

Final Report of the Evaluation of the San Mateo County Children's Health Initiative

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EXECUTIVE SUMMARY

The San Mateo County Children's Health Initiative (CHI) began in January 2003, as an effort to improve the health of low-income children in the county by assuring that they have health insurance coverage and access to care. Multiple public and private organizations have collaborated to fund and oversee the initiative. Among other activities, the CHI partners reach out to and enroll children in the health insurance program they are entitled to. The county has established the Healthy Kids program (administered by the Health Plan of San Mateo) to cover children who are not entitled to any other insurance program.

In 2003 the county funded the Urban Institute—along with its partners, consultant Dana Hughes of the University of California, San Francisco; Mathematica Policy Research; and JBS International, Inc., Aguirre Division—to conduct a five year evaluation of the CHI. This report summarizes key findings from the evaluation. More information is contained in other evaluation reports and briefs. (See Appendix B for a project bibliography.)

The CHI outreach and enrollment activities were implemented quickly in the first year, resulting in rapid enrollment growth in the new Healthy Kids program. Enrollment leveled off in subsequent years. As a result, the county has not yet had to establish a waiting list as has been done in other counties with Healthy Kids programs. Enrollment in Healthy Families (the California SCHIP program) has grown moderately since the CHI began, and enrollment in Medi-Cal has been steady (during a period of relative economic prosperity). Unfortunately, there are no accurate data to assess precisely how the initiative has affected the number of uninsured children in the county.

The Healthy Kids program has had a substantial impact on the lives of enrolled children and their families. The program has resulted in:

- Dramatic increases in the proportion of children with a usual source of medical and dental care (30 and 45 percentage point increases respectively).
- Substantial increases in the proportion of children with a medical or dental visit in the past six months (18 and 41 percentage point increases respectively).
- An almost 20 percentage point rise in the proportion of children with preventive care in the past six months.
- Reductions in the proportion of children with an overnight hospital stay in the past six months (but no change in emergency room use).
- Substantial reductions in unmet need for medical and dental care (13 and 10 percentage points respectively), as well as a virtual elimination of cost as a reason for unmet need of either type.
- Reductions in the proportion of children who miss school due to health problems.

Another positive finding from the evaluation is that the use of key services targeted by the CHI for improvement—preventive care and dental care—continues to improve after children have been enrolled in the program continuously for three years.

Given the programs' eligibility level of 400 percent of the Federal Poverty Level, one key goal for the CHI is to prevent crowd-out of private insurance. The evaluation shows that few children who enroll in Healthy Kids (or their family members) have access to private insurance. In addition, while enrollment for children in higher income groups (250–400 percent of poverty) grew faster than for other children in the first two years of the CHI, enrollment leveled off recently and accounts for only a very small percentage of children in that income group in the county.

There are some areas for continued concern and improvement as the CHI enters its sixth year. For example, while many children have mental health needs, few children are yet receiving mental health services through the Healthy Kids program. Continued improved collaboration between the agencies serving such children, and culturally appropriate outreach to families, should help to ensure that children and their families receive the help they need. Also, while most parents are very satisfied with the quality of care their child obtains under Healthy Kids, some parents feel there are areas for improvement such as their need for after-hours care and better communication with providers.

A major area of concern for the future sustainability of the CHI is the cost of the Healthy Kids program, and the ability of the county to sustain financing without help from the state or federal government. Costs have climbed per child, primarily in the areas targeted for improvement such as ambulatory care and dental care. In addition, support from private sources (foundations) has declined, resulting in more county funds being spent to fund Healthy Kids. As an economic downturn approaches, these financing concerns could become more severe.

Still, the strong positive findings from this evaluation demonstrate that the county has effectively used its investment to improve the lives of many of the county's most vulnerable children. These lessons should be used by other local governments in California and around the country to accomplish similar goals.

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CHAPTER I INTRODUCTION

This final report presents results from a five-year evaluation of the San Mateo County Children’s Health Initiative (CHI). The San Mateo CHI has a goal of achieving universal health insurance coverage for all low-income children in the county, thereby improving access to care, use of appropriate services, and health status. A new insurance program, Healthy Kids, was implemented to cover children who have no other source of health insurance and are not eligible for any other public insurance program.

This report summarizes a wide-ranging evaluation of the CHI, beginning in May, 2003, that includes the following activities:

- Three comprehensive one-week site visits in the first three years of the evaluation, with updates in person and by telephone in the last two years, designed to document the implementation of the CHI, including both successes and challenges.
- Two rounds of focus groups with parents of Healthy Kids enrollees. The focus groups were designed to collect in-depth qualitative information on parents’ perceptions of the program.
- In-depth interviews with medical and dental providers, to obtain their views of the program, and with employers, to assess their knowledge of the program and whether Healthy Kids potentially crowds out private insurance.
- Two waves of a parent survey, designed to collect information on the characteristics of enrolled children, their access to care and service use, and their health status. The Wave One survey collected data on a cross-section of enrollees in 2004. The Wave Two survey collected data in 2006 for two groups of children—those just recently enrolled and those enrolled for one year—in order to measure program effects on key outcomes.¹
- Analysis of annual data from the Health Plan of San Mateo, comparing characteristics, use, and cost of Healthy Kids enrollees over time to children of the same age enrolled in Medi-Cal (Medicaid) or Healthy Families (SCHIP).

¹ Wave One results were reported in an earlier evaluation report, so data in this report come from Wave Two. Appendix A provides more detail on the design of the survey and the impact analysis.

- Four comprehensive reports (three annual reports in the first three years and this final report).
- Three topical briefs and a “data book” documenting early Wave Two survey findings.
- Numerous conference presentations and a journal article.
- Two issue briefs that use data from this evaluation combined with results from two other county CHI evaluations (Los Angeles and Santa Clara).

See Appendix B for a bibliography of these documents and presentations.

The evaluation is designed to address the evaluation questions outlined in Table I-1. The table also shows the data sources that are used to address each evaluation question. Each of the reports described above addressed one or more of the evaluation questions, but only this report summarizes findings across all evaluation questions.

The evaluation was conducted by a team consisting of the following organizations and individuals:

- **The Urban Institute** (lead organization): Embry Howell, Genevieve Kenney, Brigitte Courtot, Louise Palmer, Ariel Klein, Jamie Rubenstein, Holly Stockdale, and Jennifer Sullivan;
- **University of California, San Francisco:** Dana Hughes;
- **Mathematica Policy Research:** Martha Kovac and Betsy Santos; and
- **JBS International, Inc., Aguirre Division:** Carmen Sum.

The remainder of the report is organized in eleven chapters. The following chapter documents the implementation of the CHI from its inception until today. Nine subsequent chapters each address key research questions, and the final chapter provides conclusions and recommendations to San Mateo County and organizations and individuals interested in expanding health insurance coverage for children.

**Table I-1
Research Questions and Data Sources for San Mateo County CHI Evaluation**

	Site Visit Interviews	Provider and Employer In-Depth Interviews	Parent Focus Groups	Health Plan of San Mateo Encounter Data	Parent Survey
Research Questions					
Who is served by the San Mateo CHI? How has the composition of enrollees changed over time?				P	S
What is the impact of Healthy Kids on access to care and use of medical services? Mental health services? Dental services?	S		S		P
What services do Healthy Kids enrollees receive and what is the cost of their care? What are the trends over time?	S		S	P	
Does Healthy Kids have an impact on the health status of children who enroll?					P
What is the impact of Healthy Kids on insurance status and crowd-out of private coverage?	S	S	S		P
Did the CHI increase community-wide collaboration to address issues of the uninsured?	P	S			
Are parents satisfied with the Healthy Kids program and its services?	S		P		P

P: Primary
S: Secondary

CHAPTER II BACKGROUND

History of the San Mateo County Children’s Health Initiative²

In early 2001, the priorities of several committed individuals, agencies, and foundations in San Mateo County converged around the goal of broadening children’s health insurance coverage. One catalyst for change was the county’s declining economy (following the dot com boom and bust) and high housing prices, which put lower income families at increasing financial risk (Huening 2006; Huening 2007).

Neighboring counties, Santa Clara and San Francisco, had recently implemented Children’s Health Initiatives (CHIs) to further the same goal. A paper by Toby Douglas, a student who would later join the Health Services Agency staff, highlighted the need for more active outreach and enrollment of uninsured low-income children into available public programs. Several foundations and the First 5 San Mateo County Commission—funded by California’s Proposition 10 tobacco tax revenue to support health, education, and childhood development of children ages 0 to 5—chose expansion of children’s health insurance coverage as a new priority. The county received new funds through a federal grant to provide outreach and enrollment services at clinics. The Hospital Consortium of San Mateo also expressed an interest and brought the potential of financing for some uninsured children through taxes in two health care districts. Shortly thereafter, a task force was formed including members from the Health Services Agency, First 5 San Mateo, the Human Services Agency, the Hospital Consortium, the Peninsula Community Foundation, the Health Plan of San Mateo (HPSM), and the Labor Council. These organizations were the main participants in early discussions of CHI implementation. In

² More detail is contained in the three annual reports for the evaluation.

May 2002, a countywide “summit” meeting on children’s health insurance gained the financial support of the county Board of Supervisors.

These discussions led to a program concept that includes outreach and enrollment activities for all three public programs (including Medi-Cal and Healthy Families), and the new insurance program, Healthy Kids. Healthy Kids was launched as a new health insurance product for children in January 2003. It is administered by the Health Plan of San Mateo, the county-sponsored health plan that insures all Medi-Cal children and about 40 percent of Healthy Families children. Due to the high cost of living in San Mateo, this new health insurance is available to uninsured children up to 400 percent of the federal poverty level (FPL).³ Additionally, undocumented children are covered, thus providing coverage to many children who had previously been excluded from other public programs.

Administration for the CHI has, until very recently, been housed at the Health Services Agency (later renamed the San Mateo County Health Department). In March 2007, CHI administration moved from the Health Department to the Health Plan of San Mateo. The move is designed to foster accountability and program improvement within the HPSM, which administers Healthy Kids. The move in location closely followed a transfer in CHI governing authority from the County Board of Supervisors to the HPSM Commission.

An Oversight Committee—consisting of many of the same members as the original task force—makes major decisions for the CHI, guided by several sub-committees. The Oversight Committee, while not a formal legal entity, has provided

³ This decision gave the San Mateo CHI the distinction of being the only such initiative in the state to cover children at such a high income level.

broad community input and advice throughout the CHI's six year history. Many people initially involved with the CHI continue to be involved, ensuring continuity of leadership throughout the initiative.

Outreach and Enrollment

One of the CHI's primary goals is to improve outreach and enrollment for all public children's health insurance programs in San Mateo County, both Healthy Kids as well as Medi-Cal and Healthy Families.

The CHI has worked to increase enrollment in several ways. These include educating the public about insurance options and assisting with enrollment paperwork, staffing a hotline for questions or concerns; disseminating flyers; and maintaining a web site. The CHI places outreach workers at community sites such as schools and clinics, as well as at one-time events such as community health fairs. At schools, outreach staff send flyers home with students in order to request information on the children's health insurance status, and in some schools the Express Lane Eligibility process combines a public health insurance application with an application for free or reduced price lunch.

In order to expedite the enrollment process, the CHI promotes the use of the One-e-App, an on-line system whose purpose is to streamline application preparation and processing and to provide a single application for all three public programs. By fall 2004 many outreach staff were using One-e-App, and by late 2005 it was fully operational.⁴

Having improved the enrollment process, the CHI has adopted new outreach priorities. One priority is an increased focus on renewal of a child's insurance, because many children drop out of Healthy Kids at the time of renewal, even when they remain eligible. The CHI has implemented several strategies to counteract this problem. While

⁴ San Mateo County was the first county in California to fully implement One-e-App for a public program.

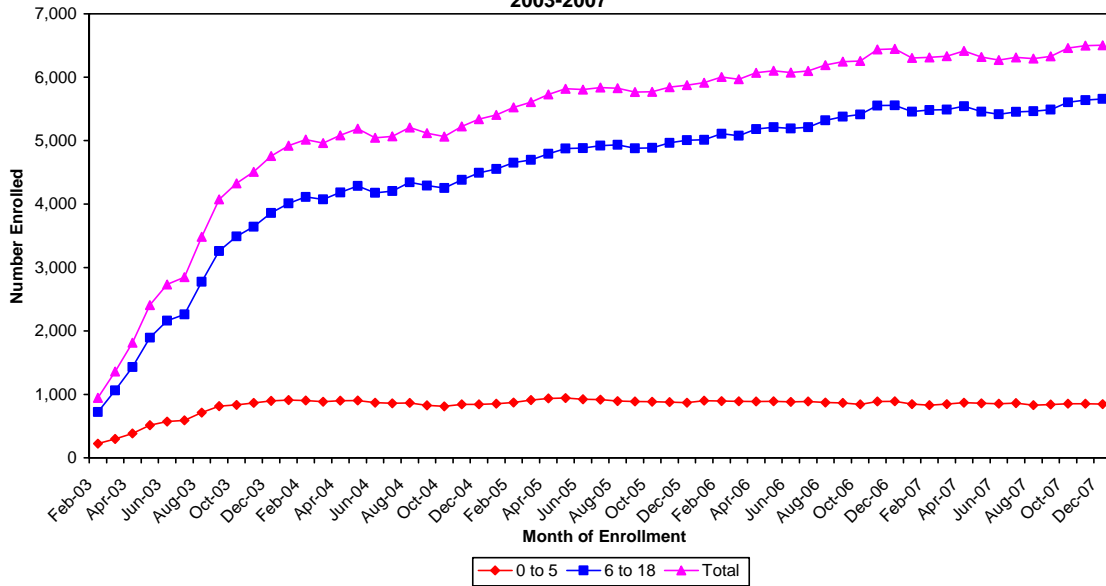
members of community-based organizations previously made reminder calls to families who are due for renewal, CHI and HPSM staff now place these calls and provide assistance with renewal applications via telephone. The CHI is better able to monitor the outcome of each renewal application, and has found that Healthy Kids retention has improved from 68 percent in December 2006 to 82 percent in November 2007 (based on data from the Health Plan of San Mateo).⁵

Figure II-1 shows enrollment growth in Healthy Kids from February 2003 through December 2007. While enrollment for children ages 0 to 5 rose quickly after the program's launch, it leveled off at about 900 children in late 2003 and has not grown much since then in spite of continued outreach efforts. Enrollment for children ages 6 to 18 continued to increase until it leveled off at about 5,500 in late 2006. Consequently (in contrast to most other counties with Healthy Kids programs) the county has not had to establish a waiting list for the program.

Figure II-2 shows enrollment growth in San Mateo County for the other two public programs, beginning in 2001 prior to the launch of Healthy Kids. Enrollment in Medi-Cal grew steadily during the recession years in the early part of the decade, leveling off at about 26,000 children in 2004. It is possible that CHI efforts, combined with the One-e-App on-line application system, have helped to prevent a decline in Medi-Cal enrollment that would have occurred as the recession waned in the mid-decade. In contrast to both Medi-Cal and Healthy Kids, Healthy Families showed a steady increase in enrollment throughout the time for which data are available (January 2002 to October 2007).

⁵ A more detailed examination of renewal rates in San Mateo County's Medi-Cal, Healthy Families, and Healthy Kids programs appears in another report (Howell et al. 2006b).

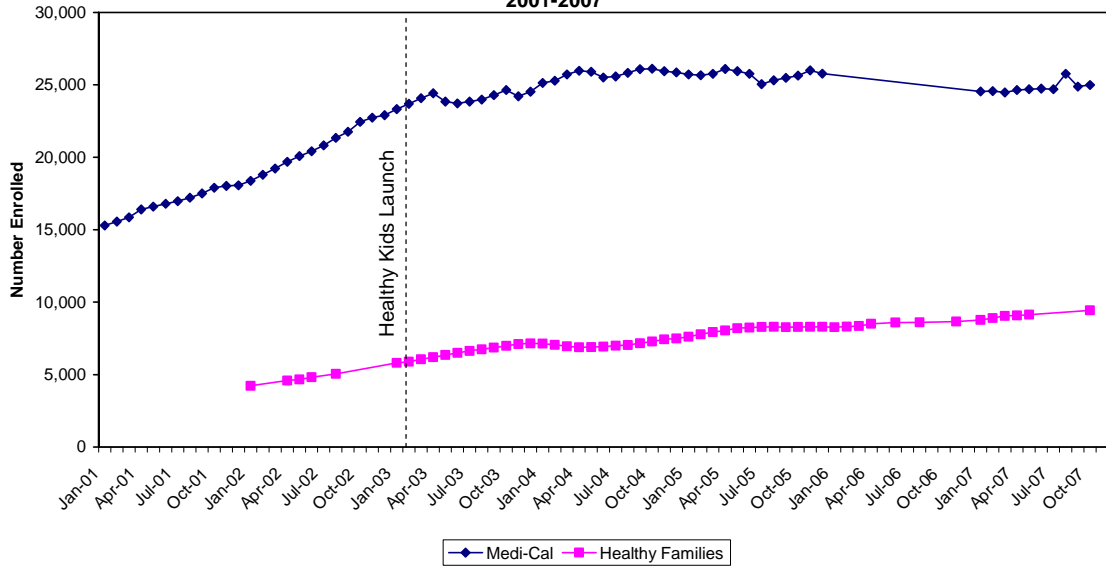
Figure II-1
Number of Healthy Kids Enrollees in San Mateo County, by Age
2003-2007



Source: Health Plan of San Mateo.

Note: Enrollment data for October to December 2007 are based on information available as of January 3, 2008.

Figure II-2
Number of Medi-Cal and Healthy Families Child Enrollees in San Mateo County
2001-2007



Sources: Medical Care Statistics Section (Medi-Cal enrollment for January 2001 to December 2005); Human Services Agency (Medi-Cal enrollment for January 2007 to October 2007); and Managed Risk Medical Insurance Board (Healthy Families enrollment).

Note: Some monthly enrollment counts are not available.

The Healthy Kids Program

San Mateo's Healthy Kids program provides medical, dental, vision, and mental health coverage to children ages 0 to 18 whose family incomes are up to 400 percent of the federal poverty level. To discourage a family from dropping private insurance ("crowd-out"), there is a six-month waiting period during which the child may not be covered by employer-sponsored insurance. Once an application is completed, the processing time is only about five days until enrollment.

Once enrolled, a Healthy Kids member receives the following benefits:

- Medically necessary hospitalization
- Physician, outpatient, and surgical services
- Prescription drugs
- Well child services
- Family planning
- Mental health
- Occupational, alcohol, and drug treatment services
- Physical and speech therapies
- Lab and X-ray services
- Dental and vision services

Parents pay a \$5 co-pay for their children's visits and prescription drugs, with some exceptions including preventive care visits. There is a maximum of \$250 per year per family in co-payments.

Healthy Kids families are responsible for quarterly premiums of between \$12 and \$60 per child, depending on income⁶. While parents may pay the premium each quarter, 90 percent of Healthy Kids parents pay their child's premiums annually and receive a "buy 3 quarters, get 1 free" incentive. In January 2008, 15 percent of enrollees used the hardship fund, which assists families who cannot afford their portion of the premium.

⁶ Premiums have essentially been stable since the beginning of the CHI, except for an increase from \$18 per quarter to \$36 per quarter for children with family incomes at 201-250 percent of the FPL, in order to be consistent with the Healthy Families premium structure.

This fund is promoted to needy families by an HPSM retention specialist, whose efforts have helped reduce the number of disenrollments due to nonpayment of premiums from 40 disenrollments in January 2007 to 11 disenrollments in December 2007.

The Health Plan of San Mateo (HPSM) manages care for Healthy Kids enrollees. At the time of enrollment, parents choose or are assigned an individual primary care provider. The HPSM contracts with a network of public, nonprofit, and private providers, including 26 pediatric practices, 18 family medicine practices, and six hospitals. However, the main network provider in the plan is the county-operated public hospital and clinic system. The HPSM has tried to increase private provider participation by increasing reimbursement rates from 123 percent of the Medi-Cal fee schedule to 133 percent in March 2006.

In addition to the premiums parents pay, the HPSM receives a monthly premium from the CHI. The premium was just over \$92 per child per month until recently⁷. Because Healthy Kids service costs have been significantly lower than expected, the CHI Oversight Committee recently approved a recommendation to lower the monthly premium to \$74 per child. This change in premiums enables the CHI to cover more children under Healthy Kids.

More ongoing follow-up with Healthy Kids members has developed as the CHI has identified areas for improvement. For example, in the past two years the CHI has adopted more concerted efforts to encourage utilization and make the program user-friendly. At enrollment, Healthy Kids families now receive more patient education and welcome calls from the HPSM. Additionally, HPSM staff make periodic calls to promote

⁷ Premiums have been lowered gradually since the program began. The initial premium was \$95.25 per child per month in 2003, and was lowered gradually to \$92.13 in June 2007.

utilization of medical, dental, and mental health services among those who have not used care.

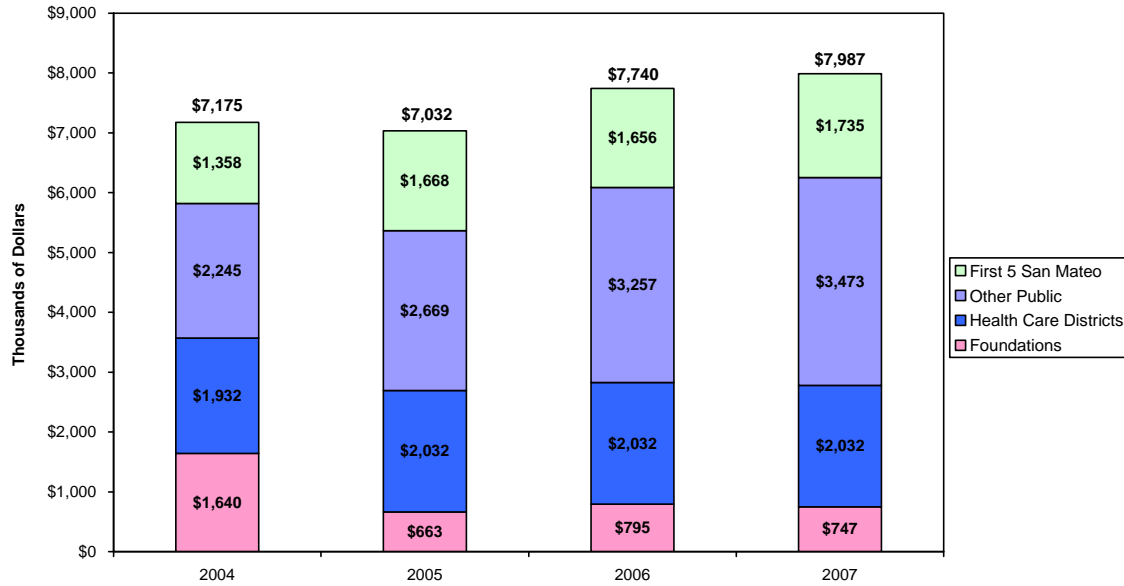
Financing the CHI

A diverse funding base supports CHI activities for outreach/enrollment, Healthy Kids premiums, and administration. Premiums are by far the biggest expense, comprising about 80 percent of the CHI expenses for 2004 to 2007.

Figure II-3 shows the level of CHI financing for 2004 to 2007, by year and type of funding. (More detail is provided in Appendix Table II-1.) Annual costs have been from about \$7 to 8 million. Funding from First 5 has held steady at about \$1.5 million per year. Other public funding (primarily from the county, but with some federal/state involvement) has increased from \$2.2 million to \$3.5 million during the four years for which data are available. Health care district funding has been constant at about \$2 million per year. Private foundation funding declined from \$1.6 million in the first year to less than a million dollars each year since.

While the role of private philanthropy has waned somewhat, it continues to be important to the funding base. Eight private foundations have contributed during 2004–2007, with four contributing over \$500,000 during the four year period. Efforts continue to identify new sources of funding. In addition, due to lower-than-anticipated expenses for services to Healthy Kids enrollees, the HPSM accumulated a reserve. Beginning in 2006, the HPSM returned 80 percent of excess revenues to the CHI. This has filled a funding gap created by a decline in foundation funding and has accommodated the slow growth in enrollment for children ages 6–18.

**Figure II-3
Financing for the San Mateo County Children's Health Initiative
2004-2007**



Source: San Mateo County Health Department.

Note: See Appendix Table II-1 for more detail.

The future outlook for CHI financing is uncertain, given that the CHI must apply for most of its funding sources each year and none is completely secure. Increasingly the county is looking to the state for help with financing the CHI.

In the past few years, there have been several attempts, through coalitions across the state, to create a statewide Healthy Kids program by expanding Healthy Families to cover all uninsured children (including undocumented children) up to 300 percent of the FPL. The most recent effort again failed due to the state's large budget deficit. However, Governor Arnold Schwarzenegger and other supporters have expressed a commitment to keep working on health care reform (Trapp 2008). At the time of this writing, advocacy groups are working to have a ballot initiative in November 2008 that would increase the tobacco tax in order to fund a children's health insurance expansion statewide.

Given the uncertainty at the state level, it is important for the San Mateo County CHI to continue to seek local funding sources to sustain the CHI. In the absence of statewide health care reform, in the near term San Mateo County hopes to continue the CHI activities with its existing funding base, while working with others in the state on longer-term health reform efforts.

Recognizing that many parents of children covered by CHI efforts remain uninsured themselves, many of those involved in the CHI have advocated for expanding its efforts to cover uninsured adults. In 2006, the county created a Blue Ribbon Task Force on Adult Health Care Coverage Expansion, which gave a recommendation in 2007 to provide health care coverage for the 36,000–44,000 uninsured low-income adults ages 19–64 living in San Mateo County (Blue Ribbon Task Force 2007). The county has enrolled over 2000 adults, with an ultimate goal of covering all low-income uninsured county residents.

CHAPTER III

WHO IS SERVED BY THE SAN MATEO CHI? HOW HAS THE COMPOSITION OF ENROLLEES CHANGED OVER TIME?

The Healthy Kids program has experienced substantial stability in the types of children who enroll in the program, but there have also been some important changes. In this chapter we present the demographic profile of children who have enrolled in Healthy Kids over time. Data come from the HPSM, which collects demographic characteristics for all enrollees. In addition—because the plan enrolls all Medi-Cal children in the county and about 40 percent of Healthy Families children⁸—we also present data comparing Healthy Kids enrollees to Medi-Cal and Healthy Families children who are enrolled in the plan.

Table III-1 shows trends in age, gender, language, family income, and child citizenship among new Healthy Kids enrollees each year from 2003 (when the program began) to 2006⁹.

Age and Gender of Healthy Kids Enrollees.

In all four years the program enrolled mainly school-aged and adolescent children, with about 45 percent of enrollees in the first year being ages 6 through 12 and about 33 percent being ages 13 through 18. The age profile of new Healthy Kids enrollees shifted some with an increase in the proportion of young children. By 2006, 2.6 percent of enrollees were infants and about 28 percent of enrollees were ages 1 through 5, an increase from 0.8 and 21.4 percent respectively in 2003. This increase is due to

⁸ From July 2006 to June 2007, 42.7 percent of new enrollees in Healthy Families within San Mateo County enrolled in the Health Plan of San Mateo, according to county administrative data.

⁹ Only children who remain enrolled for one year after enrollment are included. Thus the sample is not a cross-section of children in the program at a point in time.

**Table III-1
Demographic Characteristics
of Healthy Kids Enrollees
2003-2006**

	Total			
	2003	2004	2005	2006
N	4,375	2,000	1,829	1,417
	Percent			
Age				
<1	0.8	1.6	2.6	2.6
1-5	21.4	21.8	26.0	28.3
6-12	44.5	44.0	41.4	40.0
13-18	33.3	32.6	30.0	29.1
Gender				
Male	52.1	51.6	50.5	51.4
Female	47.9	48.4	49.5	48.6
Language				
English	9.9	12.0	15.6	13.8
Spanish	86.9	83.6	79.4	79.3
Other	3.2	4.4	5.0	6.9
Family Income				
<151% of FPL	74.7	71.8	67.9	68.9
151-250% of FPL	15.8	12.6	11.7	9.9
251-300% of FPL	5.3	8.9	12.5	11.6
301-400% of FPL	4.2	6.7	7.9	9.6
Child Citizenship or Legal Residency				
Yes	7.1	14.3	20.2	20.3
No	92.9	85.7	79.8	79.7

Source: Health Plan of San Mateo.

Notes:

- (1) Includes only children continuously enrolled during their first year of enrollment.
- (2) Appendix Table III-1 presents demographic characteristics separately for ages 0-5 and ages 6-18.

increased outreach to families with young children. Slightly more boys than girls enroll in Healthy Kids, a proportion that did not change over time

Language

Spanish is the preferred language for receiving materials and applications for most of the families of Healthy Kids enrollees. In the first year of the program, 86.9 percent of enrollees were most comfortable communicating in Spanish, compared to 9.9 percent who communicated in English and 3.2 percent who preferred another language. As the program grew, the proportion of Spanish speakers dropped slightly, and the proportion of speakers of English and other languages grew. By 2006, the proportion of Healthy Kids enrollees speaking English or other languages was around 20 percent.

Family Income

The majority of Healthy Kids enrollees live in families with incomes below 151 percent of the Federal Poverty Level (FPL), with 74.7 percent belonging to this group in 2003. Over time, the program enrolled a somewhat lower proportion of low-income children and somewhat higher proportion of high-income children. By 2006, about 69 percent of new enrollees live in families with incomes below 150 percent of the FPL, about 10 percent live in families with incomes between 151 and 250 percent of the FPL, and just over 20 percent live in families with incomes above 250 percent of the FPL.

Child Citizenship or Legal Residency

While the majority of Healthy Kids enrollees are undocumented, there has been a sizeable increase in the proportion who are citizens or legal residents of the U.S. In 2003, only 7.1 percent of enrollees were citizens or legal residents. By 2006, this proportion more than doubled, with 20.3 percent being citizens or legal residents. The trend toward

more documented enrollees is consistent with the trend toward higher-income enrollees and aligns with increased new outreach approaches targeting families with incomes above 250% FPL.

Comparisons with Medi-Cal and Healthy Families

Compared to Medi-Cal and Healthy Families children newly enrolled in the HPSM, Healthy Kids enrollees are older and more often Spanish-speaking (Table III-2). In particular, a large proportion of Medi-Cal enrollees are children under age one. This is due to Medi-Cal's more generous income eligibility levels for this age group and the fact that newborns are typically citizens of the United States. In 2006, over 50 percent of Medi-Cal children newly enrolled in the HPSM were less than one year old.

The proportion of Healthy Kids enrollees whose families speak Spanish (79.3 percent in 2006) is higher than in both other programs, with the contrast particularly strong for Medi-Cal (only 45.8 percent in the same year). This difference reflects Healthy Kids coverage of immigrant children whose families are only recently arrived in the U.S and do not meet eligibility criteria for Medi-Cal or Health Families.

**Table III-2
Demographic Characteristics of Children
Enrolled in the Health Plan of San Mateo
for One Year
2006**

	Healthy Kids	Healthy Families	Medi-Cal
N	1,417	969	4,725
	Percent		
Age			
<1	2.6	2.8	52.8
1-5	28.3	37.2	16.8
6-12	40.0	40.3	15.8
13-18	29.1	19.7	14.6
Gender			
Male	51.4	49.8	49.2
Female	48.6	50.2	50.8
Language			
English	13.8	29.2	50.8
Spanish	79.3	63.7	45.8
Other	6.9	7.1	3.4

Source: Health Plan of San Mateo.

Notes:

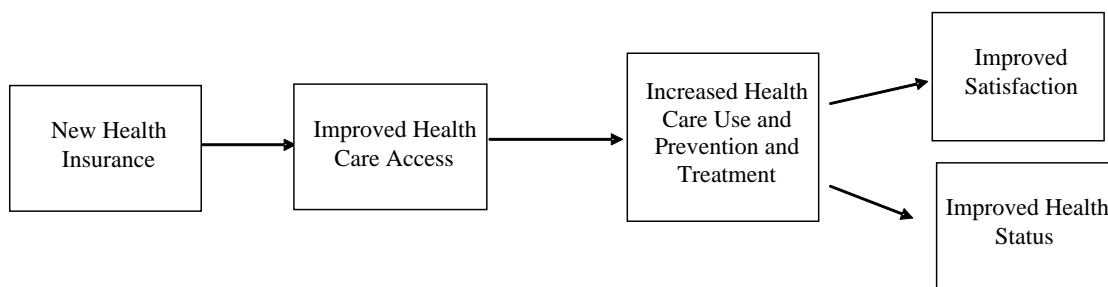
- (1) 2006 enrollees continuously enrolled during their first year of enrollment.
- (2) Healthy Families data for children enrolled through the Health Plan of San Mateo only.

CHAPTER IV
WHAT IS THE IMPACT OF HEALTHY KIDS ON
ACCESS TO AND USE OF MEDICAL CARE?

Lack of health insurance creates a major barrier to accessing and receiving medical care (Families USA 2001; Stagnitti 2002; Doyle 2005; Haas and Goldman 1994; Hadley 2007; Tilford et al. 2001; and Institute of Medicine 2002). Uninsured children are more likely to go without any medical care, to have unmet healthcare needs, or to lack a personal doctor or nurse, compared to their insured counterparts (Covering Kids and Families 2005). For children, access to a health care provider is important not only to ensure timely treatment for periodic or chronic illness, but also for preventive health care.

The major goal of the San Mateo CHI is to ensure that all children in San Mateo County have health insurance, have access to and appropriately use health services, and consequently have improved health status. The logic model showing these relationships is as follows.

Figure IV-1
Logic Model for Expected Impact of Healthy Kids



This chapter examines whether Healthy Kids has had an impact on access to and use of primary, preventive, and specialty medical care services. The major data source for

this chapter is the 2006 parent survey of Healthy Kids enrollees. The survey includes a sample of children who recently enrolled in Healthy Kids (“new enrollees”) and a sample of children who recently renewed coverage after one year in the program (“established enrollees”). Responses from new enrollee parents about their child’s access to care and use of services in the six months prior to enrolling in Healthy Kids (while most were uninsured) are compared to parent responses for established enrollees about the six months prior to the survey (while the children were enrolled in Healthy Kids).

Throughout the report, we provide descriptive comparisons between new and established enrollees in tables, and in figures we compare regression-adjusted means indicating estimates of the impact of the program.¹⁰ The impact estimates are augmented with qualitative information on access from site visit interviews with key stakeholders in each year of the evaluation, as well as data from focus groups with parents.

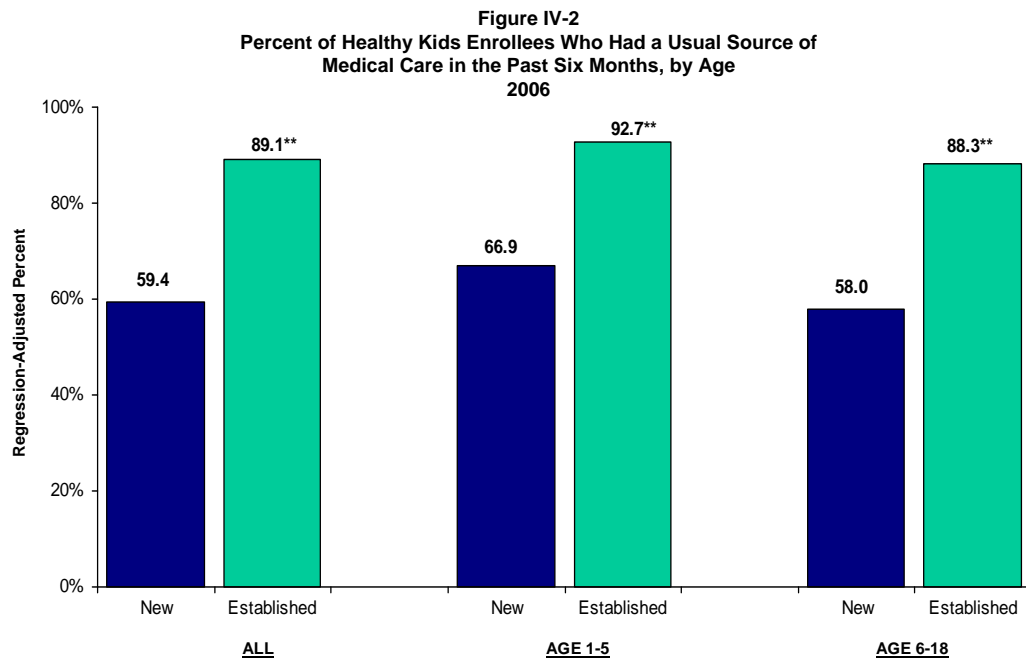
Usual Source of Care

Access to healthcare is a crucial gateway to facilitating continuous service use, and is widely measured by whether or not a person has a regular primary care doctor, or “usual source of medical care” (Starfield 1992). In the parent survey, we asked the following question: Do you have a particular place that your child usually goes if he/she is sick or you need advice about his/her health?

Enrollment in Healthy Kids has significantly increased the proportion of enrollees with a usual source of medical care, and therefore, access to care (Figure IV-2). Almost all children (89.1 percent) who have been enrolled for one year have a primary care provider whom they usually go to when they need to see a doctor, compared to only 59.4 percent of newly enrolled children. This finding holds for both age groups, suggesting

¹⁰ More detail on how impact estimates are computed is contained in Appendix A.

that access to care has improved after enrolling in Healthy Kids. This is consistent with other evaluations of Healthy Kids programs in Los Angeles and Santa Clara Counties (Trenholm et al. 2007).



** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Note: A hospital emergency room is not considered a usual source of care for this analysis.

Parents who report that their child does not have a usual source of care are asked why. Their responses reveal that it is not always an access problem as is conventionally thought. For example, almost half of parents of established enrollees and just over a quarter of new enrollee parents report it is because their child rarely falls ill (Appendix Table IV-1). Cost is a common barrier for new enrollees (28.2 percent) but much less often for established enrollees (12.9 percent).

Place of Usual Source of Care

Among those with a usual source of care, we asked the parent to name their child's usual source of care. Table IV-1 indicates that after enrollment a higher proportion of children with a usual source of care report that they use clinics/health centers as usual sources of care (from 50.9 percent to 79.5 percent of those with a usual source of care). This trend is consistent across age groups. A shift away from the emergency room as a usual source of care is most marked for older children (9.5 percent of new enrollee parents report this compared to only 3.3 percent for established enrollees). This suggests that the parents of children who newly acquire a usual source of care after enrollment in Healthy Kids are mostly choosing clinics for their child's primary care.

Table IV-1
Type of Usual Source of Care for Enrollees
with a Usual Source of Care, by Age
2006

Type of Usual Source of Care**	Total		Ages 1-5		Ages 6-18	
	New Enrollees	Established Enrollees	New Enrollees	Established Enrollees	New Enrollees	Established Enrollees
			Percent			
Private Physician	25.3	15.1	26.5	19.8	24.9	14.1
Clinic or Health Center	50.9	79.5	47.9	74.5	51.8	80.5
Kaiser	3.2	0.0	3.0	0.0	3.2	0.0
Clinic outside the county or unknown provider	13.0	2.3	21.1	3.7	10.6	2.1
Hospital Emergency Room	7.6	3.1	1.5	2.0	9.5	3.3
N	450	627	155	156	295	471

** Distributions for new and established enrollees are significantly different for all enrollees and both age groups, $p < .01$, two-tail test.

Source: Healthy Kids parent survey, 2006.

The survey provides information about characteristics of enrollees' usual sources of care (Table IV-2). There are few differences between the two groups in these characteristics. About 40 percent of both groups live within 15 minutes of their usual source of care. About 80 percent say they are treated respectfully and about 90 percent would recommend their usual source to family or friends. There are a few minor significant differences. Fewer established enrollee parents report they need advice when their child's usual source of care is closed and more parents of children ages 1 through 5 report their child has a personal doctor or nurse. Thus, while many more children have a usual source of care after enrolling and there is some shift towards clinics in where they go regularly, there is no major shift in parents' perceptions of their child's usual source of care once they have one.

Table IV-2
Characteristics of Usual Source of Care for Healthy Kids Enrollees in San Mateo County, by Age

Characteristic of Usual Source of Care	Total		Ages 1-5		Ages 6-18	
	New Enrollees	Established Enrollees	New Enrollees	Established Enrollees	New Enrollees	Established Enrollees
	Percent					
Time to get to usual source of care						
Less than 15 minutes	37.3	37.6	37.0	35.4	37.4	38.1
15 to 30 minutes	40.0	37.8	40.0	42.7	40.0	36.7
30 minutes to 1 hour	17.2	18.3	21.0	17.6	15.9	18.4
More than 1 hour	5.5	6.4	2.0	4.3	6.7	6.8
Needed advice when usual source of care closed	19.8	13.4*	25.0	24.2	18.1	11.0*
Child has a personal doctor/nurse	59.9	66.7	61.7	75.7*	59.3	64.7
Doctors always explain things in a way the parent understands	59.7	58.9	66.0	61.4	57.7	58.4
Doctors always speak a language the parent understands well	68.9	65.2	71.0	77.1	68.2	62.6
Parent always has difficulty communicating with doctors	2.3	2.6	0.0	0.5	3.0	3.0
Doctor always treats parent/child with respect	81.4	84.3	79.9	78.7	81.8	85.5
Very satisfied with amount of time spent with doctors	54.8	51.8	56.1	57.2	54.3	50.6
Would recommend usual source of care to family/friend	92.3	92.9	94.7	90.6	91.5	93.4
N	419	606	153	152	266	454

* Significantly different from new enrollees, p<.05, two-tail test.

Source: Healthy Kids parent survey, 2006.

There is room for improvement in some areas. For example, roughly 46 percent of all parents would like more time with their child's doctor, and only about 60 percent of

parents report that their child's doctor always explains things well. These concerns are corroborated by discussions with parents in focus groups. Some complained about wait times at clinics or found it difficult to schedule appointments around work:

The doctor gives an appointment for three o'clock, and they don't take me in at three; they keep you waiting for over half an hour.

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.

In summary, while parents are generally pleased with their child's usual source of medical care, there is room for improvement particularly in the areas of flexible clinic hours and communication skills.

Use of Services

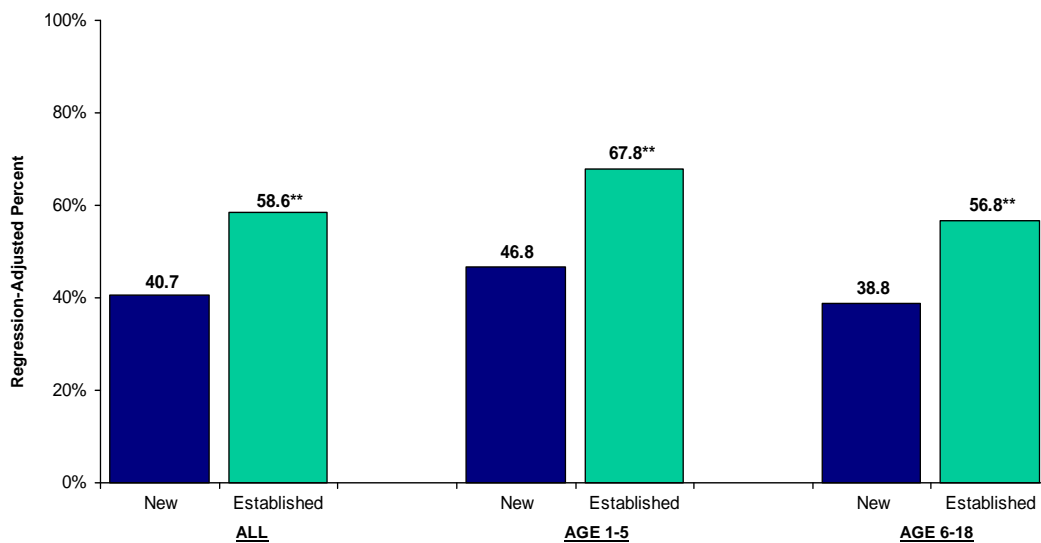
The American Academy of Pediatrics (AAP) recommends that children between the ages of 12 and 18 months have a preventive care visit every three months and thereafter every six months until their third birthday. From age three to 21, AAP recommends preventive care visits on an annual basis (American Academy of Pediatrics 2000). In the parent survey we asked about the type and number of provider visits in the 6 months either before enrollment (for new enrollees) or just before the survey (for established enrollees). The questions include:

- Did your child see a doctor or any other health care professional such as a physician assistant or nurse?
- Did he/she see a doctor or health professional for preventive care, such as a check-up, well-child visit, shots, or physical examination?
- Did your child go to a hospital emergency room?
- Did your child see a specialist?

- Did your child have an overnight hospital stay?

Enrollment in Healthy Kids increases use of several important health care services. After adjusting for differences between the two groups, almost sixty percent of established enrollees have an ambulatory visit in the six months prior to the survey compared to just 40.7 percent of new enrollees (Figure IV-3). More young (ages 1 to 5) established enrollees visit the doctor, compared to older (ages 6 to 18) established enrollees (67.8 percent and 56.8 percent respectively).

Figure IV-3
Percent of Healthy Kids Enrollees with a Medical Visit in the Past Six Months, by Age 2006



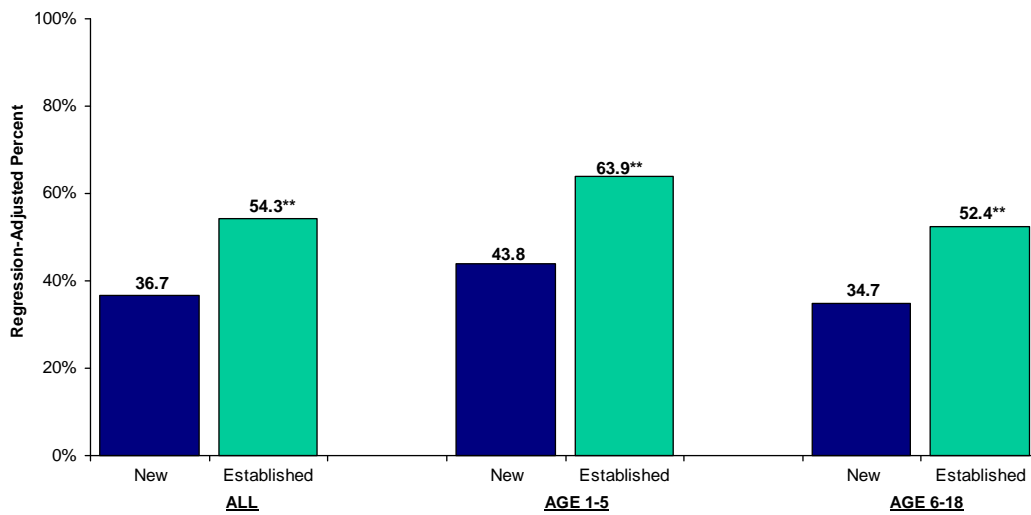
** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Preventive health care also increased after enrollment in Healthy Kids (Figure IV-4). Established enrollees are almost 20 percentage points more likely than new enrollees to have had a preventive health care visit in the past 6 months. Younger children have higher use of preventive care, and the increase in their preventive care use is equally large

as for older children. Increased use of preventive care led to about three-quarters of established enrollees' recently receiving vaccinations, compared to only 60.4 percent of new enrollees (data not shown). These findings are consistent with the findings from the evaluation of the Healthy Kids program in Santa Clara County (Trenholm et al. 2005).

Figure IV-4
Percent of Healthy Kids Enrollees with a Preventive Care Visit in the Past Six Months, by Age

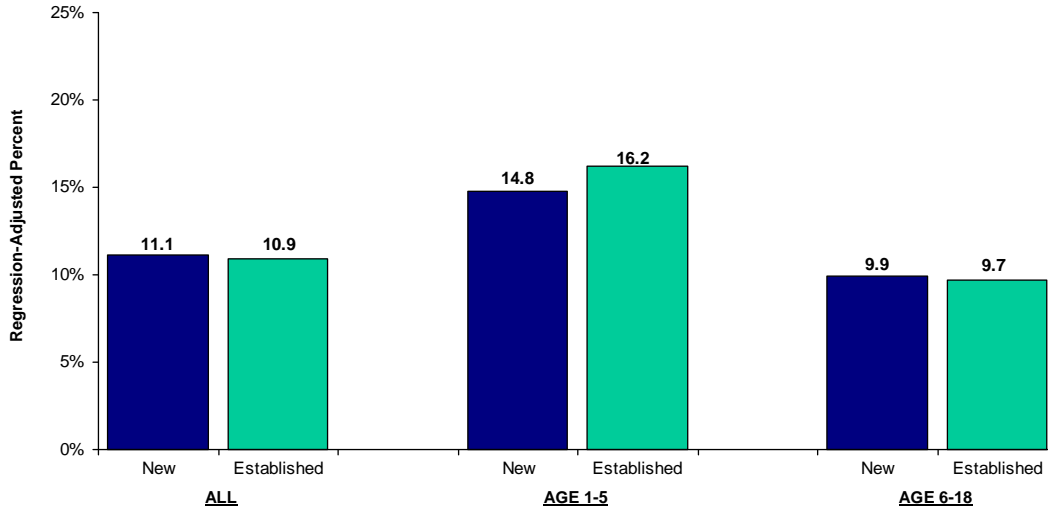


** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Enrollment in Healthy Kids did not increase the use of specialists in San Mateo County (Figure IV-5) in contrast to findings from the Santa Clara Healthy Kids evaluation. Use of specialty services was already quite high for San Mateo new enrollees in the 6 months before joining Healthy Kids (11.1 percent). This could be related to the design of the health system in San Mateo County. Safety net clinics in the county are well connected with hospitals and specialty services, potentially providing access to specialty care for uninsured children.

Figure IV-5
Percent of Healthy Kids Enrollees Who Visited a Specialist in the Past Six Months, by Age

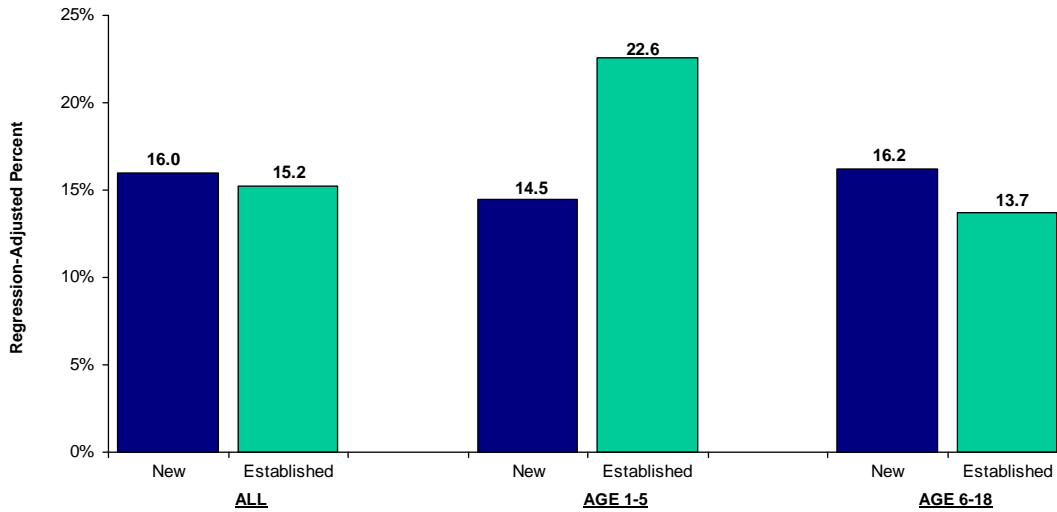


Source: Healthy Kids parent survey, 2006.

Note: No statistically significant differences between the new and established enrollees.

There also is no significant decline in emergency room use with Healthy Kids, in spite of a shift away from the emergency room as a usual source of care and an increase in preventive care. Just over 15 percent of both new and established enrollees used the emergency room in the past 6 months (Figure IV-6). This finding is consistent with similar results from the Santa Clara and national SCHIP evaluations.

Figure IV-6
Percent of Healthy Kids Enrollees with an Emergency Room Visit in the Past Six Months, by Age

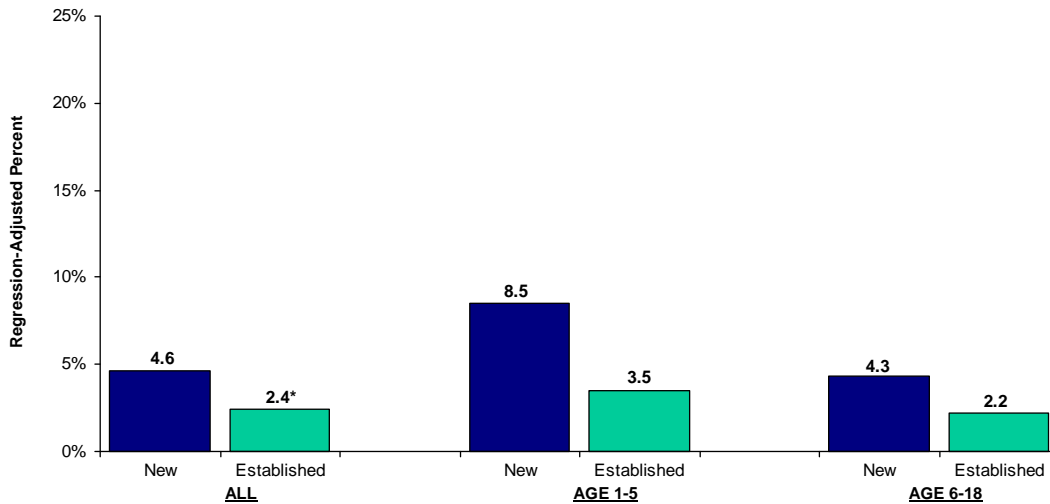


Source: Healthy Kids parent survey, 2006.

Note: No statistically significant differences between new and established enrollees.

In contrast, enrollment in Healthy Kids led to fewer inpatient hospitalizations in San Mateo County (Figure IV-7). Significantly fewer established enrollees (2.4 percent) had a hospital stay than new enrollees (4.6 percent). This result is very important since it suggests a possible cost reduction from the program. The finding is consistent across age groups but is not statistically significant at conventional levels for young children ($p < .09$). Reductions in hospital use have not been evident in other Healthy Kids evaluations or the national SCHIP evaluation.

Figure IV-7
Percent of Healthy Kids Enrollees with an Overnight Hospital Stay in the Past Six Months, by Age



Source: Healthy Kids parent survey, 2006.

* Significantly less than new enrollees, $p < .05$, one-tail test.

Unmet Health Care Needs

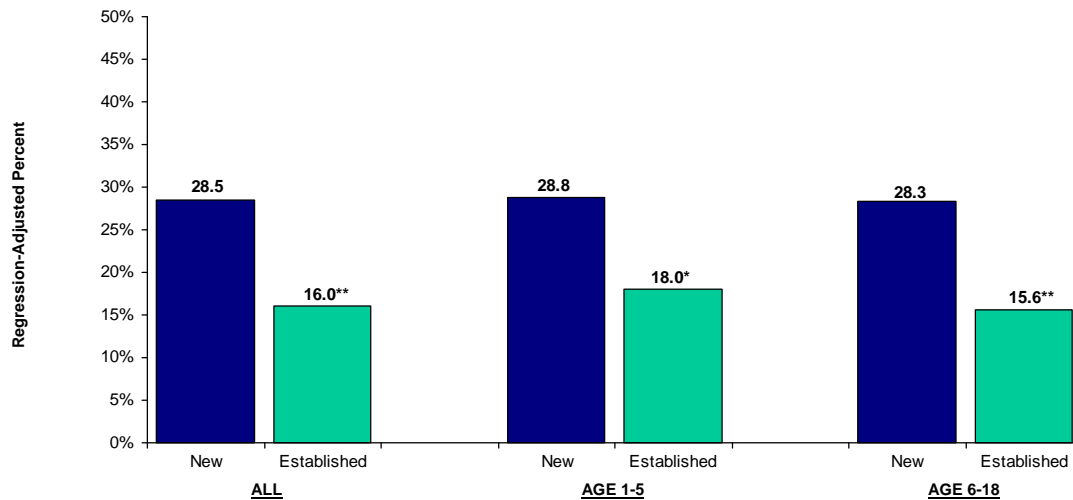
Needing medical care, but not receiving it, is another measure of access that highlights barriers to getting care. We asked parents the following questions about unmet medical needs for their children:

- During the last six months, was there any time that your child needed to see a doctor or other health professional because of an illness, accident, or injury but did not go?
- Needed to see a doctor or other health care professional for preventive care such as a well-child visit, checkup or physical examination but did not go?
- Needed to see a specialist but did not go?
- Needed a prescription drug but did not get it?

A child whose parent answered yes to any of these questions was considered to have an unmet medical need.

Across all age groups, enrollment in Healthy Kids substantially reduces the proportion of children going without needed medical care (Figure IV-8). In the six months prior to enrollment, 28.5 percent of children are reported to have an unmet medical need, compared to 16.0 percent of established enrollees in the 6 months prior to the survey. The level of unmet need for young children and older children is very similar, as is the level of reduction in unmet medical care need.

Figure IV-8
Percent of Healthy Kids enrollees with Any Unmet Medical Need in the Past Six Months, by Age



* Significantly less than new enrollees, $p < .05$, one-tail test.

** Significantly less than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

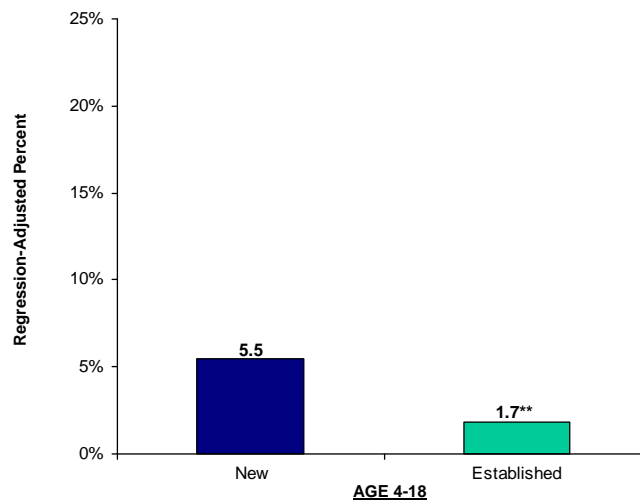
Focus group findings support the survey findings. Parents said their child's unmet needs were much greater without Healthy Kids.

I didn't take them [to the doctor without Healthy Kids]. Only when they were gravely ill, only then did I take them to the emergency room.

Parents of older children were also asked whether their child had a delay in getting needed vision care, an important service that is potentially tied to school

performance (Figure IV-9). About six percent of new enrollees experienced a delay in the six months prior to enrollment in Healthy Kids, compared to just 1.7 percent of established enrollees in the six months prior to the survey. Thus, after enrolling in Healthy Kids, almost all school age children are able to get the glasses or other vision care they need.

Figure IV-9
Percent of Healthy Kids enrollees with a Delay in Needed Vision Care in the Past Six Months, by Age

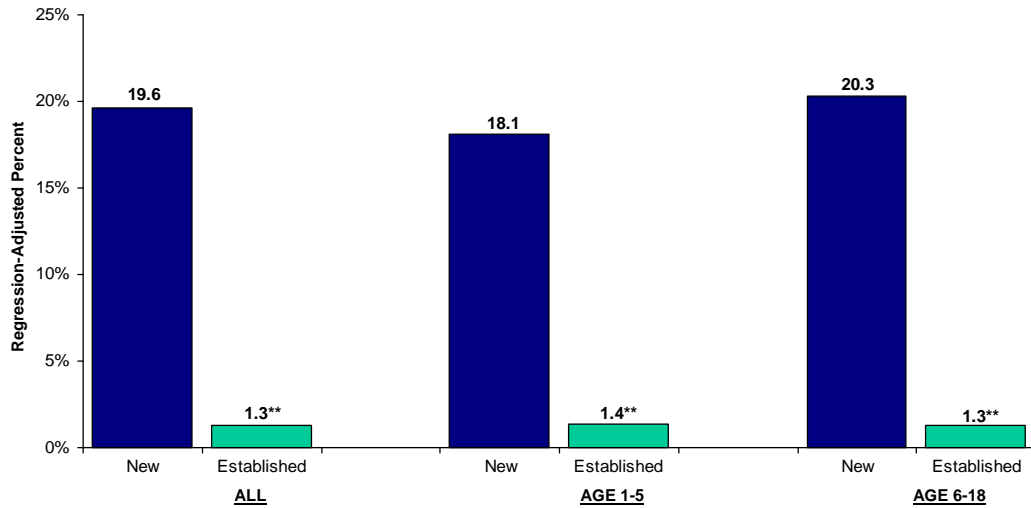


** Significantly less than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

We also asked parents who said their child had an unmet medical need the reason for the unmet need. In particular, we examined whether cost was the major barrier to obtaining medical care. As shown in Figure IV-10, this reason for unmet medical need is virtually eliminated for children who have been enrolled in the program for a year. Cost prohibited only 1.3 percent of parents of established enrollees from taking their child for needed medical care.

Figure IV-10
Percent of Healthy Kids Enrollees Reporting Cost as the Reason for Unmet Medical Need
in the Past Six Months, by Age



** Significantly different from new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Table IV-3 presents descriptive, unadjusted means for the reasons parents gave for their child’s unmet needs. The results suggest that once the barrier of cost is removed, the predominant reason for a child’s unmet health need relates to scheduling problems—whether because the parent had problems making or keeping an appointment due to conflicts (such as work) or the inability to get through on the appointment phone line.

Table IV-3
Reasons for Unmet Medical Need in the Past 6 Months

Reason for Unmet Need**	New Enrollees	Established Enrollees
	Percent	
Scheduling problem	1.2	10.9
No plan approval	0.7	4.2
Did not accept Healthy Kids plan	0.8	4.2
Cost	62.0	8.2
Didn't know where to go	3.7	3.0
Missed appointment/scheduling conflict	17.2	44.4
Other	9.3	15.2
More than one reason	5.1	9.9
N	195	112

** Distributions for new and established enrollees are significantly different, $p < .01$, two-tail test.

Source: Healthy Kids parent survey, 2006.

CHAPTER V

WHAT IS THE IMPACT OF HEALTHY KIDS ON ACCESS TO AND USE OF MENTAL HEALTH CARE?

Background

Mental health care has been shown to prevent juvenile delinquency and improve cognitive, academic, and social outcomes for children (Ramey and Ramey 1998; Zigler, Taussig, and Black 1992). However, for various reasons, not all children with mental health needs access necessary services. While mental health needs affect one in five children living in the United States, only a fifth of all children nationwide who need mental health services receive them (Jellinek et al. 1999; U.S. Department of Health and Human Services [HHS] 1999). This unmet need for mental health services is especially high for Latino children relative to other children.

In the case study site visits we learned about the mental health service delivery system in San Mateo County, and accessibility to such services for children under Healthy Kids¹¹. Mental health benefits for children are generous under all three public programs (Healthy Kids, as well as Healthy Families and Medi-Cal), with few limits imposed on them and limited cost-sharing. The County Mental Health Services Division (renamed the Behavioral Health and Recovery Services Division) organizes and manages services for children through contracts with providers. While the County has contracts with both public and private providers, our previous analysis shows that over 80 percent of Healthy Kids enrollees receive their services from public providers.

It is understandable that many children enrolled in Healthy Kids might particularly need mental health services, given that most of them recently moved from

¹¹ A previous report (Howell et al. 2006a) and brief (Palmer et al. 2007) provide an overview of mental health issues and services for the Healthy Kids program in San Mateo County.

another country and have had the stress of adapting to a new school and a new culture. In focus groups of parents of children with mental health conditions, they talked about the stress caused by such life events, and about how their child's mental health problems were first noticed:

I thought it [the mental health condition] was because we left him in Mexico. Then we brought him [to the U.S.] and he became aggressive.

My child suffered a depression after moving countries, because of language and everything.

I did [first noticed the mental health condition] because he said he felt nervous to go to school.

In the focus groups, parents also said they were satisfied with the mental health services they received and that they were readily accessible to them, once they tried to get services:

Immediately after I told the pediatrician that my son could not sleep, [a] few days later they called me at work and gave him an appointment.

The doctor contacted me with the psychologist [information] and everything was fast.

These parents, who had already used mental health services for their children, gave some reasons why other parents might be reluctant to recognize mental health problems in their children and seek help for them:

One of the problems that we as Hispanics have is that in Latin America, there's a stigma about seeing a psychologist.

The school told me and I had already noticed it [her child's mental health condition] but honestly, I felt I was to blame, I didn't want to come to terms with it.

As summarized in the previous report and brief, in spite of the fact that about 20 percent of Healthy Kids children have a mental health problem identified by their parents, only about 5 percent of Healthy Kids enrollees had a claim/encounter record with a mental health diagnosis in the period July 2004 through June 2005.¹² For this small group of children—likely including children with more serious conditions—the cost to the Healthy Kids program is high, over three times that for children without mental health care. The higher cost comes both from higher mental health care cost and higher cost for other care.

Descriptive Survey Analysis

In the two waves of the survey we asked parents with children ages 6 and above about their child's mental health conditions:

- In the past month did your child often, sometimes, or never have these experiences:
 - Can't concentrate or pay attention for long.
 - Has trouble getting to sleep.
 - Is unhappy, sad, or depressed.
 - Doesn't get along with other kids.

In addition, parents were asked:

- Does your child currently have any physical, behavioral, or mental conditions that limit or prevent his/her ability to do activities usual for his/her age? (If yes) What is the condition?

Table V-1 provides data from these two questions showing the proportion of parents who report that their child often has one of the four problems listed above. About

¹² Some mental health services from public providers may not have been billed and consequently not identified in the claims/encounter data.

20 percent of parents report that their child has a mental health problem using these measures. New enrollees have a slightly higher rate of such problems (21.8 percent) than established enrollees (17.8 percent), but the difference is not statistically significant. The two groups also have very similar rates for the particular problems identified by parents, with one exception. For the question, “Often can’t pay attention for long”—a proxy for Attention Deficit/Hyperactivity Disorder (ADHD)—the rate is 12.5 percent for new enrollees and only 7.5 for established enrollees, a significant difference. Since Healthy Kids has increased the use of ambulatory care, as shown in the previous chapter, it is possible that children are receiving treatment in such settings for their hyperactivity.

Table V-1
Current Emotional/Behavioral Problems Identified by Parents of
Healthy Kids Enrollees
Ages 6-18

Problem	New Enrollees	Established Enrollees
Often can't pay attention for long	12.5	7.5*
Often has trouble getting to sleep	6.5	6.8
Often unhappy, sad, or depressed	6.1	4.9
Often doesn't get along with other kids	3.4	3.0
Other problem	3.0	2.1
Any of the above	21.8	17.8
None of the above	78.2	82.2
N	484	519

* Significantly less than new enrollees, $p < .05$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Note: All conditions occurred in the month prior to the interview.

Impact Analysis

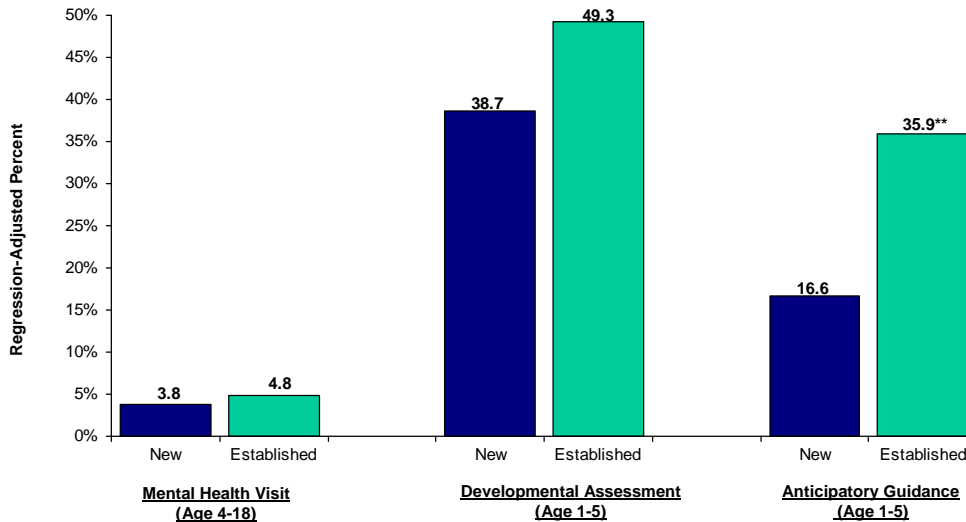
Given that most children are uninsured prior to enrolling in Healthy Kids, that many have mental health problems, and that enrolling in the program provides new access to a wide mental health network, we asked questions in the parent survey about receipt of mental health services.

For children ages 4 and above, we asked:

- During the past six months (or the six months prior to enrolling for new enrollees) did your child see or talk to a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker?

We examined whether Healthy Kids had an impact on use of mental health care for children ages 4–18, using an approach similar to that in the previous chapter concerning medical care. After adjusting for differences between the groups, only 3.8 percent of new enrollees and 4.8 percent of established enrollees (ages 4–18) had visits to mental health providers in the past six months, and the difference is not statistically significant (Figure V-1). The low rate of use reported by parents in the survey is consistent with the level of use reported in the earlier report using claims/encounter records. Given that access to mental health services has improved under Healthy Kids according to case study findings, this low use rate may be linked to some of the other barriers identified in focus groups such as the stigma parents feel when seeking formal mental health services for their children.

Figure V-1
Percent of Healthy Kids Enrollees with a Mental Health Visit, a Developmental Assessment, and Anticipatory Guidance in the Past Six Months



** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

The youngest children might not have recognized mental health problems yet, but in the course of regular preventive or primary care they may receive developmental screening or guidance from providers that address very early mental health problems. We ask the parents of children ages 1 to 5 the following questions:

- During the past six months, did your child’s provider do a “developmental assessment”? (The parent was also given cues for the types of activities in such an assessment, and asked whether the provider asked if the child did those activities.)
- During the past six months, did your child’s provider give you guidance on the following topics? (Then a list of topics is read to the parent, such as “how your child is getting along with other children.”)

We examined the impact of Healthy Kids on receipt of a developmental assessment or of anticipatory guidance on 5 or more topics, for children ages 1–5 (Figure V-1). About 40 percent of new enrollees ages 1–5 had a developmental assessment in the

past six months, not significantly lower than established enrollees (49.3 percent).

However, the rate of receipt of anticipatory guidance is significantly lower among new enrollees (16.6 versus 35.9 percent). Thus, Healthy Kids may be making a difference in identifying and addressing mental health problems early among young children.

CHAPTER VI WHAT IS THE IMPACT OF HEALTHY KIDS ON DENTAL CARE ACCESS AND USE?

Dental disease is the most common chronic disease of childhood (US Department of Health and Human Services 2000). Tooth decay is a significant problem among California elementary school children: 54 percent of kindergarteners and 71 percent of 3rd graders have a history of tooth decay, and 28 percent of children in both grades have untreated tooth decay. Poor children and children of color, particularly Latino children, are much more likely to have tooth decay and suffer the consequences of untreated disease. For example, 72 percent of Latino children have a history of decay (Dental Health Foundation 2006).

Dental Services Under Healthy Kids

The administration of dental services under Healthy Kids is managed through a contract between the HPSM and Delta Dental, which has a large dental provider network. A previous report and brief (Howell et al. 2006a; Hughes 2007) showed that the majority of Healthy Kids enrollees obtain dental services from private dentists, rather than in county clinics. There were 25 private individual dentists, and 15 dental groups, that billed for Healthy Kids services during the study period. However, care in the private sector is concentrated heavily in a few private providers; two individual dentists saw more patients than all of the remaining individual dentists combined.

There is evidence that a wider network of private dentists is potentially available to serve Healthy Kids. In 2006, CHI staff called 21 private dentists and dental groups on the list of Delta Dental participating dentists and found that all of them currently accept Healthy Kids patients with relatively short waiting times for appointments (one to three

weeks). This is in contrast to waiting times for county clinics, which are one to four months for dental care.

We interviewed 10 dentists to better understand potential barriers to access to dental services. The dentists were unaware of the extent of availability of private dentists to serve Healthy Kids although they were aware that private dentists often serve low-income children on a pro bono basis. They perceived a preference to provide services for free, rather than to seek reimbursement from public programs.

The San Mateo County CHI has taken several steps to improve dental care access and utilization. These efforts include the establishment of a dental workgroup as part of the CHI Oversight Committee and plans for HPSM staff to contact parents of children who do not utilize dental services to facilitate appropriate utilization.¹³ In addition, the CHI has attended the Delta Dental provider regional meetings to familiarize providers with Medi-Cal, Healthy Families and Healthy Kids.

The HPSM is taking steps to provide on-going education to families about the value of regular oral health care and sources of services, such as providing one-on-one education to members and updating the county dental provider list on a quarterly basis. This list is routinely disseminated to outreach and enrollment staff.

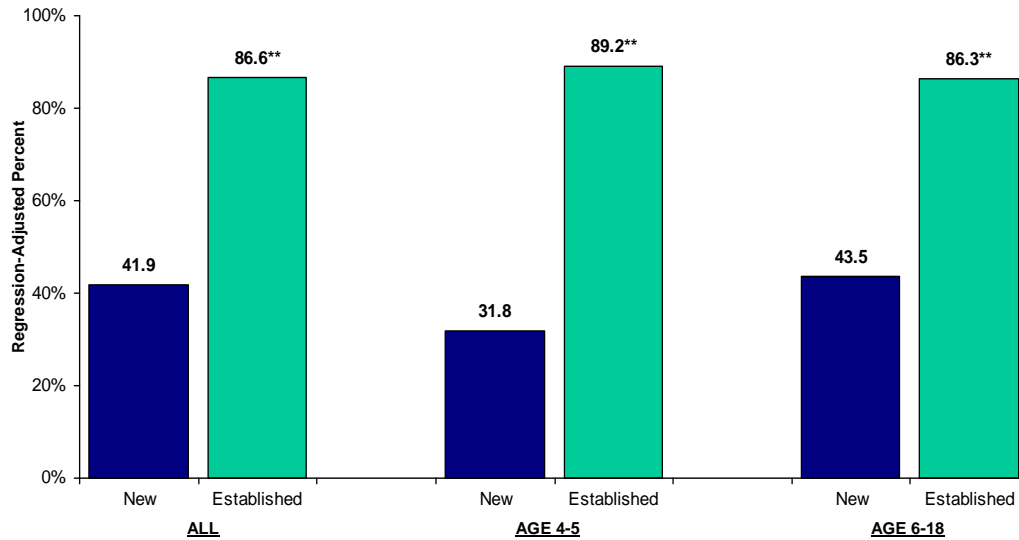
Impact Analysis

We analyzed the impact of Healthy Kids on access to and use of dental care from the parent survey, using a similar approach to that above concerning medical care. Healthy Kids had a dramatic impact on several measures of dental care access and use. For example, while only 41.9 percent of new enrollees have a usual source of dental care,

¹³ Delta Dental does not actively promote utilization of services.

86.6 percent of established enrollees do (Figure VI-1). This strong impact is found for both young children (ages 4–5) and older children (ages 6–18).

Figure VI-1
Usual Source of Dental Care in the Past Six Months

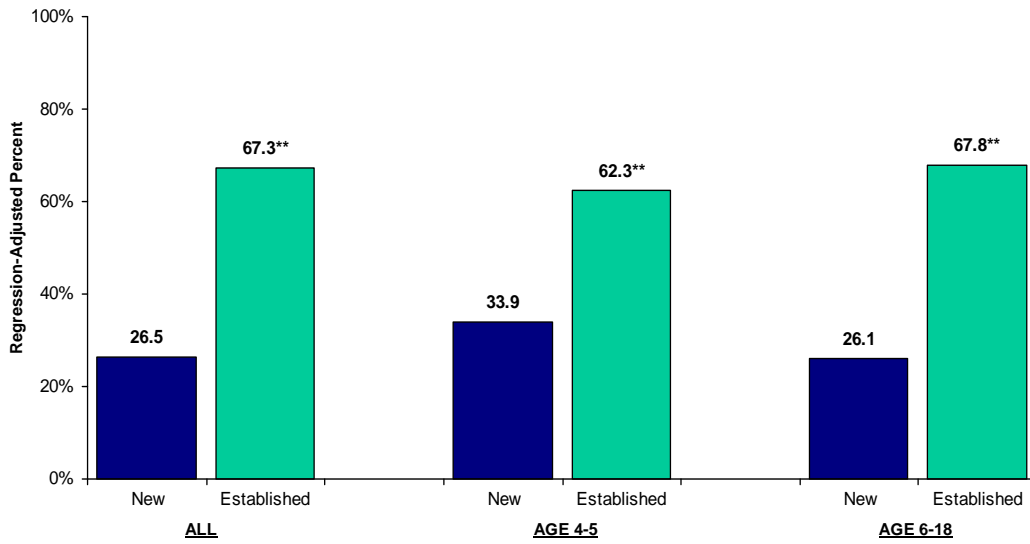


** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Enrollment in Healthy Kids also has a significant impact on dental care use (Figure VI-2). Only 26.5 percent of new enrollees have a dental visit in the past 6 months, compared to 67.3 percent of established enrollees. The strong improvements apply to both age groups (Figure VI-2). Substantial differences are also found in preventive dental visits and dental treatment. Only one quarter of new enrollees have a preventive dental visit compared to 65.2 percent of established enrollees (Figure VI-3). Among new enrollees, only 15.4 percent have a dental visit for treatment of a problem in the past 6 months compared to 45.5 percent of established enrollees (Figure VI-4). Again, this degree of improvement occurs across both age groups.

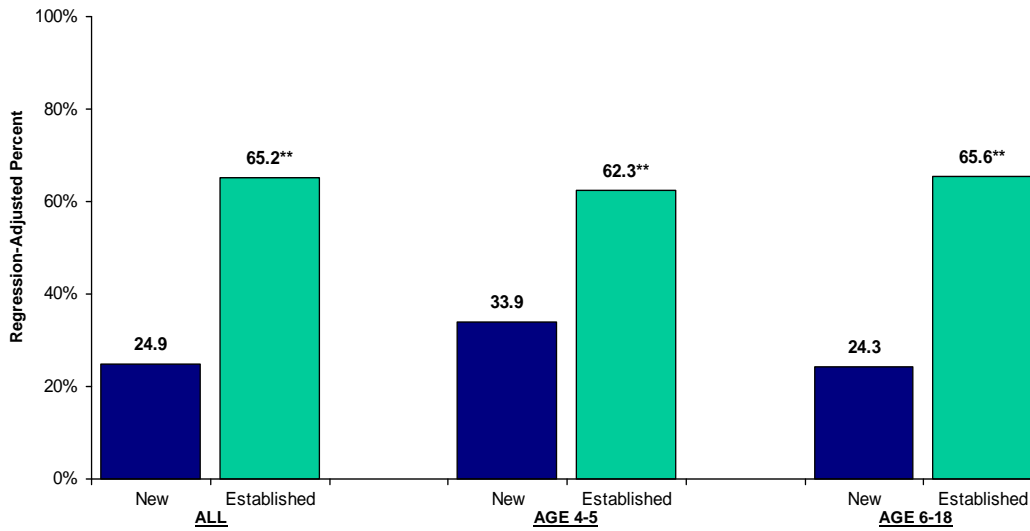
Figure VI-2
Children with a Dental Visit in the Past Six Months, by Age



** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

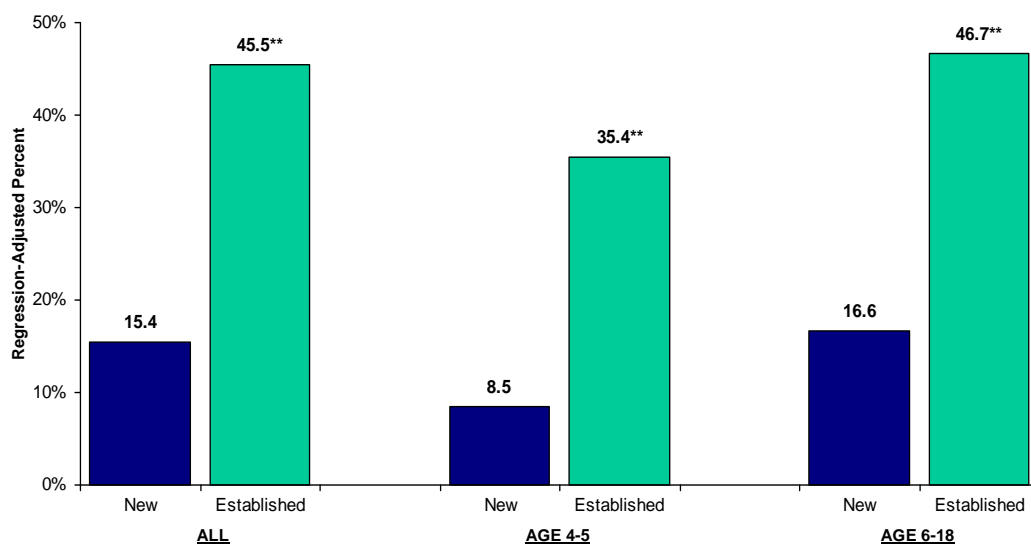
Figure VI-3
Children with a Preventive Dental Visit in the Past Six Months, by Age



** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Figure VI-4
Children with a Dental Visit for Treatment in the Past Six Months, by Age

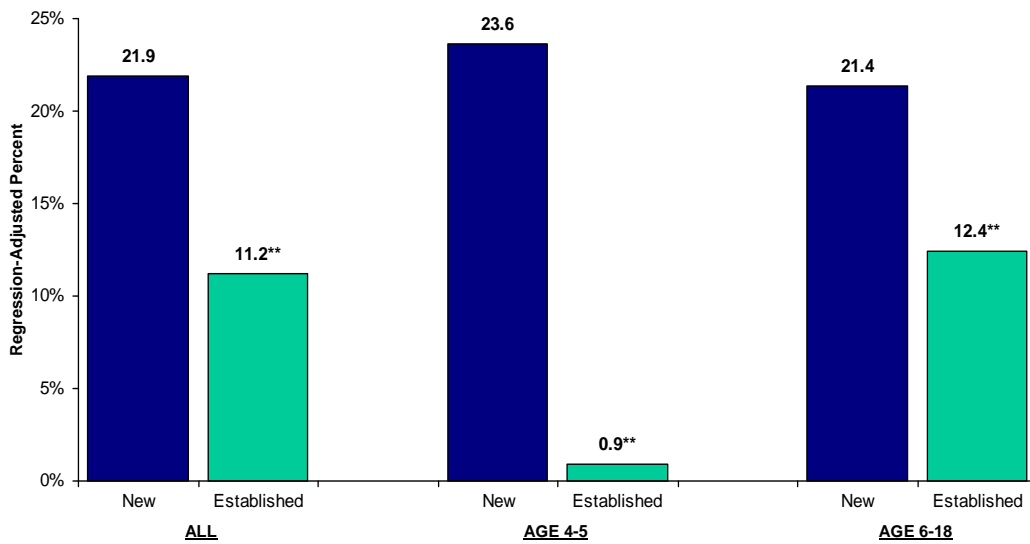


** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Finally, as with medical care, the Healthy Kids program significantly reduces the likelihood of having an unmet need for dental care. Nearly 22 percent of the parents of newly enrolled children say that in the past six months their child needed dental care but did not go, compared to only 11.2 percent of parents of established enrollees (Figure VI-5). Unmet need is essentially eliminated among young children ages 4–5. The percentage of children for whom cost is the reason for unmet dental need dropped from 17.2 percent among new enrollees to 0.7 percent among established enrollees (Figure VI-6).

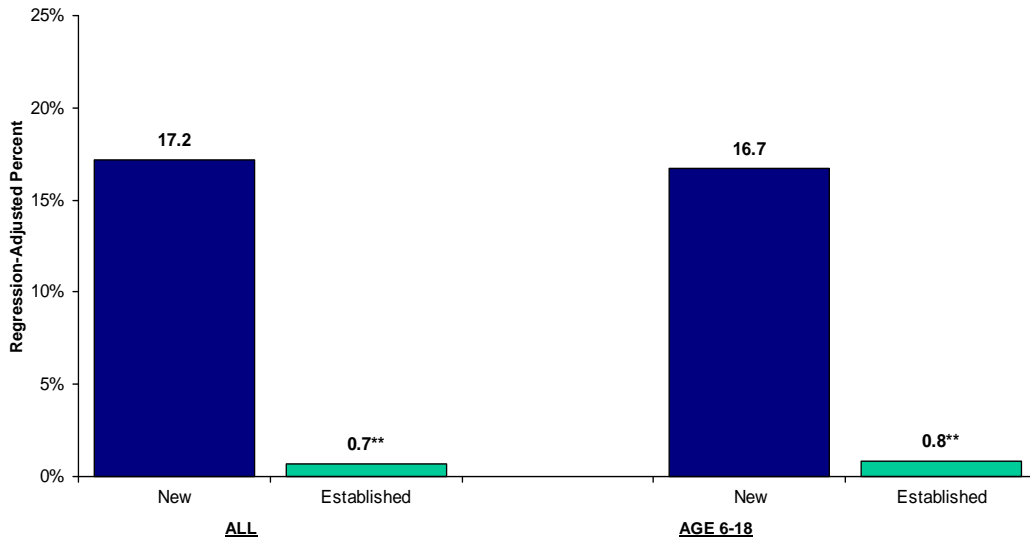
Figure VI-5
Percent of Children with Any Unmet Dental Need in the Past Six Months



** Significantly less than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Figure VI-6
Cost Is a Reason for Unmet Dental Need, by Age



** Significantly less than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

CHAPTER VII WHAT ARE TRENDS IN USE AND COST OF SERVICES?

The past three chapters have examined access to and use of medical, mental health, and dental services under the Healthy Kids program, using primarily data from the parent survey of 2006. Administrative data from the HPSM, which are routinely collected as part of paying for services, can be used to examine trends in the program over time. These data have the advantage over survey data of being for all children, giving a consistent picture of how service use changes over time, and providing information on the cost of services.¹⁴

We obtained data from the HPSM for all children who enrolled in each year of the program from 2003 to 2006 who stayed enrolled for a full year. This included 4,343 children enrolling in 2003; 1,969 enrolling in 2004; 1,781 enrolling in 2005; and 1,380 enrolling in 2006. While the children who are continuously enrolled for one full year are not the full group of Healthy Kids enrollees, they are a large majority of enrollees. In another study (Howell et al. 2006b), we showed that almost 90 percent of children who enrolled in 2003 stayed enrolled for 12 months (although many dropped off the program at renewal just after 12 months). The study also examined differences in use and cost for continuously and discontinuously enrolled children and found them to be very similar. Consequently, the data provided here on continuously enrolled children represent well the full group of Healthy Kids enrollees in their first year on the program.

Trends in Use of Services

Table VII-1 shows very substantial increases in the percent of children receiving a preventive care visit in their first year of enrollment (from 33.4 percent for the first cohort

¹⁴ Because data are collected in a different manner and for different time periods, the utilization estimates presented in this chapter differ somewhat from those in Chapter IV and Chapter VI.

enrolled in 2003 to 57.0 percent among those who enrolled in 2006). The HPSM concentrated on improving preventive care use, after receiving initial data on the relatively low proportion receiving preventive care in the first year of Healthy Kids. The largest boost came between 2004 and 2005 (an increase from 39.6 percent to 52.3 percent), a period of time when the plan had received the initial data on use from the evaluation's first annual report and was beginning to obtain HEDIS data on similar measures. Consistent with this trend, there is an increase in all ambulatory care use from 69.2 percent using ambulatory care in the 2003 cohort to 80.2 percent in the 2006 group.

**Table VII-1
Trends in Annual Use of Services by Healthy Kids Enrollees**

Type of Service	Enrollment Year			
	2003	2004	2005	2006
	Percent			
Had Preventive Visit	33.4	39.6	52.3	57.0
Had Any Ambulatory Visit	69.2	73.7	78.4	80.2
Had Emergency Room Visit	12.2	12.0	15.3	16.4
Had Hospital Stay	0.8	1.2	0.9	0.9
Had Dental Visit	56.2	55.6	53.5	56.4
Had Vision Visit	8.3	8.9	8.0	8.4
Had Prescription	32.6	33.0	34.3	37.8
N	4,343	1,969	1,781	1,380

Source: Health Plan of San Mateo

Notes:

- (1) Includes only children continuously enrolled for first year, and utilization in first year of enrollment.
- (2) Data for children less than one year old are excluded.

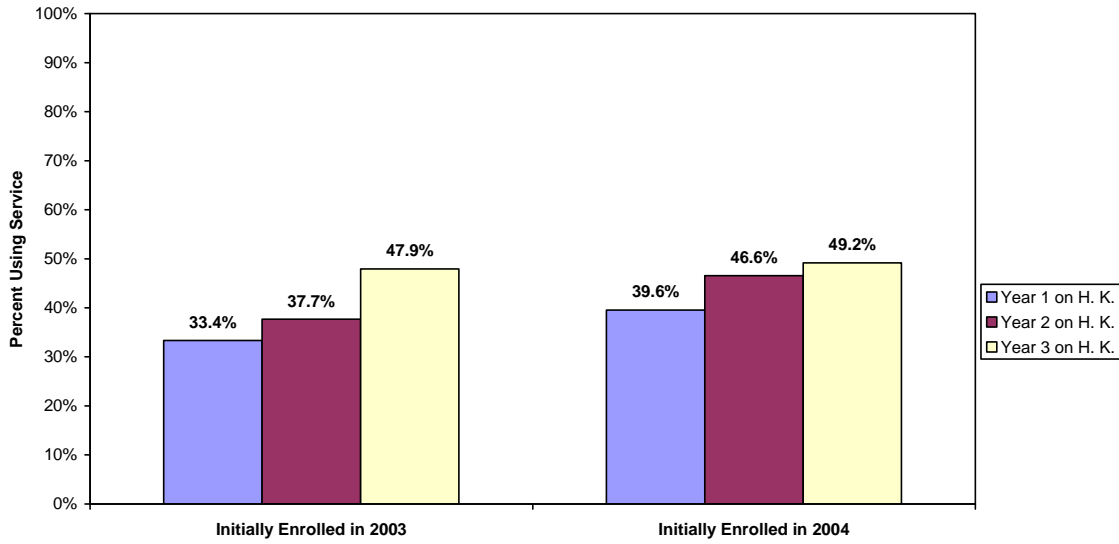
Perhaps less encouraging is an increase in emergency room visit use from 12.2 percent (2003 cohort) to 16.4 percent. The greatest increase occurs in the same period as the preventive care use increase, suggesting that preventive care did not immediately offset ER use.

Use of other types of services (hospital, dental, vision, and prescription drugs) has not changed substantially during the period. In particular, hospital use remains low. Only about one percent of children have a hospital stay documented in the claims/encounter data in their first year of enrollment in each year. Since this is a lower rate of hospital use than reported in the parent survey, it is possible that some hospitalizations are covered by Emergency Medi-Cal and not billed to Healthy Kids.

Trends within Cohorts

Another important trend is shown in Figures VII-1 through VII-3, which provide data on the use of preventive, ambulatory, and dental care for children who remain on the program for one, two, or three years continuously. The figures show, for example, the use rate in the first year of the program for all children enrolled for one full year, the use rate in the second year of the program for all children enrolled for two full years, and the use rate in the third year of the program for all children continuously enrolled for three full years. Annual use of preventive, ambulatory, and dental care climbs steadily for the cohorts initially enrolled in 2003 and 2004 (the only two cohorts with three years of post-enrollment data available). This suggests that there is an education effect concerning the value of preventive and dental care that continues to increase parents' awareness of and use of such services when children are continuously enrolled for three full years. The increases are also consistent with the plan's initiatives to increase use of preventive care for all children enrolled in Healthy Kids, and provide another view of those effects. An important caveat to this analysis is that the children who remain continuously enrolled for three years are a small proportion of all children who enroll (only about a third).

**Figure VII-1
Trends in Use of Preventive Services Within Cohorts of Healthy Kids Enrollees
2003-2006**

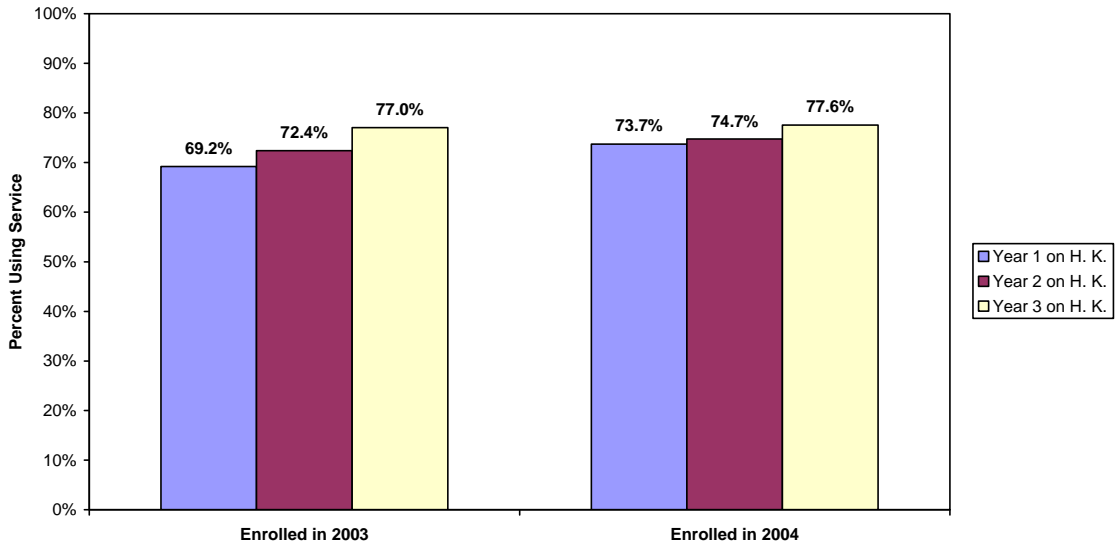


Source: Health Plan of San Mateo.

Notes:

- (1) Data for children less than one year old are excluded from this analysis.
- (2) Continuously enrolled, 1-3 years.

**Figure VII-2
Trends in Use of Ambulatory Services Within Cohorts of Healthy Kids Enrollees
2003-2006**

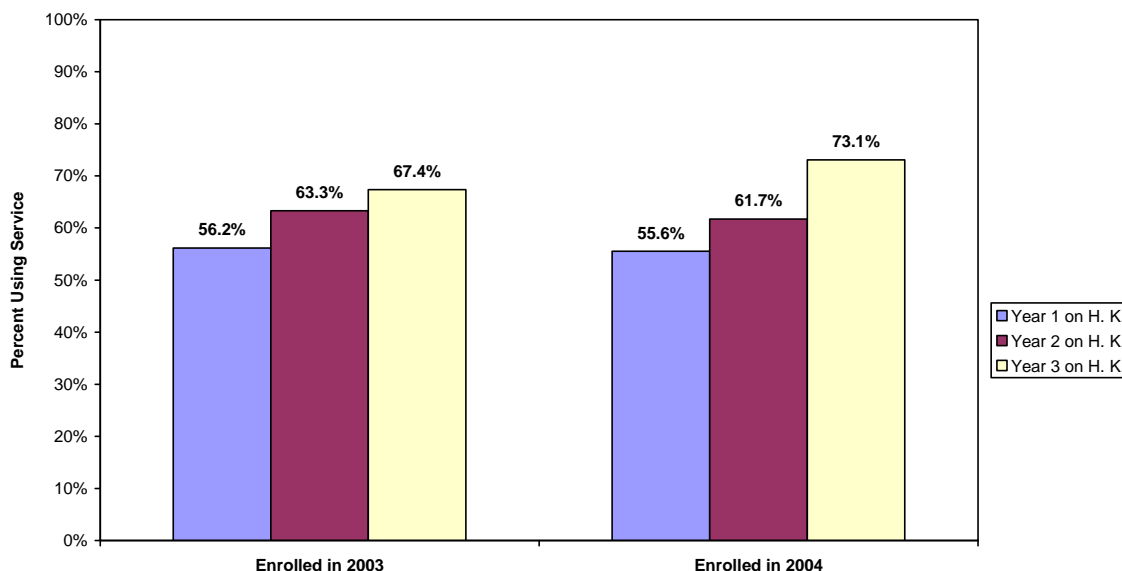


Source: Health Plan of San Mateo.

Notes:

- (1) Data for children less than one year old are excluded from this analysis.
- (2) Continuously enrolled, 1-3 years.

Figure VII-3
Trends in Use of Dental Services Within Cohorts of Healthy Kids Enrollees



Source: Health Plan of San Mateo.

Notes:

- (1) Data for children less than one year old are excluded from this analysis.
- (2) Continuously enrolled, 1-3 years.

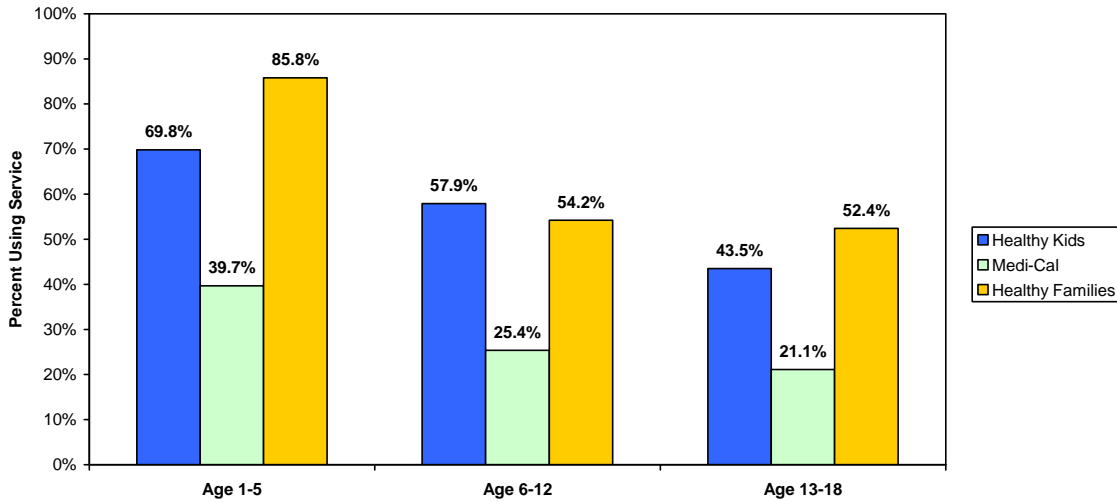
Comparisons to Medi-Cal and Healthy Families

Since all Medi-Cal children and about 40 percent of Healthy Families children are enrolled in the Health Plan of San Mateo, it is possible to examine use of preventive care in those programs and compare them to use for Healthy Kids enrollees.¹⁵ As shown in Figure VII-4, Healthy Kids who enrolled in 2006 are more similar to Healthy Families children in comparable age groups in preventive care use, and both of those programs have substantially higher use than Medi-Cal children. For example, among school-aged children ages 6–12 in 2006, about 55 percent of both Healthy Kids and Healthy Families children use preventive care in the first year they enrolled in the program, while only

¹⁵ Dental care for Medi-Cal and Healthy Families is managed by other organizations, so dental service data are not available for those programs.

about 25 percent of Medi-Cal enrollees do so. According to HPSM staff, HEDIS data also show a low level of preventive care use among Medi-Cal children.¹⁶

Figure VII-4
Use of Preventive Services for Healthy Kids, Medi-Cal, and Healthy Families Enrollees in the Health Plan of San Mateo 2006



Source: Health Plan of San Mateo.

Notes:

- (1) Healthy Families data are for children enrolled through the Health Plan of San Mateo only.
- (2) Includes only children who enrolled in 2006 and remained continuously enrolled for first year. Utilization is presented for first year of enrollment only.

Cost of Services

Table VII-2 shows trends in the average cost for Healthy Kids in their first year enrolled in the program from 2003 to 2006. The average cost per child increases from \$440 in 2003 to \$719 in 2006. The average cost climbs by 30 percent from 2003 to 2004, levels off between 2004 and 2005, and then climbs again by 30 percent between 2005 and 2006.

The table also shows the cost per service for each cohort. Costs are going up most rapidly for ambulatory care (where utilization has increased) and prescriptions, each of

¹⁶ Because some primary care physicians receive capitated reimbursement from the HPSM under Medi-Cal, this may explain some of the lower preventive care use reported in the claims/encounter data.

which more than double in the period. Costs are also growing for emergency room services (where utilization also has increased), and dental services but not for hospital services.

Table VII-2
Trends in Average Cost Per Type of Service
for Healthy Kids Enrollees
2003-2006

Type of Service	Enrollment Year			
	2003	2004	2005	2006
	Average Cost Per Year			
Total Ambulatory	\$ 166	\$ 231	\$ 268	\$ 366
Outpatient/Clinic	129	173	191	255
Other Physician	37	59	77	110
Emergency Room	21	23	26	32
Hospital	34	73	27	32
Dental	182	200	191	235
Vision	7	7	6	6
Prescriptions	23	28	25	47
Other	8	15	1	1
Total	\$ 440	\$ 577	\$ 545	\$ 719
N	4,343	1,969	1,781	1,380

Source: Health Plan of San Mateo.

Notes:

- (1) Includes only children continuously enrolled for first year, and utilization in first year of enrollment.
- (2) Data shown are for cost per child.
- (3) Data for children less than one year old are excluded from this analysis.

CHAPTER VIII

WHAT IS THE IMPACT OF HEALTHY KIDS ON HEALTH STATUS?

The ultimate goal of the San Mateo County Children's Health Initiative is to improve the health status of newly insured children in the county. Such effects could have long-term positive consequences for children throughout their lives, through improved health, school performance, and employment (Case and Paxson 2006). The evaluations of the Los Angeles and Santa Clara Children's Health Initiatives found impacts on health status for children enrolled in Healthy Kids in those counties (Howell and Trenholm 2007; Howell, Dubay, and Palmer 2008).

In those studies, and in previous annual reports for the San Mateo evaluation, we describe the health status of children enrolled in Healthy Kids, showing that they are generally in poorer health than children nationwide. In addition, they have numerous conditions that can be ameliorated through regular contact with primary care.

In Wave Two of the parent survey we asked a series of questions of both new and established enrollee parents to determine whether the Healthy Kids program improved children's health status in their first year of enrollment. These questions include:

For all children:

- In general, would you say your child's health is excellent, very good, good, fair or poor?
- Does your child currently have any physical, behavioral, or mental conditions that limit or prevent his/her ability to do activities usual for his/her age? (If yes) What is the condition?
- What is your child's weight and height¹⁷?
- Has a doctor or other health care professional ever said that your child has asthma?

¹⁷ Height was asked only of adolescents; since many parents of younger children did not know their child's height in the Wave One survey.

- Does your child have any trouble seeing (even when wearing glasses)?
- In the past 12 months has your child had a dental problem that caused you concern?
- Baseline health status: Why did you enroll your child in Healthy Kids? When parents said they enrolled the child to get medical care or a prescription covered, the child was considered to be enrolled for a medical reason.

For children ages 1–5 only:

- In the past month has your child had an accident, high fever, or any other condition that worried you a great deal? (If yes) What was the condition?
- Concerns with child development: the parent is asked about nine different developmental areas (for example, how the child talks and makes speech sounds), and whether they are concerned “a lot,” “a little,” or “not at all.”
- Baseline health status: Thinking back to the first year of your child’s life, was his/her health better than, the same as, or worse than other infants?

For children ages 5 and older only:

- How many days of school did your child miss because he/she was sick during the past four weeks?

For children ages 6 and older only:

- Baseline health status: Thinking back to when your child started school, was his/her health better than, the same as, or worse than other children?

This comprehensive set of questions allows us to take a broad view of the health of children enrolled in the San Mateo Healthy Kids program, and to examine their health status from various perspectives.

Baseline Health Status

Table VIII-1 shows a comparison between the health status of new and established Healthy Kids enrollees prior to entering the program. This is important to examine, because it gives a picture of whether these two groups are similar or different in

**Table VIII-1
Baseline Health Status of Healthy Kids Enrollees
2006**

	Percentage	
	New Enrollees	Established Enrollees
Health in Infancy (Children Ages 1-5)		
Better Than Other Infants	43.8	40.9
About the Same as Other Infants	49.8	51.1
Worse Than Other Infants	6.4	8.0
N	221	162
Health When Starting School (Children Ages 6-18)		
Better Than Other Children	23.5	26.3
About the Same as Other Children	73.5	70.8
Worse Than Other Children	3.0	2.9
N	484	519
Enrolled for a Medical Reason	37.3	35.9
N	705	681

Source: Healthy Kids parent survey, 2006.

Note: There are no statistically significant differences between new and established enrollees.

their health status at a time before the program could affect their health. Two measures are provided: whether the parent indicated their child was in worse, similar, or better health than other children their age prior to enrollment (either in infancy or at the time of school enrollment) and whether the parent enrolled the child for a medical reason (indicating that the child had a medical problem at the time of enrollment). As shown, the two groups are very similar, with about the same percentages enrolling for medical reasons (around 35 percent), or being in worse health than others their age either in infancy (6 percent for new enrollees and 8 percent for established enrollees) or at school enrollment (3 percent for both groups). There are no statistically significant differences between the two groups. These two variables are included as control variables in the regressions for the impact analysis.

Descriptive Results

About 25 percent of both new and established enrollees are in excellent health (as perceived by their parents) and another 17 percent of new (and 19 percent of established) enrollees are in very good health (Table VIII-2). While the rates of children with excellent or very good health are similar to those found in Santa Clara County's Healthy Kids evaluation, they are substantially lower than national or statewide rates for children. For example, in 2005 in California 75.1 percent of privately insured children were in excellent or very good health.

The table also shows the percent of children ages 5 and above who missed school in the past month due to health reasons. Again, the two groups of children (new and established) are similar, but slightly more of the established group have no missed school days (59.2 percent) than the new enrollees (52.5 percent).

Table VIII-2
Health Status of Healthy Kids Enrollees
2006

	Total	
	New Enrollees	Established Enrollees
Health Status		
Excellent	25.3	25.8
Very Good	17.2	19.3
Good	34.2	33.5
Fair	22.2	20.4
Poor	1.1	1.0
Limitation in Normal Activities	6.6	4.3
N	705	681
School Days Missed Due to Illness in Past Month (Age 5+)*		
None	52.5	59.2
1-2	29.6	26.7
3-4	7.5	9.3
5-10	7.0	4.5
More than 10	3.4	0.3
N	529	563

* Distributions for new and established enrollees are significantly different, $p < .05$, two-tail test.

Source: Healthy Kids parent survey, 2006.

A descriptive profile of the types of conditions from which Healthy Kids enrollees suffer can be constructed from the various questions asked in the survey listed above. It is not a complete list, since it comes from parent reports (not clinical exams) and not all questions were asked of both young and older children. Still, it provides a qualitative look at the conditions causing health problems among Healthy Kids enrollees (see Appendix Table VIII-1). About 30 percent of parents reported some condition needing medical care in their children shortly before or at the time of the interview. This percentage is almost

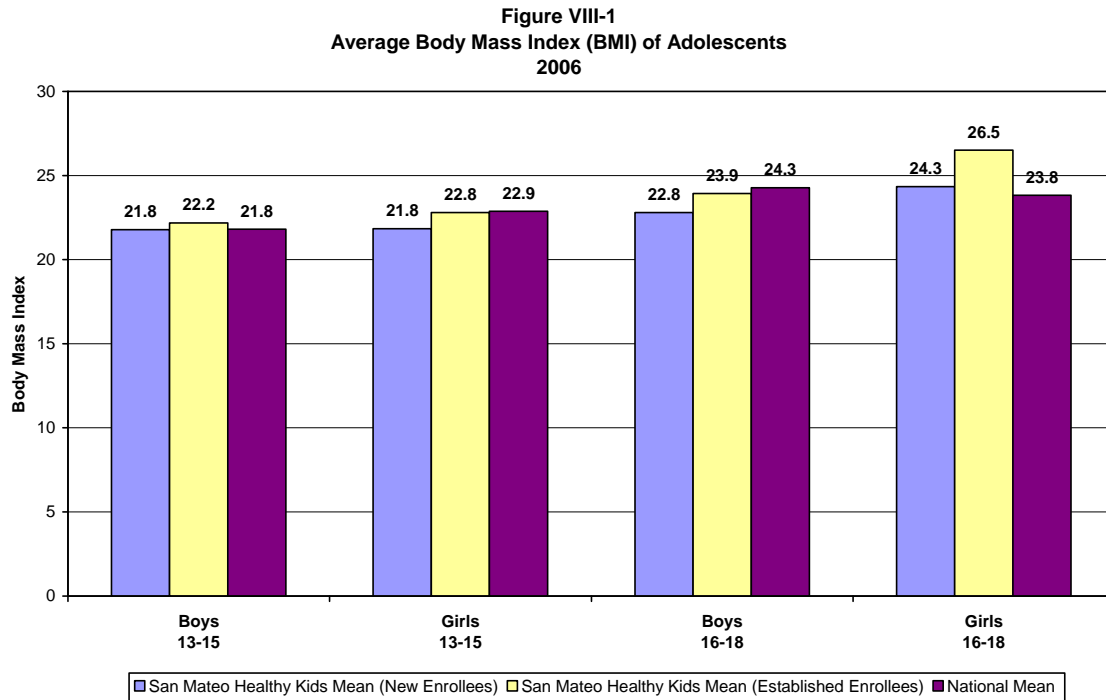
identical for new and established enrollees. It is also quite close to the percentage who enrolled their child for a medical reason, giving some confidence that about one-third of Healthy Kids children have a medical condition needing primary care at any given time. The list illustrates that the health needs of Healthy Kids enrollees are wide-ranging, from mild problems to more serious chronic conditions. Almost all are potentially treatable by accessible primary care. For two conditions, allergies/sinus problems and orthopedic problems, the percentage of new enrollees with problems is significantly higher than for established enrollees.

Obesity is a growing problem among U.S. children. A recent paper showed Latino girls to be almost twice as likely to be overweight as their non-Latino white peers (Haas et al. 2003). Previous analysis provided in the evaluation's second annual report shows that Healthy Kids enrollees are generally similar in weight to their national age/gender group. In addition, the body mass index (a combination of weight and height for adolescents)¹⁸ is also similar.

We here present new information from the most recent survey, which allows us to examine the body mass index of adolescents just after they enroll in Healthy Kids and then one year later (Figure VIII-1). While it seems unlikely that enrollment in Healthy Kids would increase or decrease body mass index (BMI) for those at a normal weight for height, it could affect those who are abnormally small or large and thus change the distribution. More likely, just being in the United States an additional year for these youth could lead to increased weight for height, through the adoption of unhealthy eating habits. While none of the differences between new and established enrollees are

¹⁸ See: http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/childrens_BMI_formula.htm.

statistically significant, perhaps due to small sample sizes within age/gender groups, there is a consistent pattern of slightly higher BMI after one year of enrollment for each age/gender group shown.¹⁹ This is particularly true for girls. At ages 13–15 new enrollee girls have an average BMI of 21.8 and established enrollee girls have an average BMI of 22.8. At ages 16–18, the BMIs are 24.3 and 26.5 respectively.



Sources: Healthy Kids parent survey, 2006; and NHANES 1999-2002 data from Ogden et al. 2004

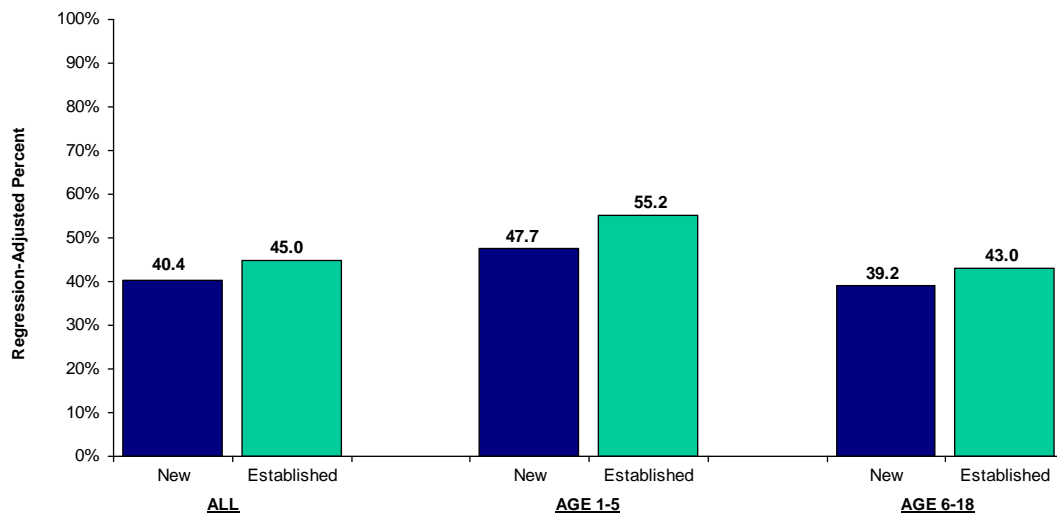
Impact Analysis

The design of the Wave Two survey allows for an analysis of the impact of the Healthy Kids program on health status during the first year of enrollment, by comparing the health status of new and established enrollees, after adjusting for differences in characteristics of the two groups. Given that the impact of the Healthy Kids program on access to and use of medical care is very pronounced as shown in Chapter IV, and that

¹⁹ Caution is advised since 45% of parents do not know either their adolescent's weight or height, or both, leading to a large amount of missing data.

many of the conditions that Healthy Kids enrollees have are amenable to good primary care (as shown above), we hypothesize that the health status of children could improve. Given that it is only possible to study impacts after one year of enrollment, there are possibly longer term effects on health status that are not detected with this evaluation.²⁰

Figure VIII-2
Percent of Healthy Kids Enrollees Reporting Excellent or Very Good Health Status, by Age



Source: Healthy Kids parent survey, 2006.

Note: No statistically significant differences between new and established enrollees.

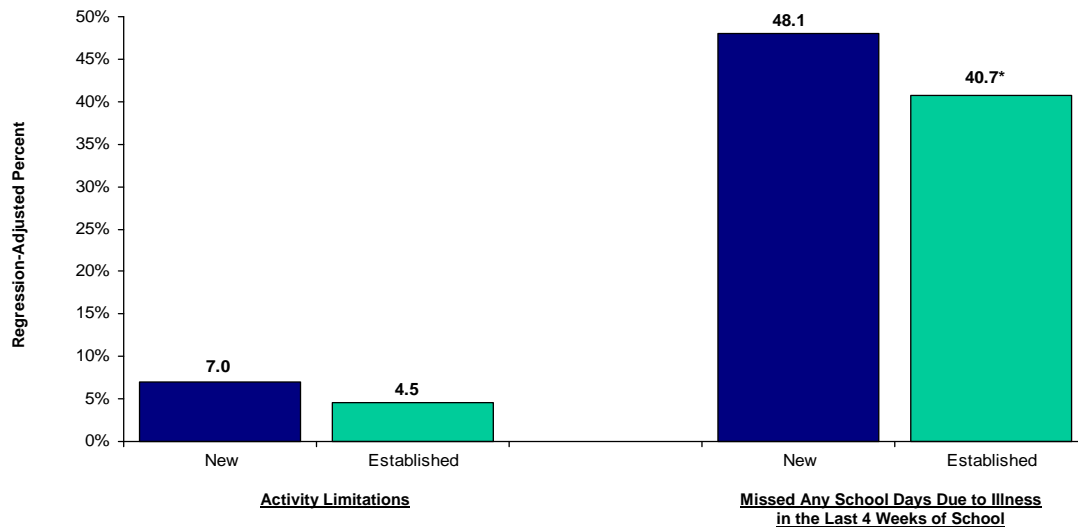
Figure VIII-2 shows no significant impact of Healthy Kids on perceived health status. (This corresponds to the descriptive results noted above in Table VIII-2). However, when we divide the children into those who enroll for medical reasons and those who do not, there is a significant improvement among children who enroll for medical reasons. In this group, 25.0 percent of new enrollees are in excellent/very good

²⁰ An impact on the health status of young children in Los Angeles was not detected in the cross-sectional design (similar to the San Mateo analysis), but was evident from a longitudinal analysis (Howell, Dubay and Palmer 2008).

health, in contrast to 34.3 percent of established enrollees (data not shown). While this is promising, “regression to the mean” could be responsible for some of this improvement. (See Howell and Trenholm 2007 for more discussion of this issue.)

Similar results are found for the percent of children with activity limitations (Figure VIII-3). While results are in the hypothesized direction, they are not statistically significant (data not shown).

Figure VIII-3
Percent of Healthy Kids Enrollees Aged 6-18 Reporting Activity Limitations and Missed School Days



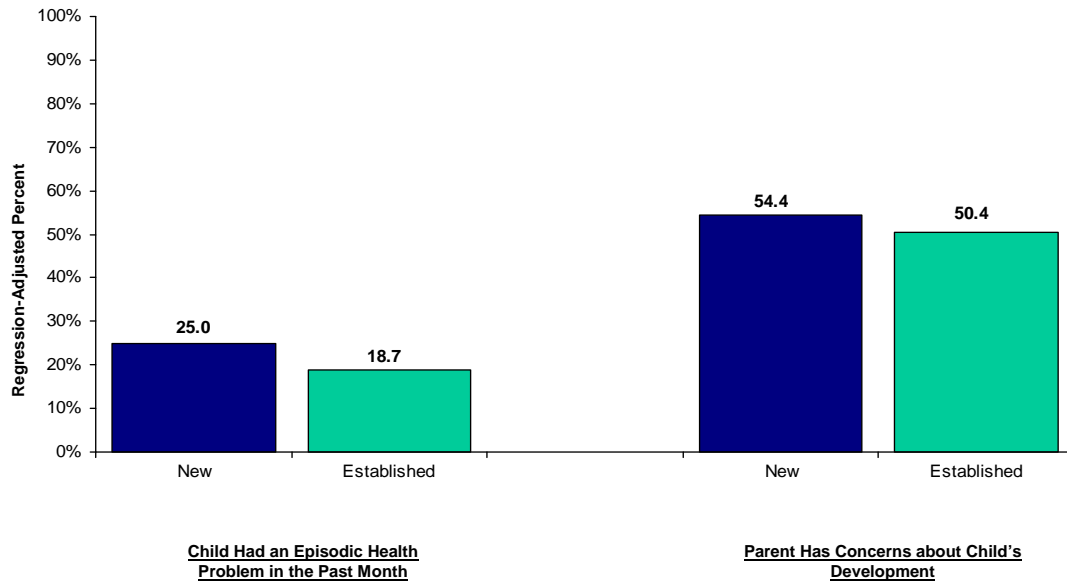
* Significantly less than new enrollees, $p < .05$, one-tail test.

Source: Healthy Kids parent survey, 2006.

Still, in spite of the insignificant findings concerning perceived health status and activity limitations, the program did have a positive impact on school attendance. Figure VIII-3 shows the impact of Healthy Kids on missing any school days in the past month due to health problems. Significantly fewer established Healthy Kids enrollees missed school days due to health in the month prior to the interview (40.7 percent) compared to new enrollees (48.1 percent). In addition, the impact is concentrated among those

children who do not enroll for a medical reason, suggesting that regression to the mean is not a major contributor to the finding. This is similar to a finding in the Santa Clara Healthy Kids impact study, which also found a significant effect on missing 3 or more school days among children who did not enroll for medical reasons.

Figure VIII-4
Percent of Healthy Kids Enrollees Aged 1-5 Reporting Episodic Health Problems and Parent Concerns about Child's Development



Source: Healthy Kids parent survey, 2006.

Note: No significant differences between new and established enrollees.

To further investigate the younger children's health (ages 1–5), we asked some special questions of parents concerning their child's development and episodic health problems. As shown in Figure VIII-4, differences between the new and established young children are in the hypothesized direction but are not statistically significant. For example, 25.0 percent of new enrollees had an episodic health problem (such as a fever, cold, or stomach problem)²¹ in the past month, while 18.7 percent of established enrollees had such a problem.

²¹ Accidents were excluded from this measure.

CHAPTER IX

WHAT IS THE IMPACT OF HEALTHY KIDS ON INSURANCE STATUS AND CROWD-OUT OF PRIVATE COVERAGE?

A key question about San Mateo’s Healthy Kids Program is to what extent the new program substitutes for—or “crowds out”—employer-sponsored insurance coverage. This issue is of particular concern in San Mateo County, because the program expands eligibility to children whose family incomes are up to 400 percent of the Federal Poverty Level (FPL), and the potential for crowd-out is higher at higher incomes (CBO 2007). In order to minimize the potential for crowd-out, the Healthy Kids program requires that children have a six-month period with no employer-sponsored insurance coverage, if they have voluntarily dropped their previous coverage before enrolling. In addition, the sliding-scale premium includes premiums for all income levels, though families can apply for assistance to help them pay the premiums.²²

This chapter presents new information on this issue from the 2006 parent survey. The analysis draws on questions asked of parents of established enrollees about their child’s health insurance coverage prior to enrolling in Healthy Kids, as well as questions about the family’s health insurance coverage at the time of the survey²³. A similar analysis was provided in the Second Annual Report using data from the 2004 parent survey.

²² The premiums charged for higher-income families tend to be lower in San Mateo’s Healthy Kids Program compared with the rest of the nation. Nationwide of the 15 states that offer SCHIP at 251 percent of the FPL and charge premiums, the average quarterly contribution is \$168 per child (Selden et al. 2008) compared to \$36 per child in San Mateo.

²³ Data for new enrollees are not presented, but results are similar to those shown for established enrollees.

Coverage Prior to Enrollment

Few Healthy Kids parents report that their child had employer-sponsored coverage prior to enrolling in the program (Table IX-1). Over 40 percent have no coverage whatsoever prior to enrolling, and very few have private coverage (9 percent). Of those that do, most lost private coverage because their parent lost employer-sponsored coverage or because the private coverage was not affordable (data not shown). The coverage patterns are similar for children in the younger (ages 1 to 5) and older (ages 6 to 18) groups.

Table IX-1
Coverage Status of Children Just Before Enrolling
in the Healthy Kids Program
2006

	Percentage		
	Total	Ages 1-5	Ages 6-18
Uninsured	41.7	42.0	41.7
Private Coverage			
Employer-Sponsored Insurance	8.9	6.4	9.4
Private Non-group	2.4	2.0	2.4
Public Coverage			
Emergency Medi-Cal	42.2	37.9	43.1
Medi-Cal	6.2	10.8	5.2*
Healthy Families	5.5	5.2	5.6
Healthy Kids	0.1	0.0	0.1
WELL Program	5.0	1.6	5.7
Insurance Program in Another Country	0.4	0.4	0.4
Other	6.5	6.0	6.6
N	681	162	519

* Difference between age groups is significant at the .05 level, two-tail test.

Source: Healthy Kids parent survey, 2006.

Notes:

- (1) Estimates are derived from the sample of established Healthy Kids enrollees.
- (2) Percentages do not sum to 100 because more than one type of coverage could be reported.

Understanding how Emergency Medi-Cal interacts with the Healthy Kids program is important because Emergency Medi-Cal may be a source of financing for some of the services used by HK enrollees. Over 40 percent have Emergency Medi-Cal prior to enrolling. Among those children, 44 percent still have Emergency Medi-Cal at the time of the survey, 7.1 percent of parents are not sure, 8.5 percent dropped Emergency Medi-Cal around the time of enrollment, 15.2 percent dropped Emergency Medi-Cal before enrollment, and the rest said that their child no longer has Emergency Medi-Cal and dropped it at some point after Healthy Kids enrollment.

The survey also shows that some parents continue to use Emergency Medi-Cal to cover their child's health care after enrollment in Healthy Kids. Parents of 3.8 percent of established enrollees report using the Emergency Medi-Cal card to cover services while their child is enrolled in Healthy Kids. Of the few established enrollees whose parents say that they have used the Emergency Medi-Cal card, 30 percent say that the visit was for an emergency or for urgent care; 17 percent say they did not have their Healthy Kids card yet or could not find it, 17 percent say the provider preferred Medi-Cal or only accepted Medi-Cal, and 15 percent say they are not sure which card the provider used. These estimates are imprecise, given the very small sample size (30 children), but suggest that more study on this topic is warranted.

In addition, the use of Emergency Medi-Cal appears to be growing in San Mateo County. In the 2004 survey, 22 percent of Healthy Kids parents report that their child had Emergency Medi-Cal either alone or in combination with some other coverage prior to enrolling in Healthy Kids; by 2006, that figure has grown to 42 percent.

Access to Employer Coverage

Access to affordable employer-sponsored health insurance coverage is very limited for Healthy Kids enrollees and very few Healthy Kids enrollees are foregoing subsidized employer-sponsored coverage. While overall one in five live in families in which there is an offer of dependent coverage, just one in ten have dependent coverage available that has some type of subsidy from the employer (Table IX-2). Moreover, this likely overstates the degree to which the available employer-sponsored coverage is affordable since few of the parents themselves have coverage under these plans. Only 5.6 percent of enrollees' parents have an offer of subsidized dependent coverage which the parent has taken up for him/her self. Younger enrollees have somewhat greater access to private coverage that already includes their parents than older enrollees (9.5 vs. 4.8 percent).

Table IX-2
Access to Employer-Sponsored Coverage Among Healthy Kids Enrollees
2006

	Percentage		
	Total	Ages 0-5	Ages 6-18
Dependent Coverage Offer Through Employer	19.0	22.3	18.4
Dependent Coverage Offer, and Employer Pays Some or All of the Premium	9.9	14.6	9.0
Dependent Coverage Offer, and At Least One Parent Has Employer Coverage	11.3	13.8	10.8
Dependent Coverage Offer, Employer Pays Some or All of the Premium, and At Least One Parent Has Employer Coverage	5.6	9.5	4.8
N	681	162	519

Source: Healthy Kids parent survey, 2006.

Notes:

- (1) Estimates are derived from the sample of established Healthy Kids enrollees.
- (2) Children whose parents have insurance from Kaiser are included in percentages of children whose parents have employer coverage.
- (3) Some enrollees are excluded from analysis if survey responses that indicate the availability of employer-sponsored coverage have missing values.
- (4) There are no significant differences between ages 0-5 and ages 6-18.

Coverage Patterns of Parents and Siblings

Because eligibility for different public insurance programs for children (Medi-Cal, Healthy Families, and Healthy Kids) depends on a child's age and immigration status, it is possible for parents or other children in the same family to qualify for coverage under different public programs (and in some instances, not to qualify for any program). Having people in the same family with different forms of coverage may cause difficulties for families because it can mean that the families need to deal with different administrative rules and provider networks. Among the Healthy Kids enrollees who have siblings—who constitute about three quarters of all established enrollees—31.4 percent have a sibling with Medi-Cal, 21.3 percent have a sibling with Healthy Families, and about 10 percent have an uninsured sibling (Table IX-3).

**Table IX-3
Coverage Patterns Among the Siblings of Healthy Kids Enrollees
2006**

	Percentage		
	Total	Ages 0-5	Ages 6-18
Healthy Kids Enrollees With One or More Siblings			
At least one sibling enrolled in Medi-Cal	31.4	35.3	30.7
At least one sibling enrolled in Healthy Families	21.3	15.9	22.3
At least one sibling uninsured	9.3	3.8	10.3
N	460	94	366

Source: Healthy Kids parent survey, 2006.

Notes:

- (1) Includes established Healthy Kids enrollees who have one or more siblings (77.6 percent of the total established enrollees sample).
- (2) There are no significant differences between ages 0-5 and ages 6-18.

Most Healthy Kids enrollees (66.4 percent) have a parent who is uninsured (Table IX-4). Among the parents who have health insurance, many report limited public coverage—23.7 percent report that they are enrolled in the WELL Program,²⁴ and about 10 percent report that they have Emergency Medi-Cal. While 10 percent have coverage from Kaiser and about 13 percent have private insurance, it is rare for both parents to have private coverage (data not shown). This suggests that the costs associated with dependent coverage deter covering other family members beyond the employee.

**Table IX-4
Insurance Status of Healthy Kids Enrollees' Parents
2006**

	Percentage of Enrollees with At Least One Parent in Category
Uninsured	66.4
Private Coverage	
Employer-Sponsored Insurance	13.1
Private Non-group	0.5
Kaiser	10.0
Public Coverage/Other	
Emergency Medi-Cal	9.9
Medi-Cal	2.7
WELL Program	23.7
Other	2.5
N	681

Source: Healthy Kids parent survey, 2006.

Notes:

- (1) Includes established enrollees ages 0-18.
- (2) Percentages do not add to 100 because children can have parents in more than one category.

²⁴ A county-based program that offers reduced-cost outpatient care.

Enrollment/Take-Up among Higher-Income Children

According to administrative data from the HPSM, in February 2008, 844 Healthy Kids enrollees had incomes between 251 and 400 percent of poverty, constituting 13.6 percent of all Healthy kids enrollees (Table IX-5). The percentage of all enrollees who are in the higher income group grew from only 5.6 percent in the first month of the program to over 10 percent two years later. However, the percentage has leveled off at about 14 percent of the total Healthy Kids caseload.

**Table IX-5
Number and Percentage of Healthy Kids Enrollees
in High-Income Families
2003-2008**

	251-400 percent of Federal Poverty Level	
	Number of Enrollees	Percentage of Total Enrollees
February 2003	41	5.6
February 2004	462	9.4
February 2005	602	11.3
February 2006	769	12.8
February 2007	849	13.5
February 2008	844	13.6

Source: Health Plan of San Mateo.

Estimates from the American Community Survey suggest that 13,534 children in San Mateo County have incomes between 300 and 400 percent of poverty.²⁵ Thus, about 3 percent of children in that income bracket are enrolled in Healthy Kids.

²⁵ Urban Institute Tabulations of the 2006 American Community Survey.

CHAPTER X
WHAT IS THE EFFECT OF THE CHI ON
COLLABORATION AND THE LOCAL HEALTH SYSTEM?

The health care delivery system for low-income children and families in California is a confusing patchwork of inadequately financed programs. The result is an array of uncoordinated services, placing a burden on families and providers to piece together comprehensive care.

In order to reduce the burden on families and county administrative systems, the San Mateo CHI seeks to improve “systems integration,” that is to improve the communication and co-ordination between the various programs that serve low-income children and their families. Some of the desired outcomes of this process include: simplification of the public program application and enrollment process; better organization of services to ensure that clients receive the care they need; and streamlined administrative functions to avoid duplication of functions and reduce costs. One CHI staff member described the goal as follows: “The idea is to create a system that is seamless for the clients.”

To evaluate progress towards this goal, we interviewed representatives from each of the organizations that have participated in the process. This includes the following agencies: the Health Plan of San Mateo; the Human Services Agency; the Health Department; and other partners, for example schools and community based organizations. We sought their opinions both about what has occurred and about how it has improved the county systems for low-income families.

Key informants report that systems integration efforts have produced greater satisfaction among agency staff, through improved understanding of each others' goals, activities, and challenges, as well as through more streamlined processes for program enrollment and improved service linkages.

Improved Organizational Linkages

Within the CHI, one cornerstone of systems integration is close communication across child-serving organizations. Communication occurs primarily through the CHI Oversight Committee which is comprised of the leadership of the HPSM, the HSA, First 5, the Health Department, the Hospital Consortium of San Mateo, and the Silicon Valley Community Foundation. In the first few years of the CHI, the Oversight Committee met on a monthly basis, which led to enhanced communication and continual improvements in the process of enrolling children in appropriate programs and providing appropriate services. Currently, it meets less frequently, since program oversight has shifted to the HPSM. There is a general consensus that the Committee is effective as a means for information sharing and decision making.

Communication has also been enhanced through the relocation of the principal CHI staff from the health department to the HPSM. This has enabled staff from these two key players to regularly plan and execute program improvements collectively through more frequent contact and communication. As an example, this collaboration is viewed as having improved the quality of the new member packets and orientation process.

Table X-1
San Mateo County Children’s Health Initiative Committees

Committee Name	Membership	Meeting Schedule
CHI Oversight Committee	County and community partners: Silicon Valley Community Foundation; CAAs, HPSM, clinic representatives, HSA, CHI staff	Monthly
Healthy Kids Policies and Operations Workgroup	CHI, HSA, Legal Aid, HPSM, CBOs, San Mateo Medical Center	Monthly
South County Health Coverage Outreach Committee	CHI, HSA, clinic representatives	Bi-monthly
North County Health Coverage Outreach Committee	CHI, HSA, clinics representatives	Bi-monthly
One-e-App internal workgroup	CHI, HSA, HPSM	Bi-weekly
CHI Evaluation Committee	CHI, HSA, HPSM, CBOs	Quarterly
HK Retention Workgroup	CHI, HPSM, CBOs	Monthly

Note: CHI—Children’s Health Initiative; HK—Healthy Kids; CAA—Certified Application Assistor; HSA—Human Services Agency; HPSM—Health Plan of San Mateo; CBO—Community Based Organization.

There are also a number of oversight sub-committees with broad membership where issues associated with the specific topics are discussed (see Table X-1). Because of overlapping, comprehensive membership, these committees provide an opportunity for information sharing and collaborative problem solving. Most of the sub-committees also function across health insurance programs (meaning that they address issues related not

just to Healthy Kids, but to Medi-Cal and Healthy Families as well). This enables all programs and services to be knowledgeable about other programs and services.

As an example of organizational linkages at a more operational level, the San Mateo City School District receives a grant from the Health Department specifically to align the work of the CHI and schools. Staff funded by the grant are placed in schools to seek out uninsured children and assist their parents in enrolling them in appropriate programs. This effort to place CAAs in schools, has promoted better coordination between schools and health and social services agencies. The school district provides space and internet access for the CAAs; the CHI provides the CAAs with promotional materials, training, and other forms of support.

One key informant described the partnership between schools and the CHI as a “win-win situation,” because the schools find it easier to meet the needs of their students with the support of the CHI and the CHI is able to use school settings to extend health insurance to children and their parents.

Other efforts are underway to achieve better integration between medical, dental and mental health services. For example, parents are more routinely being informed about mental health benefits by CAAs and offered suggestions about where to obtain care if needed. Similarly, CHI staff and others are looking for ways to inform clients that they are eligible to seek dental providers in the private sector, where waiting lists are significantly shorter than at public dental clinics. To identify children who need referrals to services, the CHI and the HPSM also routinely review utilization data to identify and contact clients who have not utilized preventive medical and dental services within 6 months of enrollment.

Improved Tools and Systems

The establishment of the CHI—with its focus on Medi-Cal, Healthy Families and Healthy Kids—has led to the development and use of new common systems and tools across the three child public health insurance programs. In particular, the agencies that determine eligibility and facilitate enrollment have worked together from the beginning of the CHI. For example, the agencies share enrollment data bases and staff receive the same training across all three programs. As a result, all staff communicate to clients the same information about program benefits, how to obtain access to services, and how to re-enroll.

The most important example of these innovations is the One-e-App, an on-line application system used by all certified application assistors (CAAs) when they assist parents with applications. Widespread use of the One-e-App has had many benefits. In particular, it has promoted system integration by providing on-line linkages between programs. Key informants report that this linkage has greatly simplified the enrollment process both for CAAs and for families that are eligible for more than one public program.

CHAPTER XI

ARE PARENTS SATISFIED WITH THE HEALTHY KIDS PROGRAM AND ITS SERVICES?

Studies show that a lack of health insurance causes parents to feel worried and stressed, in addition to creating financial hardships (Lave et al. 1998). Indeed, evaluations of SCHIP and Healthy Kids in other California counties show that having coverage successfully reduces the financial and emotional stress of trying to access affordable health care for their children (Howell, Dubay and Palmer 2008; Trenholm et al. 2005; Kenney et al. 2007; Kenney 2007). Parent satisfaction with the quality of services is an indicator of satisfaction with the program and the impact it has had on the quality of life for the families of children enrolled in Healthy Kids.

This chapter presents evaluation findings that assess whether parents are satisfied with the program and the quality of services received through it. To answer this question, we draw on the following two sources of data:

- 2004/2005 focus group discussions with parents of enrollees; and
- The 2006 parent survey.

From the parent survey we use several questions:

Confidence in getting care: During the past six months, how confident were you that your child could get health care if he/she needed it? (Possible responses are very confident; somewhat confident; not very confident; and not at all confident.)

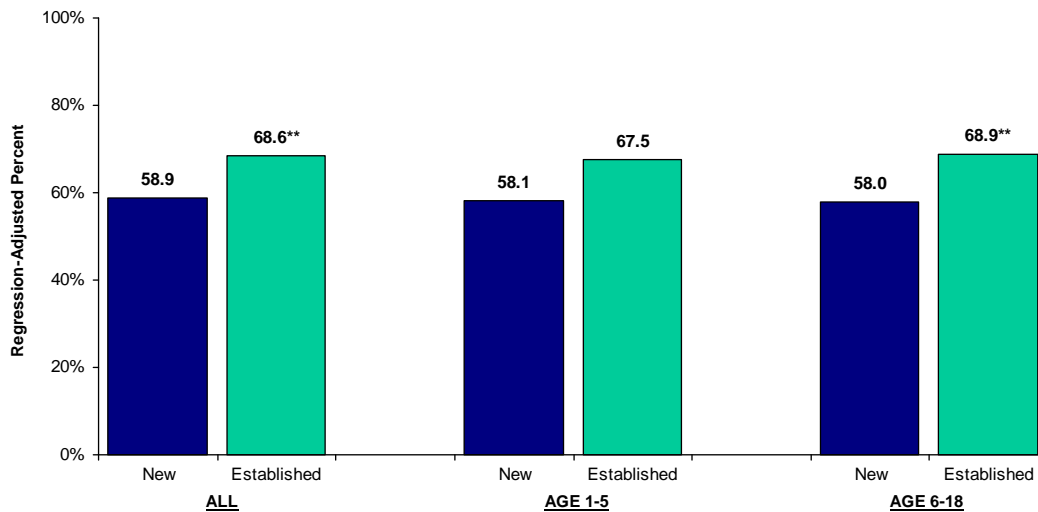
Satisfaction with quality of care: During the past six months, how satisfied were you with the quality of health care your child received? (Possible responses are very satisfied; somewhat satisfied; somewhat dissatisfied; or very dissatisfied.)

Health care causes financial hardship: During the past six months, how often did your child's health care need create financial difficulties? (Possible responses are a lot; somewhat; a little; or not at all.)

Health care needs cause worries: How worried were you about meeting your child’s health care needs? (Possible responses are very, somewhat, not very, not at all).

Healthy Kids enrollment increases parent satisfaction with the quality of their child’s health care services (Figure XI-1). Almost 70 percent of parents of established enrollees are very satisfied compared to 58.9 percent of parents of new enrollees. This pattern is consistent for both age groups, although the difference in the estimates for the youngest enrollees is not statistically significant at conventional levels ($p=.07$). Data from focus groups with parents support the survey findings that most parents are pleased with their child’s providers and the services their children receive.

Figure XI-1
Percent of Parents of Healthy Kids Enrollees Very Satisfied with the Quality of Services Received in the Past Six Months, by Age



** Significantly greater than new enrollees, $p<.01$, one-tail test.

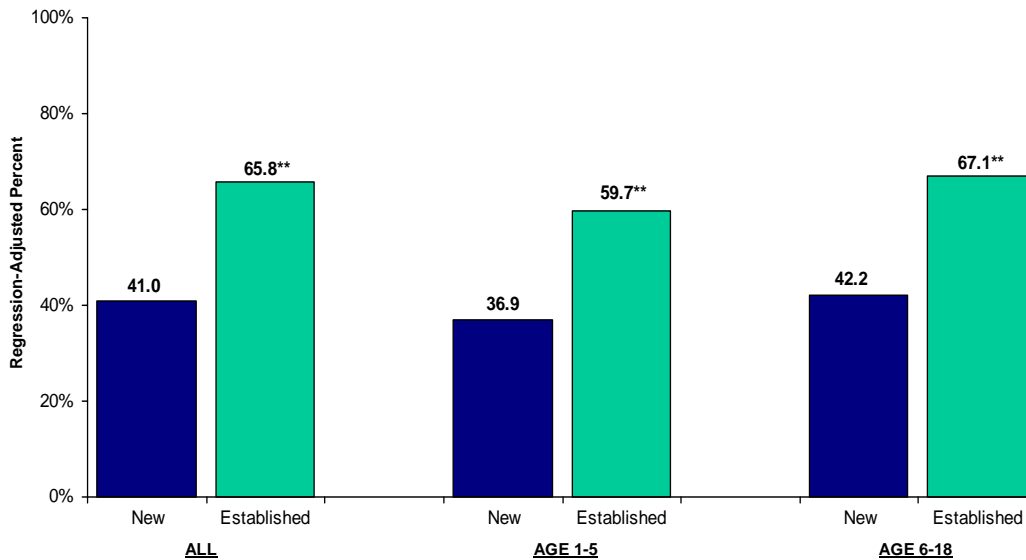
Source: Healthy Kids parent survey, 2006.

On the other hand both survey data and focus group findings suggest there remains room for improvement. For example, according to the survey, about a third of parents of established enrollees are not very satisfied with their child’s health care

quality. Focus groups suggest that this is not due to poor quality medical care in most cases, but rather to the need for improvement in clinic staff’s customer service skills.

Healthy Kids also increases parent confidence that they can get needed health care for their child (see Figure XI-2). Only 41.0 percent of parents of new enrollees are very confident compared to 65.8 percent of established enrollee parents. Although parents of the youngest children are less confident overall, the percentage point increase in confidence as a result of the program is about the same between the two age groups.

Figure XI-2
Percent of Parents of Healthy Kids Enrollees Very Confident that Child Could Get Care in the Past Six Months, by Age

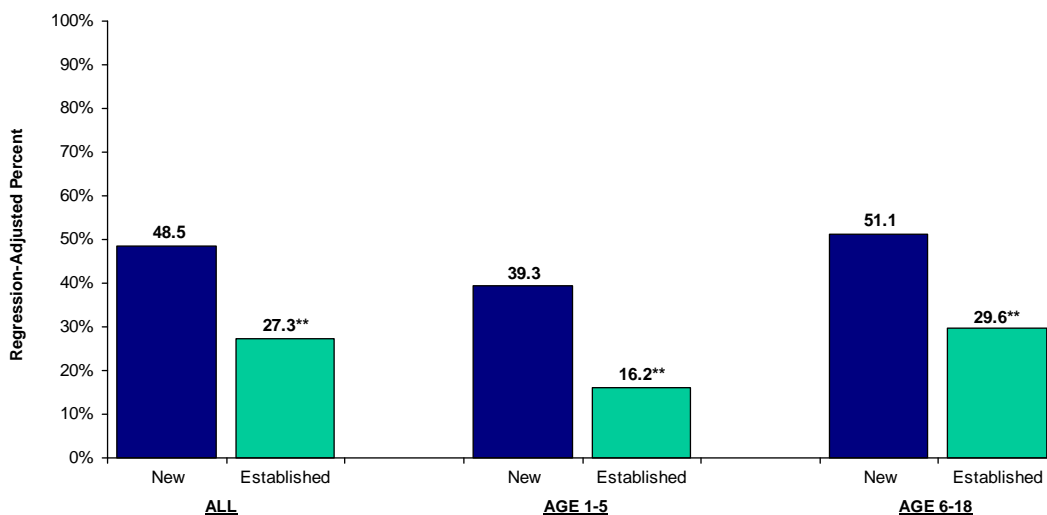


** Significantly greater than new enrollees, p<.01, one-tail test.

Source: Healthy Kids parent survey, 2006.

The program also reduces parent worry about meeting their child’s health care needs (Figure XI-3). The proportion of parents who worry about meeting their child’s needs is much lower for parents of established enrollees than new enrollees (27.3 percent versus 48.5 percent, respectively).

**Figure XI-3
Percent of Parents of Healthy Kids Enrollees Very Worried about Meeting Child's Health Care Needs
in the Past Six Months, by Age**



** Significantly less than new enrollees, p<.01, one-tail test.

Source: Healthy Kids parent survey, 2006.

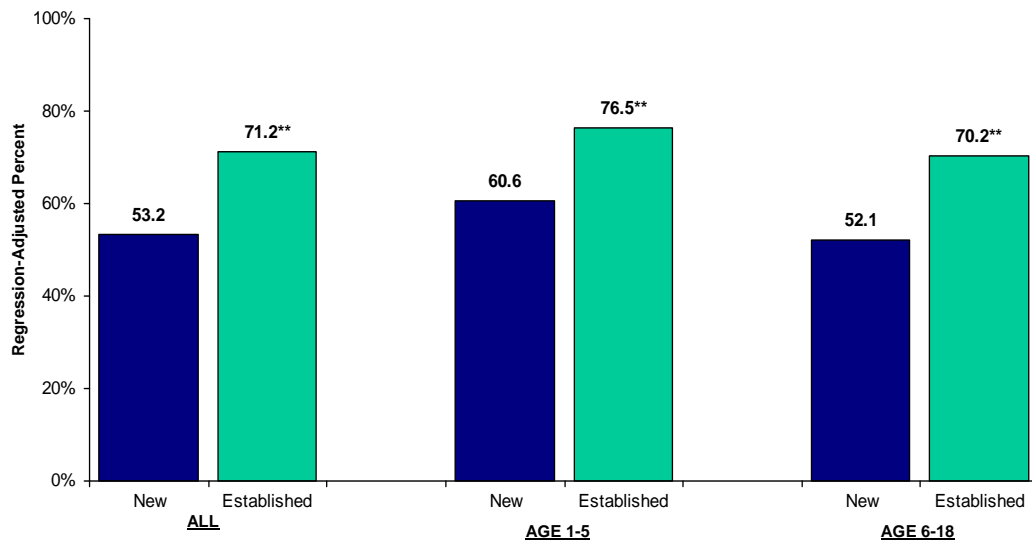
In the focus groups parents said that they find comfort from knowing their child has health insurance and can access care when needed.

It's worrisome when [children] don't have insurance.

In case they get sick, it is good that they are covered.

The survey reveals another positive program impact on improving quality of life for families, that is that Healthy Kids significantly reduces the economic pressures associated with health care costs (Figure XI-4). Almost three-quarters of established enrollee parents report they experience little or no financial difficulty because of expenses related to their child's health care compared to just over half of new enrollee parents (53.2 percent).

Figure XI-4
Percent of Parents of Healthy Kids Enrollees Reporting Little or No Financial Difficulty Due to Child's Health Care Needs in the Past Six Months, by Age



** Significantly greater than new enrollees, $p < .01$, one-tail test.

Source: Healthy Kids parent survey, 2006.

These improvements in quality of life for families with children enrolled in Healthy Kids in San Mateo County are similar to those found in evaluations of similar initiatives elsewhere in California (Trenholm et al. 2007).

CHAPTER XII CONCLUSIONS AND RECOMMENDATIONS

At the end of the first five years of the San Mateo County Children’s Health Initiative, it is possible to draw some clear conclusions about the county’s efforts to improve the health of its low income children. The evaluation reveals very strong, positive effects of the CHI, as well as some challenges that remain for the future.

Key Positive Effects of the CHI

The CHI has successfully achieved its primary goal of enrolling low income uninsured children in public health insurance and increasing access to and use of appropriate services. As evidence of this success, there has been a large increase in the proportion of enrolled children who have a usual source of medical and dental care after enrolling in Healthy Kids. This has led to significantly more preventive medical and dental services among enrollees. Finally, there has been a dramatic reduction in unmet need for medical and dental services. Administrative data from the HPSM show these improvements in use of preventive medical and dental care continue over at least the first three years of enrollment.

Both qualitative and quantitative evaluation results indicate new insurance coverage provides parents with an increased sense of security that they can get needed health care for their children. In the words of one parent who commented on the benefits of Healthy Kids, “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.” Additionally, survey data show that being enrolled in the program increases the parents’ satisfaction with the quality of health care services their children receive.

These improvements in access to care and use of appropriate services have led to better health soon after enrollment for some children. A consistent pattern across multiple measures of health, and in both younger and older children, suggests improved health after a year in the program. Most notably, those who enroll in Healthy Kids for a year are significantly less likely to miss school because of health problems. A study with larger samples may detect significant results for other measures²⁶.

There has been some concern that San Mateo's Healthy Kids program could lead to crowd-out of employer coverage, given that it includes eligibility levels up to 400 percent of the Federal Poverty Level. However, evaluation findings show that very few children have private insurance before they enroll in Healthy Kids. Moreover, most Healthy Kids enrollees, even those in higher-income families, do not have access to affordable subsidized employer-sponsored coverage. As further evidence, while the Healthy Kids caseload in the 250 to 400 percent FPL group grew some in the early years of the program, it has leveled off at around 14 percent of enrollees, and only a small fraction (just around 3 percent) of all San Mateo children in the 250 to 400 percent FPL group are currently enrolled in Healthy Kids.

Finally, only a third of Healthy Kids enrollees have an insured parent, and very few of the parents have private insurance coverage. Previous research has shown that when parents lack insurance coverage they are less likely to receive primary care and more likely to have unmet health needs (Dubay and Kenney 2003). In addition, their lack of health insurance may affect their children's care (Perry 2008).

²⁶ Further analysis combining data from San Mateo and Santa Clara CHI evaluations shows statistically significant findings across a wider range of health status outcomes.

An important secondary goal of the CHI is to increase the integration of health services for low income children. For example, almost half of all Healthy Kids enrollees have one or more siblings in a different public program, adding to the complexity for their parents to enroll their children in the appropriate program. The evaluation found that the CHI has led to greater co-operation among key public agencies (such as the Health Department, the Human Services Agency, and schools) that did not work closely together in the past, and this has helped to address these issues. At the “micro” level, the county has made the application process for fragmented public health insurance programs seamless for families through its ground-breaking implementation of the One-e-App on-line application system.

Service Delivery Challenges

While the evaluation has shown that CHI efforts have led to large improvements in health care for low income children, there remain some areas for improvement. Even after children are enrolled in insurance, some parents identify barriers to accessing care, such as difficulties scheduling appointments (for example, because clinic phone lines are busy). They also may have trouble finding evening and weekend appointment times that do not conflict with their work hours.

The HPSM has made substantial progress in its efforts to contact parents, assist them with navigating the health system, and educate them about the importance of preventive care. Still evaluation results show use of the emergency room remains high. To address this, the plan’s parent education should incorporate a component that teaches parents how to monitor and interpret common signs of young childhood illnesses, such as fever, as well as information on how to get after-hours advice for such problems.

Healthy Kids enrollees have rates of mental health problems that are similar to other children. However, the program is still not reaching all children who need such services, especially for children with the more complex mental health problems that require formal mental health care. These barriers include perceived stigma with obtaining formal mental health care and a lack of awareness about the services available.

While access to preventive and dental care is greatly improved after enrollment in insurance, there are still a substantial number of Healthy Kids enrollees who do not obtain preventive medical or dental care in a given year. This could be related to some capacity constraints in the public clinic system—the most common provider of both medical and dental care. Qualitative information suggests some capacity exists in the private sector to serve more Healthy Kids children. An improved dialogue between public and private sectors, to educate private providers about Healthy Kids and other public insurance, should be combined with continued emphasis on parent education on system navigation, to ensure all children receive preventive and primary care. In addition, the HPSM can play an important role in monitoring the quality of care for Healthy Kids enrollees in both the public and private sectors.

The CHI has greatly strengthened some cross-agency linkages, but challenges remain to full service integration between all child-serving sectors, such as the juvenile justice system and foster care. In addition, it is important to continue to strengthen the developing linkages between the medical, mental health, and dental health sectors, ensuring a seamless system for families.

Data from the Health Plan of San Mateo suggest use of preventive care for Medi-Cal children is lower than for Healthy Kids and Healthy Families children. The HPSM

could use some of the effective approaches it has developed for the Healthy Kids program to improve preventive care use for Medi-Cal enrollees.

Financial Challenges

Having demonstrated that new health insurance provided through the San Mateo CHI has large benefits for newly covered children and their families, the initiative faces the challenge of continuing to fund such benefits for all low income children in the county. We have shown that the cost of care continues to climb some. With the economy entering a recession, enrollment also could increase more rapidly than in the past. In addition, the demand for public coverage among higher-income children—which has remained low so far—could grow in the coming years, especially if premiums for employer-sponsored insurance increase at a high rate.

In the face of increased program costs, sources for covering the cost of care remain limited. The stalemate at the state-level over potential financial support for county-based children's health initiatives means that for the near future support will be from local sources. As a consequence, the county's contribution to the cost of the CHI—which has risen over the year—may climb, or the program may again face the possibility of establishing a waiting list.

There are some other options the county could consider for increasing the financing for CHI activities. For example, the county could create a premium assistance program for the small fraction of enrollees with access to subsidized employer coverage. It will be important to continue to monitor the proportion of enrollees who are higher income, and what proportion of this group has potential access to employer-sponsored

coverage. In addition, the cost-effectiveness of such an approach depends on how much subsidy employers are providing, among other factors.

Another approach could be to use Healthy Kids as a “wrap around” program for Emergency Medi-Cal. (Given the low rate of hospital care covered by the HPSM as shown earlier, emergency Medi-Cal may be currently covering some costs.) About 40 percent of Healthy Kids enrollees had emergency Medi-Cal prior to enrolling in Healthy Kids, and about half retained emergency Medi-Cal after enrolling in Healthy Kids. While very few parents reported they used their child’s emergency Medi-Cal card after enrollment, the cost of the services that were used is unknown. More research is needed to understand the interaction between Healthy Kids and emergency Medi-Cal to investigate whether some formal interaction between the programs is feasible. A similar approach might be feasible for preventive care through the CHDP program. However, it would be critical to ensure that such financial interactions do not affect the administrative burden for families or already-stretched public agency staff.

Conclusion

In conclusion, the evaluation of the first five years of the San Mateo County Children’s Health Initiative has shown strong positive effects for many low income families and strengthened the public system serving those families. While challenges remain to sustain the initiative financially and continue to improve service delivery, the first five years of the CHI have improved the lives of many children and their families in the county.

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APPENDIX A
SURVEY AND ANALYSIS METHODOLOGY

Introduction

This report presents both descriptive and impact results based on data collected in 2006 in a survey of parents²⁷ of children enrolled in the Healthy Kids program of San Mateo County. This appendix presents information on the survey design and methods, as well as how the data were analyzed to interpret the impact of Healthy Kids on enrollees in the program.

Survey Methods

Mathematica Policy Research (MPR) conducted the 2006 parent survey under contract with the Urban Institute.²⁸ The goal of the survey was to assess the impact of the program on children enrolled for a year compared with children who were newly enrolled.

Instrument. MPR and UI staff designed the survey instrument, which was very similar to the survey instrument used for the Wave One survey and in other evaluations of Healthy Kids programs in Los Angeles and Santa Clara Counties. The instrument was designed for computer-assisted telephone interviewing (CATI) administration, in English and Spanish, with an approximate length of 40 minutes.²⁹

MPR conducted a pilot test of the survey instrument prior to the start of data collection. The purpose of the pilot test was to measure the length of the survey, test the flow and sequencing of questions, clarify question wording for respondents, and clarify instructions for the interviewers. A small group of bilingual interviewers, all of whom

²⁷ Interviews were conducted with the adult in the household most familiar with the child's health care. Ninety-five percent were biological parents (most mothers) and the remainder were step/foster/adoptive parents or other relatives. As indicated later in the appendix, some data collection occurred in early 2007.

²⁸ MPR also conducted a survey of a cross-section of enrollee parents in 2004 as part of the evaluation; results from that survey are provided in an earlier report (Howell et al. 2005).

²⁹ The survey instrument is available from report authors upon request.

were familiar with the survey and study population were trained. An endorsement letter, printed on the Health Plan of San Mateo (HPSM) letterhead, was mailed to a small sample of Healthy Kids enrollee families selected for the pilot test prior to making telephone contact. A dozen enrolled families completed an interview. We made minor modifications based on the pilot test experience to clarify questions and improve data quality.

Sample Design. Samples were selected at five points in time from Health Plan of San Mateo monthly enrollment files. The sample was stratified by age (0–5 and 6–18) and by length of enrollment. Those newly enrolled are called “new” enrollees, and those enrolled for one year are called “established” enrollees. In a particular month’s enrollment file, new enrollees are those who enrolled in that month and established enrollees are those who enrolled one year ago in that same month. We over-sampled children ages 0–5. The resulting four strata are: (1) new enrollees ages 0–5 years; (2) new enrollees ages 6–18 years; (3) established enrollees ages 0–5 years; and (4) established enrollees ages 6–18 years. The goal of the survey was to complete 1,400 interviews overall, 400 from the 0–5 year old strata, 1,000 from the 6–18 year old strata, and an approximately even number of new and established enrollees in both age groups. We released a total of 1,835 of cases for interviewing in five waves: 319 cases in stratum 1; 621 cases in stratum 2; 225 cases in stratum 3; and 670 cases in stratum 4. Survey weights were constructed to account for the complex sample design.

Sample selection took place in two stages. In order not to overburden parents with more than one child enrolled in the Healthy Kids program, we only asked them questions about one of their children. Consequently, first eligible families were sampled; if a family

contained more than one eligible child, one child was selected at random. An eligible family was one with at least one eligible child. An eligible child was ages 0–18 with an enrollment date (or re-enrollment date) in one of the months specified for the round of sampling, and who had neither been selected before nor had a sibling selected before.

At the time of the interview, new enrollees had been enrolled in Healthy Kids an average of 3.7 months and established enrollees had been enrolled an average of 15.9 months. For many of the key questions, new enrollee parents were asked about the six months prior to the date when their child enrolled in Healthy Kids (while they were uninsured), and established enrollee parents were asked about the six month period prior to the interview. Thus the recall period for new enrollee parents was an average of four months longer than established enrollees for those questions.

Interviews were conducted over a 13 month period, from April 2006 until May 2007. The reason for this prolonged field period was a smaller-than-anticipated flow of new children into the program (especially for the 0–5 age group) and a desire not to collect data during summer months for school-age children in order to assure complete data on the number of school days missed due to health problems.

Data Collection Procedures. Prior to the first telephone contact, sampled parents received an endorsement letter from the Health Plan of San Mateo introducing the survey and its sponsor. The letter emphasized the importance of participating, provided confidentiality procedures, stated that there was no penalty for declining to respond; and provided a toll-free number at MPR to call with questions. All respondents who completed a survey interview received a \$15 gift certificate from Albertsons, a local grocery store.

Response to the survey was excellent, and there were few refusals. We completed 1,404 interviews out of the 1,835 sampled cases, for an overall response rate of 76.5 percent. Table A-1 shows the final disposition of cases. The factor that accounted for the majority of nonresponse was respondents who could not be located. These were respondents whose addresses and phone numbers were no longer correct, and (despite use of intensive locating procedures) they could not be located. Other reasons for nonresponse included cases where the respondent indicated that the child was no longer enrolled in Healthy Kids. A very small percentage of nonresponse was due to respondent refusal or a respondent’s inability to speak either English or Spanish.

**Table A-1
Final Disposition of Sample**

	Number	Percent
Complete	1,404	76.5
Refusal	27	1.5
Language Barrier	23	1.2
Reported - Child Not Currently Enrolled in Healthy Kids	73	3.9
Located, Effort Ended	71	3.8
Not Located	237	12.9
Total	1,835	100.0

Descriptive and Impact Analyses

We examined the impact of Healthy Kids on outcomes in several domains, including: access to health care; use of services; unmet need for health services; health status; and parent satisfaction. For the analysis, established enrollees represent the “treatment” group (children who have been exposed to Healthy Kids enrollment for about one year), while new enrollees are the comparison group, representing uninsured children.

Descriptive comparisons between new and established enrollees are presented in tables in the report. Significant differences between the two groups are measured using either F-tests or Chi-square tests.

To distinguish them from descriptive (unadjusted) results, impact estimates are presented in figures in the report. Since it was not possible to have a randomized design, it was critical to use a regression model to adjust for differences in the treatment and comparison groups. For example, established enrollees had lived longer in San Mateo County and were somewhat older than new enrollees. These factors could have affected many important outcomes.

A logistic regression model using the following formula makes these adjustments and tests for statistical significance in differences between groups. The model is specified as follows:

$$\ln (P_i/1-P_i) = b_1 + b_2\text{New} + b_kX,$$

Where P_i is equal to the probability that the outcome i equals 1; New indicates that that the child is a new enrollee and X is a vector of control variables, as follows: age, household income, sex, family structure (spouse/adult partner in household), citizenship, child's health during infancy (or at the time he/she began school) relative to other infants (or children the same age), whether the child enrolled for a medical (or dental) reason, ethnicity/language spoken, number of children in the household, parent's education, household employment status, length of time child has lived in San Mateo County, and quarter the child enrolled in Healthy Kids. The regression modeling was programmed in STATA, which accounts for the complex sample design of the survey. Regression adjusted means were also calculated by STATA.

For simplicity of presentation, the figures present regression-adjusted means to compare outcomes of new and established enrollees. Adjusted means reflect the levels and changes that would occur if all enrollees had the characteristics of established enrollees. The statistical test for significance in each difference comes from the regression model above, and tests whether b_2 is significantly different from zero. To accommodate the regression adjustment process, 17 new enrollee infants were excluded, so that the ages in both groups ranged from 1 to 18.

APPENDIX B
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APPENDIX C
APPENDIX TABLES

**Appendix Table II-1
Financing for the San Mateo County Children's Health Initiative
2004-2007¹**

Source	2004 ²		2005		2006		2007		Total	
	\$	% Premium Funding	\$	% Premium Funding	\$	% Premium Funding	\$	% Premium Funding	\$	% Premium Funding
First 5 San Mateo	1,358,241	70%	1,667,597	57%	1,656,278	57%	1,734,816	55%	6,416,932	59%
Subtotal	\$ 1,358,241	70%	\$ 1,667,597	57%	\$ 1,656,278	57%	\$ 1,734,816	55%	\$ 6,416,932	59%
Public Financing										
San Mateo County ³	2,088,799	82%	2,668,758	100%	2,516,640	100%	2,608,108	100%	9,882,305	96%
CAA Reimbursements	-	-	-	-	15,830	0%	16,000	0%	31,830	0%
C-CHIP Assembly Bill 495	-	-	-	-	208,133	100%	104,066	100%	312,199	100%
Medi-Cal Administrative Activities (MAA)	127,500	0%	-	-	483,000	0%	483,000	0%	1,093,500	0%
Outreach, Enrollment, Retention and Utilization (OERU)	-	-	-	-	33,556	0%	261,666	0%	295,222	0%
San Mateo Medical Center	29,000	0%	-	-	-	-	-	-	29,000	0%
Subtotal	\$ 2,245,299	76%	\$ 2,668,758	100%	\$ 3,257,159	84%	\$ 3,472,840	78%	\$ 11,644,056	84%
Health Care Districts										
Sequoia Health Care District	1,281,882	100%	1,350,000	100%	1,350,000	100%	1,350,000	100%	5,331,882	100%
Peninsula Health Care District	650,167	100%	682,250	100%	682,250	100%	682,250	100%	2,696,917	100%
Subtotal	\$ 1,932,049	100%	\$ 2,032,250	100%	\$ 2,032,250	100%	\$ 2,032,250	100%	\$ 8,028,799	100%
Other Foundations										
Blue Shield	100,000	100%	100,000	100%	183,332	100%	315,884	100%	699,216	100%
California Endowment	50,000	100%	250,000	100%	333,333	100%	325,000	100%	958,333	100%
California Health Care Foundation	560,000	89%	100,000	100%	100,000	100%	-	-	760,000	92%
David and Lucile Packard Foundation	545,090	0%	88,200	0%	-	-	-	-	633,290	0%
Kaiser Foundation	35,000	0%	25,000	0%	35,000	0%	15,000	0%	110,000	0%
Lucile Packard Children's Hospital	100,000	100%	100,000	100%	100,000	100%	50,000	100%	350,000	100%
Peninsula Community Foundation	250,000	100%	-	-	-	-	-	-	250,000	100%
United Way of the Bay Area	-	-	-	-	43,500	0%	40,666	0%	84,166	0%
Subtotal	\$ 1,640,090	61%	\$ 663,200	83%	\$ 795,165	90%	\$ 746,550	93%	\$ 3,845,005	77%
Grand Total	\$ 7,175,679	78%	\$ 7,031,805	75%	\$ 7,740,862	71%	\$ 7,986,456	68%	\$ 29,934,792	69%

¹ Funding data for 2003 are unavailable. Funding data for 2004 through 2007 exclude the cost of the evaluation.

² Some data are for fiscal years and some for calendar years. Some data are estimated.

³ 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.

Source: San Mateo County Health Department.

Appendix Table III-1
Trends in Demographic Characteristics of Healthy Kids Enrollees
by Enrollment Year and Age
2003-2006

	Ages 0-5				Ages 6-18			
	2003	2004	2005	2006	2003	2004	2005	2006
N	969	467	524	438	3,406	1,533	1,305	979
Gender								
Male	50.6	51.8	53.1	50.5	52.5	51.6	49.5	51.9
Female	49.4	48.2	46.9	49.5	47.5	48.4	50.5	48.1
Language								
English	12.2	14.1	18.3	14.2	9.3	11.4	14.5	13.7
Spanish	84.9	82.2	77.9	81.0	87.5	84.0	80.0	78.5
Other	2.9	3.7	3.8	4.8	3.2	4.6	5.5	7.8
Family Income								
<151% of FPL	71.5	66.6	60.5	60.5	75.6	73.4	70.8	72.7
151-250% of FPL	16.5	10.0	9.6	7.8	15.6	13.4	12.6	10.8
251-300% of FPL	6.5	12.6	20.2	18.5	4.9	7.8	9.4	8.5
301-400% of FPL	5.5	10.8	9.7	13.2	3.9	5.4	7.2	8.0
Child Citizenship or Legal Residency								
Yes	10.6	22.7	30.5	30.8	6.2	11.7	16.1	15.6
No	89.4	77.3	69.5	69.2	93.8	88.3	83.9	84.4

Source: Health Plan of San Mateo.

Note: Includes only children continuously enrolled during their first year of enrollment.

Appendix Table IV-1
Reasons for Not Having a Usual Source of Care Reported
by Parents of Enrollees of Healthy Kids in San Mateo County

Reason for Not Having a Usual Source of Care**	New Enrollees	Established Enrollees
	Percent	
Child seldom sick	28.6	45.6
Recent arrival to area	20.9	3.7
Doesn't know where to go	6.7	4.6
Cost is too high	28.2	12.9
Child uses emergency room as a usual source of care	9.8	26.0
Other	5.8	7.3
N	272	73

** Distributions for new and established enrollees are significantly different, $p < .01$, two-tail test.

Source: Healthy Kids parent survey, 2006.

**Appendix Table VIII-1
Current Physical Problems Identified by Parents of Healthy Kids Enrollees
2006**

Problem	Total			Ages 1-5			Ages 6-18		
	New Enrollees	Established Enrollees	Total	New Enrollees	Established Enrollees	Total	New Enrollees	Established Enrollees	Total
Accident	1.3	1.7	3.0	4.0	4.9	8.9	0.6	1.0	1.6
Allergies/sinus problem	1.4	0.1**	1.5	0.8	0.0	0.8	1.6	0.1**	1.7
Asthma/breathing problem/lung disorder	9.9	12.2	22.1	8.0	14.3	22.3	10.4	11.8	22.2
Cerebral palsy	0.1	0.0	0.1	0.2	0.0	0.2	0.1	0.0	0.1
Cold/flu/sore throat/pneumonia/tonsillitis	0.7	1.6	2.3	2.9	1.0	3.9	0.1	1.7	1.8
Diabetes	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.1
Digestive/stomach/eating problem/vomiting	2.5	2.0	4.5	3.2	1.8	5.0	2.3	2.1	4.4
Ear aches/ear infections	0.6	0.0	0.6	1.2	0.0	1.2	0.5	0.0	0.5
Eye problem/problem seeing	8.5	7.4	15.9	1.0	1.4	2.4	10.5	8.6	19.1
Fever	5.4	4.7	10.1	16.7	12.5	29.2	2.3	3.0	5.3
Headaches	0.6	1.2	1.8	0.0	0.0	0.0	0.7	1.4	2.1
Hearing problem	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.3	0.3
Hernia	0.1	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.2
Orthopedic problem	1.3	0.3*	1.6	2.7	0.6	3.3	0.9	0.2	1.1
Skin problems/rash	0.9	0.7	1.6	0.0	1.9	1.9	1.2	0.4	1.6
Speech problem	0.8	0.7	1.5	1.2	1.8	3.0	0.7	0.5	1.2
Tuberculosis	0.4	0.3	0.7	0.0	0.9	0.9	0.5	0.1	0.6
Urinary tract problem	0.4	0.3	0.7	0.0	0.6	0.6	0.5	0.3	0.8
Other problem	1.6	1.2	2.8	1.5	0.4	1.9	1.6	1.4	3.0
Any of the above	28.9	28.5	57.4	34.4	32.3	66.7	27.5	27.7	55.2
None of the above	71.1	71.5	142.6	65.6	67.7	133.3	72.5	72.3	144.8
N	705	681	1386	221	162	383	484	519	1003

* Significantly less than new enrollees, p<.05, one-tail test.

** Significantly less than new enrollees, p<.01, one-tail test.

Source: Healthy Kids parent survey, 2006.

Notes:

(1) All conditions occurred in the month prior to the interview.

(2) Children may have more than one reported condition.