
Difficult		6.6
	Total	**100**

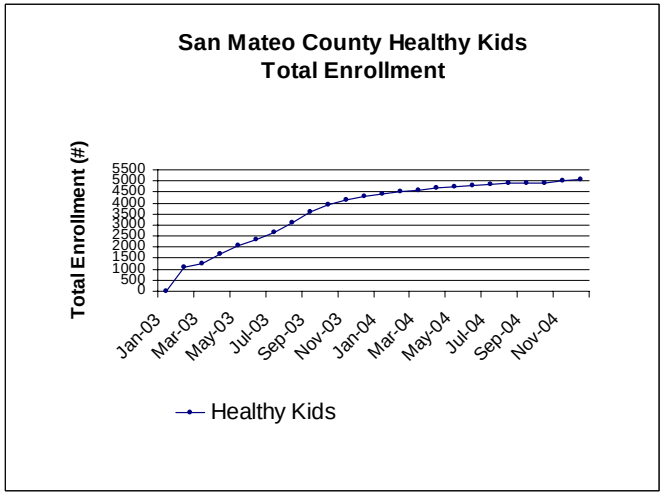
Source: Healthy Kids Client Survey.

Figure 4
Enrollment Trends in Public Programs
2003-2004









Source: Administrative data, Health Plan of San Mateo (Medi-Cal, Health Families, and Healthy Kids enrollment); California Department of Social Services (Food Stamps Enrollment).
Note 1: New contractor assumed responsibility for Healthy Families administration.

Healthy Families enrollment grew steadily, as did Healthy Kids, during 2003, although it leveled off in 2004. It is difficult to clearly discern the reasons for these patterns, since CHI outreach activities continued at a steady level throughout the period. The leveling off for Healthy Kids is likely the result of problems with re-enrollment discussed above. The dip in Healthy Families enrollment is because of problems with the state enrollment vendor during 2004.

Governance. The CHI has maintained the informal, collaborative governance structure that developed early in the initiative. The program is not administered by a formal, nonprofit entity, but rather by a partnership that evolved in the planning phase and has remained stable throughout the initiative's early years. A brief memorandum of understanding was developed and signed by key partners, which serves as a guide.

Two key committees oversee planning and implementation (table 2). As indicated, the dominant partners (about 70 percent of the membership of the key policy committees) represent governmental agencies (most prominently the San Mateo County Health Services Agency and the San Mateo County Human Services Agency, as well as the quasi-governmental county-sponsored managed care plan, the Health Plan of San Mateo). These governmental partnerships have been essential in working through many operational details involved in enrolling and providing health insurance coverage to new children. In particular, the close partnership between county health and social services agencies, which traditionally had been very separate, has been critical to the initiative's success. These somewhat unusual connections evolved in the early stages of the initiative, due to strong leadership guiding the county's health and social services agencies.

Table 2
Membership of Policy Committees

Membership by Type	Oversight Committee*	Policy and Procedures Committee	Total	%
County Government	Number of Members			
San Mateo Health Services Agency	6	4	10	30.3
San Mateo Human Services Agency	3	3	6	18.2
Health Plan of San Mateo	2	4	6	18.2
Subtotal	11	11	21	66.7
Other Funders				
Peninsula Community Foundation	1	0	1	3.0
First 5 Commission	3	0	3	9.1
Subtotal	4	0	4	12.1
Other				
Hospital Consortium of San Mateo County	4	0	4	12.1
Central Labor Council	1	0	1	3.0
Legal Aid Society of San Mateo County	0	2	2	6.1
Subtotal	5	2	7	21.2
Total	**20**	**13**	**33**	**100.0**

* Key decison-making group.

Because the HPSM functions as a "public plan" for the county, it is a quasi-governmental agency with oversight from the San Mateo Health Commission, with members appointed by the county Board of Supervisors.[7] The Commission is legally accountable to the Board for addressing any financial or other problems that may arise.

The remaining membership of key committees comes from a range of private sector stakeholders, including funders (such as the First 5 Commission). The diversity of this nongovernmental membership serves an important purpose in creating a constituency for the CHI among various groups. Still, the three main stakeholders—health services, human services, and the health plan—dominate decision-making.

The key policy and planning committees still meet regularly, although the frequency of meetings has declined as the initiative has matured. In addition, an outreach committee and an evaluation committee meet monthly.

The Healthy Kids Program. Table 3 offers an overview of the Healthy Kids program. The basic components of the program have remained stable since its beginning. The program covers all children age 0 to 18. In order for children to qualify for the program, their family's income may not exceed 400 percent of the federal poverty level (FPL). This means that there is a small "notch group" (higher-income families with income between 250 and 400 percent of the FPL) who do not qualify for other public programs (the upper limit for Healthy Families is 250 percent of the FPL). The upper income threshold was set at 400 percent due to the high cost of living in San Mateo County.

[7] In California, special public plans are set up to operate managed-care arrangements for Medi-Cal enrollees. San Mateo County has the County Organized Health Plan model, in which there is a single plan for Medi-Cal managed care (California Health Care Foundation 2004). Healthy Kids enrollees must enroll in the local plan, the Health Plan of San Mateo.

Table 3
Key Features of the Healthy Kids Program

Health Plan	Health Plan of San Mateo
Age Group	0-18
Income Group	0-400% of Poverty
Waiting Period*	6 months
Benefit Limits:	
Inpatient	None
Outpatient	None
Dental	2 cleanings/year, no orthodontics
Vision	$75 limit on frames, $110 limit on elective contact lenses
Outpatient Mental Health	20 visits/year
Prescripton Drugs	None
Copayments:	
Inpatient	None
Outpatient	None
Dental	None
Vision	$5
Outpatient Mental Health	$5
Prescripton Drugs	$5
	$250 copay limit per family per year, excluding dental
Family Premiums**	
0-150% of poverty	$4/child/month
151-250% of poverty	$6/child/month
251-300% of poverty	$12/child/month
300-400% of poverty	$20/child/month
Premium Subsidy (Excluding Family Contribution)	$89/member/month

Source: Health Plan of San Mateo.

*The waiting period is the time during which parents must not drop a child's private insurance before enrolling in Healthy Kids.
* *Parents are billed for premiums on a quarterly basis, but may pay the first three quarters in advance and receive the fourth quarter free.

Primarily because of concerns about crowd-out from private insurance for higher-income families, the county established a six-month waiting period during which a family can have no private insurance before enrolling in Healthy Kids.

The benefit package offers generous coverage relative to private insurance. It covers dental, vision, and mental health services (although with some limits). There are no limits on inpatient stays, outpatient services, or prescription drugs. Very limited copayments are charged for outpatient services (although none for inpatient or dental services).

The total premium per enrolled child received by the plan is $93.25 per month, which consists of two components—the amount provided from premium subsidies (by far the largest component) and the amount provided by families. This amount is slightly higher than the monthly statewide Medi-Cal capitation rate.[8] The monthly premium does not vary by the age of the child or other factors. The small portion that is paid by families ranges from $4 per child per month for low-income families below 150 percent of the FPL (the majority of families) to $20 per child per month for higher-income families. Families also receive a discount if they pay in advance.[9]

An important feature of the program is that the HPSM is the sole health plan for Healthy Kids. This means that families who enroll are "locked in" to this plan for service provision. The predominant network provider is the county-operated public hospital and clinic system (San Mateo Medical Center). While some private providers participate in this

[8] Fox, Harriette B., Stephanie J. Limb, Margaret A. McManus, and Ruti G. Levtov. 2005. An Analysis of States' Capitation Methods and Pediatric Rates, 1997-2003. The Medicaid Managed Care Trends Project: Issue Brief 6.
Available at http://www.mchpolicy.org/publications/documents/MedicaidEligibilityOptionsFactSheet.pdf (accessed June 16, 2005).

[9] Parents are billed for premiums on a quarterly basis, but may pay the first three quarters in advance and receive the fourth quarter free.

plan, many private providers are reluctant to participate in government programs like this one (because of lower payment rates and other factors). Most private providers have no economic motivation to participate, since there is already a shortage of private doctors in the county (because of the high cost of living for young doctors choosing practice locations). Provider issues will be further discussed later in the report.

Financing the CHI. Developing adequate financing for the CHI has been a constant challenge, since most of the money has been raised locally during difficult economic times. Table 4 shows the sources of financing for the San Mateo County CHI in 2004. As shown, there is a very diverse funding base, both for premium and outreach financing. Two health districts (quasi-governmental entities with special taxing authority) and the county government contributed the greatest shares to the overall $7.175 million budget (27 percent and 24 percent, respectively). The First 5 Commission contributed an additional 13.2 percent from tobacco tax revenues. The remaining two-thirds of the total funding comes from taxpayers.

Premium dollars accounted for about 78 percent of the total CHI expenditures in 2004. The remainder of the overall budget paid for outreach/enrollment activities (including publicity materials and overhead expenses—17.6 percent) and for administration (4.6 percent). The mix of funding sources is similarly as diverse for outreach funding as it is for premiums. The David and Lucile Packard Foundation contributes the highest amount, followed by the First 5 Commission and a collection of smaller private foundations. A group of smaller foundations—including the United Way of the Bay Area, the Kaiser Foundation, and the

Table 4
Financing for the Children's Health Initiative
2004

Source by Type of Expense	$ (1000's)	%
Healthy Kids Premiums:		
County Government*	1,706	23.8
First 5 Commission	945	13.2
Health Districts	1,932	26.9
Foundations:		
California Health Care Foundation	500	7.0
The California Endowment	50	0.7
Peninsula Community Foundation	250	3.5
Other	200	2.8
Subtotal	$5,583	77.8%
Outreach:		
First 5 Commission	206	2.8
Foundations:		
David and Lucile Packard Foundation	545	7.6
Other**	383	5.3
Medi-Cal Administrative Activities	128	1.8
Subtotal	$1,262	17.6%
Administration*:**	$330	4.6%
Grand Total	**$7,175**	**100.0%**

Note: Some data are for fiscal years and some for calendar years. Some data are estimated.
Source: San Mateo County Health Services Agency.

*The County commitment is a $2.7 million dollar match. In 2004 part of this funding was placed in reserve for future use towards premium expenses.

**Includes contributions from the United Way of the Bay Area, the Kaiser Foundation, the Lucile Packard Foundation for Children's Health and the San Mateo Medical Center, and other smaller private foundations.

*** Funded through same foundations as outreach grantors. The cost of the evaluation is excluded from this total.

Lucile Packard Foundation for Children's Health—as well as the San Mateo Medical Center—also fund the CHI for administration.

State Policy Changes and Issues: The state's economic trends mirror those of the county, with continued relatively high unemployment. Consequently, the state has experienced severe budget deficits over the past few years.

At the time of the first annual report, Governor Schwarzenegger proposed severe budget cuts to many health and human services programs, including a cap to Healthy Families enrollment and a 10 percent reduction in Medi-Cal payments to providers. Ultimately, neither of these proposals was enacted—and children's health programs were otherwise protected—though new threats to health programs are incorporated in the governor's current budget. Specifically, the governor recommends reduced funding to counties across the board, which will contribute to counties' already tight budgets, as well as reduced federal matching funds for Medi-Cal and Healthy Families. For example, his proposal would require Medi-Cal beneficiaries with incomes above the federal poverty level to pay a monthly premium in order to maintain their Medi-Cal coverage. On the other hand, the budget—if passed—would reinstate the $50 payment to certified individuals who complete applications on behalf of potential beneficiaries.

Further, "Medi-Cal Redesign" is an ambitious effort to restructure the $30 billion program. These plans were unveiled in January 2005. The plan includes a proposal to shift the processing of Medi-Cal applications from counties to the single point of entry at the state level (MRMIB). Most of the Medi-Cal administrative payments made to counties by the state for processing Medi-Cal applications would revert to the state and presumably finance processing through the private vendor, which could lead to staff reductions at the

Human Services Agency. While some observers are concerned that the current vendor is not prepared to take on a major additional responsibility,[10] others feel that it would bring some needed efficiencies.

Another important part of the Medi-Cal redesign plan has less direct impact on San Mateo County. The financing change would shift responsibility for DSH (disproportionate share hospital) matching funds from the state to counties, and would mandate covering the aged and disabled in county managed-care plans.

AB 495, state legislation passed in 2002, enables counties to use county funds to draw down federal SCHIP/Healthy Families reimbursement for documented children with family incomes between 250 percent of FPL (the Healthy Families income level) and 300 percent of FPL (the federal SCHIP income limit). This legislation stemmed from the fact that California returns federal SCHIP funds because of lower-than-expected enrollment levels. Although the funding allocations are small because the number of children who fall within this narrow income bracket is small, they can help offset some of the shortfall in funding for children age 6 to 19. San Mateo is one of the counties eligible for this funding under the first round of implementation; eventually, all counties that want to participate will be eligible.

Legislation to extend the San Mateo Children's Health Initiative model to every county in California was introduced in mid-February 2005 [AB 772 (Chan/Frommer) and SB 437 (Escutia/Alquist)]. This legislation, "California Healthy Kids," is built in part on the successes of San Mateo and the other early CHI counties. The bill, which has gained widespread support and is gaining unexpected momentum, would establish the California Healthy Kids program as an umbrella for Healthy Families, Medi-Cal, and all remaining

[10] There are many current problems in processing applications for Healthy Families.

uninsured children with family incomes below 300 percent of the FPL. In addition, Healthy Families health plan membership would be available to children with family incomes above 300 percent FPL under California Healthy Kids at full premium costs. The San Mateo CHI wrote a letter to the sponsors of the legislation [the 100% Campaign and the Pacific Institute for Community Organization (PICO) Coalition] in support of the bill, while urging that outreach and enrollment be retained at a local level.

QUESTION 1: WHICH CHILDREN ARE SERVED BY THE CHI, AND WHAT ARE THEIR DEMOGRAPHIC AND HEALTH STATUS CHARACTERISTICS?

To examine the demographic and health characteristics of children in San Mateo County's Healthy Kids program, we used data from both the Health Plan of San Mateo (HPSM) and the client survey. The two data sources are complementary, since the health plan data contain a small amount of information for all Medi-Cal, Healthy Families, and Healthy Kids enrollees in the HPSM, and the survey contains very extensive information for a small group of Healthy Kids enrollees. By combining the two data sources, we provide a more complete picture of publicly insured children in San Mateo County.

Demographic Characteristics. Table 5 shows the age distribution of the 23,256 Medi-Cal, Healthy Families, and Healthy Kids children age 1 to 18 enrolled in HPSM from February 2003 through January 2004 (in the case of Healthy Kids, these are the first years' enrollees), and who remained continuously enrolled for one subsequent year. The table also shows family income and documentation status for Healthy Kids enrollees.

The ages of the children enrolled in the three public programs are quite different. While about 40 percent of Medi-Cal enrollees are very young (age 1 to 5), only 21.6 percent of Healthy Kids and 28.3 percent of Healthy Families children are in that age group. In contrast, the highest proportion of Healthy Families and Healthy Kids enrollees are school aged (6 to 12 years). Healthy Kids enrollees are the most likely to be adolescents (age 13 to 18). The young age profile of Medi-Cal enrollees is the result of several factors, including the fact that all children born in the United States are citizens (and therefore documented and eligible for Medi-Cal rather than Healthy Kids), Medi-Cal eligibility criteria is more generous for young children, and younger parents with very young children generally tend to have lower incomes. In addition,

Table 5
Characteristics of Healthy Kids, Healthy Families, and Medi-Cal Enrollees 2004[1]

Characteristics	Healthy Kids	Healthy Families	Medi-Cal
Total N	4,515	2,212	16,529
Age[2]			
1-5	21.6%	28.3%	41.5%
6-12	44.9	50.7	37.1
13-18	33.4	21.0	21.4
Family Income (Level of Poverty)			
Below 151%	78.3%	NA	NA
151-250%	12.9	NA	NA
251-300%	4.7	NA	NA
301-400%	4.1	NA	NA
Legal Status			
Documented	6.6%	NA	NA
Undocumented	93.4	NA	NA

Source: Administrative data, Health Plan of San Mateo.

Note: NA indicates Not Available.

[1]Health plan data are for children who enrolled in one of the three programs between February 2003 and January 2004 who were continuously enrolled for at least 12 subsequent months. Client survey data are for children enrolled in January 2004.

[2]Children under age 1 were excluded from this analysis because the major purpose of the analysis was to compare Healthy Kids enrollees with other insurance groups, and there are almost no infants in Healthy Kids.

among immigrant children, adolescents are the least likely to have been born in the United States or have the documentation necessary to enroll in Medi-Cal or Healthy Families.

The majority of Healthy Kids enrollees in this sample (78.3 percent) come from families with incomes at or below 150 percent of FPL, and another 12.9 percent have incomes in the 151–250 percent range. These data show that the program is reaching primarily low-income children, all of whom would be financially eligible for other public programs, but lack appropriate documentation. (Fully 93.4 percent of children on the program are undocumented, according to health plan records.) About 9 percent of children have family incomes above 250 percent of FPL, so these children qualify for Healthy Kids based on their higher income.[11]

Healthy Kids children come from primarily monolingual Latino families, most of whom come from Mexico (table 6). Fully 91.6 percent of low-income children are Latino, and their parent took the client survey interview in Spanish. This is also true for 60.2 percent of the parents of higher-income Healthy Kids enrollees. Most Latino parents (81.4 percent) identify their children as Mexican; the remaining children are of diverse Central or South American backgrounds, including Colombian, Brazilian, Guatemalan, Honduran, Nicaraguan, Peruvian, and Salvadoran. While essentially all of the lower-income enrollees were born outside the United States (76.3 percent in Mexico), a substantial portion (about a quarter) of higher-income enrollees were also born abroad. A majority of higher-income children are citizens (79.0 percent), as are at least one of their parents (60.8 percent). Nearly all the lower-income parents were also born abroad, as well

[11] As of January 2004, 4,477 children were enrolled in the low-income group and just 367 children were enrolled in the higher-income group.

Table 6
Age, Ethnicity, Language, and Citizenship
Healthy Kids Enrollees and Parents
2004

	Lower-Income	Higher-Income	Total
Age			
0-5	15.3	28.2	16.5
6-12	47.5	40.8	46.8
13-18	37.3	31.0	36.7
Child's Ethnicity			
Latino, English Interview	2.9 *	14.1	3.9
Latino, Spanish Interview	91.6 *	60.2	88.7
Other	5.5 *	25.8	7.4
For Children Who Are Latino:			
Brazilian	1.4 *	0.0	1.3
Colombian	1.0	6.0	1.4
Guatemalan	3.5	1.4	3.4
Honduran	0.7	1.4	0.7
Mexican	81.6	78.2	81.4
Nicarguan	0.3	2.8	0.5
Peruvian	4.1	4.2	4.1
Salvadoran	6.6	7.4	6.7
Other	0.7	5.6	1.0
More than One	0 *	7.0	0.5
Country of Birth			
US	0.3 *	73.2	7.2
Brazil	2.2 *	0.0	2.0
Canada	0.6	0.0	0.6
China	0.0	1.0	0.1
Colombia	1.0	3.2	1.2
El Salvador	5.8 *	0.0	5.2
Guatamala	2.9 *	0.0	2.6
Hong Kong	0.0	1.0	0.1
Korea	0.6	0.0	0.6
Mexico	76.3 *	10.7	70.1
Nicaragua	0.3	0.0	0.3
Peru	3.8	1.9	3.6
Philippines	2.6	7.1	3.0
Vietnam	0.0	1.0	0.1
Other	3.5	1.0	3.3
Language Spoken at Home			
English	22.1 *	47.3	24.4
Spanish	91.1 *	67.3	88.8
Chinese	0 *	5.8	0.6
Portugese	1.9 *	0.0	1.7
Tagalog/Philipino	2.2 *	11.0	3.1
Other	2.9	4.9	3.1
English and Another Language	20.1	35.3	21.6
Child is a Citizen	2.2 *	79.0	9.6
At Least One Parent is Foreign Born	99.7 *	88.0	98.6
At Least One Parent is a Citizen	7.3 *	60.8	12.4
N	314	97	411

Source: Healthy Kids Client Survey.

* Difference between Low-income and Higher-Income is significant at the .05 level.

as almost 90 percent of parents of higher-income children. Thus, the Healthy Kids program is essentially a program serving immigrant children (either born abroad or whose parents were born abroad).

In addition to being from largely immigrant families, most children in both income groups are Spanish-speakers. Language diversity in the remaining sample reflects the diversity in countries of origin of the other children.

One indication of acculturation is the percentage of children who speak English at home. Among the low-income enrollees, only 22.1 percent speak any English at home (almost always along with another language—20.1 percent of all children). While the higher-income families are also primarily immigrant families, about half (47.3 percent) speak English at home, with 12 percent speaking only English at home (data not shown).

Most Healthy Kids enrollees come from large households, usually with both parents present (table 7). Over three-quarters (77.7 percent) of low-income enrollees and 89.3 percent of higher-income enrollees live in a household with both parents, and a sizable portion of both groups have adult family members in the household who are not parents. Most also have siblings; among low-income enrollees, half (50.4 percent) come from families with three or more children, while among higher-income enrollees, half (50.6 percent) come from two-child families.

Most children do not have a parent who completed high school or a GED program, although the rate of completion is much higher among higher-income parents (73.8 percent vs. only 39.6 percent for lower-income parents). Indeed, 13.1 percent of low-income enrollees do not have a parent who completed 6th grade.

Table 7
Family Composition, Parent Education and Employment, and Length of Time in San Mateo County
Healthy Kids Enrollees
January 2004

	Lower-Income	Higher-Income	Total
Household Composition			
Number of Parents			
1	22.3*	10.7	21.2
2	77.7*	89.3	78.8
Number of Other Adults in Household			
0	51.3	58.9	52.0
1-2	38.4	34.3	38.0
3+	10.3	6.8	9.9
Number of Children in Household			
1	16.5	27.6	17.6
2	33.1*	50.6	34.8
3+	50.4*	21.8	47.7
Highest Education Level of at Least One Parent			
Grades 0-5	13.1	6.8	12.5
Grades 6-11	47.3*	19.5	44.7
High School Degree	39.6*	73.8	42.8
Parents' Employment Status [1]			
Unemployed	7.3	4.9	7.1
Part-Time	31.8*	7.8	9.8
Full-Time	60.9*	87.3	8.5
Length of Time in San Mateo County			
<1 Year	8.3	5.8	8.0
1-3 Years	50.4*	29.8	48.4
4 or More Years	41.4*	64.4	43.6
N	314	97	411

Source: Healthy Kids Client Survey.
* Difference between Low-income and Higher-Income is significant at the .05 level.

[1] If the household has a single parent, the data apply to that parent. If the household has two parents, unemployed means both are unemployed; part-time means at least one works part-time and neither work full-time; full-time means both either or both work full-time.

Almost all Healthy Kids enrollees in the survey sample have a working parent, though many parents do not work full-time. Part-time employment is much more common for the low-income parents (31.8 percent).

Although almost all Healthy Kids enrollees are in immigrant families, more than 90 percent of both income groups have lived in San Mateo County for more than a year. Still, there is a difference in their length of time in the county. Half of the lower-income children have lived in the county from one to three years, while 64.4 percent of higher-income enrollees have lived in the county for four or more years. The higher-income enrollees' longer time in the county, and consequently in the United States, is probably a major reason for their higher income, higher education, better employment status, and better language proficiency.

Health Status. As with most children, most Healthy Kids enrollees are in excellent, very good, or good health (table 8), as reported by their parents in response to survey questions. Still, many children have substantial health problems. More than 20 percent are in fair or poor health, and 11.4 percent have some limitation in their normal activities because of health problems. In contrast, for all children nationally in 2003, only 2 to 5 percent of children were in fair or poor health, and only about 6 percent had activity limitations.[12] The rates for health problems among Healthy Kids enrollees are also high when compared with poor Hispanic children nationally.[13] The parents of about 30 percent of children are concerned about at least one physical condition that their child has; this percentage is constant across the three age groups shown in the table (0–5, 6–12, and 13–18 years). However, the prevalence of some health problems increases with age. For

[12] Summary Health Statistics for the U.S. Population: National Health Interview, 2003. CDC/NCHS.
[13] Feingold, Kenneth, and Laura Wherry. 2004. Snapshots of America's Families: Race, Ethnicity, and Health. Available at http://www.urban.org/UploadedPDF/310969_snapshots3_no20.pdf (accessed February 18, 2005).

example, almost four times as many adolescents have activity limitations when compared with the youngest children.

Table 8
Health Status
Healthy Kids Enrollees
January 2004

	Age of Child			
	0-5	**6-12**	**13-18**	**Total**
Health Status				
Excellent	18.9	23.6	20.2	21.6
Very Good	23.0	16.1	17.8	17.9
Good	44.1	39.8	35.7	39.0
Fair	14.1	18.1	25.5	20.1
Poor	0 *	2.5	0.8	1.4
Limitation in Normal Activities	4.7	10.2	16.0	11.4
Physical Problem Limits Ability Attend School Regularly (Age 5+)	1.7	1.2	2.9	1.9
Parent is Concerned About Some Physical Health Condition	30.7	30.6	30.3	30.5
Physical Condition Causing Concern				
Asthma	10.9	12.4	9.1	11.0
Diabetes	0.0	0.6	0.0	0.3
Hearing Problem	1.7	1.4	0.0	1.0
Allergies/Sinus Problems	0 *	4.1	1.8	2.6
Breathing/ Chest Problems	1.1	0.8	1.9	1.3
Overweight	0.0	2.1	0.8	1.2
Headaches	1.7	3.3	4.2	3.4
Foot/Leg Pains or Problems	5.3	1.2	3.1	2.6
Stomach/Gastrointestinal Problems/Weight Loss	0 *	2.9	2.4	2.2
Other	7.5	8.7	7.8	8.2
Vision Problem (Age 3+)	2.4	8.9	11.3	9.0
Dental Problem (Age 3+)	31.0	38.5	23.0 *	31.6
Emotional/Behavioral Problems				
Often Can't Pay Attention for Long	13.6	14.6	9.0 *	12.4
Often Has Trouble Getting to Sleep	5.3	4.7	7.6	5.9
Often Unhappy, Sad, or Depressed	5.2	5.1	7.3 *	5.9
Often Doesn't Get Along with Other Kids	2.3	5.7	5.8	5.2
Any of the Above	22.5	19.4	20.7	20.4
Above Condition(s) Limits or Prevents Child from Doing School Work (For those with problems) (Age 5+)	43.1	37.3	41.1	39.2
School Days Missed Due to Illness in Past Month (Age 5+)				
None	60.5	58.9	59.1	59.1
1-2	29.3	29.1	31.3	30.0
3-4	8.5	9.6	7.8	8.8
5-10	1.7	1.8	1.8	1.8
10+	0.0	0.6	0.0	0.3
N	76	191	144	411

Source: Healthy Kids Client Survey.

* Significantly different from age 6-12 at the .05 level.

Parents named asthma and headaches as the most prevalent health problems their children experienced. Vision and dental problems were also common among Healthy Kids enrollees. Parents of about 10 percent of children reported a vision problem and about a third reported an untreated dental problem. These numbers underscore the importance of the access to dental and vision services provided by the Healthy Kids program. While vision problems increase with age, dental problems are most prevalent among children age 6 to 12.

Health problems can affect school attendance and performance. While only 1.9 percent of parents reported that their child had a physical health problem that limited the child's ability to attend school regularly, about 40 percent of parents reported that their child missed at least one day of school in the past month because of health, and slightly more than 10 percent reported at least three missed days.

Emotional and behavioral problems can also lead to academic and social difficulties. Table 8 shows that about 20 percent of children in all three age groups often have one or more emotional/behavioral problems, consistent with national patterns. About 12 percent of parents reported that their child often can't concentrate or pay attention for very long; 5.9 percent reported that their child often has trouble getting to sleep; 5.9 percent reported that their child has often been unhappy, sad, or depressed; and 5.2 percent reported that their child often doesn't get along with other kids. There were differences in age groups according to the type of problem. The prevalence of attention difficulties ("often can't pay attention for long") was more common among young and school-age children, while depression was more common among adolescents. Among children with an emotional/behavioral problem, 39.2 percent of parents whose children were age 5 or over reported that the condition limits or prevents the child from doing schoolwork.

Nationally, the proportion of children who are overweight is increasing, causing increasing rates of diabetes and other health problems.[14] The Healthy Kids client survey asked parents about the height and weight of their children. Due to underreporting of these data, and some very high values for weight, we trimmed the data and include heights only for adolescents.[15]

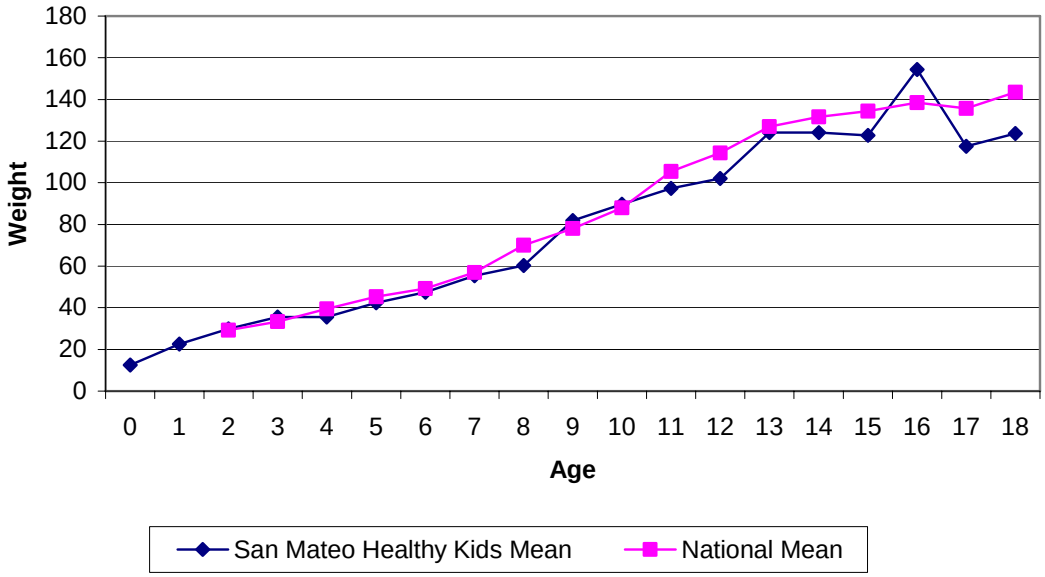
The average weights of Healthy Kids enrollees in San Mateo County are very similar to those of children of the same age and sex nationally (figures 5 and 6). However, Healthy Kids adolescents are, on average, one to three inches shorter than children nationally (figure 7). In spite of this height difference, body mass indices of Healthy Kids adolescents do not differ significantly from those of adolescents nationally (figure 8). So, while Healthy Kids enrollees may face similar health risks to children nationally from obesity, it does not appear from these data that they face significantly higher risks.

Table 9 presents selected diagnoses of Medi-Cal, Healthy Families, and Healthy Kids enrollees continuously enrolled in the Health Plan of San Mateo for one year. Diagnoses are those reported in claims/encounter data. The diagnostic profile of the three programs is similar for most measures with important exceptions. Asthma and otitis media are more prevalent for Medi-Cal and Healthy Families, and tuberculosis is much more prevalent for Healthy Kids. Fully 5.7 percent of Healthy Kids enrollees have been treated for possible tuberculosis and, for 3.0 percent, it is their most expensive diagnosis.

[14] Ogden, Cynthia L., Cheryl D. Fryar, Margaret D. Carroll, and Katherine M. Flegal. 2004. "Mean Body Weight, Height, and Body Mass Index, United States 1960–2002." Advance Data No. 347. Centers for Disease Control and Prevention.

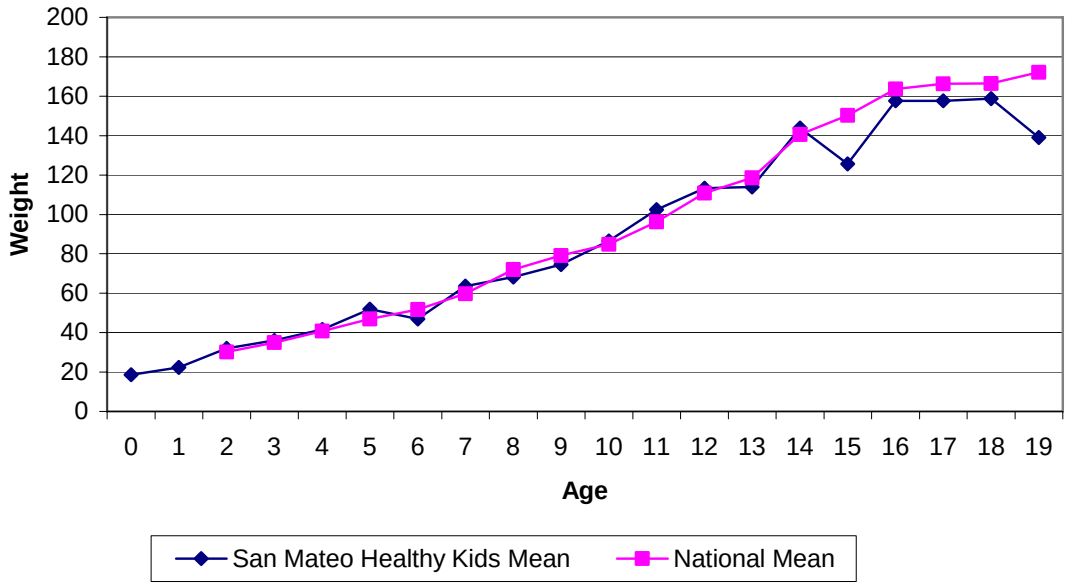
[15] While item response was good for most of the client survey, a high proportion of parents of younger children did not know their child's height (55 percent). Item non-response for height for children age 13 and up was lower, 21 percent, so their height and body mass index (BMI) data are presented. We eliminated heights and weights that were greater than three standard deviations above the national mean for the child's age and gender.

Figure 5
Average Girls' Weights by Age
2004



Source: Healthy Kids Client Survey (2004) and NHANES for national data (2002).

Figure 6
Average Boys' Weights by Age
2004



Source: Healthy Kids Client Survey (2004) and NHANES for national data (2002).

Figure 7
Average Height of Adolescents
2004

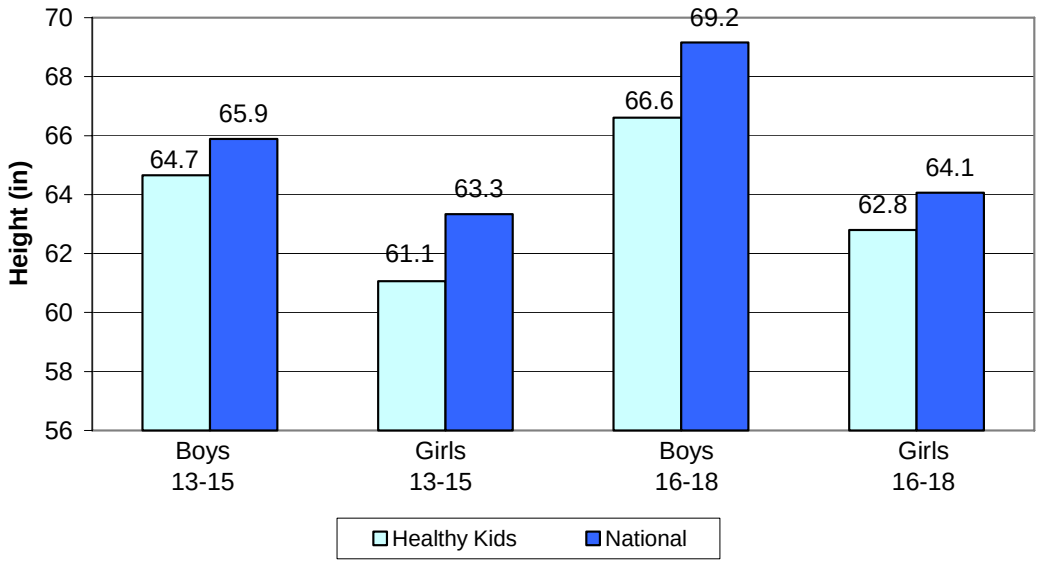
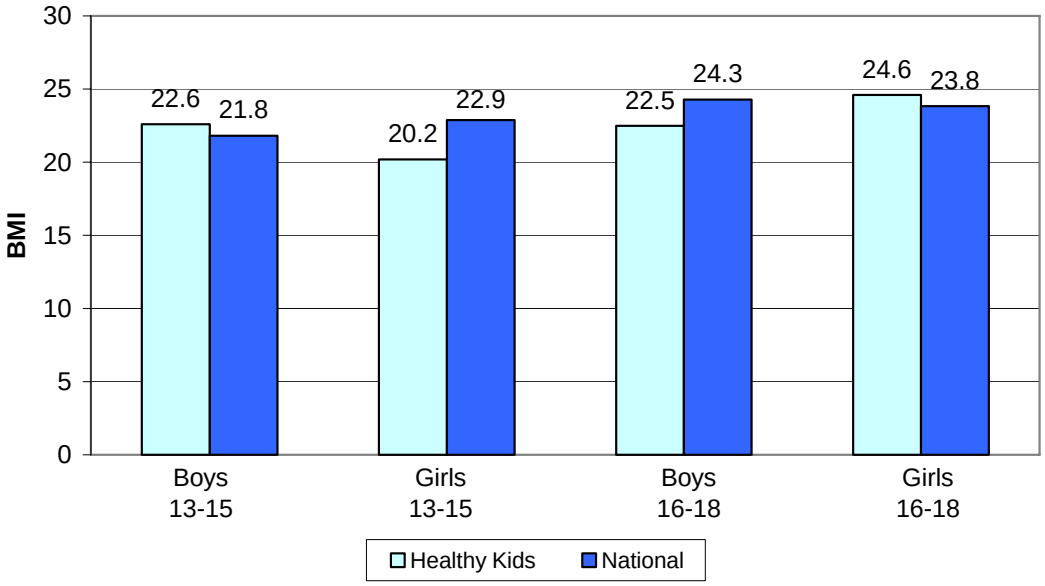


Figure 8
Average Body Mass Index (BMI) of Adolescents
2004



Sources: Healthy Kids Client Survey (2004) and 2002 NHANES for national data.

Table 9
Prevalence of Selected Diagnoses and Most Expensive Diagnoses for Children Enrolled in the Health Plan of San Mateo 2004[1]

	Insurance Program					
	Healthy Kids	Healthy Families	Medi-Cal	Healthy Kids	Healthy Families	Medi-Cal
Diagnosis	% With Selected Diagnosis[2]			% Most Expensive Diagnosis		
Asthma	4.2	6.6	8.2	1.7	2.2	2.2
Diabetes	0.2	0.2	0.2	0.0	0.1	0.1
Fractures	1.4	2.0	2.4	0.8	1.2	1.4
Mental Disorders	2.5	2.7	2.7	1.1	1.2	0.8
Otitis Media	5.1	9.2	19.0	1.5	2.0	3.3
Pneumonia/Influenza	0.9	1.7	3.3	0.3	0.8	0.7
Poisoning	0.2	0.5	8.6	0.0	0.0	1.0
Tuberculosis	5.7	1.1	0.7	3.0	0.5	0.4
N	4,515	2,212	16,529	4,515	2,212	16,529

Source: Health Plan of San Mateo.

[1]Health plan data reflect children who enrolled in Healthy Kids, Healthy Families, and Medi-Cal between February 2003 and January 2004 who have been continuously enrolled for at least 12 months.

[2]Children may be counted under more than one diagnosis category if more than one diagnosis was reported in the encounter data.

QUESTION 2: WHAT WAS THE CHILDREN'S HEALTH INSURANCE COVERAGE BEFORE ENROLLING IN HEALTHY KIDS, AND WHAT ACCESS DO ENROLLEES HAVE TO EMPLOYER-SPONSORED COVERAGE?

Healthy Kids is designed to provide coverage to undocumented children whose family incomes are below 250 percent of the federal poverty level and to children whose family incomes are between 250 and 400 percent of the federal poverty level. The San Mateo expansion is unique among other California CHIs in that it covers children in families whose incomes are between 300 and 400 percent of the federal poverty level. A key issue for the county is the extent to which this new program is substituting for other coverage that children would have in the absence of the program ("crowd-out"). This is the first assessment of the extent to which the new county-based initiatives in California may be substituting for other sources of coverage.

The analysis relies on responses in the client survey from parents about their child's previous insurance coverage experience, as well as their own experience. Separate analyses are presented for children whose family incomes are below 250 percent of the federal poverty level (the low-income group) and for children whose family incomes are between 250 and 400 percent of the federal poverty level (the high-income group). Enrollees in these two groups are expected to have very different access to employer-sponsored insurance (ESI) and prior coverage patterns given that ESI coverage rates vary with income and citizenship status.[16,17,18,19]

[16] Lessard, Gabrielle, and Leighton Ku. 2003. "Gaps in Coverage for Children in Immigrant Families." *The Future of Children*, 13(1): 101-115.
[17] Ku, Leighton, and Timothy Waidmann. 2003. "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care among the Low-Income Population." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
[18] Brown, E. Richard, Ninez Ponce, Thomas Rice, and Shana Alex Lavarreda. 2002. "The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey." Los Angeles, CA: UCLA Center for Health Policy Research.

The Healthy Kids program requires that children seeking coverage wait a period of six months with no employer-sponsored coverage before enrolling (i.e., there is a six-month waiting period for coverage).[20] Families are also required to pay premiums at all income levels, and higher premiums are required at higher income levels. For example, families whose incomes are between 301 and 400 percent of the FPL are required to pay $20 per child per month. There is no maximum placed on the premiums that a given family has to pay. These premiums are higher than those charged by the Healthy Families program (which are between $6 and $9 per child per month for children whose family incomes are between 150 and 250 percent of the federal poverty level, with a per-family maximum of between $18 and $27 per month). Families can obtain assistance paying their Healthy Kids premiums in San Mateo, but until recently the availability of such assistance had not been widely advertised.

The survey included questions about the child's health insurance coverage status just before and during the six months before enrolling in the Healthy Kids program. Respondents were asked the specific type of coverage a child had in the prior period, including whether they had Medi-Cal (full-scale or emergency), Healthy Families, or Healthy Kids coverage: employer-sponsored coverage; private nongroup coverage; or some other type of coverage specified by the respondent. The only coverage category that was specified by a large enough group of respondents to comprise another category was

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[19] Kenney, Genevieve, Jamie Rubenstein, Anna Sommers, Stephen Zuckerman, Myoung Kim, and Frederic Blavin. "Experiences of Medicaid and SCHIP Enrollees in Two States" in Kenney, Genevieve, Christopher Trenholm, Lisa Dubay, Myoung Kim, Lorenzo Moreno, Jamie Rubenstein, Anna Sommers, and Stephen Zuckerman. "The Experience of SCHIP Enrollees and Disenrollees in Ten States: Findings from the Congressionally Mandated SCHIP Evaluation." Draft Report. Mathematica Policy Research, Inc. and the Urban Institute, April 2004.

[20] In observations of screening interviews during site visits, during which application assistors ask questions about prior coverage, it did not appear that the six-month waiting period is always rigorously enforced, and there is no routine checking of insurance coverage data sources to assure compliance.

the WELL Program.[21] Respondents were also asked if they or their spouse had health insurance coverage, whether they or their spouse had an employer that offered health insurance coverage to dependents, and whether they could enroll their child. For those whose employers offered dependent coverage, information was obtained on what share (none, some, or all) of the premium for dependent coverage is paid by the employer. These questions are used to assess the enrollees' access to and the affordability of employer-sponsored insurance coverage.

The possible substitution of Healthy Kids coverage for employer-sponsored insurance is assessed using a methodology adapted from Sommers and others, an approach that was used to study substitution in a number of SCHIP and Medicaid programs as part of a congressionally mandated study. The extent to which families appear to be dropping employer-sponsored coverage in order to enroll their child in the program is assessed by looking at the coverage status of the child directly before and in the six months before enrolling in the program. The extent to which Healthy Kids enrollees may be foregoing employer-sponsored coverage is assessed using the information on (1) the parent's take-up of employer-sponsored coverage and (2) the extent to which the employer offered dependent coverage and contributed something toward the premium. Families are classified as foregoing employer-sponsored insurance if one of the parents is enrolled in an employer plan that could cover dependents and at least some of the premium for dependent coverage is paid by the employer.

[21] The WELL program, which stands for Wellness, Education, Linkage, Low-cost, is a program that uninsured residents of San Mateo County can enroll in order to receive reduced-cost medical services at San Mateo Medical Center. Certain eligibility criteria apply.

Table 10 shows the age and health status of Healthy Kids enrollees by income. The higher-income children tend to be younger and in better health. Also, as shown earlier (tables 6 and 7), they are more likely to be non-Hispanic and they have lived in San Mateo county for longer periods of time. Children in the higher-income group have parents with more education and are more likely to have working parents compared with the children in the lower-income group.

Table 10
Selected Characteristics of Healthy Kids Enrollees by Income
January 2004

	All	Lower-Income	Higher-Income
Age			
0-5	16.5	15.3	28.2 *
6-12	46.8	47.5	40.8
13-18	36.7	37.3	31.0
Health is Fair or Poor			
Yes	21.5	22.6	10.9 *
No	78.5	77.4	89.1 *
N	411	314	97

Source: Healthy Kids Client Survey.

* Significantly different from lower income at the .05 level.

Overall, it appears that very few parents were dropping employer coverage in order to enroll their children in the Healthy Kids program. Table 11 shows the coverage status of children just before enrolling in the Healthy Kids program. More than half (56.6 percent) of the children had been uninsured and almost all of these (94 percent) had been uninsured for at least six months (see appendix A). About a third had some type of limited public coverage (22.4 percent participated in Emergency Medi-Cal, and 6.7 percent reported coverage through the WELL Program). Thus, altogether, about 87 percent of Healthy Kids

enrollees were either uninsured prior to enrolling or had some type of restricted public coverage. Only 6.7 percent of the enrollees were reported to have had coverage through an employer just before enrolling, some of whom may not have dropped this coverage voluntarily.

Table 11
Coverage Status of Children Just Before Enrolling in the Healthy Kids Program
January 2004

	All Enrollees	Lower-Income	Higher-Income
Uninsured	56.6	58.1	41.4 *
Private Coverage			
ESI	6.7	4.8	24.6 *
Private Non-group	2.4	1.6	9.7
Public Coverage			
Emergency Medi-Cal	22.4	24.4	2.9 *
Medi-Cal	2.9	2.3	8.8 *
Healthy Families	1.1	0.0	11.6 *
Healthy Kids	0.6	0.6	0.0
Well Program	7.5	8.0	2.9 *
Other	3.9	3.9	3.9
Total	**104.0**	**104.0**	**106.0**

Source: Healthy Kids Client Survey.
*Difference between low-income and higher-income is significant at the .05 leve

As expected, coverage patterns differ dramatically for the two income groups. Children in the higher-income category were much less likely than those in the lower-income group to have been uninsured before enrolling (41.4 vs. 58.1 percent) and to have been enrolled in Emergency Medi-Cal (2.9 vs. 24.4 percent). These higher-income children were also more likely to have had employer coverage (24.6 vs. 4.8 percent) or participated in regular Medi-Cal (8.8 vs. 2.3 percent) or Healthy Families (11.6 vs. 0.0 percent),

compared with children in the lower-income category. So, even for these higher-income children, the risk of uninsurance (loss of coverage by Medi-Cal or Healthy Families) is very high.

Table 12 provides further evidence that access to employer coverage is very limited for all income groups. Overall, while about one in five Healthy Kids enrollees' parents have an employer who offers dependent coverage (36.3 percent for higher-income enrollees), employers contribute toward premium costs for only 13.4 percent of enrollees (19.4 percent for higher-income enrollees). These proportions diminish considerably when you consider whether the parents themselves "takes up" coverage, suggesting that they can afford it. Only 6.3 percent of enrollees (14.3 percent of higher- income enrollees) have parents with an offer of dependent coverage, employers that contribute toward the premium, and a parent that has taken up the offer of employer-sponsored coverage for him/herself. Thus, it appears that very few Healthy Kids enrollees are foregoing affordable employer-sponsored coverage.

Table 12
Access to Employer-Sponsored Coverage among Healthy Kids Enrollees
January 2004

	All Enrollees	Low-Income	Higher-Income
Dependent Coverage Through Employer	20.2	18.4	36.3*
Dependent Coverage Offer, Employer	13.4	12.8	19.4
Dependent Coverage Offer, and At Least One Parent Has Employer Coverage	10.3	8.6	26.1*
Dependent Coverage Offer, Employer Pays Some or All of the Premium, and At Least One Parent Has Employer Coverage	6.3	5.4	14.3*

Source: Healthy Kids Client Survey.

*Difference between low-income and higher-income is significant at the .05 level.

This analysis suggests that very few of the children enrolled in San Mateo's Healthy Kids program have other affordable options for insurance coverage. Past research on undocumented and noncitizen children more broadly suggests that they have very low rates of employer-sponsored coverage and that many of their parents work in jobs that do not include benefits, such as employer-sponsored insurance coverage.[22,23,24] The low access to employer-sponsored coverage among the children in the higher-income group is more surprising. Rates of employer-sponsored insurance are about 82 percent nationwide for children whose family incomes are between 250 percent and 400 percent of the federal poverty level.[25]

One of the more striking findings from this analysis was that almost one-quarter of the Healthy Kids enrollees previously had Emergency Medi-Cal coverage. More analysis is needed to understand how Emergency Medi-Cal coverage and Healthy Kids enrollment are related. It is possible that an acute incident triggers enrollment in Emergency Medi-Cal, which subsequently leads to enrollment in the Healthy Kids program. Alternatively, the Healthy Kids program may now be covering services that previously would have been financed under Emergency Medi-Cal. To the extent that this is happening, fewer state and federal dollars are supporting services for undocumented children in the county. Should the county face resource constraints in the Healthy Kids program in the future, determining

[22]Ku, Leighton, and Timothy Waidmann. 2003. "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care among the Low-Income Population." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
[23] Lessard, Gabrielle, and Leighton Ku. 2003. "Gaps in Coverage for Children in Immigrant Families." *The Future of Children*, 13(1): 101-115.
[24] Brown, E. Richard, Ninez Ponce, Thomas Rice, and Shana Alex Lavarreda. 2002. "The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey." Los Angeles, CA: UCLA Center for Health Policy Research.
[25] Urban Institute Tabulations of the 2004 Current Population Survey.

how to tap into these federal and state resources could allow the program to serve more children.

Survey findings that most Healthy Kids enrollees do not have access to affordable health insurance was confirmed by information obtained in focus groups of parents. With very few exceptions, the parents attending these focus groups were uninsured themselves, and before enrolling in Healthy Kids, their children were either uninsured or covered only by Emergency Medi-Cal. Only six participants (and notably, only one from the focus group of higher-income group parents) said they currently had health insurance themselves. Some parents mentioned that they previously had insurance in their county of origin.[26] One parent of an established enrollee, though uninsured herself, said her husband had private insurance through his employer. Other than one parent whose infant was covered by Kaiser, all of these insured parents said that their insurance did not cover their children

Further analysis of the issue of prior coverage and crowd-out will be conducted in future years of the evaluation using such additional data sources as a countywide, population-based survey and focus groups of employers. In addition, another survey wave of Healthy Kids enrollees will be conducted in 2006. This will allow for a reassessment of these issues at a point when the Healthy Kids program is more mature.

[26] Parents specifically mentioned Costa Rica, Guatemala, Mexico, and Peru as countries where they had health insurance in the past.

QUESTION 3: HOW WELL ARE HEALTHY KIDS ENROLLEES ABLE TO ACCESS HEALTH SERVICES?

Once enrolled in Healthy Kids, children's access to health care appears to be generally good, especially for medical care. In the Healthy Kids client survey, parents were asked: "Do you have a particular place that your child usually goes if he/she is sick or you need advice about his/her health?" An affirmative response to this question indicated that the child had a "usual source of care," which is one generally accepted measure of adequate access to care. Parents were also asked whether they had a usual source of dental or vision care for their children.

Most children enrolled in Healthy Kids had a usual source of medical care (88.1 percent, see table 13). An additional 4.5 percent reported that they had a usual source of care—the emergency room.

Fewer (72.3 percent) reported a usual source of dental care, which reflects poorer access to this critical service. While fewer had a usual source of vision care (46.2 percent), many children probably received vision-screening services in other settings.

We investigated the lack of a dental usual source of care further, and asked parents if there had been a time when their child needed to see a dentist but did not; about 12 percent said yes. However, when asked why, only 3 parents responded that the unmet need for dental care was because the cost of care. Apparently, provider availability, rather than cost, may be the major problem for those having dental access problems. (See the discussion below of dental provider issues that emerged from parent focus groups and interviews with individual dentists.)

Lower-income or otherwise more disadvantaged children do not have significantly more access problems than others in the Healthy Kids program (table 13). For example, children whose parents took the survey in Spanish were more likely to have a usual source of care than those whose parents took it in English.

Table 13
Usual Source of Care
Healthy Kids Enrollees
January 2004

	Percent with Usual Source of Care		
Demographic Characteristics	**Medical Care**	**Dental Care***	**Vision Care***
Age			
0-5	89.6	62.0	44.9
6-12	91.2	74.5	48.7
13-18	83.6	72.2	43.4
Income:			
< 250% FPL	87.9	71.9	46.0
>250% FPL	90.0	76.4	48.4
Interview Language:			
Spanish	88.9	73.0	46.3
English	80.7	64.7	45.2
Length of Time in San Mateo County			
<1 Year	81.3	55.0	32.7
1-3 Years	84.5	69.4	43.1
4+ Years	93.2	77.6	51.2
Total, All Children	88.1%[1]	72.3%	46.2%

Source: Health Kids Client Survey.

*Usual source of both dental and vision care includes only children age four and older.
[1]An additional 4.5% reported the emergency room as a usual source of care.

When asked to name their usual sources of medical care, parents named a variety of places (table 14). The most common sources were Fair Oaks Family Health Center (21.6 percent) and the Willow Clinic (15.4 percent).

Table 14
Places Serving as Usual Source of Care
Healthy Kids Enrollees
January 2004

	%
Place	
Coastside Family Medical Center	4.8
Fair Oaks Family Health Center	21.6
Foster City Pediatric Medical Group, Inc.	0.7
Lucile Packard Pediatric Clinic	2.2
Lucile Salter Packard Children's Hospital	3.0
PediaHealth Medical Group, Inc.	3.4
North County Health Center	14.1
Ravenswood Family Health Center	7.5
San Mateo Medical Center	7.1
South San Francisco Health Center	4.8
Stanford Family Practice	2.4
39th Avenue Health Clinic	7.1
Willow Clinic	15.4
Other	5.9
Total	100%

Source: Healthy Kids Client Survey.

Parents were asked a series of questions about how they liked their usual source of care (table 15). As shown, 40.8 to 77.2 percent of parents—depending on the measure—responded positively about various aspects of their usual source of care. At the lower end, only 40.8 percent could reach the doctor when the usual source of care was closed. While these parents have access to emergency room services for a crisis, this low proportion

reflects a problem in primary care access for a substantial number of children. At the other end, 77.1 percent responded that their doctor treated them with courtesy. Since most of the other measures fell between these extremes, we are left with a "cup half empty/half full" impression of satisfaction with usual sources of care. For example, about half the parents (50.2 percent) said "the doctor always explains things well," but conversely about half reported that their doctor did not. There is substantial room for improvement, based on these parents' impressions.

Table 15
Positive Impressions of the Usual Source of Medical Care
Healthy Kids
January 2004

Characteristic of Usual Source	%
Close By (less than 15 minutes)	49.4
Can Reach Doctor When Closed	40.8
Has Regular Doctor at Place	42.1
Doctors Always Explain Things Well	50.2
Doctors Always Speak My Language	51.2
Doctors Always Treat Me With Courtesy	77.2
Very Satisfied With Amount of Time Spent With Doctor	44.9
Would Recommend to Family/Friend	55.1

Source: Healthy Kids Client Survey.

Table 16 shows a broader view of general parental satisfaction with access to care under Healthy Kids. Parents were asked about their confidence in being able to access care for their children. As shown, more than two-thirds of parents were very confident about getting care for their children, very satisfied with their ability to get care, and had little or no financial difficulty getting care. There was substantial uniformity across various demographic subgroups in these measures.

Table 16
Satisfaction with and Confidence in Access to Health Care
January 2004

	Very Confident Getting Care	Very Satisfied With Care	Little or No Financial Difficulties Getting Care
Age	%	%	%
0-5	67.3	71.2	79.1
6-12	70.9	71.3	71.2
13-18	67.4	66.5	67.2
Gender			
M	72.0	69.9	73.2
F	65.9	69.2	68.8
Income (% of Poverty)			
≤250	69.8	69.7	70.1
>250	62.1	68.5	79.9
Interview Language			
Spanish	69.6	71.2	70.4
English	63.6	52.7	78.0
Length of Time in San Mateo County			
<1 year	81.7	77.5	69.7
1-3 years	70.8	70.4	72.3
4 years or more	65.0	67.2	70.0
Citizenship			
USA	61.2	68.6	82.1
Other	69.6	69.7	69.6
Number of Parents at Home			
One	67.9	74.2	60.4
Two	69.3	68.3	73.9
Highest Education of Either Parent			
<5	75.4	71.5	58.9
6-11	67.2	72.5	71.1
12+	69.6	65.5	75.0
At Least One Parent Foreign Born			
Yes	69.0	69.6	70.6
No	70.1	63.2	100.0
Total	69.0	69.6	71.1

Source: Healthy Kids Client Survey.

Another measure of access to care is unmet need. Parents were asked whether, while their child was enrolled in Healthy Kids, there was ever a time when their child needed to have a particular type of care, but did not receive it. Table 17 shows that very few parents reported an unmet need. The largest rate of unmet need was for dental care (11.4 percent).

Table 17
Unmet Need While on Healthy Kids
Healthy Kids Enrollees
January 2004

	%
Child Needed to Have Service, but Did Not	
Preventive Care	8.1
Specialist Care	6.3
Doctor	1.8
Dentist	11.4
Prescription Drug	0.9

Source: Healthy Kids Client Survey.

At the close of the interview, parents were asked an open-ended question about whether they had anything further to say about Healthy Kids (Table 18). These responses reflect parents' generally positive impressions of the access to care provided by Healthy Kids. Of 190 responses (none was required), two-thirds used the opportunity to express positive feelings about the program. These mothers' remarks are representative of the unsolicited positive comments: "This is a good program, because it covers the medical needs of my children, as well as dentist and eye care." Another said, "I think it is a good program. The last few times my children have gotten sick, I have taken them for care and they have treated us well."

Table 18
Feedback on Healthy Kids[1]
January 2004

	Number of Respondents	%
Positive Comments[2]	125	30.4
Problems with Healthy Kids		
Medical Access Issues	18	4.4
Dental Access Issues	12	2.9
Vision Access Issues	4	1.0
Language Access Issues	3	0.7
Want Adult/Parent/Other Child Coverage	13	3.2
Need More Information/Help	12	2.9
Not Treated with Respect	2	0.5
Transportation Issue	1	0.2
Subtotal	65	15.8
No Response to Question (not required)	221	50.1
Total	**411**	**100.0**

Source: Healthy Kids Client Survey.

[1]Reponses to Question: "Do you have any final comments regarding the Healthy Kids Program? Any comments you have will be kept confidential and not attributed to you personally."

[2]Respondent was happy or very happy with the program. Reponses included, "The service given to my children is great and I hope that it continues," and "It is a very good program, and I am happy to have it."

On the other hand, a few parents had some concerns with access. For example, one parent commented: “Dental care should be more available to the Healthy Kids program; a lot of dentists don’t participate in Healthy Kids.”

In summary, while access is generally good, there seem to be several areas where access could be improved—for example, access to after hours appointments and dental care. The second wave of the client survey will provide an estimate of how access has improved for children after they enroll in Healthy Kids.

QUESTION 4: WHAT SERVICES DO HEALTHY KIDS ENROLLEES RECEIVE, AND HOW DOES THEIR USE COMPARE WITH MEDI-CAL AND HEALTHY FAMILIES CHILDREN'S USE?

Now that the children who enrolled in Healthy Kids during the first year of the program have been enrolled for a full year, it is possible to take a closer look at their utilization of health services and to compare their use rates with Healthy Families and Medi-Cal enrollees who participate in the Health Plan of San Mateo. All Medi-Cal children are enrolled in HPSM, but only some parents whose children participate in Healthy Families choose HPSM; consequently the data do not represent the full experience of all Healthy Families enrollees in San Mateo County. In addition, in order to obtain comparable utilization rates, we analyze data only for children who stayed enrolled for one full year. Consequently, the data represent a group of children who were enrolled in HPSM between February 2003 and January 2004 and were continuously enrolled for 12 subsequent months.

The utilization data are presented in tables 19 and 20. Data are broken into three age groups: 1 to 5 years, 6 to 12 years, and 13 to 18 years. Children under age 1 were excluded from this analysis because its major purpose was to compare Healthy Kids enrollees with other insurance groups, and there are almost no infants in the Healthy Kids program. State-level data from the California Health Interview Survey are provided in table 20, when available, in order to provide a benchmark against which to compare the San Mateo utilization rates.

Table 19 shows the rate of preventive and nonpreventive care visits across all three programs and age groups. Of the 4,515 children age 1 to 18 who were continuously enrolled in Healthy Kids at least 12 months, only 33.1 percent received a preventive care

visit in the first year that they were enrolled. This rate is lower than the rates among Healthy Families (42.3 percent) or Medi-Cal enrollees (38.3 percent). While use of preventive care is higher among the youngest children (age 1 to 5), it is still much lower for Healthy Kids, where the rate is 49.0 percent compared with 62.5 and 57.2 percent for Healthy Families and Medi-Cal children, respectively.

More of the preventive care visits for enrollees in all programs were provided at public and nonprofit clinics than in private doctors' offices, and the difference was most striking for Healthy Kids. Nearly three times as many Healthy Kids enrollees had a preventive care visit at a clinic (26.6 percent) than in another provider setting (9.0 percent). About the same proportion, 24.3 percent of Healthy Families enrollees and 22.1 percent of Medi-Cal enrollees, had preventive care visits in clinics. However, a much higher proportion of enrollees in these latter programs received preventive care visits in settings other than clinics: 20.8 percent of Healthy Families enrollees, and 18.8 percent of Medi-Cal enrollees, which accounts for their higher overall use of preventive care. It is unclear whether this represents a preference among Healthy Kids parents for clinic care, or some barrier they experience accessing private providers. Most of the children enrolled in Healthy Kids were originally seen at public clinics; therefore, families may elect to stay with their original providers after enrolling in the program. As noted below in the discussion of provider issues, many providers are unaware of Healthy Kids and do not participate; others do not have Spanish-language-speaking staff.

Preventive care may be provided at the time of visits for other health problems ("sick visits"). Table 19 also shows the percentage of children who had any ambulatory care visit during the year. In this case, Healthy Kids enrollees are much more similar to

Healthy Families and Medi-Cal enrollees in their use of services. For example, among the youngest children, 82.1 percent of Healthy Kids, 89.1 percent of Healthy Families, and 80.6 percent of Medi-Cal enrollees had at least one ambulatory care visit during the year. The two other age groups were also similar, although their services use rates were lower than those for the youngest children. It is possible that in their first year of enrollment, Healthy Kids enrollees were using services for specific health problems more regularly than children who have had access to health insurance before, such as those enrolled in Healthy Families and Medi-Cal. As with the preventive care visits, Healthy Kids enrollees are more likely to receive their other ambulatory care in clinics than in other provider offices.

The annual rates of ambulatory care visits among HPSM enrollees from all three public programs are lower than the national average. For example, 78.6 percent of all children nationally had an ambulatory visit in 2000,[27] while 69.0, 74.6, and 68.7 percent of Healthy Kids, Healthy Families, and Medi-Cal enrollees, respectively, had a visit in 2004.

Table 20 shows rates of use for hospitals; emergency rooms; and dental, vision, and drug services among HPSM's enrollees in Healthy Kids, Healthy Families, and Medi-Cal. Data on dental services are available only for Healthy Kids, and data for vision services are available only for Healthy Kids and Medi-Cal enrollees, due to capitation of those services in the other programs.

Hospitalization rates are low in all three programs and lowest for Healthy Kids. Only 35 children (fewer than 0.1 percent) in Healthy Kids had hospital stays, and rates were only slightly higher among Healthy Families (1.2 percent) and Medi-Cal (2.4

[27] National Center for Health Statistics. 2003. Health, United States, 2003 with Chartbook on Trends in the Health of Americans. Hyattsville, MD.

percent) enrollees. In contrast, the statewide child hospitalization rate was 3.5 percent in 2001.[28]

The pattern of lower use in the Healthy Kids program holds for all age groups and all services. For example, only 12.1 percent of Healthy Kids enrollees used the emergency room their first year, compared with 16.1 percent of Healthy Families enrollees and 27.1 percent of Medi-Cal enrollees. For all children in California in 2001, the rate was 19.0, according to the California Health Interview Survey. Some Healthy Kids and Healthy Families enrollees may have had hospitalizations prior to their enrollment that were covered by Emergency Medi-Cal. This would artificially suppress the Healthy Kids and Healthy Families rates.

Dental care is more common than preventive medical care, with 56.0 percent of enrollees having had at least one visit during their first year on the program. This rate is highest for 6 to 12-year-olds (61.7 percent). Rates of dental care are lower in Healthy Kids than for all California children (75.7 percent for all children and 87.3 percent for 6-12 year olds).

Since vision care is capitated in Healthy Families, data on vision care visits are only available for Healthy Kids and Medi-Cal enrollees. Utilization rates are low and relatively similar for both programs. Among Healthy Kids enrollees, 8.3 percent had a vision care visit during the observation period, compared with 6.3 percent of Medi-Cal enrollees. Within the age groups, children age 13 to 18 had the highest rates, at 10.4 percent for Healthy Kids and 9.9 percent for Medi-Cal.

While parents were asked about their child's service use in the client survey, the data on utilization from this round of the survey are not as useful as the health plan data

[28] California Health Interview Survey, 2001.

because the reference periods for the survey varied depending on the length of time the child had been in the Healthy Kids program at the time of the survey. Parents were asked, for example, “While enrolled in Healthy Kids, how many times did (CHILD) see a doctor or any other healthcare professional, such as a physician assistant or nurse?” Since the length of time in the Healthy Kids program varied substantially, the rates of service use detected from the survey will be biased. One way to adjust for this is to calculate monthly rates of service use. In addition, one unique feature of the survey process was a linkage with encounter records from the HPSM. Such a comparison suggests ways in which either survey or encounter records might be biased.

Table 21 compares services ever used on the program and monthly service use based on from the survey reports and the associated encounter records. In all cases, a higher percentage of parents reported that their child ever received a particular service while enrolled in Healthy Kids than is reflected in the encounter records. For example, for physician care, 57.6 percent of parents reported a visit, with only 47.6 percent of children in the survey having encounter records for a physician service, and an even greater differential for dental services. These data confirm anecdotal reports of underreporting in encounter data. However, for Healthy Kids enrolled in the Health Plan of San Mateo, all claims are paid on a fee-for-service basis (there is no capitation), so the encounter records reflect actual claims for services. Still, it seems surprising that parents would over-report their child’s service use to this large degree.

Table 21 also shows the average number of visits per month from each data source. While the rates are similar from both data sources, they are slightly higher from the

encounter data for physician and emergency room care. This may suggest that parents remember well that their child had a particular service, but not the number of services.

Table 19
Preventive and Nonpreventive Ambulatory Visits
Healthy Kids Enrollees
2004[1]

Type of Visit	Healthy Kids	Healthy Families	Medi-Cal[2]
Total N	4,515	2,212	16,529
1-5	977	626	6,862
6-13	2,029	1,121	6,137
13-18	1,509	465	3,530
Preventive Care (% with any visit)			
Clinic			
1-5	41.0	39.5	35.6
6-12	23.3	18.8	13.8
13-18	21.7	17.2	10.5
Total (age 1-18)	26.6	24.3	22.1
Other doctor			
1-5	11.7	27.2	26.1
6-12	9.4	18.1	14.2
13-18	6.8	18.7	12.6
Total (age 1-18)	9.0	20.8	18.8
Total Preventive (Clinic and Other Doctor)			
1-5	49.0	62.5	57.2
6-12	30.2	34.5	26.7
13-18	26.8	33.8	21.7
Total (age 1-18)	33.1	42.3	38.3
Other Ambulatory Care (% with any visit)			
Clinic			
1-5	57.2	51.1	55.3
6-12	46.7	38.5	38.5
13-18	48.4	39.4	39.3
Total (age 1-18)	49.5	42.2	45.6
Other doctor			
1-5	14.1	33.4	44.4
6-12	10.9	26.6	28.0
13-18	12.3	28.4	33.3
Total (age 1-18)	12.0	28.9	35.9
Any Ambulatory visit (% with at least one visit of any type: Preventive or Other)			
1-5	82.1	89.1	80.6
6-12	66.5	69.3	60.6
13-18	64.0	68.0	59.8
Total (age 1-18)	69.0	74.6	68.7

Source: Health Plan of San Mateo Administrative data.

[1]Health plan data reflect children who enrolled in Healthy Kids, Healthy Families, and Medi-Cal between February 2003 and January 2004 who have been continuously enrolled for at least 12 months.

[2]Medi-Cal data may be under counted to an unknown degree, due to capitation of some ambulatory care providers and less than complete encoding data submission.

Table 20
Hospital, Emergency Room, Dental, Vision, and Prescription Drug Use
Healthy Kids Enrollees
2004

Type of Visit	Healthy Kids	Healthy Families	Medi-Cal	California Children
Total N	4,515	2,212	16,529	9,584,000
1-5	977	626	6,862	2,539,000
6-13	2,029	1,121	6,137	3,739,000
13-18	1,509	465	3,530	3,306,000
Hospital Stay (% with any hospital stay)				
1-5	1.2	2.2	2.7	4.4
6-12	0.6	0.5	1.3	2.3
13-18	0.7	1.5	3.9	4.2
Total (age 1-18)	0.8	1.2	2.4	3.5
Emergency Room Visits (% with any visit)				
1-5	16.7	25.2	34.3	22.8
6-12	10.6	11.8	20.7	15.4
13-18	11.1	14.2	24.1	20.3
Total (age 1-18)	12.1	16.1	27.1	19.0
Dental Visits (% with any visit)				
1-5	50.8	NA	NA	56.3
6-12	61.7	NA	NA	87.3
13-18	51.6	NA	NA	84.5
Total (age 1-18)	56.0	NA	NA	75.7
Vision Visits (% with any visit)				
1-5	2.1	NA	2.0	NA
6-12	9.7	NA	8.9	NA
13-18	10.4	NA	9.9	NA
Total (age 1-18)	8.3	NA	6.3	NA
Prescriptions (% with at least one prescription)				
1-5	43.3	58.8	61.8	NA
6-12	30.0	40.6	43.8	NA
13-18	28.8	38.5	45.3	NA
Total (age 1-18)	32.5	40.0	51.6	NA

Source: Administrative data, Health Plan of San Mateo.

Health plan data reflect children who enrolled in Healthy Kids, Healthy Families, and Medi-Cal between February 2003 and January 2004 who have been continuously enrolled for at least 12 months.
California data from the 2001 California Health Interview Survey (CHIS).

Table 21
Use of Selected Services
Healthy Kids Enrollees
2004

	Survey Reports	Encounter Records
Physician Care		
% With Visit While Enrolled	57.6	47.6
Average Number of Visits per Month	0.30	0.39
Dental Care		
% With Visit While Enrolled	62.5	49.0
Average Number of Visits per Month	0.22	0.16
Emergency Room Visits		
% With Visit While Enrolled	17.7	7.9
Average Number of Visits per Month	0.03	0.04
Hospital Stays		
% With a Stay While Enrolled	0.9	None Reported
Average Number of Stays per Month	0.001	

Source: Healthy Kids Client Survey (survey reports) and Health Plan of San Mateo (encounter records for those children in the survey).

Note: Parents of children enrolled in Healthy Kids in January, 2004, were asked about their child's service use for the entire period they were on Healthy Kids.

QUESTION 5: WHAT IS THE COST OF CARE FOR HEALTHY KIDS ENROLLEES AND HOW DOES IT COMPARE WITH THE COST OF CARE FOR MEDI-CAL AND HEALTHY FAMILIES CHILDREN?

The care for Healthy Kids is financed through premiums paid to the Health Plan of San Mateo for each enrolled child. We previously showed (table 4) that the CHI paid the plan about $5.6 million for premiums in 2004, which was $93.25 per child per month (including the family's contribution), or $1,119 per child per year. The cost of care to CHI funders can be measured using these amounts, as well as the expenditures for outreach and administration also shown previously. However, it is also interesting to know what was spent by the plan, how it varied by age of the child and diagnosis, and how it differed from spending for Healthy Families and Medi-Cal enrollees.

Table 22 shows the average cost per type of service to the HPSM over one year for a cohort of enrollees from each program who were continuously enrolled for a year, according to clinics' encounter records. The average cost per enrollee to the HPSM is dramatically different for each program, ranging from $298 for Healthy Families, to $442 for Healthy Kids, to $827 for Medi-Cal. Most of the difference between Healthy Kids and Healthy Families enrollees is explained by the fact that the HPSM is not responsible for vision or dental care for Healthy Families enrollees, so data are not available on the cost of those services.

Dental care is a very important component of the cost of the Healthy Kids program. For school-age children (age 6 to 12) and adolescents (age 13 to 18), dental care is the largest component of their average annual cost, and for children age 1 to 5, it is the second most expensive component of their annual cost, following outpatient/clinic care (data not shown).

Table 22
Average Annual Cost of Services, Children Age 0–18
Per Child by Type of Service
2004[1]

	Healthy Kids	Healthy Families	Medi-Cal
Outpatient/Clinic	$128	$90	$142
Other Physician	41	74	62
Emergency Room	21	29	71
Hospital	32	54	353
Vision	7	NA	4
Dental	182	NA	NA
Prescriptions	24	43	121
Other	8	8	74
Total	$442	$298	$827
Total Without Hospital, Dental, or Vision	$221	$244	$470

Source: Administrative data, Health Plan of San Mateo.

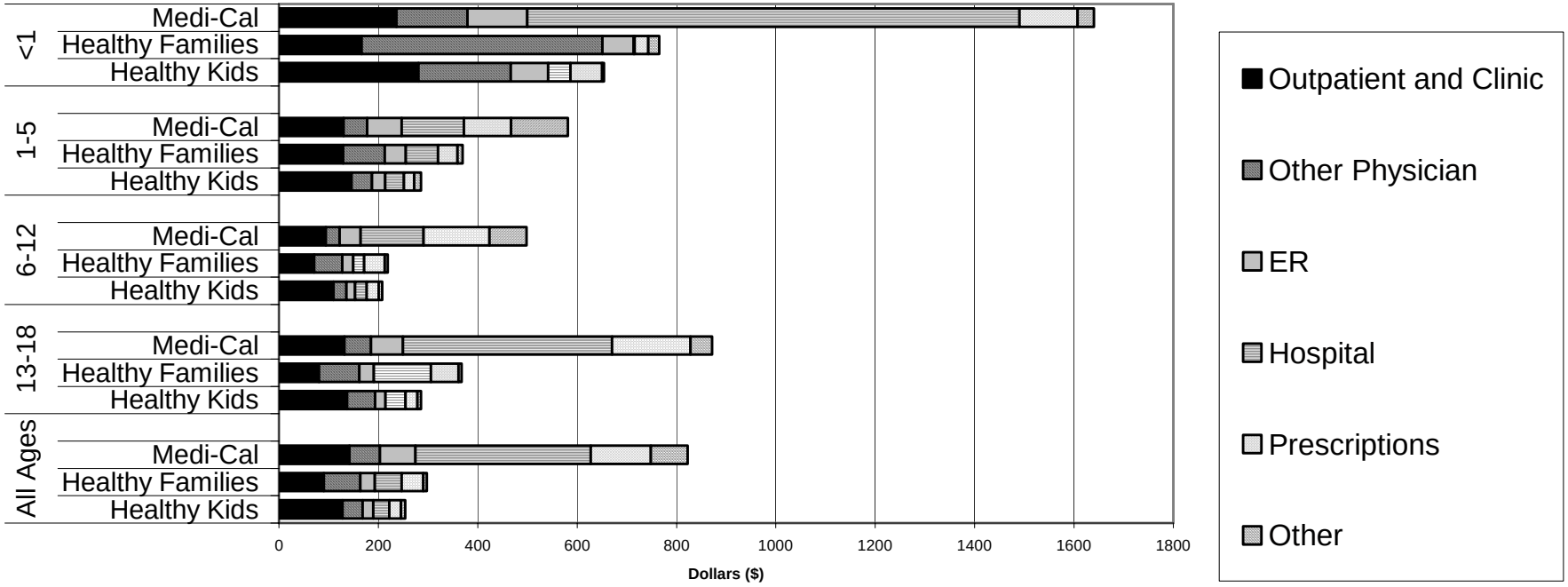
[1]Health plan data reflects children who enrolled in Healthy Kids between February 2003 and January 2004 who have been continuously enrolled for at least 12 months.

A portion of the difference in costs between Medi-Cal and the two other programs is explained by the much higher cost of hospital care for Medi-Cal children (due in part to the large number of high-cost infants and pregnant adolescents on the program). When hospital, dental, and vision costs are removed from the average cost, Healthy Kids cost $221 per year, compared with $244 for Healthy Families and $470 for Medi-Cal. Medi-Cal children are, thus, fully twice as expensive as Healthy Kids children, probably reflecting the more serious case mix for these children, but also a high rate of emergency room use among Medi-Cal participants. Indeed the Medi-Cal costs may be underrepresented, due to capitation of some portion of primary care in that program (which does not occur for Healthy Kids and Healthy Families).

Figure 9 illustrates the average cost for different age groups, by health insurance program. As shown, the primary care costs (outpatient, clinic, and other physician) are rather similar across the three programs when the comparisons are made within age groups. For example, for children age 1 to 5, the average cost of clinic and other physician care was $187 for Healthy Kids, $213 for Healthy Families, and $177 for Medi-Cal. Emergency room and, especially, hospital care are much higher for Medi-Cal, even within the age groups where maternity care is not a factor.

The average cost paid by the plan to providers for Healthy Kids enrollees is considerably less than the average cost paid per year in premiums to the plan. If the premiums paid to the plan for Healthy Families enrollees are similar to Healthy Kids premiums (we were told that they are), then the same is true for that program. The excess revenues from those two programs could be used to offset Medi-Cal losses for the plan, especially for the elderly and disabled. We were told that this happened in the first year of

Figure 9
Average Annual Cost of Services by Age Group and Program[1]
2004[2]



Source: Administrative data, Health Plan of San Mateo.

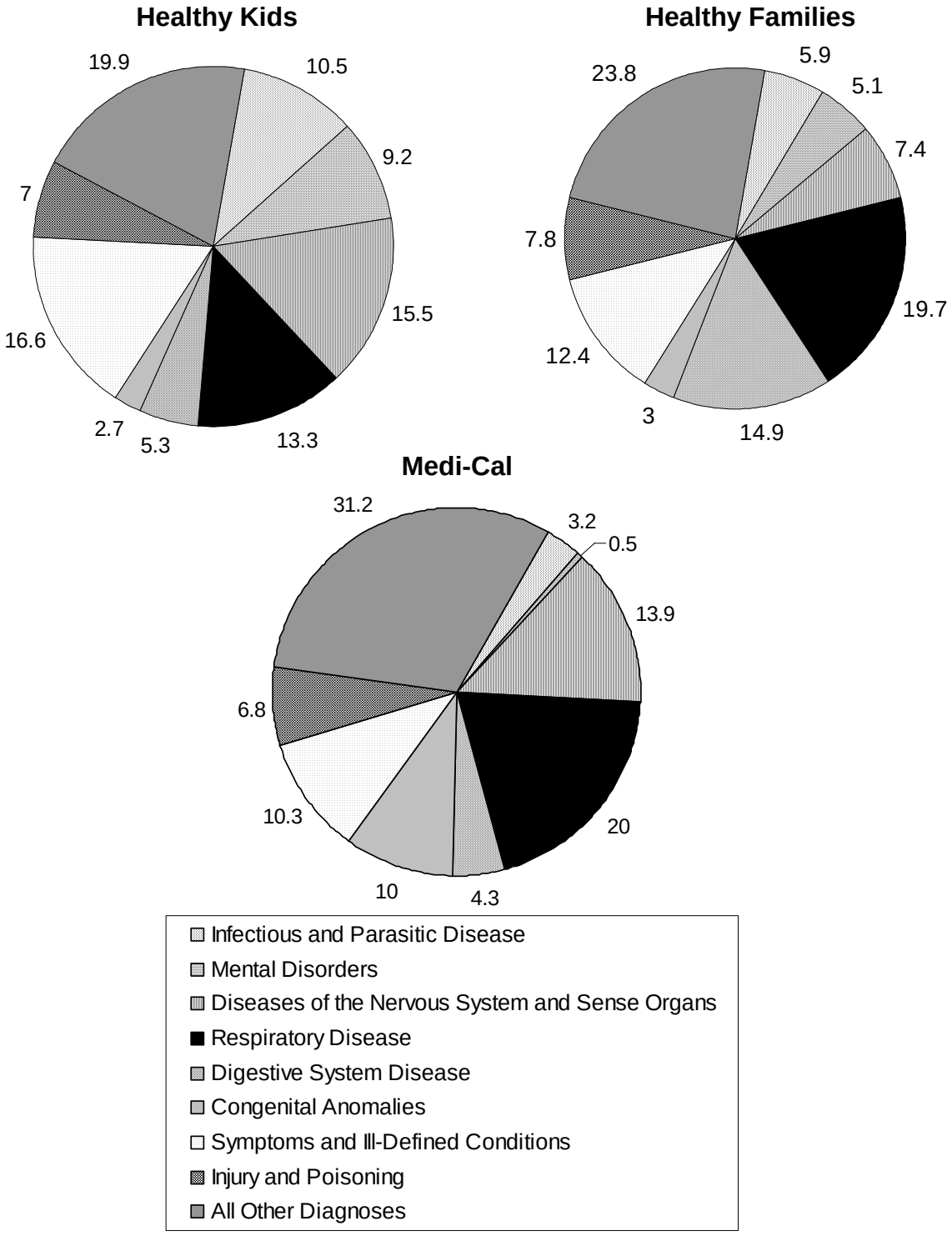
[1]The costs of dental and vision care are excluded from the figure.
[2]Health Plan data reflect children who enrolled in Health Kids between February 2003 and January 2004 who have been continuously enrolled for at least 12 months.

Healthy Kids, but that excess revenues from Healthy Kids now are returned to the funders in proportion to their contribution to the CHI.

Figure 10 shows how expenditures for care for children enrolled in the HPSM are distributed across major diagnostic categories. The categories included are infectious and parasitic disease; mental disorders; diseases of the nervous system and sense organs; respiratory disease; digestive system disease; congenital anomalies; symptoms/ill-defined conditions; injury and poisoning; and all other conditions. Only expenditures associated with V codes (exams without diagnoses), E codes (causes of injury or poisoning), and claims without any diagnosis are excluded.

The diagnostic cost profiles mirror some of the findings regarding the prevalence of different conditions discussed earlier. For the Healthy Families and Medi-Cal programs, about 20 percent of expenditures are for respiratory disease; only 13.3 percent of Healthy Kids expenditures cover respiratory disease. (This category includes asthma, as well as colds.) In addition, the Healthy Kids program experiences a higher proportional cost for infectious disease (including tuberculosis).

Figure 10
Allocation of HPSM Costs across Major Diagnostic Categories
Healthy Kids, Healthy Families, and Medi-Cal
2004[1]



Source: Administrative data, Health Plan of San Mateo.
[1]Health plan data reflects children who enrolled in Healthy Kids between February 2003 and January 2004 who have been continuously enrolled for at least 12 months.

QUESTION 6: WHAT ARE PARENTS' EXPERIENCES WITH THE HEALTHY KIDS PROGRAM, AND ARE THEY SATISFIED WITH THE SERVICES THEIR CHILDREN RECEIVE?

With the help of the Aguirre group, five focus groups with parents of Healthy Kids enrollees met in late 2004 and early 2005. The goal of these focus groups was to learn about families' experiences obtaining health care for their children before enrolling in Healthy Kids, how they learned of the program, their experiences with the enrollment process, their satisfaction with Healthy Kids thus far, and any barriers they encountered in accessing services. These topics are covered in the client survey, but the focus groups provide a more in-depth, qualitative assessment of these issues from parents' perspectives.

Table 23 provides an overview of the types of parents included in the groups. All groups were held in Spanish and had 6 to 12 participants. Group meetings lasted approximately an hour and a half.

Table 23
Parent Focus Groups
2004-2005

Type of Group	Date	Number of Participants
Parents of Established Enrollees	November 2004	10
Parents of Established Enrollees with Family Incomes at 250-400% of FPL	January 2005	6
Parents of New Enrollees	January 2005	6
Parents of Enrollees Age 0-5	March 2005	10
Parents of Enrollees Age 0-5	April 2005	12

Note: Parents had household incomes of 250 percent of FPL or less unless otherwise noted.

Outreach, Enrollment, and Renewal Process. When asked how they learned of the Healthy Kids program, parents responded that they found out about it through the child's school, at clinics, at the hospital when using Emergency Medi-Cal coverage, when applying for Healthy Families, through their social worker, through providers when accessing care using the WELL program or when obtaining obstetrical services, at enrollment fairs, through television advertisements, and through word of mouth. The most common avenues were the child's school (either through health fairs held for parents on the school campus or through pamphlets sent home with the child), or clinics, often when the child was receiving a physical to fulfill school enrollment requirements. Parents from the five focus groups all reported hearing about Healthy Kids in similar ways. They also reported that outreach materials were available in both English and Spanish, and none claimed to experience problems accessing materials in the appropriate language.

When asked why they chose to apply for Healthy Kids for their child, parents most commonly said they signed up either because their child was sick, or because they valued insurance and wanted their child to be covered.

> "My son was in need of a doctor, so I applied for the program."

Some mentioned instances prior to obtaining Healthy Kids coverage when their child had an issue that required medical attention and the cost of care was very high. Parents also reported that they found the cost of Healthy Kids to be inexpensive and liked the flexibility of choosing whether to pay premiums annually or quarterly. Most parents had not heard very much about the program prior to applying, but those who had heard of it recalled others mentioning that it was a good, inexpensive program for children born outside the United States.

Parents from all groups reported that they found the application process simple or that application assistance was easy to access if needed. In four of the groups, most parents reported having received assistance completing the application, but among parents in the higher-income group, only two reported having received assistance completing the application. Since application assistance is a mandatory part of the application process, some parents in the higher-income group may have misunderstood the question. Some who indicated that they received help said they did so not because the application was difficult, but because it was important to them to complete it correctly. According to one parent of an established enrollee,

> "It isn't that you don't understand what [the application] says, but rather, it's the fear of not knowing what to put down, and you're always asking, 'Can I put this?'"

Parents expressed two fears: that filling out the application incorrectly could delay their child's coverage and that applying could put their immigration status at risk. In the end, at least for the parents who participated in the focus groups, they talked with application assistors to get the facts and tried to do what they thought was best for their child. Their comments reflect this.

> "It's worrisome when [children] don't have insurance."
>
> "In case they get sick, it is good that they are covered."
>
> "You can't play with your children's health."
>
> "What am I going to do? Leave my child dying of pain [because of my fear of immigration]? As a parent, you would risk your life for your children's lives."

Parents in all five groups commented that, once they applied, the enrollment process was very quick, with most waiting only a week or two between application submission and notification that their child had been accepted in the Healthy Kids program. In one of the groups of established enrollees, all participants said they received

notification of their child's enrollment status one month after they submitted the application. However, many waited a long time after learning their child had been accepted into Healthy Kids before they actually received their insurance card in the mail. Most said they received their card within one to two months, but several, even one parent of an established enrollee, were still waiting to receive their cards.

The biggest potential deterrent to seeking Healthy Kids coverage was parents' fears that applying could jeopardize their immigration status. In all five groups, parents expressed their hesitance because "public charge" could harm their immigration status. This problem was mentioned by parents in all groups, although less so in the higher-income group, which is to be expected because many of these children are presumably ineligible for other public insurance programs because of their family income, not their immigration status. Parents' comments on their fears included:

> "They ask a lot of questions."
>
> "It seems risky and binding. The first thing you ask yourself is, 'Will I hurt myself if I do this?'"
>
> "I think that a majority of people think that something will happen."

Some were even hesitant to attend the focus group because they were concerned that,

> "…immigration was going to be outside. I didn't even want to come here today because I was afraid."

Parents' fears were usually calmed by a *promotora* or application assistant who explained that Healthy Kids coverage is not related to immigration status. As one parent explained,

> "That was the first question I asked, because I said in the future, if I'm in the process of getting my papers and if [Healthy Kids] was going to affect me, I would prefer not to do it. They [the *promotora*] told me that in no way, not for myself or for my child, in no way, it had nothing to do with it, that everything we said there was private."

Another parent said she was concerned about immigrations issues initially, but one of her relatives with a child enrolled in Healthy Kids told her it didn't affect immigration status, so she chose to apply after all.

As described above, the renewal rate has been less than desirable, so parents were asked about the ease of the renewal process. Parents who had been through the renewal process generally commented that it was an easy process, and that they found out within a few days if their renewal was successful. Parents received a letter and, in a few cases, a phone call reminding them to renew. Some got assistance to complete the renewal forms, but others reported that they completed the paperwork on their own. Again, application assistance is a mandatory part of the renewal process, so some parents may have misunderstood the question. Parents reported that renewing was easier than applying for the first time. According to one parent,

> "This process was much easier and faster than the first time."

Access to Care. Parents were also asked about their experience with access to care before and after enrolling in Healthy Kids. Prior to enrolling their children in Healthy Kids, parents claimed to have found it difficult to access health services for their children. One parent mentioned that they delayed taking their child to a provider for health services until the problem became an emergency.

> "I didn't take them. Only when they were gravely ill, only then did I take them to the emergency room. …When I didn't have insurance, I had to take my son. Seven months later I received a bill and had to pay for it. It was for four hundred dollars."

Other parents described similar experiences in which they received an unexpectedly high bill long after services had been provided for their child. Many also mentioned having Emergency Medi-Cal for their children. The most common sources of care before enrollment in Healthy Kids were the emergency room, mobile "health vans," school

clinics, community clinics, and services provided at San Mateo Medical Center through the WELL program. Obtaining dental care was particularly challenging; parents reported difficulties getting appointments with dentists at community clinics, waiting long periods of time to be seen for dental appointments in clinics, taking their children to private dentists and paying the fees out-of-pocket, and taking their children to Mexico for dental care.

Since enrolling their children in Healthy Kids, most parents reported that they take their child to the doctor more often than they did before they had Healthy Kids coverage. Most parents did not seem to have had difficulties finding providers for their children. However, some needed more information on how to select a provider, and some claimed not to have received the provider directory. One parent in the higher-income group complained,

> "I haven't found a dentist or an optometrist. This year they didn't send me the book, so I didn't have anywhere to look."

Another parent in the same group reported,

> "It's always very confusing to me even if I see the book because it's too long, and the doctors are too far from where I live."

Although overall satisfaction with access to care under Healthy Kids was high among the parents in the focus groups, many mentioned that scheduling appointments was sometimes problematic. Many parents had difficulty getting to the doctor's office at the times appointments were available, and some also complained of having to wait a long time for their child to be seen after arriving for an appointment. One parent explained,

> "The only thing I don't like is that the doctor gives an appointment for three o'clock, for example, and they don't take me in at three, they keep you waiting for over half an hour."

In another group,

> "We don't like the [clinic] employees because they keep us waiting. The doctors we like, but not the waiting."

Parents of newly enrolled children also had scheduling difficulties.

> "It's sometimes difficult [to take my children to the doctor] because of the appointments. They don't have afternoon appointments and that's when I have more flexibility with respect to my schedule as well as my children's."

> "On two occasions that I had appointments for my son I missed them because the program called me telling me they changed my appointment to a time I can't take him. I get out of work at a certain time in the afternoon, and they change it to a morning appointment at a time that I can't come."

An additional concern for some parents was that their child did not see the same provider each time he or she had a doctor's appointment.

> "Here in the clinic in East Palo Alto…the doctor who sees [my children] is there Mondays, Wednesday and Fridays. If I take them any other day of the week, they get a different doctor. I would like for just one doctor to see my children."

Given that the vast majority of Healthy Kids enrollees are Spanish-speakers, it is of particular importance that providers and clinic staff speak Spanish or have interpreters readily available.

> "For me, it is very important, because what good is it for me to understand a little English, and tell them four things when in my language I might be able to speak well?"

The majority of parents reported that their child's doctor and/or dentist either spoke Spanish or had assistants available to translate. This was highly valued by parents, even those who knew English.

> "I would be able to do it in English, but I feel more secure in Spanish."

Some parents of established enrollees complained that the translators at the clinics were impatient with them.

> "I ask questions when I have my doubts [when something is being interpreted], and at times, the interpreter gets mad when you do this."

> "When you have medications…that's when it's important. And sometimes, to the interpreters, it's like, 'it's the same', 'she's crazy', 'she's asking the same thing', or 'the doctor already told you.' [T]here are different personalities."

Some parents had poor experiences with dentists who did not speak Spanish.

> "The problem with the dentist is that he speaks English. There aren't many dentists that speak Spanish."

When parents are unable to find providers who speak Spanish, some choose not to take their child to the English-speaking provider, despite having Healthy Kids coverage.

> "I went to the dentist, and I wanted to keep taking my daughter to continue her treatment, but since I don't understand him well, I decided not to return…I'm thinking of taking her [back], but I will go with someone who knows more English so that I can ask them when I don't understand [the dentist]. I know some English, more or less, but they speak so fast I don't understand them."

Though some parents find access to dental care difficult once their children are enrolled in Healthy Kids, it is still better than before enrollment. Some parents said that before enrolling their children in the program, they took their children back to Mexico if they needed dental care. Other than the language issues mentioned previously, parents who had accessed dental care for their children said they were satisfied with the care they received. Some who had not yet accessed dental care mentioned having difficulty finding a dentist that participated in Healthy Kids, and said they had not received a list of participating dentists from the health plan.

> "I don't have dental service because I don't know where to go. I have asked. And on this third time that I went, they said they were going to send me a packet with information of where to take him."

Another parent of a new enrollee had similar troubles.

> "My daughter had a cap on her tooth from Mexico, and it came off and she's had to stay like that because we haven't been able to find a dentist."

The only other issue that a few parents raised was their desire for Healthy Kid to cover other more intensive dental care and orthodontic work. These parents might learn that their child needs such services when visiting the dentist for a normal check-up, but they cannot always afford to pay for them out-of-pocket.

> "A year ago, my son started to go to the dentist. I didn't take him before. When I took him, they charged me $1,800 just to get a check-up and a filling, so I said, no, I'm not going to take him anymore. Then I took him to Healthy Kids and they told me that what he needed, Healthy Kids didn't cover it, and that I had to pay out of my pocket."

In addition to questions about access to primary care and dental care, parents were also asked about their experiences accessing specialty care as well as prescription medications for their children while enrolled in Healthy Kids. Several parents in each focus group had experience with referrals to specialists, most often for dental care. Parents generally found it easy to follow through on referrals for specialty care for their children and reported that specialists accepted Healthy Kids and provided high-quality care. On a few occasions, parents spoke of their inability to follow through on a provider's recommendation because Healthy Kids did not cover the service (i.e., orthodontic work, intensive dental work, jaw surgery). However, for the most part, parents were pleased with the referrals and specialty care their children received. Parents' comments included:

> "They treated my daughter well."
>
> "I am [satisfied with the specialist care provided]. They treated my daughters well."
>
> "The dentists referred us, then they called the insurance [plan] first to see if they accepted the insurance, and I think that the insurance [plan] said yes. They [the dentist] called me in and gave me the appointment and I took my son."

One parent on an established enrollee spoke at length of having difficulty finding a trauma surgeon for her daughter when she broke her arm.

> "We couldn't find one [a trauma surgeon], not even in the guide [list of providers], and the hospital didn't even refer her or say anything. The ones that were at Sequoia hospital weren't on our insurance."

Most parents have gotten prescriptions filled for their children since enrolling them in Healthy Kids. The majority reported that is was easy to get the prescription medicines they needed at area pharmacies, and many mentioned specific pharmacies they preferred because the staff speak Spanish. Parents' comments included:

> "It is easy and they speak Spanish."
>
> "It was easy. We went to Long's Drugs and the girl got on the computer and saw everything and she said yes, but that we had to pay a co-payment of five dollars for each medicine."

Some parents, particularly those in the group of established enrollees who met in November 2004, said that some of the medications prescribed for their children were not covered by Healthy Kids.

> "When they prescribe some medications, sometimes they aren't covered."
>
> "When they have prescribed medicines for my son's bronchioles, the medicine wasn't covered by Healthy Kids."
>
> "I received a prescription that, when I went to the pharmacy, wasn't covered. I went back to the doctor and he gave me another medicine that was covered."

During the discussion of prescription medications, a few parents claimed to be having trouble affording the over-the-counter medications their children's doctors recommended. One parent had to buy her child's allergy medicine out-of-pocket.

> "Not all prescriptions are covered. For example, my daughter has allergies so she is always coughing and the doctor told me that it was because of her allergies and prescribed Alavert, which isn't covered, and either way, it's expensive."

Generally, though, parents have found accessing prescription medications for their children simple and inexpensive with Healthy Kids.

Preventive Care Information. A few parents were aware of the concept of preventive care and its importance to their child's health before they enrolled their child in Healthy Kids. Many, however, did not claim to know very much about preventive care and said they had not received any information on its importance from the HPSM or providers since enrolling their child in Healthy Kids. No one in the group of parents of new enrollees or the group of higher-income parents said they had received any information about preventive care from the HPSM or their child's providers. Parents of children who had

participated in the program longer seemed to be more informed. For example, one parent of an established enrollee had been told about preventive care by the child's provider.

> "My children's doctor told me that I have to take my children to regular check-ups, even though I might not see anything wrong with them."

Similarly, in one of the other groups of parents of established enrollees, most parents (six out of the nine in the group) had been told about preventive care by their child's doctor.

> "The doctor told me the first time I brought him here, and they gave me a paper that tells you to please bring your child in for their check-up."

None of the parents in any of the groups had heard of the term "well child" though, and it was an unfamiliar concept for some of the parents.

> "They don't explain a lot of things here. They haven't explained that [preventive care] to me. I don't take my child to the doctor more than I have to."

These findings suggest that more information about well child care could be helpful to parents of Healthy Kids enrollees.

Satisfaction with Provider Services. While most parents were pleased with their providers and the service their children received, a few were critical of clinic staff, whom they regarded as unfriendly or unhelpful if the parents had questions.

> "They don't treat me well. There are women that answer you with few words. They don't treat you how they should."

Another parent of a new enrollee explained,

> "You come to the clinic, and there isn't a 'Good morning, how are you?' or, 'What can we help you with?'"
>
> "Over the phone, when I make appointments, they are very curt. They leave you waiting half an hour on the phone."

When one parent from another group of established enrollees was asked what Healthy Kids could do to make the services better, she responded,

> "Tell the people we're paying the insurance to [doctors and dentists and clinic staff] that maybe it's not a large amount, but how [we] are treated should be the equal, because it's

> their job and they have to do it right for us, too. [We] pay and should be treated right, the same as everyone else."

Views on Cost Sharing. Almost across the board, parents approved of the minimal cost-sharing requirements for Healthy Kids enrollees. Comments included,

> "It is within your budget."
>
> "There is no price for children's health care."
>
> "The payments are affordable, I think anyone can pay them."
>
> "We pay very little in comparison to the benefits we receive."
>
> "It's a reasonable amount. It is more important to give that amount towards health care than to other things. With a minimum wage, you can do it."

Only two parents mentioned that they knew people with children who would probably be eligible for Healthy Kids but chose not to apply for coverage because they thought it was too expensive. Parents also liked the flexibility of payment options the program offers. Many took advantage of the cost savings offered for paying annually rather than quarterly.

Other Comments. Overall, parents said that Healthy Kids is making a positive difference in their lives and their children's lives.

> "When your children get sick, you know you won't be without money for the rent. It's reassuring to know that you can take them to their doctor and that you don't have to worry."

When asked for suggested program changes, parents offered several common responses, including a more generous dental benefit; coverage extension to individuals age 19 to 21 or even to adults; more accommodation with respect to scheduling appointments; and more written resources in Spanish explaining how to use the program, the specific benefits it covers and does not cover, and a current list of participating providers.

Conclusions and Recommendations. The results of the parent focus groups confirm that parents were generally pleased with Healthy Kids and they valued the opportunity to enroll their children in a health insurance program. The parents interviewed found the

application easy to complete and appreciated the help of the application assistors. They also appreciated the availability of application materials and health services in Spanish. The program is so positive in their view that many parents expressed an interest in a comparable program for adults.

Despite these overall positive perceptions, parents identified a few areas of concern. Some remained nervous about how enrolling their children in the Healthy Kids program would affect their immigration status. Continued efforts are needed to assure parents that enrollment in Healthy Kids does not constitute a "public charge."

Those interviewed indicated that access to primary care, specialty care, and prescription medications is sufficient, but that access to dental services is difficult (though better than it was before enrollment in Healthy Kids). Even when a participating dentist was identified, it was still hard to secure an appointment. Improved access to dental care should be a focus of attention. Parents also asked that more appointments for all services be made available after school and after work.

Parents were not always clear about how to locate a doctor or how to make an appointment; available information was considered complex and cumbersome. A simple document that explains these basic processes would be helpful. Some parents also suggested that providers needed clearer information about the Healthy Kids drug formulary to ensure that, whenever possible, prescriptions were written for medications on the formulary.

QUESTION 7: ARE PROVIDERS SATISFIED WITH THE PROGRAM?

The CHI partners were interested to learn from physicians and dentists about their experiences as providers to children enrolled in public programs and about reasons for their nonparticipation in these programs. Initially, we planned to conduct provider focus groups (separately for physicians and dentists, and broken down further into those who participate in public programs and those who do not). However, recruitment proved extremely difficult. We turned then to a different methodology—individual interviews over the phone. Recruitment for this new study design was also challenging, but we ultimately interviewed 20 providers (table 24). This process included five nonparticipating physicians and five who do serve publicly insured children, including two who practice in public clinics, as well as five participating and five5 nonparticipating dentists. The 15-to-20-minute interviews were conducted between December 2004 and April 2005 using a standardized protocol.

Table 24
Providers Interviewed

Provider Type	Participating	Nonparticipating
Physicians	5*	5
Dentists	5	5

* Two of these physicians work in public clinics; all other physicians and dentists interviewed work in private practice.

Physicians: Interviewees were asked how they felt about public insurance programs for children (Medi-Cal, Healthy Families, and Healthy Kids) and whether they currently or previously served enrollees in these programs. The majority of physicians were unfamiliar with Healthy Kids, though some had at least heard of the program, and three were unaware of Healthy

Families. The two exceptions were pediatricians practicing at public clinics; these individuals were well versed in all three programs. (Two physicians initially indicated that they were familiar with Healthy Kids, but after further discussion, it became clear that they confused Healthy Kids with Healthy Families.)

While half of those interviewed accepted public insurance, only one actually served Healthy Kids patients. Of the four who accepted Medi-Cal and Healthy Families, all restricted the number of publicly covered children in their practice either by setting a cap or by refusing to take additional children. Restrictions can also effectively occur in busy practices when open appointments are two to three months beyond the time of the request. One doctor said that he no longer took any new patients from the Health Plan of San Mateo due to perceived difficulties with authorizations and long (nine-month) delays in receiving payment. When asked why they devoted at least part of their practice to publicly insured children, most providers indicated that they do so out of a desire to offer "community service." "We have a philosophy of serving the advantaged and disadvantaged," one physician commented. "It's my way of giving back," said another.

Half of the doctors interviewed did not accept public insurance. One person worked in a practice that accepted only those patients enrolled in PPOs, thereby precluding Medi-Cal, Healthy Families, and Healthy Kids. Three of the other four nonparticipating physicians were unaware of both the Healthy Kids and Healthy Families programs, but indicated that their practices were sufficiently full that they didn't need to accept Medi-Cal patients.

Each of the physicians interviewed, whether or not they serve publicly insured children, described why they or their colleagues do not take Medi-Cal (and in some cases Healthy Families) patients. Among those with knowledge about Healthy Families, a few felt it is a "better" program than Medi-Cal ("The paperwork is easier;" "There's no problem with the

[Healthy Families] paperwork; it's no worse than private insurance"), but most had no comments on Healthy Families either, because they were unfamiliar with the program.

The strongest sentiments were expressed about the Medi-Cal program, and by both those who accepted this insurance and those who did not. Four of the nonparticipating physicians indicated that taking Medi-Cal patients was not worth the effort given the low reimbursement rates and the complex and burdensome paperwork involved. Commented one doctor: "I haven't had any particularly bad experiences [with Medi-Cal]; it's just not worth the hassle." Those who restrict their practices to Medi-Cal children already among their patient load (i.e., they won't take new Medi-Cal patients) echoed these views. We were told, "Medi-Cal is an enormous burden and we don't get paid enough to make it worthwhile," and "The compensation is lousy."

A few doctors also pointed to the Medi-Cal population as problematic. One of the interviewees said that "some Medi-Cal patients are more demanding, have low compliance, and cause problems in the waiting room." Another said, "They're not easy to deal with and may be more litigious."

The Health Plan of San Mateo compounds some of these problems, according to three physicians. One described abrupt changes in policy that almost always resulted in more paperwork. For example, during the month before the interview, the Health Plan "significantly" modified its treatment authorization plan, which placed a huge administrative burden on this doctor's office staff. "Every time we pick up a piece of paper is time spent." This same physician described another example: "We requested payment for a Doppler exam and out of the blue they decided not to pay. And they did in the past." When the office attempted follow up with the Health Plan, the provider reported, "the Medical Director never got back to us." Another reported that physicians received conflicting and incomplete information about which providers they could refer children to for specialty services and about the current formularies; "Half of the

formulary is not true!" The third physician who raised issues about the Health Plan described what he referred to as "intrusive regulations….For example, they require that we put a lock on our drugs. It's not worth it for the 10 cents on the dollar that they pay us."

Several of the physicians interviewed indicated that referrals to specialty services were difficult in the county. One described the ability to make mental health referrals as "terrible." "Only kids who have a serious mental health condition can get care," she said. "Children with developmental delays or even autism don't have access." Lack of mental health services was the biggest concern for this physician as well: "We have to send kids [with mental health conditions] back to school for treatment because there are long waiting lists at the county." In addition to mental health, those interviewed reported difficulties referring publicly insured children to pediatric subspecialties. "Learning about which specialists to send kids to takes a lot of time," one doctor told us.

Given the high proportion of low-income children in San Mateo County who are immigrants and who speak a language other than English, we sought to assess the extent to which physicians had the ability to communicate with families in their own language. The availability of languages other than English varied among those interviewed. Four physicians (two participating and two nonparticipating) reported that only English is spoken in their offices; all tell patients to bring someone with them to the office who can interpret. One of these occasionally can locate a third party who can translate over the phone. Two other offices attempt to arrange translation services as needed, but the doctors confessed that "it doesn't always work." The public clinics have Spanish-speakers available at all times and arrange for other languages as needed. One physician's office has the capacity for French, Indian, Mandarin and Spanish, and another office has Spanish-speaking staff who can interpret as needed.

We attempted to gauge the "cultural competency" of the providers, but without use of a standardized tool, this was difficult. However, it seems fair to conclude that those offices that have only English-language capacity cannot be considered culturally competent. Those that had different language capacity available were closer to meeting this objective; however, translation services alone do not constitute competency, so no firm conclusions about cultural competency can be reached.

Dentists. As with the physicians, dentists were asked how they felt about public insurance programs for children (Medi-Cal, Healthy Families, and Healthy Kids) and whether they currently or previously served such children. Five of the dentists interviewed accepted public insurance and five did not. Unlike the physicians, the participating dentists were more likely to accept Healthy Families and Healthy Kids payment and less likely to accept Denta-Cal/Medi-Cal.[29] While two of these dentists took children from all three programs, two only accepted Healthy Families and Healthy Kids. Of the former, one has a private practice devoted exclusively to publicly insured children and the other works in a dental clinic.

Some of the dentists interviewed, like the physicians, participated in public programs as a community service ("I do it to pay back"). Some nonparticipating dentists performed other types of community service. For example, two of the dentists volunteered in a dental clinic.

When asked why the nonparticipating dentists do not take public insurance, a wider range of responses was offered. One dentist said, "That's what [the public clinics] are for." Another dentist had a very small private practice and did not take new patients, so effectively had no public patients at the time of the interview: "Today there are plenty of other sources of care for Medi-Cal and Healthy Families [kids] like Western, so there's really not the need for people like me to do it." Still another signed up to take Healthy Families patients just a month before the

[29] Dental care is provided by Healthy Kids through HPSM; however, dental care under Medi-Cal and Healthy Families is provided through arrangements with specialized dental care plans.

interview ("I haven't been approached about Healthy Kids"), but does not participate in Medi-Cal due to "excessive paperwork and low reimbursement." The final noncontracting dentist cited the same reasons ("The pay schedule is low compared to our fee schedule" and "LOTS of paperwork"). This individual indicated that if a person with Medi-Cal really needs care, they will provide it, but they do it for free.

Most of the dentists interviewed described why they or their colleagues did not take Medi-Cal (and, in some cases, Healthy Families). One dentist who only accepted Healthy Families beneficiaries described a number of problems, for example, that when a child presents with a Healthy Families card, it is the responsibility of the dental office to verify at each visit that the child remains eligible that day (or risk nonpayment).

According to those interviewed, a number of problems common to Medi-Cal and Healthy Families discouraged participation. "There are lots of disincentives to take public insurance," said one dentist, including low reimbursement ("They pay one-third of traditional fees") and "excessive paperwork and regulations." One dentist who no longer takes Medi-Cal echoed the complaint about paperwork and added, "Medi-Cal requires an X ray to justify every filling. That's too much!" Still another said, "We would love to [accept public insurance] but we need fees to cover overhead and costs. They [the state] need[s] to review all fee schedules and come up with something that is reasonable."

A number of the dentists described issues related to payment for anesthesia. We were told that it was difficult—if not impossible—to obtain payment for office-based anesthesia for both Healthy Families and Medi-Cal children. Instead, the payers preferred to reimburse for in-patient anesthesia, according to the dentists. Another dentist related that he submitted an invoice to Healthy Families for payment for anesthesia and the program wouldn't pay. The family had to pay out-of-pocket.

Another payment issue related to root canals. One dentist who does a high volume of root canals told us, “The number one reason why root canals fail is that the patient fails to get a permanent filling or crown. Ten percent of all root canals fail for this reason. And Medi-Cal and Healthy Families don’t require this.” Two dentists spoke about a Healthy Families and Medi-Cal requirement for a postoperative X ray to “test the quality of the work.” According to both, it can be “hit or miss” as to whether it is approved, depending on the person who makes the review. If the result doesn’t pass the quality test, no reimbursement is made. “We have to fight for approval [payments] for root canals!” one dentist said. The approval process also compounded the paperwork burden, they reported.

When asked if these payment and authorization issues also related to the Healthy Kids program, three of the dentists who served Healthy Kids patients said yes, and two said they didn’t think so. To the extent that these issues were related to Delta Dental policies for Healthy Families patients, they should also have affected Healthy Kids patients as well. However, those interviewed seemed much more knowledgeable about and focused on Medi-Cal and Healthy Families policies and practices than on Healthy Kids, so it is difficult to know whether the issues are the same.

Like the physicians, some of the dentists tended to blame the patients as well as the programs. We were told: “Medi-Cal patients are unreliable.” “Someone with Medi-Cal comes in without any previous care. They’re abusing it!” “Medi-Cal patients only come in when there’s a crisis.” “We would rather provide free care.” This provider also reported encountering patients who “say that they have other insurance. Two parents said they had Delta Dental but it was really Healthy Families.” Another dentist was more sympathetic. He said, “Healthy Families and Healthy Kids patients are the ‘best patients.’” “Sometimes Medi-Cal patients can be more work,” he added, “but these are people living on a thread.”

The ability of dental office staff to speak languages other than English is mixed. Three dentists, including the dentist whose practice consists of 100 percent publicly insured patients, indicated that staff members instruct patients to bring in a translator. Among the other four dentists, one has Spanish-speaking staff; another has staff speaking Chinese, Tagalong, Korean and Armenian (but not Spanish); another Chinese, Vietnamese, and Japanese (but not Spanish, "Spanish can be a problem"); and still another has an interpreter on staff who speaks Tagalong and Chinese and staff who speak Spanish ("most staff are bi-lingual; half of my patients are Spanish-speaking").

Summary. The primary objective of this component of the evaluation was to learn from providers how more dentists and physicians could be encouraged to serve children enrolled in public insurance programs. We wanted to learn about providers' perceptions of the San Mateo Healthy Kids program. As it turned out, the majority of those with whom we spoke either had not heard about the program or had heard the term but were unfamiliar with the details (or confused Healthy Kids with Healthy Families.) This finding suggests a need to communicate more with providers about the program.

A secondary objective was to determine the problems, more broadly, that doctors and dentists have with all three public health insurance programs for children. Many of the problems that the providers identified (excessive paper work, low reimbursement, and cumbersome regulations) are beyond the control of the San Mateo County CHI and, while important to document, require leadership at the state level to resolve. However, some issues emerged that could be addressed locally.

Many of the providers characterized low-income patients, particularly Medi-Cal beneficiaries, as "difficult" or noncompliant. This may, in part, reflect the bureaucratic hurdles associated with the program, as opposed to difficulties with the individual patients. It is also true

that Medi-Cal recipients are, by definition, extremely low-income, and often face the need to balance competing demands on their time and resources.

Specific recommendations emerged around practices of the Health Plan of San Mateo. Clearly, there is room for improved communication between the plan and providers. Several providers indicated that they need better information about where they can refer children for specialty services. While there is certainly a dearth of pediatric specialists willing to accept public insurance, those that are available should be made known to providers on a regular basis. Improved communication around changes in reimbursement and authorization policies would also be valuable.

Finally, we repeatedly heard from physicians that there is a significant shortage of mental health services in the county. On the other hand, utilization of county mental health services, at least for Healthy Kids, is far lower than expected and the system has the capacity to serve more children. Physicians, especially private practice doctors, need to know that services are available and how to access this care.

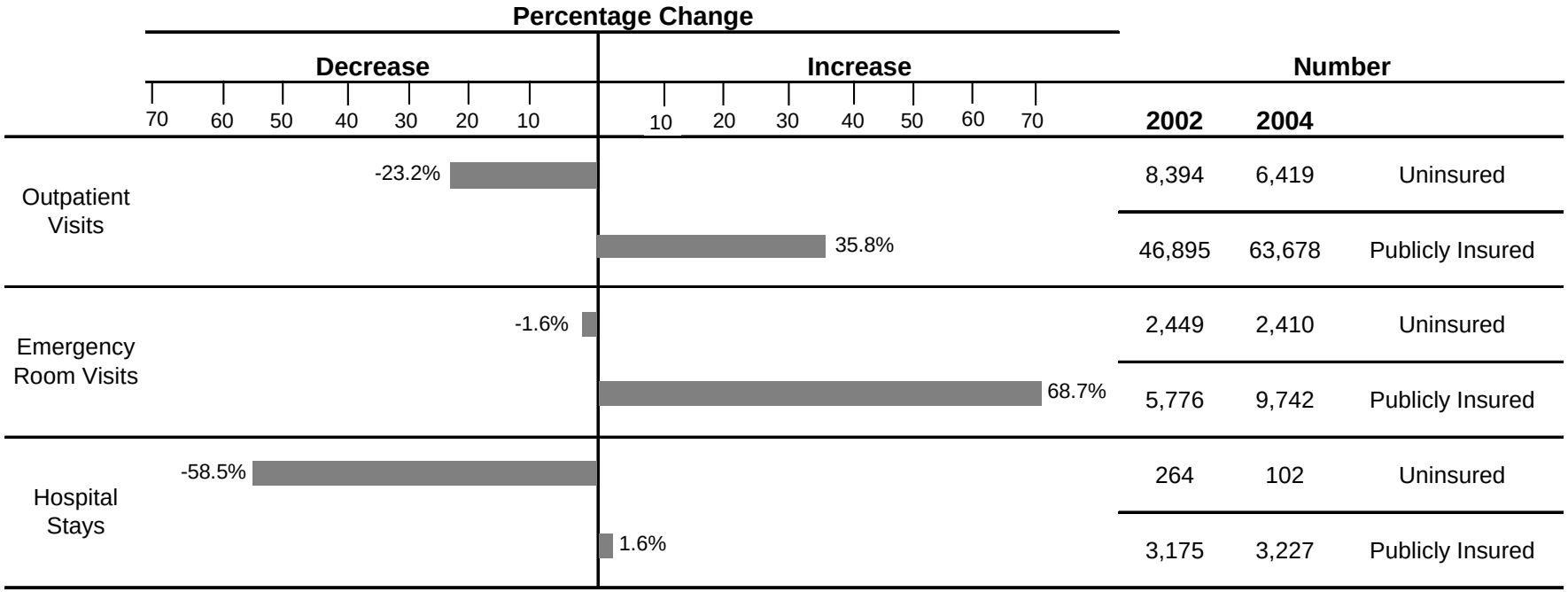
QUESTION 8: HOW DOES THE CHI AFFECT THE FINANCIAL STATUS OF SAN MATEO COUNTY PROVIDERS?

One expectation of the CHI was that it might help the financial status of the county health care system. This could occur by providing health care coverage to children who would otherwise be uninsured, thereby increasing the patient revenue for providers, and decreasing their bad debt/charity care. The Hospital Consortium of San Mateo County, a participant in the Children's Health Initiative, facilitated the collection of aggregate data on this topic from its member hospitals (Mills-Peninsula Hospital, San Mateo Medical Center, Seton Medical Center, and Sequoia Hospital) as well as from Lucile Packard Children's Hospital. (Lucile Packard is in adjacent Santa Clara County, but serves many children from San Mateo County.) The two San Mateo County Kaiser hospitals did not provide data, as they are not members of the consortium.

We requested data on outpatient visits, emergency room visits, hospital stays, and uncompensated care from all five hospitals. Figure 11 shows summary data on trends in visits/stays, and the tables in appendix B provide detailed data for these measures by hospital and age group. As shown in figure 11, outpatient visits, emergency room visits, and hospital stays for uninsured children declined between 2002 and 2004. In contrast, publicly insured visits/stays increased consistently across all three types of service. While it is difficult to attribute the decline in uninsured visits/stays entirely to the CHI, it seems reasonable to assume that CHI-sponsored outreach, especially clinic outreach, is responsible for some of the decline.

Because all the hospitals did not distinguish between Medi-Cal, Healthy Families, and Healthy Kids (grouping all three programs together in some cases), it is not possible to tease out the effects of each program in the aggregate. However, for hospitals that did have such data, Medi-Cal dominated the profile of visits/stays. For example, for San Mateo Medical Center, of

Figure 11
Change in Number of Visits/Stays from 2002 to 2004
San Mateo County Uninsured and Publicly Insured Children



	Number		
	2002	2004	
Outpatient Visits	8,394	6,419	Uninsured
	46,895	63,678	Publicly Insured
Emergency Room Visits	2,449	2,410	Uninsured
	5,776	9,742	Publicly Insured
Hospital Stays	264	102	Uninsured
	3,175	3,227	Publicly Insured

Source: Lucile Packard Children's Hospital; Mills-Peninsula Hospital; San Mateo Medical Center; Seton Medical Center; and Sequoia.

Note: Lucile Packard Children's Hospital does not operate an emergency room.

132 public insurance discharges in 2004, only 25 were for Healthy Families or Healthy Kids (18.9 percent). And at Lucile Packard Children's Hospital, where the most publicly insured children go for inpatient care, of 2,167 publicly funded discharges, only 2.4 percent were for Healthy Families or Healthy Kids.

The role of Emergency Medi-Cal (which can cover care for undocumented children, as well as other low-income uninsured children) in covering the emergency room and hospital care for children who would otherwise be uninsured does not appear to have increased between 2002 and 2004. At the two hospitals that distinguished Emergency Medi-Cal from "full scope" Medi-Cal (Lucile Packard and Sequoia, see appendix B tables), the level of Emergency Medi-Cal emergency room and hospital visits/stays held fairly steady over the period, while the number of full scope Medi-Cal visits/stays increased.

The hospital outpatient departments seem to be the place where the effect of the CHI can potentially be distinguished most readily. There were 1,930 fewer uninsured outpatient visits for uninsured children between 2002 and 2004 (a decline of 23.9 percent), and 16,783 more publicly insured visits (an increase of 36.1 percent). If economic conditions were leading to increased use of hospital outpatient departments for care, without any intervention to assure insurance coverage, one would assume that uninsured visits would increase at the same rate as publicly insured visits.

Assuming that all of the decreased uninsured outpatient, emergency room, and hospital visits/stays were offset by an increase in publicly insured visits/stays, table 25 shows an estimate of the improvement in hospital financial performance that could be attributed to the CHI. The number of visits/stays that are offset is the difference between the number of visits/stays in 2004 and 2002. The cost of each visit/stay that is "saved" is taken from the average per visit/stay cost

for child Medi-Cal patients from the Health Plan of San Mateo. The cost offset is relatively small, only $333,853, when calculated in this manner.

Table 25
Estimated Offset in Hospital Uninsured Costs from the CHI
2004

	Number of Visits/Stays Offset[1]	Cost per Visit/Stay[2]	Total Offset
Outpatient Department	1,930	$141	$272,130
Emergency Department	39	$71	$2,769
Hospital Stays	162	$352	$57,024
		Total	331,623

Note: Lucile Packard Children's Hospital; Mills-Peninsula Hospital; San Mateo Medical Center; Seton Medical Center; and Sequoia Hospital.

[1]Calculated by subtracting the number of uninsured visits/stays in 2004 from the number in 2002.
[2]Average cost for Medi-Cal children to the Health Plan of San Mateo for each type of visit/stay in 2004.

One might also assume that some of the increased visits/stays come from increased utilization of services by previously uninsured children. This is particularly true for outpatient care. While the benefits of this additional care would potentially accrue to the children, it would not be reflected in improved financial performance of hospitals, since these are new visits, not previously uninsured visits.

We also requested data on uncompensated care for uninsured children. Among the four hospitals that provided such data (all but San Mateo Medical Center), uncompensated care for uninsured children was a modest amount: $80,292 in 2002 and a somewhat increased $140,554 in 2004. Three hospitals also reported uncompensated care associated with Medi-Cal, and these numbers also increased during the period and dwarfed the uncompensated care for uninsured children.

Consequently, it appears that the financial performance of the four San Mateo County hospitals providing data, and Lucile Packard Children's Hospital, have been affected by the CHI in only a minor way. Factors associated with Medi-Cal reimbursement appear to be a much more important factor than decreases in the number of uninsured children associated with the CHI.

CONCLUSIONS

The findings of this second annual report of the San Mateo Children's Health Initiative Evaluation point to significant gains made by the CHI in terms of covering high need, uninsured children and providing the means for them to obtain care. Our interview, focus group, and survey data analyses suggest, however, that there are some areas for improvement. Summary observations and recommendations follow.

Outreach, Enrollment, and Retention

- Outreach and enrollment activities continue at an intensive level, now supported through the One-e-App online application process. Although One-e-App implementation has not been completely smooth, it is generally proceeding well.

- There are two areas of concern:

    - **Lower-than-expected rates of retention:** A comprehensive plan to improve retention has been approved and largely implemented. Early evidence suggests that this plan is producing positive results. We recommend continued monitoring of this effort.

    - **Lack of growth in Medi-Cal for children**: Medi-Cal for children has not grown recently. We recommend that this issue be carefully analyzed (as the CHI has done regarding retention issues). Given that the CHI is facing a cap on enrollment of children age 6 to 18 in Healthy Kids, it is particularly important to examine whether any children are being covered by Healthy Kids who could be covered by Medi-Cal.

Healthy Kids Enrollees

- Most Healthy Kids enrollees come from large, extended immigrant families and have resided in San Mateo County for some time. Almost all have a working parent. Most children are poor and speak Spanish at home. This shows that outreach is targeting children in great need.

- Many Healthy Kids enrollees have health problems, with about a third of parents reporting concern about physical health problem, a third reporting dental problems, and a fifth report emotional or behavioral health problems. Healthy Kids adolescents have obesity rates similar to adolescents nationally.

Insurance Coverage and Crowd-out

- Few Healthy Kids enrollees have other options for health insurance coverage, so crowd-out does not appear to be a major issue. Virtually none of the undocumented children enrolled in the Healthy Kids program had access to affordable employer-sponsored coverage.

- Higher-income children have greater access to employer coverage. The CHI might consider an initiative to engage employers in sharing the cost of premiums. Before adopting this option, it is important to gather more information about the size of the 250–400 percent of FPL income group within the county. In focus groups in the coming year, we will explore the extent to which employers would add coverage if such an option were available, and whether—in contrast—some would drop current dependent coverage.

- Many Healthy Kids enrollees are enrolled in Emergency Medi-Cal before enrolling in Healthy Kids. While some state and federal support may be forgone when children enroll in Healthy Kids, Healthy Kids coverage is far more comprehensive than Emergency Medi-Cal. Options to recoup federal and state matching funds for children who could have services covered under Emergency Medi-Cal should be considered.

Access to Care

- Almost all Healthy Kids children have a usual source of care, but about 10 percent do not. In addition, a substantial portion of parents have some concern about their usual source of care, such as the lack of after-hours care. About half said that their doctor did not always explain things well. Thus, while access to care for Healthy Kids enrollees is generally good, there is room for improvement.

The Parent View of Healthy Kids

- In general, parents are very pleased with the Healthy Kids program. Application materials and health services are widely available in Spanish. Many parents express an interest in a comparable program for adults.

- Despite these overall positive perceptions, areas of concern remain. Some parents have a concern about "public charge"; many parents indicated that they initially were reluctant to apply because of fear of jeopardizing their immigration status. Parents should be assured that applying for Healthy Kids will not affect their immigration status.

- Parents say that access to primary care and prescription medications is good, but that access to dental services is difficult. Even when a participating dentist is identified, it can be hard to secure an appointment. Improved access to dental care should be a focus of attention.

- Parents are not always clear about the scope of services covered by Healthy Kids. Some say they do not always know how to locate a doctor or how to make an appointment. A simple document that explains these basic processes would be helpful for parents.

Use of Services and Cost

- Use of services offered by Healthy Kids is lower than for Medi-Cal and Healthy Families. Rates of preventive care are low for all three programs, lowest for Healthy Kids. When all ambulatory care is considered, rates are higher. Seventy percent of children have an annual visit, still lower than national norms. Efforts to improve use of preventive care should be considered.

- Healthy Kids and Healthy Families enrollees are inexpensive compared with Medi-Cal children. The premiums paid for care appear to be higher than the cost, given their relatively low use rates. The CHI should explore more closely the Healthy Kids premium compared with the services covered.

- Hospitals incurred savings from the CHI through improved rates of insurance for children in outpatient, emergency room, and inpatient care. However, savings are minor compared with the overall uncompensated care costs in the county.

Providers

- Most physicians, even those who participate in other public programs, are unfamiliar with Healthy Kids. Getting the word out about the program to private physicians is important. Dentists who participate in other public programs are more familiar with Healthy Kids.

- Physicians and dentists are frustrated with "excessive paperwork," low reimbursement, and added "hassle" associated with treating children enrolled in Med-Cal (and to a lesser extent, Healthy Families). While these problems are beyond the direct control of the CHI, the concerns of local providers should be conveyed to state officials.

- According to some of the physicians interviewed, the Health Plan of San Mateo compounds some of these problems by changing policies, failing to provide adequate information about how to refer for specialty services and current formularies, and imposing "intrusive regulations." These comments (and the strong feelings associated with them) suggest a need for the plan to communicate with participating physicians about their concerns.

By and large, the leadership of the San Mateo County Children's Health Initiative is aware of the issues identified above. Hopefully, the additional information provided by the evaluation will help as the CHI continues to grow and develop.

Appendices

Appendix A
Coverage Status of Children in the Six Months Before Enrolling in the Healthy Kids Program
January 2004

	All Enrollees	Income <250% FPL	Incomes 250-400% FPL
Uninsured	53.5	55.2	37.5*
Private all 6 Months	6.8	4.5	28.5*
Public all 6 Months	23.0	23.2	21.4
Public and Private all 6 Months	1.3	1.3	1.0
Other	15.4	15.8	11.7
N	407	310	97

Source: Healthy Kids Client Survey.

* Difference between lower-income and higher-income groups is significant at the .05 level.

Appendix B
Table 1
Outpatient Visits by Age and Payer
FY 1999-2004[1]

		Age 0-5		Age 6-18[2]		Total	
		Uninsured	Medi-Cal, Healthy Families, Healthy Kids	Uninsured	Medi-Cal, Healthy Families, Healthy Kids	Uninsured	Medi-Cal, Healthy Families, Healthy Kids
Lucile S Packard Children's Hospital[3]							
	1999	1,089	5,818	651	2,625	1,740	8,443
	2000	516	2,633	391	1,501	907	4,134
	2001	537	2,675	385	1,675	922	4,350
	2002	395	2,680	307	1,881	702	4,561
	2003	268	2,893	229	2,196	497	5,089
	2004	233	2,850	229	2,641	462	5,491
	% Change, 1999-2004	-78.6%	-51.0%	-64.8%	0.6%	-73.4%	-35.0%
San Mateo Medical Center							
	2002	2,134	21,141	3,944	14,207	6,078	35,348
	2003	2,037	22,625	5,418	15,895	7,455	38,520
	2004	1,534	27,098	3,106	21,210	4,640	48,308
	% Change, 2002-2004	-28.1%	28.2%	-21.2%	49.3%	-23.7%	36.7%
Mills Peninsula Hospital							
	2002	146	837	276	524	422	1,361
	2003	131	885	213	607	344	1,492
	2004	131	970	220	939	351	1,909
	% Change, 2002-2003	-10.3%	15.9%	-20.3%	79.2%	-16.8%	40.3%
Sequoia Hospital							
	2001	201	60	60	83	261	143
	2002	148	40	62	49	210	89
	2003	84	45	68	76	152	121
	2004	19	37	35	82	54	119
	% Change, 2001-2004	-90.5%	-38.3%	-41.7%	-1.2%	-79.3%	-16.8%
Seton Medical Center							
	2002	292	1,277	370	1,293	662	2,570
	2003	261	1,809	359	1,597	620	3,406
	2004	300	2,050	340	1,898	640	3,948
	% Change, 2002-2004	2.7%	60.5%	-8.1%	46.8%	-3.3%	53.6%
Total - All Hospitals							
	2002	3,115	25,975	4,959	17,954	8,074	43,929
	2003	2,781	28,257	6,287	20,371	9,068	48,628
	2004	2,217	33,005	3,930	26,770	6,147	59,775
	% Change, 2002-2004	-28.8%	27.1%	-20.8%	49.1%	-23.9%	36.1%

Source: Lucille Packard Children's Hospital; Mills-Peninsula Hospital; San Mateo Medical Center; Seton Medical Center; and Sequoia Hospital.
[1]All data available are presented, but years available vary by hospital. The fiscal year runs July through June for all hospitals except Lucile S. Packard Children's Hospital and Mills-Peninsula Hospital. The Lucile Packard fiscal year runs September through August, and the Mills-Peninsula fiscal year runs January through December.
[2]Data is for the group of children age 6-17 for the Lucile S. Packard Children's Hospital. For all other hospitals, data reflects children age 6-18.
[3]Hospital is in Santa Clara County, but data here reflect outpatient visits by residents of San Mateo County only.

Appendix B
Table 2
Emergency Room Visits by Age and Payer
FY 1999-2004[1]

		Age 0-5		Age 6-18		Total	
		Uninsured	Medi-Cal, Healthy Families, Healthy Kids	Uninsured	Medi-Cal, Healthy Families, Healthy Kids	Uninsured	Medi-Cal, Healthy Families, Healthy Kids
San Mateo Medical Center							
	2002	301	1,153	869	976	1,170	2,129
	2003	295	1,534	775	1,294	1,070	2,828
	2004	331	1,963	793	1,666	1,124	3,629
% Change, 2002-2004		10.0%	70.3%	-8.7%	70.7%	-3.9%	70.5%
Mills Peninsula Hospital							
	2002	159	791	241	478	400	1,269
	2003	205	1,155	238	636	443	1,791
	2004	229	1,562	226	775	455	2,337
% Change, 2002-2003		44.0%	97.5%	-6.2%	62.1%	13.8%	84.2%
Sequoia Hospital							
	2001	181	429	193	302	374	731
	2002	157	550	162	360	319	910
	2003	112	749	119	119	231	868
	2004	134	914	150	559	284	1,473
% Change, 2001-2004		-26.0%	113.1%	-22.3%	85.1%	-24.1%	101.5%
Seton Medical Center							
	2002	247	831	313	637	560	1,468
	2003	224	1,120	286	838	510	1,958
	2004	267	1,305	280	998	547	2,303
% Change, 2002-2004		8.1%	57.0%	-10.5%	56.7%	-2.3%	56.9%
Total - All Hospitals							
	2002	864	3,325	1,585	2,451	2,449	5,776
	2003	836	4,558	1,418	2,887	2,254	7,445
	2004	961	5,744	1,449	3,998	2,410	9,742
% Change, 2002-2004		11.2%	72.8%	-8.6%	63.1%	-1.6%	68.7%

Source: Lucile Packard Children's Hospital; Mills-Peninsula Hospital; San Mateo Medical Center; Seton Medical Center; and Sequoia Hospital.
[1]All data available are presented, but years available vary by hospital. The fiscal year runs July through June for all hospitals except Mills-Peninsula Hospital. The Mills-Peninsula fiscal year runs January through December.

Appendix B
Table 3
Hospital Stays by Age and Payer
FY 1999-2004[1]

		Age 0-5		Age 6-18[2]		Total	
		Uninsured	Families, Healthy	Uninsured	Families, Healthy	Uninsured	Families, Healthy
Lucile S Packard Children's Hospital[3]							
	1999	46	1,650	8	228	54	1,878
	2000	85	1,801	14	197	99	1,998
	2001	40	1,762	5	232	45	1,994
	2002	22	1,726	7	240	29	1,966
	2003	21	1,890	3	231	24	2,121
	2004	35	1,896	11	271	46	2,167
% Change, 1999-2004		-23.9%	14.9%	37.5%	18.9%	-14.8%	15.4%
San Mateo Medical Center							
	2002	0	44	16	52	16	96
	2003	0	30	12	47	12	77
	2004	6	68	17	64	23	132
% Change, 2002-2004		600.0%	54.5%	6.3%	23.1%	43.8%	37.5%
Mills Peninsula Hospital							
	2002	16	494	3	69	19	563
	2003	7	551	9	66	16	617
	2004	12	527	3	71	15	598
% Change, 2002-2003		-25.0%	6.7%	0.0%	2.9%	-21.1%	6.2%
Sequoia Hospital							
	2001	8	64	4	14	12	78
	2002	8	59	162	360	170	419
	2003	7	14	2	5	9	19
	2004	7	6	0	8	7	14
% Change, 2001-2004		-12.5%	-90.6%	-100.0%	-42.9%	-41.7%	-82.1%
Seton Medical Center							
	2002	9	111	3	20	12	131
	2003	4	112	2	26	6	138
	2004	8	281	3	35	11	316
% Change, 2002-2004		-11.1%	153.2%	0.0%	75.0%	-8.3%	141.2%
Total - All Hospitals							
	2002	55	2,434	191	741	246	3,175
	2003	39	2,597	28	375	67	2,972
	2004	68	2,778	34	449	102	3,227
% Change, 2002-2004		23.6%	14.1%	-82.2%	-39.4%	-58.5%	1.6%

Source: Lucille Packard Children's Hospital; Mills-Peninsula Hospital; San Mateo Medical Center; Seton Medical Center; and Sequoia Hospital.
[1]All data available are presented, but years available vary by hospital. The fiscal year runs July through June for all hospitals except Lucile S. Packard Children's Hospital and Mills-Peninsula Hospital. The Lucile Packard fiscal year runs September through August, and the Mills-Peninsula fiscal year runs January through December.
[2]Data is for the group of children age 6-17 for the Lucile S. Packard Children's Hospital. For all other hospitals, data reflects children age 6-18.
[3]Hospital is in Santa Clara County, but data here reflect outpatient visits by residents of San Mateo County only.