

Project Pathfinder: Assessing Renewal Outreach in the Florida Healthy Kids Program

**A Report Prepared for the
Florida Healthy Kids Corporation**

Prepared By

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I. EXECUTIVE SUMMARY

In State Fiscal Year (SFY) 2004-2005, the renewal process for the Florida Healthy Kids Program changed from a passive process to an active process by requiring all families to provide documentation to verify program eligibility during each redetermination period. To assist families with this new process, the Florida Healthy Kids Corporation implemented “Project Pathfinder.” Project Pathfinder refers to a statewide, re-enrollment campaign designed to ensure that eligible children continue to receive health benefits.

As part of the 2005-2006 Florida Healthy Kids Program evaluation, the Institute for Child Health Policy (ICHP) was asked to evaluate the effectiveness of these outreach strategies by examining the following for families who were targeted for this outreach effort: (1) renewal dispositions of families targeted for outreach; (2) sociodemographic and health status characteristics of children whose families completed the renewal process compared to those who did not complete the renewal process; (3) the effectiveness of outreach strategies designed to promote renewal; and (4) families’ experiences with the renewal process. The following data sources were used to conduct this study: (1) administrative enrollment data provided by the Florida Healthy Kids Corporation; (2) health care claims and encounter data submitted by all of the health plans participating in the Florida Healthy Kids Program; and (3) telephone survey data from a random sample of families who were among those targeted for outreach.

Renewal Outcomes

- Approximately 53 percent of children renewed their coverage and were continuously enrolled in one of the four KidCare program components during the six months following the renewal date. Another 4 percent were disenrolled and then reinstated, and the remaining 43 percent were disenrolled and were not reinstated during the six month post-renewal period.

Health and Sociodemographic Characteristics

The health and sociodemographic characteristics show several differences between those children who remained continuously enrolled and those who disenrolled:

- Health status varied significantly between the two groups ($\chi^2=21.71$; $p=.0166$) with somewhat higher percentages of children with significant acute conditions in the continuously enrolled group compared to the disenrolled groups.
- Age varied significantly ($\chi^2=14.42$; $p=.0061$). A larger percentage of children in the 12 to 18 year old age cohort were disenrolled than those in the 5 to 11 year old age cohort.
- Income varied significantly between the two groups ($\chi^2=14.89$; $p=.0049$). In the disenrolled and not reinstated group, there is a smaller percentage of children with incomes greater than 200% FPL compared to children who were continuously enrolled or who were disenrolled and reinstated.

Family Surveys

- More than 70 percent of the respondents found the renewal process to be somewhat or much more difficult than it needed to be.
- More than 70 percent of all respondents indicated that they somewhat or strongly agreed that they are asked for too much background paperwork during the renewal process.
- Families seeking assistance during the renewal process had difficulty getting help: less than 40 percent of all respondents who tried to get help from the toll-free number indicated that they were able to reach someone easily.
- Families who were targeted for outreach were less likely to recall receiving letters or phone calls from the program about renewal than the Healthy Kids renewal population overall.

- The two main reasons given for renewing coverage were: (1) families cannot afford other coverage and (2) families do not have access to other coverage.
- The two main reasons given for not renewing coverage were: (1) families forgot or did not get around to doing the paperwork and (2) families planned on getting another source of coverage.
- Indicators of program dissatisfaction were low among families who chose not to renew their children's coverage and do not seem to be strong factors in families' decision-making about renewal: only 2 percent cited general satisfaction with the program as a reason for not renewing.
- Only 46 percent of children whose coverage was not renewed had obtained another source of health insurance; 54 percent were uninsured. The two main reasons families gave for not having another source of coverage were: (1) they cannot afford it and (2) they are waiting to get back into the Florida Healthy Kids Program.

Implications

- The Florida Healthy Kids Corporation may want to target families of adolescents, lower income families, and those whose children are healthy for follow-up during the renewal process.
- Future outreach strategies to be considered are: (1) identifying the most effective ways to locate and maintain contact with enrollees, (2) identifying families that are most likely to not renew their children's coverage because of difficulty with the renewal process, and (3) helping those families to complete the renewal process in order to ensure that eligible children do not lose coverage.

- Focusing on the renewal process is important because 54 percent of those who did not renew coverage were uninsured at the time of the survey. Uninsured children are at risk for poor access to needed health care services.

II. BACKGROUND

In State Fiscal Year (SFY) 2004-2005, the renewal process for the Florida Healthy Kids Program changed from a passive process to an active process by requiring all families to provide documentation to verify program eligibility during each redetermination period.¹ In the past, families whose children were enrolled in Healthy Kids (and other Title XXI KidCare components) received a letter notifying them about renewing their children's coverage. Families were asked to contact the program to report any changes or to update information about their income and health insurance coverage. Much like the former application process, reported changes during the renewal phase were self-attested. Nonrespondent families with no changes to report maintained Healthy Kids coverage for their children if they continued to pay their premiums. Accounts were updated for families reporting changes, and their children remained enrolled in the program if they continued to pay their premiums.

Beginning on July 1, 2004, the renewal process became an active one requiring information from all families participating in the Florida Healthy Kids Program. During the redetermination process, all families are now required to complete a Renewal Request form supplemented with (1) proof of income² and (2) information about their access to employer-sponsored family coverage and the cost of such coverage if it is available to them. If families do not respond, their children are disenrolled from the program.

To assist families with this new process, the Florida Healthy Kids Corporation implemented "Project Pathfinder." Project Pathfinder refers to a statewide, re-enrollment campaign designed to ensure that eligible children continue to receive health benefits. The following activities have been carried out under Project Pathfinder:

- Newsletters were mailed to Healthy Kids families in June 2004 to inform them about the changes in the renewal process and the documents that they would need to submit with their renewal forms. These newsletters also were used to flag incorrect addresses so that Healthy Kids could undertake efforts to locate those families.
- Renewal letters with the Renewal Request forms are sent out to families approximately two months in advance of their children’s renewal dates. The first set of renewal letters and forms were mailed in early July 2004 for enrollees with September 2004 renewal dates. These mailings are supplemented with automated telephone calls to the enrollees’ families to let them know to expect the renewal materials and encourage them to submit the Renewal Request as quickly as possible. The mailings and calls are in English or Spanish as appropriate.
- Extensive efforts are made to reach families whose renewal information is not received in a timely manner in order to keep eligible children enrolled. The Florida Healthy Kids Corporation follows up with families who have not completed the renewal process to: (1) request additional information for families who submit a Renewal Request but do not include all of the necessary information or documentation, or (2) remind families who have not submitted a Renewal Request of the importance of doing so. The follow up calls include both automated calls and “in-person” telephone calls made by an outbound call center.
- During October 2004 and November 2004, the Florida Healthy Kids Corporation conducted a door-to-door campaign to make personal contact with parents of children who had not yet submitted a Renewal Request. This campaign targeted households in high non-response zip codes in Broward, Duval, Escambia, Hillsborough, Lee, Leon,

Miami-Dade, Orange, Palm Beach, Pinellas, Polk, St. Lucie, Santa Rosa, and Volusia counties. Volunteers visited the homes of families who had not submitted any renewal documentation, providing them with the renewal form, instructions, and information about the importance of re-enrollment. If no one answered the door, door hangers with renewal materials and information were left at the residence.

As part of the 2005-2006 Florida Healthy Kids Program evaluation, the Institute for Child Health Policy (ICHP) was asked to evaluate the effectiveness of these outreach strategies.

III. DATA SOURCES AND MEASURES

A. Data Sources

The following data sources were used:

1. Enrollment files provided by the Florida Healthy Kids Corporation. The enrollment files contain information about the child's age, gender, family income, and enrollment status. This information was used to identify which children were up for renewal from September 1, 2004 through February 30, 2005, which covers the first six-month redetermination period after the policy change went into effect, and whether they successfully renewed their coverage or were disenrolled. These renewals constituted the first complete renewal cycle after the change from a passive renewal process to an active renewal process. These enrollment files were linked to enrollment files provided by the Department of Children and Families in order to identify children who transferred from Healthy Kids to Medicaid.
2. Health care claims and encounter data submitted by all of the health plans participating in the Florida Healthy Kids Program. The person-level claims and

encounter data contain Physician's Current Procedural Terminology (CPT) codes and International Classification of Diseases, 9th Revision (ICD 9-CM) codes. Claims and encounter data from July 1, 2003 through June 30, 2004 were used to characterize the children's health status prior to the program changes.

3. Telephone survey data from a random sample of families who were up for renewal from September 2004 through February 2005 and who were targeted for the door-to-door outreach campaign. A total of 100 interviews were conducted among the families who were targeted for these household visits to ensure that sufficient information is available about families' attitudes about this focused outreach strategy. The surveys were conducted from June 2005 through August 2005 in both English and Spanish. These surveys supplemented 588 interviews that were conducted among a random sample of all Healthy Kids enrollees who were up for renewal. Some of the results from those interviews are included in this report for comparison purposes. The full results of the analyses of the effect of the renewal policy changes on overall enrollment in the Florida Healthy Kids Program are contained in a separate report entitled "Renewal Policy Changes and Enrollment in the Florida Healthy Kids Program."

B. Measures Used

The Clinical Risk Groups (CRGs) was used to classify enrollees' health status. This system classifies individuals into mutually exclusive clinical categories by reading ICD-9-CM diagnosis codes from all health care encounters, except those associated with providers known to frequently report unreliable codes (e.g., non-clinician providers and ancillary testing providers).³ It assigns all diagnosis codes to a diagnostic category (acute or chronic) and body system, and

assigns all procedure codes to a procedure category. Each individual is grouped to a hierarchically defined core health status group, and then to a CRG category and severity level, if chronically ill.

Chronic and acute illnesses are generally classified only if there has been at least two outpatient encounters for that diagnosis separated by at least a day. There are a few diagnoses that require only one outpatient encounter based diagnosis, and these include the codes for mental retardation, Down's Syndrome, blindness, and procedural codes such as chemotherapy and renal dialysis. Enrollees in the program for six months or longer are included in the analyses. Some continuity of enrollment is required to classify individuals accurately. The health status classifications of children meeting the enrollment criteria are reported in these analyses. The health status of children not meeting the enrollment criteria is reported as "not classified." The CRG health status categories are defined below:

Healthy includes children who were seen for preventive care and for minor illnesses. This category also includes children who were enrolled but did not use health care services during the classification period.

Significant Acute Conditions are those acute illnesses that could be precursors to or place the person at risk for developing a chronic disease. Examples in this group are head injury with coma, prematurity, and meningitis.

Minor Chronic Conditions (both *single minor* and *multiple minor*) are those illnesses that can usually be managed effectively throughout an individual's life with typically few complications and limited effect upon the individual's ability, death and future need for medical care. This category includes attention deficit / hyperactive disorders (ADHD), minor eye

problems (excluding near-sightedness and other refractory disorders), hearing loss, migraine headache, some dermatological conditions, and depression.

Moderate Chronic Conditions are those illnesses that are variable in their severity and progression, but can be complicated and require extensive care and sometimes contribute to debility and death. This category includes asthma, epilepsy, and major depressive disorders.

Dominant Chronic Conditions are those illnesses that are serious, and often result in progressive deterioration, debility, death, and the need for more extensive medical care. Examples in this group include diabetes, sickle cell anemia, chronic obstructive lung disease and schizophrenia.

Chronic Pairs and Triplets are those individuals who have multiple primary chronic illnesses in two (Pairs), or three or more body systems (Triplets).

Metastatic Malignancies include acute leukemia under active treatment and other active malignant conditions that affect children.

Catastrophic Conditions are those illnesses that are severe, often progressive, and are either associated with long term dependence on medical technology, or are life defining conditions that dominate the medical care required. Examples in this group include cystic fibrosis, spina bifida, muscular dystrophy, respirator dependent pulmonary disease and end stage renal disease on dialysis.

To classify the health status of children who were up for renewal, the CRG categories were grouped as follows: (1) Healthy, (2) Significant Acute, (3) CSHCN – Minor Conditions (single minor conditions and multiple minor conditions), (4) CSHCN – Moderate Conditions, (moderate chronic conditions), and (5) CSHCN – Major Conditions, (dominant chronic, chronic

pairs and triplets, metastatic malignancies, and catastrophic conditions). The CRG categories were collapsed into the preceding categories by following instructions from the developers.

IV. POST-RENEWAL ENROLLMENT PATTERNS

During October 2004 and November 2004, the Florida Healthy Kids Corporation conducted a door-to-door campaign to make personal contact with parents of children who had not yet submitted a Renewal Request. This campaign targeted households in high non-response zip codes in Broward, Duval, Escambia, Hillsborough, Lee, Leon, Miami-Dade, Orange, Palm Beach, Pinellas, Polk, St. Lucie, Santa Rosa, and Volusia counties. The Florida Healthy Kids Corporation provided the Institute for Child Health Policy with a file identifying the families targeted for this campaign. This file was linked to enrollment files, and the following enrollment criteria were applied: (1) only those children who were enrolled in Healthy Kids in each of the two months prior to their renewal date were included and (2) children age 18 at the time of renewal were excluded (so that those who were aging out of the program were not included in the analyses). The enrollment patterns for the 2,013 children who were targeted for this focused outreach effort and met the enrollment criteria are provided in Table 1.

The enrollment patterns are examined for the six months following the children's renewal dates. The children are classified into three enrollment categories: (1) continuously enrolled, (2) disenrolled and reinstated, and (3) disenrolled and not reinstated. *Continuously enrolled* children are defined as those children who were in the Florida Healthy Kids Program when they were up for renewal and who have continuous coverage in any of the four KidCare program components – Healthy Kids, MediKids, CMS, or Medicaid – for the six months following their renewal due date, allowing for no more than a one month lapse in coverage. These children are considered to

have successfully renewed their coverage. Although the children examined in this study were enrolled in Healthy Kids at the time of renewal, subsequent coverage in any of the four programs is indicative of continuity of coverage and a successful renewal. Children classified as *disenrolled and reinstated* are those children who were not enrolled in any of the four program components for at least two consecutive months after the renewal date and then (after the disenrollment spell) are reinstated with enrollment in any of the four KidCare programs for at least two consecutive months within the six month post-renewal period. The “disenrolled and reinstated” children might also be considered “renewed with a break in coverage.” Children are considered to be *disenrolled and not reinstated* if they were disenrolled for at least two consecutive months and were not re-enrolled in any of the four KidCare program components (or any combination of these programs) for at least two consecutive months.

Of the 2,013 children included in this analysis, approximately 53 percent renewed their coverage and were continuously enrolled in enrolled in one of the four KidCare program components during the six months following the renewal date (Table 1). Another 4 percent were disenrolled and then reinstated. The remaining 43 percent were disenrolled and were not later reinstated during the six month period following the renewal date. Of those who were disenrolled and not reinstated, 74 percent show an “account status reason” in the administrative records of “cancelled due to renewal.” Therefore, failure to complete the renewal process accounts for most of the disenrollment.

| Table 1: Enrollment Patterns of Children Up for Renewal During the Six Months Following the Renewal Date | | | | |
|---|------------------|----------------|-----------------------------|---------------------------|
| Renewal Dates: September 2004 – February 2005 | | | | |
| | Frequency | Percent | Cumulative Frequency | Cumulative Percent |
| Continuously Enrolled | 1064 | 52.86 | 1064 | 52.86 |
| Disenrolled and Reinstated | 75 | 3.73 | 1139 | 56.59 |
| Disenrolled and Not Reinstated | 874 | 43.41 | 2013 | 100.00 |

The renewal rates among the population targeted for the outreach effort are considerably lower than the renewal rates for the Florida Healthy Kids population overall: approximately 73 percent of all children who were up for renewal in the Florida Healthy Kids Program between September 2004 and February 2005 renewed their coverage and were continuously enrolled in Healthy Kids or another KidCare program component during the six months following the renewal date. Approximately 23 percent disenrolled and were not reinstated. It is important to note that the reason families were targeted for the door-to-door outreach is because they were located in areas with high non-response rates to the renewal requests, so it is not surprising that the renewal rates for these families were lower even with the outreach initiative.

To place these numbers in context, earlier analyses of the SCHIP programs in Kansas, New York, and Oregon found large drops in enrollment at the time of redetermination, with approximately 33 percent to 50 percent of children becoming disenrolled. A significant portion of these children, however, re-enrolled within two months. Analyses of Florida's SCHIP program conducted at the same time found no spike in disenrollment at the time of redetermination, with only 5 percent disenrolled (using the passive renewal process).⁴ These findings suggest that Florida's active redetermination process is associated with greater disenrollment from Healthy Kids relative to the passive renewal process, but also less

disenrollment associated with an active renewal process than has occurred in other SCHIP programs (i.e., New York, Kansas, and Oregon).

Tables 2 and 3 show the program the children were last enrolled in (during the six-month post renewal period) for those who remained continuously enrolled or were disenrolled and reinstated. The “last program of record” is the program that the child was enrolled in during the last month of the post-renewal period being examined (i.e., the sixth month following the renewal date). Of the 1,064 children who remained continuously enrolled, 88 percent were enrolled in Healthy Kids in the sixth month following renewal (Table 2). Approximately 11 percent had moved to Medicaid coverage and less than one percent switched to CMS. These results are consistent with those for the Healthy Kids renewal population overall.

| Program | Frequency | Percent | Cumulative Frequency | Cumulative Percent |
|---------------------|------------------|----------------|---------------------------------|-------------------------------|
| CMS | 2 | 0.19 | 2 | 0.19 |
| Healthy Kids | 940 | 88.35 | 942 | 88.53 |
| Medicaid | 122 | 11.47 | 1064 | 100.00 |

Of the 75 children who disenrolled and later re-enrolled, 75 percent were enrolled in Healthy Kids in the sixth month following re-enrollment (Table 3), and the remaining 25 percent had moved to Medicaid coverage. These results also are consistent with those for the Healthy Kids renewal population overall.

| Table 3: Last Program of Record for “Disenrolled and Reinstated” Children Renewal Dates: September 2004 – February 2005 | | | | |
|--|------------------|----------------|---------------------------------|-------------------------------|
| Program | Frequency | Percent | Cumulative Frequency | Cumulative Percent |
| HK | 56 | 74.67 | 56 | 74.67 |
| Medicaid | 19 | 25.33 | 75 | 100.00 |

V. SOCIODEMOGRAPHIC AND HEALTH CHARACTERISTICS OF RENEWERS AND NON-RENEWERS

Table 4 shows the health and sociodemographic characteristics for the children who were up for renewal by post-renewal enrollment category. The health and sociodemographic characteristics show several differences between those children who remained continuously enrolled and those who disenrolled. Health status varied significantly between the two groups ($\chi^2=21.71$; $p=.0166$) with a higher percentage of children who disenrolled with no subsequent re-enrollment (72.54 percent) classified as “healthy” compared to those who were continuously enrolled (66.07 percent) or disenrolled and reinstated (66.67%). There also is a higher percentage of children with significant acute conditions in the continuously enrolled group compared to both of the disenrolled groups (8.74 percent for those continuously enrolled versus 6.67 percent for those disenrolled and reinstated and 4.69 percent for those disenrolled and not reinstated). These findings are consistent with those for the Healthy Kids renewal population overall.

No significant differences were noted between the two groups in gender. However, age did vary significantly ($\chi^2=14.42$; $p=.0061$). A larger percentage of children in the 12 to 18 year

old age cohort were disenrolled than younger children. This finding was obtained even after excluding those that were age 18 at the time of renewal and soon to age out of the program. Place of residence also was significant ($\chi^2=14.43$; $p=.0060$) with a somewhat higher percentage of children who reside in rural areas and small towns disenrolling compared to those who were continuously enrolled or those who were disenrolled and reinstated. In addition, income varied significantly between the two groups ($\chi^2=14.89$; $p=.0049$). In the disenrolled and not reinstated group, there is a smaller percentage of children with incomes above 200% the FPL compared to children who were continuously enrolled or who were disenrolled and reinstated.

These results suggest that families may be making decisions about whether to renew coverage for their children based on their family income and their children's ages and health status. The findings suggest that the Healthy Kids Corporation may want to target families of adolescents, families below 200% FPL, and those whose children are healthy for follow-up during the renewal process.

**Table 4. Health and Sociodemographic Characteristics of Children
by Post-Renewal Enrollment Category**

| Letters Sent Period: July 2004 to December 2004 | | | | | | | | |
|---|-------------------------|--------|-----------------------|--------|----------------------------|--------|--------------------------------|--------|
| Renewal Dates: September 2004 to February 2005 | | | | | | | | |
| Characteristic | Children up for Renewal | | Enrollment Trend | | | | | |
| | | | Continuously Enrolled | | Disenrolled and Reinstated | | Disenrolled and Not Reinstated | |
| | N | % | N | % | N | % | N | % |
| Total | 2013 | | 1064 | 52.83% | 75 | 3.73% | 874 | 43.42% |
| Health Status Categories (CRGs) | | | | | | | | |
| Healthy | 1387 | 68.90% | 703 | 66.07% | 50 | 66.67% | 634 | 72.54% |
| Significant Acute | 139 | 6.91% | 93 | 8.74% | 5 | 6.67% | 41 | 4.69% |
| Minor Chronic (Single & Multiple) | 83 | 4.12% | 51 | 4.79% | 1 | 1.33% | 31 | 3.55% |
| Moderate Chronic (Single) | 83 | 4.12% | 49 | 4.61% | 2 | 2.67% | 32 | 3.66% |
| Major Chronic (Dominant/Multiple Chronic, Malignancies, & Catastrophic) | 3 | 0.15% | 2 | 0.19% | 0 | 0.00% | 1 | 0.11% |
| No CRG | 318 | 15.80% | 166 | 15.60% | 17 | 22.67% | 135 | 15.45% |
| Gender | | | | | | | | |
| Male | 1011 | 50.22% | 523 | 49.15% | 39 | 52.00% | 449 | 51.37% |
| Female | 1002 | 49.78% | 541 | 50.85% | 36 | 48.00% | 425 | 48.63% |
| Age | | | | | | | | |
| 1-4 | 2 | 0.10% | 2 | 0.19% | 0 | 0.00% | 0 | 0.00% |
| 5-11 | 979 | 48.63% | 554 | 52.07% | 39 | 52.00% | 386 | 44.16% |
| 12-18 | 1032 | 51.27% | 508 | 47.74% | 36 | 48.00% | 488 | 55.84% |
| RUCA | | | | | | | | |
| Urban/Large towns | 1966 | 97.67% | 1051 | 98.78% | 74 | 98.67% | 841 | 96.22% |
| Rural/Small towns | 46 | 2.29% | 13 | 1.22% | 1 | 1.33% | 32 | 3.66% |
| Unknown | 1 | 0.05% | 0 | 0.00% | 0 | 0.00% | 1 | 0.11% |
| FPL Categories | | | | | | | | |
| 0-150% | 1267 | 62.94% | 676 | 63.53% | 41 | 54.67% | 550 | 62.93% |
| 151-200% | 488 | 24.24% | 231 | 21.71% | 25 | 33.33% | 232 | 26.54% |
| >200% | 258 | 12.82% | 157 | 14.76% | 9 | 12.00% | 92 | 10.53% |

VI. FAMILIES' PERSPECTIVES AND SATISFACTION

The Institute for Child Health Policy conducted surveys of families who were up for renewal in the Florida Healthy Kids Program from September 2004 through February 2005 and who were targeted for the door-to-door outreach campaign. The Institute interviewed a total of 100 families who were targeted for this focused outreach effort. The primary focus of the surveys was families' experiences during the new renewal process. Questions about demographics and program satisfaction also were asked. This report focuses on the results of the surveys among those families who were targeted for the outreach effort with comparisons to the Healthy Kids renewal population overall. The methods and results of the surveys for the overall population are contained in a separate report entitled: "Renewal Policy Changes and Enrollment in the Florida Healthy Kids Program."

A. Sample Selection

The Florida Healthy Kids Corporation provided the Institute for Child Health Policy with a file identifying the families targeted for this campaign. This file was linked to enrollment files to determine which families renewed and did not renew their children's coverage. Survey respondents were restricted to children who were enrolled in the Florida Healthy Kids Program. Children with critical missing information (e.g., phone numbers) and duplicate families members (i.e., more than one enrolled child in a household) were deleted from the eligible population. There were 1,345 children eligible overall, with 534 children eligible for the "renew" sample and 811 children eligible for the "nonrenew" sample. A total of 100 interviews were completed: 50 with families who completed the renewal process and 50 with families who did not complete the renewal process. The surveys were conducted from June 2005 through August 2005 in both English and Spanish. The cooperation rate was 93 percent.

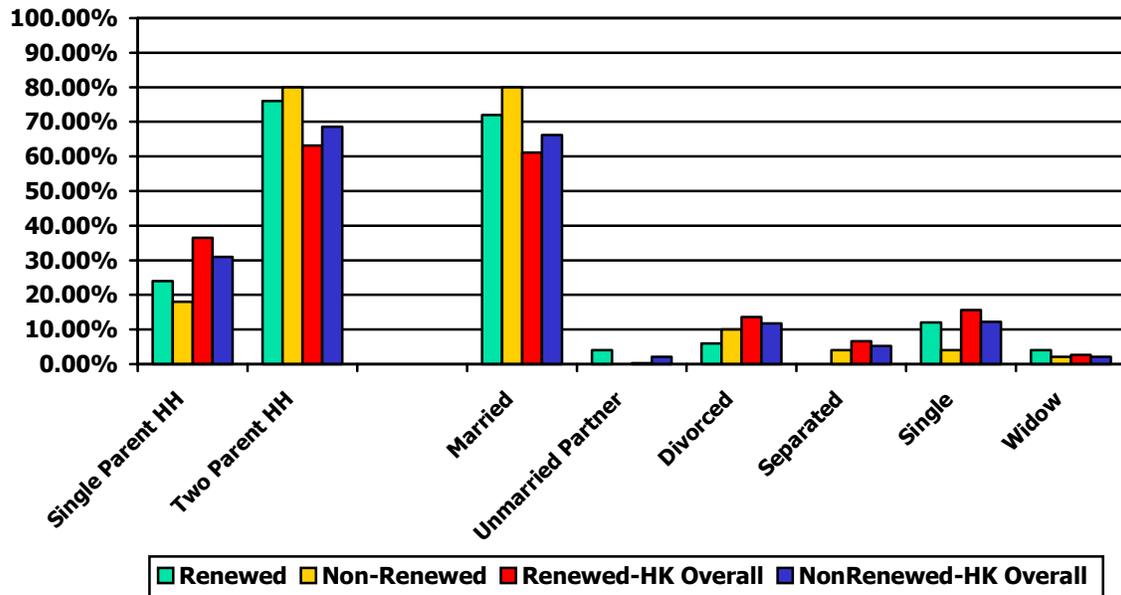
B. Survey Results

The primary focus of the surveys was families' experiences during the new renewal process and renewal outreach. Questions about demographics and program satisfaction also were asked.

Household and Sociodemographic Characteristics

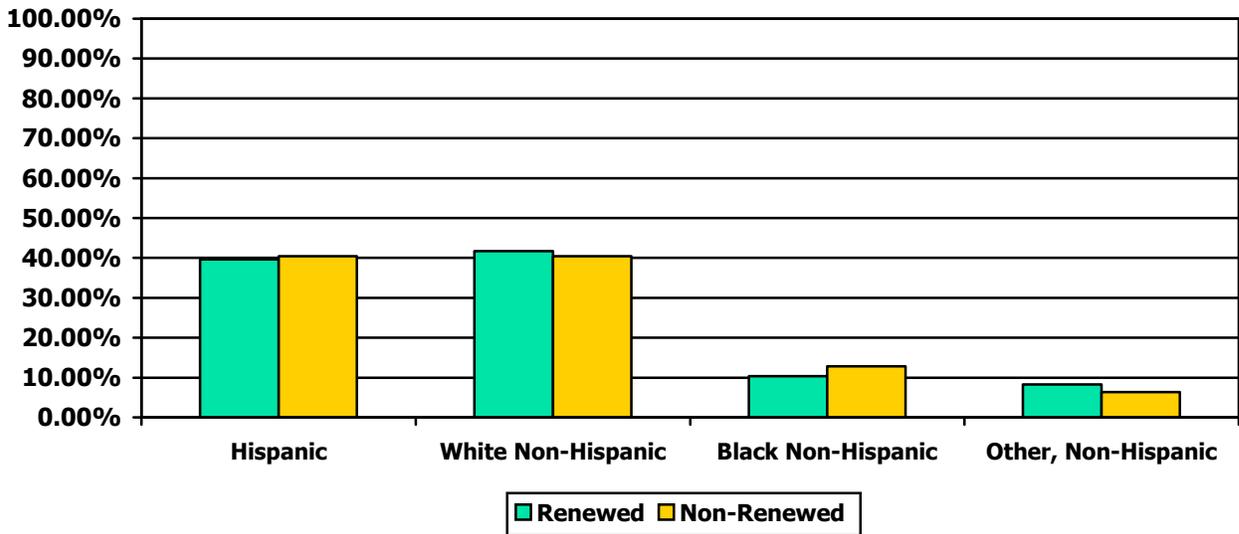
Household Characteristics. Figure 1 compares the household characteristics of the survey respondents in the targeted outreach population to the survey respondents for the overall Healthy Kids renewal population. The respondents in the targeted outreach population were more likely to be married and less likely to characterize their household type as a single parent household than the Healthy Kids population overall. Approximately 76 percent of all respondents in the targeted outreach population are married, and about 21 percent reside in a single parent household.

Figure 1: Respondent Household Type and Marital Status



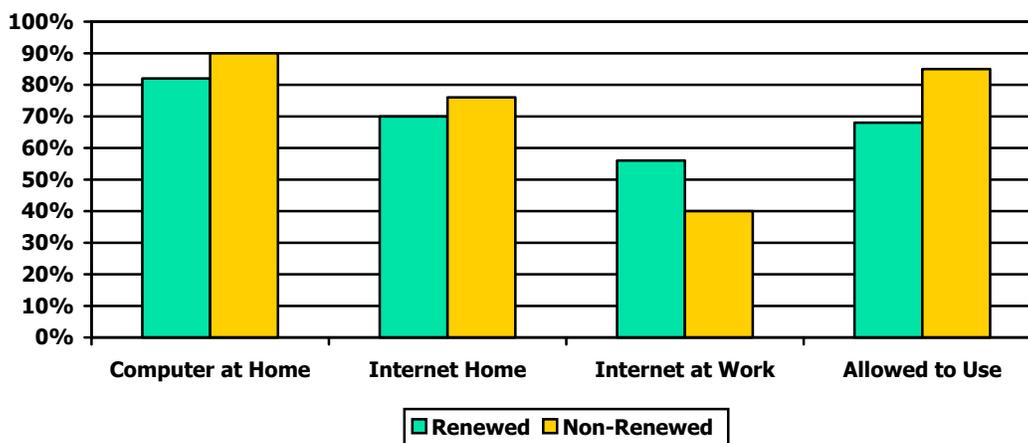
Race and Ethnicity. The demographic characteristics of the children who renewed and did not renew coverage are the same (Figure2). Overall, 40 percent of the children are Hispanic, 41 percent are non-Hispanic white, and 11 percent are non-Hispanic black.

Figure 2: Children's Race and Ethnicity



Computer and Internet Access. Eighty-six percent of all respondents in the targeted outreach group have computer access at home with 82 percent of renewers and 90 percent of non-renewers reporting access to a home computers (Figure 3). Seventy percent of renewers and 76 percent of non-renewers report having Internet access at home. Non-renewers were less likely to report Internet access at work but more likely to indicate that their employer would allow them use the Internet at work to access health care information (for those who have access).

Figure 3: Computer and Internet Access



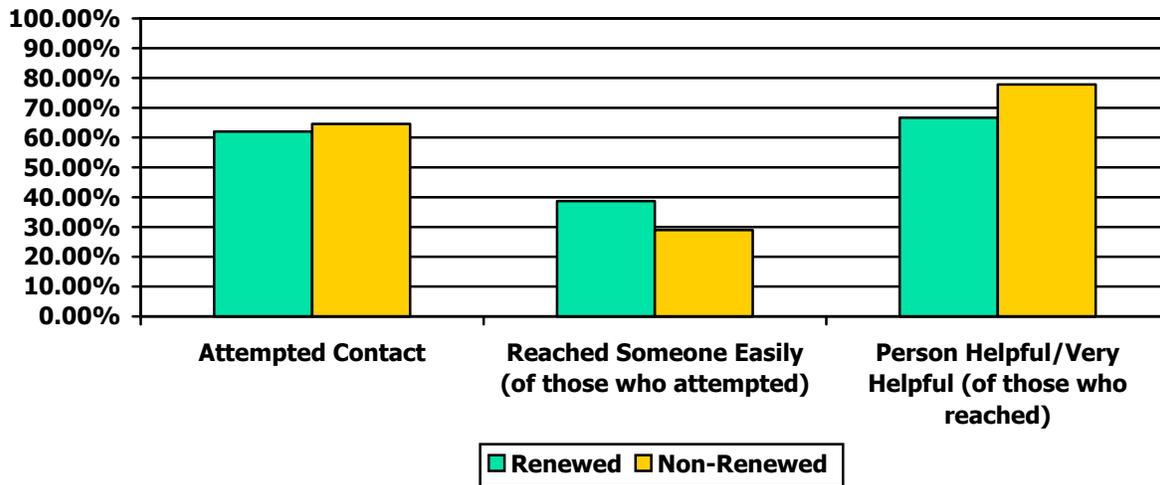
Renewal Experiences

Renewal Process and Experiences. Survey respondents in the targeted outreach group were somewhat more likely to indicate that they were told that they would need to renew coverage each year when they signed up for Healthy Kids than were respondents in the overall Healthy Kids renewal population (Table 5). When asked their opinions about the renewal process, respondents in the targeted outreach group were more likely to indicate that the renewal process was somewhat or much more difficult than it needed to be compared to the Healthy Kids population overall. More than 70 percent of all respondents in both populations indicated that they somewhat or strongly agreed that they are asked for too much background paperwork during the renewal process. But the majority of respondents indicated that they felt that the Florida Healthy Kids Program made the renewal forms easy to fill out. Those who renewed coverage were more likely to say the forms were easy to fill out compared to non-renewers.

| | Targeted Outreach | | HK Overall | |
|---|-------------------|-------------|------------|-------------|
| | Renewed | Non-Renewed | Renewed | Non-Renewed |
| Was told that would need to renew enrollment every year when signed up for Healthy Kids | 56% | 45% | 46% | 39% |
| Felt that the renewal process was somewhat more difficult or much more difficult than it needed to be | 70% | 75% | 50% | 67% |
| Somewhat agree or strongly agree that they are asked for too much background paperwork, such as pay stubs or income documentation | 74% | 70% | 71% | 73% |
| Somewhat agree or strongly agree that the Healthy Kids Program has made the renewal forms easy to fill out | 92% | 83% | 84% | 64% |

The experiences of renewers and non-renewers in contacting the toll-free number for assistance were generally similar (Figure 4). Approximately 63 percent of all respondents attempted to contact the toll-free number about renewing their children’s coverage. Of those who called, both groups had difficulty obtaining assistance with less than 40 percent of all respondents indicating success in reaching someone: 39 percent of those who completed the renewal process reported reaching someone easily compared to 29 percent of those who did not complete the process. Most of those who reached someone indicated that they found the person to be helpful or very helpful with non-renewers reporting higher levels of satisfaction than renewers.

Figure 4: Renewal Survey- Experiences Calling Toll-Free Number



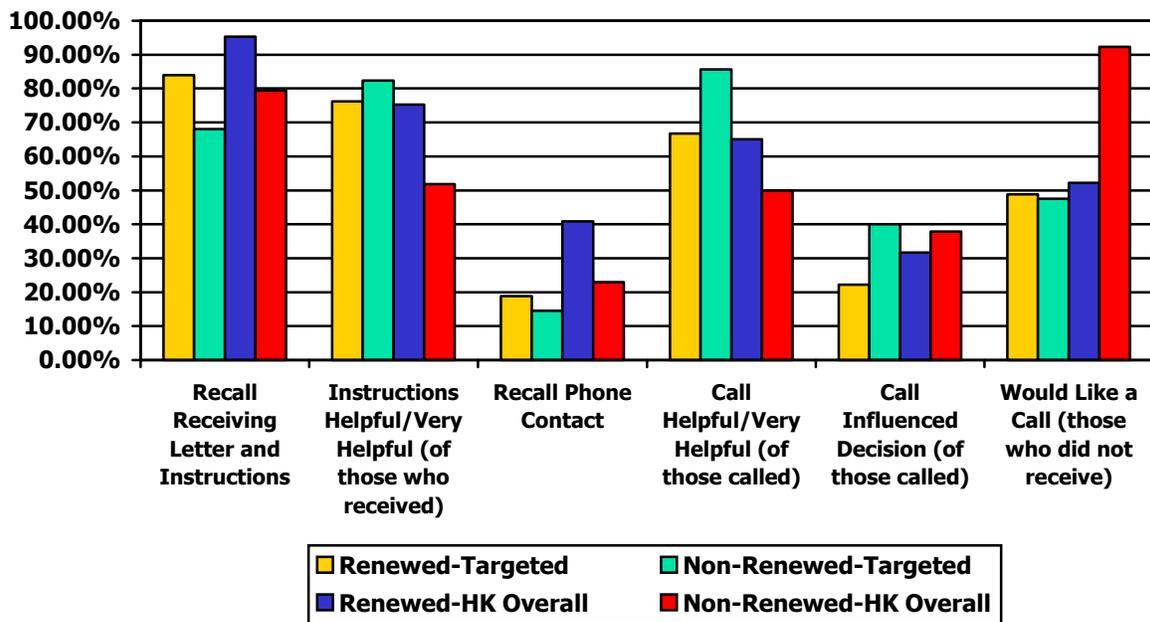
Experiences with Healthy Kids Outreach Efforts. The Healthy Kids Program engaged in extensive outreach efforts to ensure that eligible children remained enrolled in the program through a series of letters and phone calls, as well as a targeted “door-to-door” campaign that included in-person visits to households in areas with high non-response rates. Parents were asked whether they recalled these outreach efforts and if so, whether it affected their renewal decision.

Figure 5 compares the renewal outreach experiences of families up for renewal in the targeted outreach group with those of the Healthy Kids renewal population overall. Most survey respondents in the targeted outreach group recalled receiving a letter with renewal instructions with renewers more likely to recall receiving the letter (84 percent) than non-renewers (68 percent). Overall, respondents in the targeted outreach group were less likely to recall receiving a letter than other Healthy Kids survey respondents, but the targeted outreach respondents were more likely to indicate that they found the written instructions to be helpful compared to other

Healthy Kids respondents. In contrast to the letters, most survey respondents did not recall receiving a phone call, with a significantly smaller percentage of those in the targeted outreach group reporting getting a call compared to other Healthy Kids respondents: only 18 percent of renewers and 14 percent of non-renewers recall getting a phone call (versus 41 percent and 23 percent, respectively, in the Healthy Kids renewal population overall). Most of those who did receive a call in the targeted outreach reported finding the call to be helpful or very helpful; interestingly, a greater percentage of non-renewers found the call to be helpful than renewers (86 percent of non-renewers and 67 percent of renewers). A much smaller percentage, 22 percent of renewers and 40 percent of non-renewers, indicated that the call influenced their renewal decision. Approximately 48 percent of both renewers and non-renewers in the targeted outreach group who did not renew coverage and did not recall receiving a phone call indicated that they would like to have received a call. This is a different result from the overall Healthy Kids renewal survey respondents among whom 92 percent of non-renewers indicated that they would have liked to have received a call.

Overall, those targeted for the door-to-door campaign were less likely to recall having received a letter or a phone call than survey respondents in the overall Healthy Kids renewal population. This may explain, in part, why this group had a higher nonresponse rate in the first place and was targeted for the door-to-door visits.

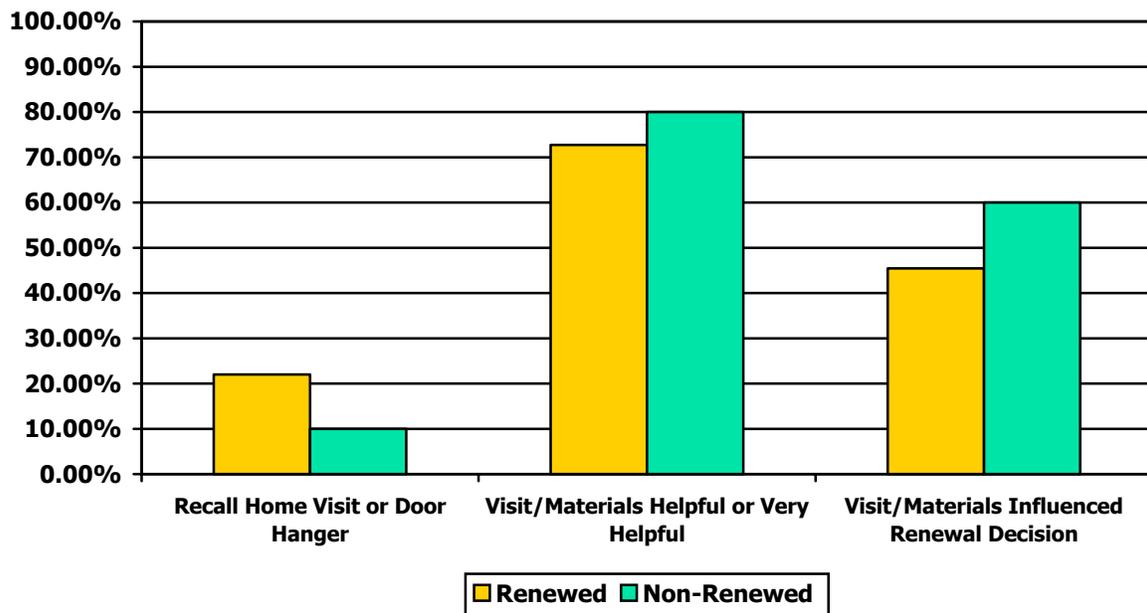
Figure 5: Outreach Experiences - Letters and Phone



During October 2004 and November 2004, the Florida Healthy Kids Corporation conducted a door-to-door campaign to make personal contact with parents of children who had not yet submitted a Renewal Request. This campaign targeted households in high non-response zip codes in Broward, Duval, Escambia, Hillsborough, Lee, Leon, Miami-Dade, Orange, Palm Beach, Pinellas, Polk, St. Lucie, Santa Rosa, and Volusia counties. Volunteers visited the homes of families who had not submitted any renewal documentation, providing them with the renewal form, instructions, and information about the importance of re-enrollment. If no one answered the door, door hangers with renewal materials and information were left at the residence. Figure 6 presents the survey finding from families regarding this outreach effort. Very few families recalled receiving either a personal visit or a door hanger with those who renewed more likely to recall receiving such contact than those who did not renew (22 percent versus 10 percent). More

than 70 percent of those who received a visit or a door hanger indicated that they found the representative/materials to be helpful or very helpful. Approximately 45 percent of those who renewed coverage and 60 percent of those who did not renew coverage indicated that the visit or materials influenced their renewal decision.

Figure 6: Outreach Experiences - Household Visits



Reasons for Renewing or Not Renewing Coverage. Respondents were asked to indicate their primary reason for renewing or not renewing their children’s coverage. The reasons are indicated in Table 6 in descending order of response frequency. Of those who renewed coverage, 51 percent indicated that the primary reason for doing so was that they cannot afford other coverage. The second most frequently cited reason, offered by 29 percent of respondents, was that they do not have access to other coverage. Twelve percent indicated that they want to be sure their child has health insurance as the primary reason for renewing coverage.

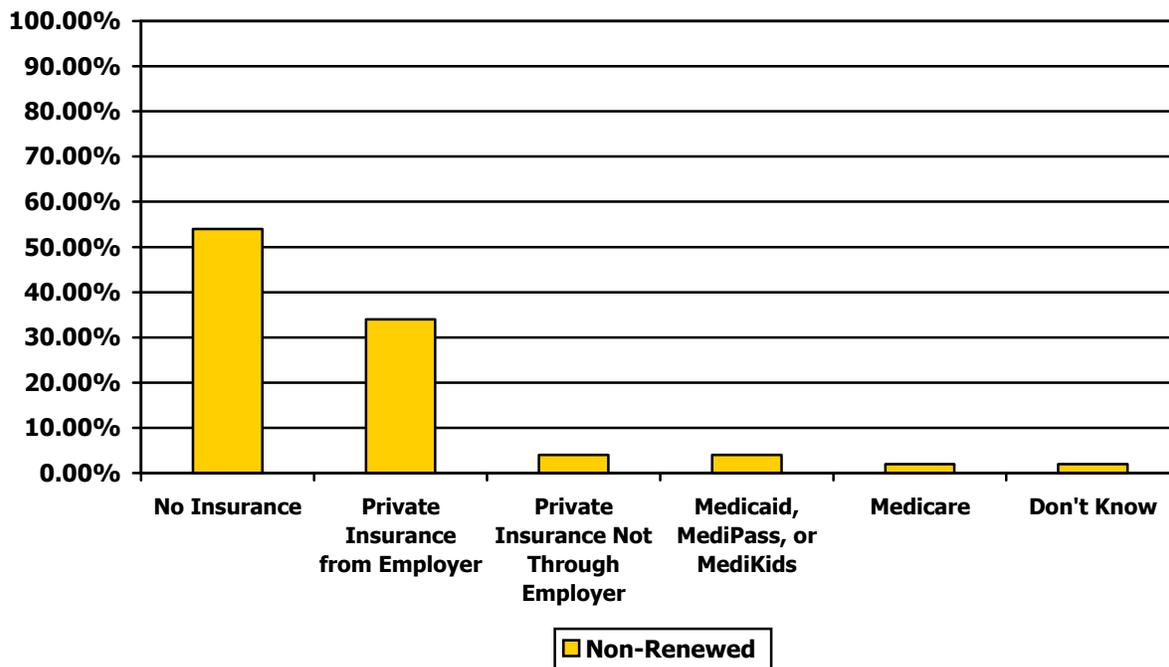
| Table 6: Reasons for Renewing/Not Renewing Coverage | |
|--|--|
| Reasons for Renewing Coverage | Reasons for Not Renewing Coverage |
| Cannot afford other coverage (51%) | Forgot or did not get around to doing paperwork (16%) |
| Do not have access to other coverage (29%) | Planning on getting other insurance for child (16%) |
| Want to be sure child has health insurance (12%) | Never received renewal documents (10%) |
| Child has frequent illness or chronic condition (2%) | Did not think child was eligible anymore (8%) |
| Renewal process is easy (2.0%) | Other – Cancelled by the program (8%) |
| Other (2%) | Other – Renewal process issues (8%) |
| Don't know /Refused (2%) | Sent in materials but program said they were not sent (6%) |
| | Could not get required background information (6%) |
| | Dissatisfied with premium payment (4%) |
| | Did not want child in the program anymore (4%) |
| | Dissatisfied with the program in general (2%) |
| | Dissatisfied with child's physician (0%) |
| | Child was healthy so coverage was not needed (0%) |
| | Other (10%) |
| | Don't know/Refused (2%) |

There was a range of reasons for not renewing coverage among those in the targeted outreach group. The two reasons cited most frequently, by 16 percent of respondents each, were: (1) the respondent forgot or did not get around to doing the paperwork and (2) the respondent was planning on getting other insurance for the child. Several of those who indicated that they were getting other insurance indicated that they were getting coverage through their employer. Ten percent of non-renewers indicated that they never received the renewal documents, 6 percent indicated that they sent the materials in but were told that they had not sent them in, and 6 percent indicated that they simply forgot to renew coverage. Respondents also were given the option to indicate “other” and specify a reason. Using this option, 8 percent of non-renewers indicated that they were cancelled by the program, and another 8 percent cited issues associated with the renewal process such as not being able to reach the toll-free number to get assistance, not having enough time, and too much paperwork. Indicators of program dissatisfaction generally were low, and do not seem to be strong factors in families’ decision-making about renewal. Dissatisfaction with premium payments was cited by 4 percent of respondents, general

dissatisfaction with the program was cited by 2 percent of respondents, and no respondents indicated dissatisfaction with the child's physician. These results suggest that future outreach efforts should be directed toward: (1) identifying families that are most likely to not renew their coverage because of difficulty with the renewal process (versus not renewing for other reasons such as having other sources of affordable insurance available) and (2) helping those families to complete the renewal process in order to ensure that eligible children do not lose coverage.

Insurance Status of Non-Renewed Children. Only 46 percent of the children whose Healthy Kids coverage was not renewed have gotten another source of health insurance; 54 percent were uninsured at the time of the survey (Figure 7). Fewer non-renewing children in the targeted outreach group were without coverage compared to non-renewers in the Healthy Kids population overall (54 percent versus 64 percent). Of the non-renewing children in the targeted outreach group that have health insurance coverage, 77 percent (or about 34 percent of all of those who did not complete the process) have employer-sponsored insurance (ESI), 9 percent purchased private insurance directly themselves, 9 percent have Medicaid, MediPass or MediKids, and 5 percent have Medicare. Sixty-five percent of children who switched to another source of coverage were able to keep the same primary care provider. These results are summarized in Figure 7, which shows insurance coverage as a percentage of all children whose coverage was not renewed.

Figure 7: Insurance Status of Children Who Did Not Complete the Renewal Process



Of the 54 percent of respondents who indicated that they had not selected another source of insurance coverage for their child, the two reasons that were cited most frequently were: (1) they cannot afford other coverage (85 percent) and (2) they are waiting to get back into the Healthy Kids Program (59 percent). Respondents were allowed to indicate more than one reason.

What Families Say About Improving the Renewal Process. When asked to reflect upon their experiences and suggest ways that the renewal process could be improved, the suggestions were very similar to those provided by those offered by the survey respondents in the overall Healthy Kids renewal population: (1) reduce the amount and complexity of paperwork and documentation requirements, (2) make it easier to contact the program and get assistance, and (3) provide better and more frequent communication from the program. Families indicated that they found complying with the documentation requirements to be difficult and burdensome. Some

respondents requested additional consideration for self-employed parents, who have difficulty complying with the income documentation requirements. Families also were frustrated by the problems they encountered in obtaining assistance, citing difficulty reaching someone at the toll-free number. They also expressed a desire for customer service representatives who are more knowledgeable and helpful. Other suggestions for improvement were to provide more advance notification and follow-up reminders. Some respondents suggested better program organization, citing experiences with lost paperwork.

Program Satisfaction

Experiences with Paying Premiums. Families were asked about their experiences and attitudes toward premium payment in the Healthy Kids Program. Their responses are summarized in Table 7 below. Overall, families are satisfied with paying a premium for their children's health care coverage and with the amount they pay. Non-renewers were somewhat less likely to indicate that they found the premium amount to be "about the right amount" and somewhat more likely to indicate that the premium amount was "too little" compared to renewers.

The attitudes toward premium payment are consistent among renewers and non-renewers. Fully 96 percent indicated that paying the premium is "worth it" for the care and coverage received by their children. However, approximately 11 percent of all respondents indicated that sometimes they feel that paying the premium is a "waste of money" because their children are healthy. Virtually all families agreed or strongly agreed that they felt good about paying for part of their children's health care coverage and that it is worth the peace of mind knowing their child is covered.

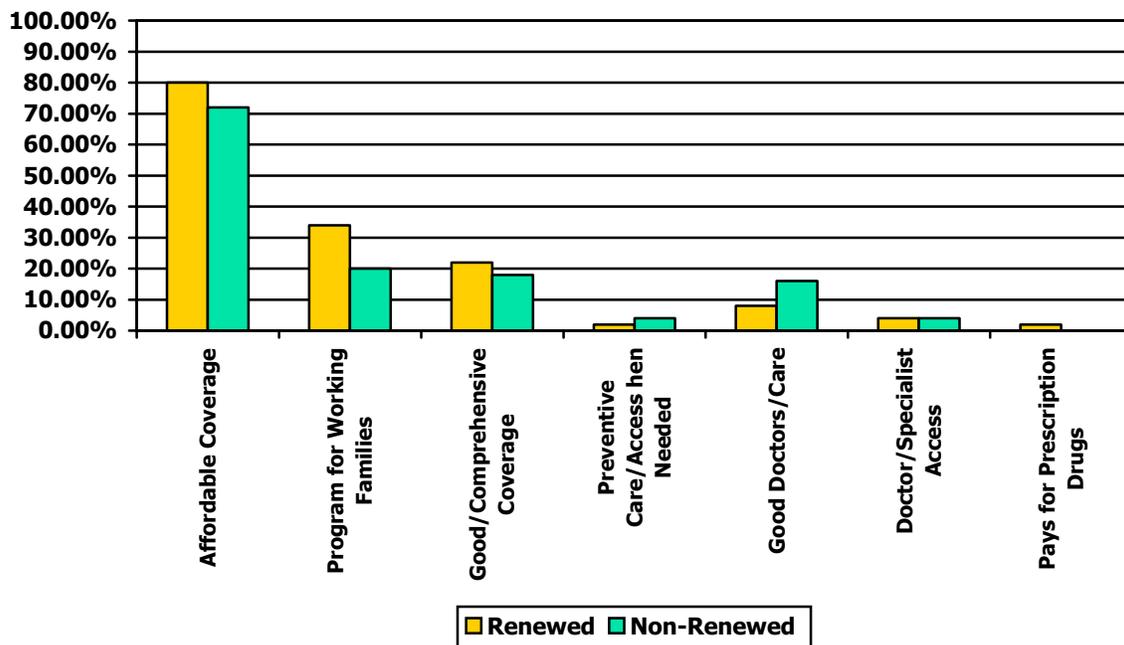
| Table 7: Experiences with Paying Premiums | | |
|--|----------------|--------------------|
| | Renewed | Not Renewed |
| Is/Was the premium. . . ? | | |
| About the right amount | 78.0% | 66.0% |
| Too much | 20.0% | 20.0% |
| Too little | 2.0% | 14.0% |
| How often is/was paying the premium difficult for you financially? (of those who indicated the premium is not too much) | | |
| Almost every month | 5.0% | 2.5% |
| Every couple of months | 27.5% | 15.0% |
| Rarely | 35.0% | 37.5% |
| Never a month when paying is/was difficult | 32.5% | 45.0% |
| Agree or strongly agree that paying the premium is/was well worth it for the care and coverage received | 96.0% | 96.0% |
| Agree or strongly agree that sometimes paying the premium is/was a waste of money because child is healthy. | 14.6% | 8.2% |
| Agree or strongly agree that respondent is happy to pay the premium because s/he feels better paying part of the cost of child's coverage. | 98.0% | 100.0% |
| Agree or strongly agree that respondent is worth the peace of mind knowing that child is covered. | 96.0% | 98.0% |

Program Satisfaction. Families were asked questions about their experiences with the quality of care in the Florida Healthy Kids Program and their general satisfaction with the program. Most respondents indicated high levels of satisfaction with the program with no significant differences between renewers and non-renewers in the targeted outreach group (Table 8). This is different than the results from the Healthy Kids renewal population overall where renewers reported higher levels of satisfaction than non-renewers. More than 90 percent of the targeted outreach group was satisfied or very satisfied with their child's physician in the Florida Healthy Kids Program, and three-quarters of renewers and non-renewers rated the quality of care as excellent or very good. There was somewhat less satisfaction with the program generally, with about 67 percent of respondents rating the program as excellent or very good.

| | Renewed | Non-Renewed |
|--|----------------|--------------------|
| Satisfied or very satisfied with child's physician while in the Healthy Kids Program | 91.7% | 93.9% |
| Rate quality of care as very good or excellent | 75.5% | 75.5% |
| Rate Healthy Kids Program overall as very good or excellent | 68.0% | 66.0% |

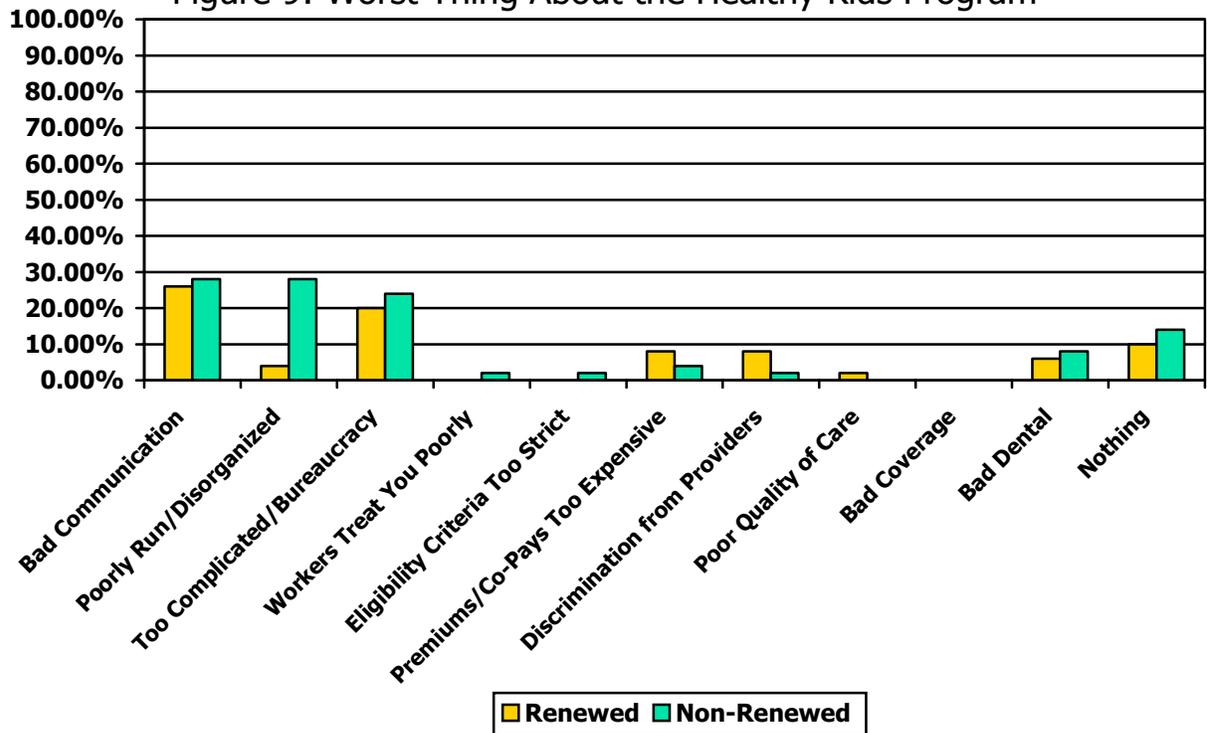
Respondents also were asked to indicate “in a word or two” what they felt were the best and worst aspects of the Florida Healthy Kids Program, and their responses could be categorized into more than one category (Figures 8 and 9). Approximately 76 percent of both renewers and non-renewers indicated that the best aspect of the Healthy Kids Program is that it provides affordable coverage for children. The second “best” aspect cited most frequently, by 34 percent of renewers and 20 percent of non-renewers, is that it is a program for working families. Access to good or comprehensive coverage was cited by 20 percent of all respondents.

Figure 8: Best Thing About the Healthy Kids Program



When asked about the “worst thing about the Healthy Kids Program,” the response given most frequently was bad communication, with approximately 27 percent of renewers and non-renewers alike citing this reason. Both groups also had a fairly high percentage of respondents (22 percent overall) indicating that the program was too complicated and involved too much bureaucracy, with many of these comments pertaining directly to the renewal process. Non-renewers were much more likely to indicate that the program was poorly run or disorganized than renewers (28 percent versus 4 percent). However, there were also respondents who indicated that they had no complaints about the program, with 10 percent of renewers and 14 percent of non-renewers who had nothing negative to say.

Figure 9: Worst Thing About the Healthy Kids Program



VII. DESCRIPTIVE ANALYSES OF HEALTH CARE EXPENDITURES FOR CHILDREN

WHO REMAIN ENROLLED

The presumed benefit of effective outreach is that eligible children remain enrolled. The cost of outreach ideally should be weighed against the potential costs associated with untreated conditions and the additional administrative costs associated with re-enrolling children versus keeping them enrolled. Research has found that children with intermittent coverage are more likely to have delayed care, unmet medical needs, and unfilled prescriptions.⁵ Periods of reduced access to care may increase the overall costs of care if untreated conditions worsen.

It is very difficult to assess the impact of remaining enrolled in the program on children's health in the short term. Often, complications or problems associated with poor healthcare in childhood are not observed until the adult years. We did examine trends in healthcare expenditures for children enrolled in the Florida Healthy Kids Program for 6, 12, and 24 months to determine if expenditures dropped with increasing lengths of enrollment. This information is descriptive only and should be viewed cautiously. There are many reasons why health care expenditures can decline across time, including regression to the mean.

Figures 10 and 11 show the per member per month (PMPM) expenditures of children enrolled in the Healthy Kids Program for 6, 12, and 24 months respectively by health status and by the most frequent chronic conditions. These expenditures were calculated by using claims and encounter data provided by the health plans that participate in the Florida Healthy Kids Program. The person-level claims and encounter data contain Physician's Current Procedural Terminology (CPT) codes and International Classification of Diseases 9th Revision (ICD9-CM) codes. Claims and encounter information was used from January 2004 through December 2004 to classify children's health status, health care expenditures, and health care use rates for children

enrolled in the Florida Healthy Kids Program for 6 months and 12 months in 2004. Claims and encounter data from January 1, 2003 to December 31, 2004 was used to classify children's health status and health care expenditures for children enrolled in the Florida Healthy Kids Program for 24 months from January 1, 2003 through December 31, 2004. The *Practice Management Information Incorporated (PMIC)* listing of physician fees was linked to the CPT codes.⁶ The PMIC contain information from millions of paid claims nationally. The reported paid amount at the 50th percentile was used for each CPT code. In addition, a per diem of \$1,500 was assigned to each day of an inpatient stay. A wholesale price index was used to assign charges to the pharmacy data. The health plans participating in the Florida Healthy Kids Program do not provide their actual paid amounts, therefore it was necessary to use the fee schedule.

The PMPM expenditures for enrollees with chronic health conditions is greater for new enrollees (those enrolled only 6 months) compared to established enrollees enrolled for 12 months or longer (Figure 10). It is possible that disruptions in care for these children can be especially costly.

Figure 10: PMPM Expenditures by Health Status
 Healthy Kids Enrollee Pool – 6, 12, and 24 months Post-Enrollment

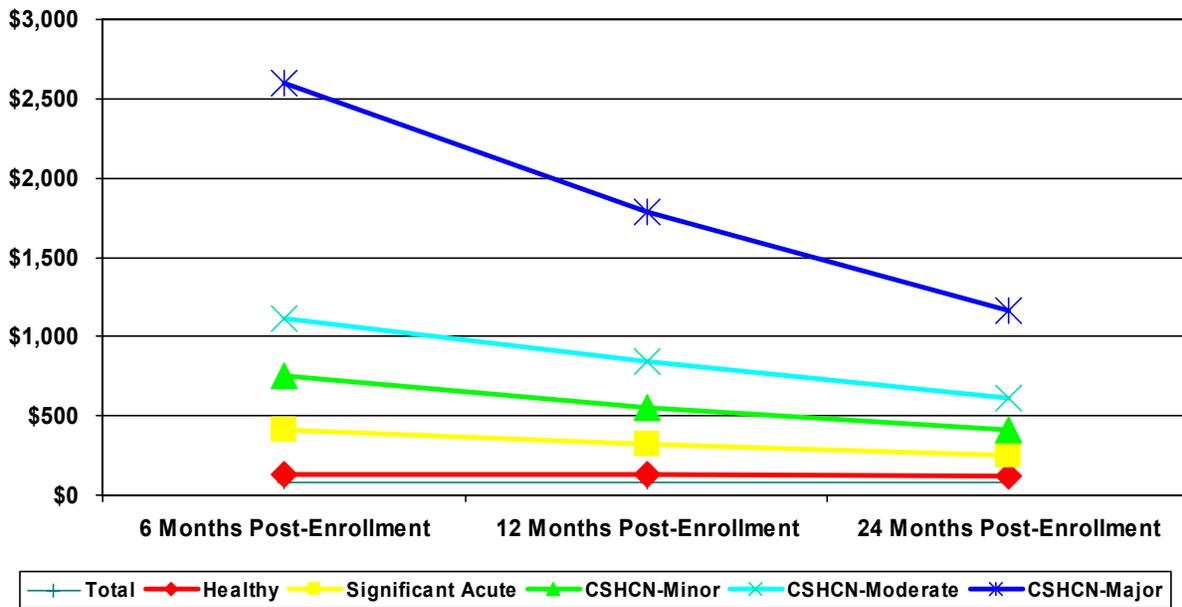
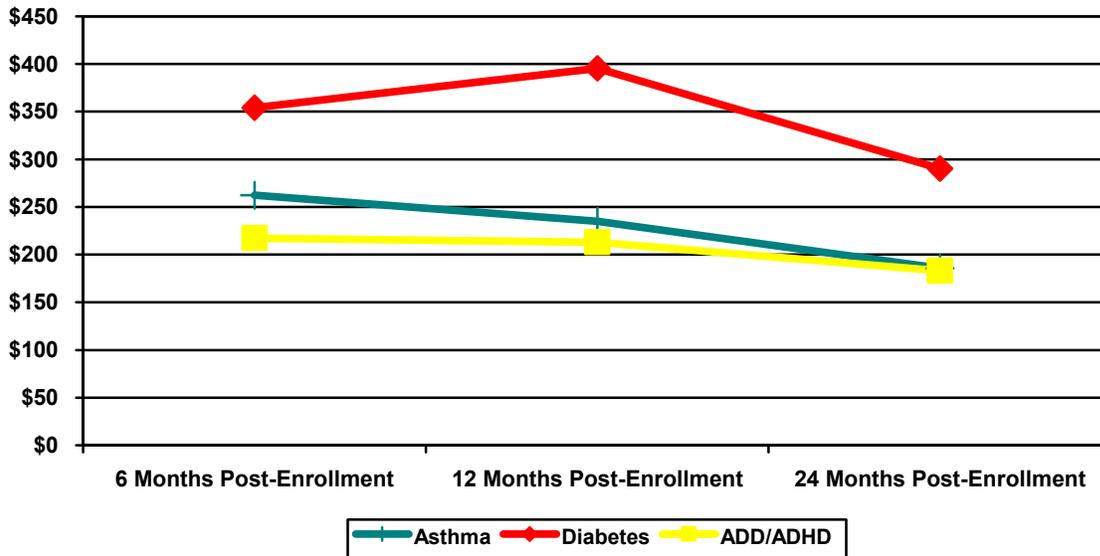


Figure 11 shows PMPM expenditures for Healthy Kids enrollees with the most frequently observed chronic conditions. New enrollees with asthma and ADHD have greater PMPM expenditures than children enrolled for 12 and 24 months. The PMPM expenditures for children with diabetes appear to increase initially, but then decrease significantly over the 12- to 24-month period.

Figure 11 PMPM Expenditures by Most Frequent Chronic Conditions
 Healthy Kids Enrollee Pool – 6, 12, and 24 months Post-Enrollment



These trends suggest that it may be less costly in terms of health expenditures to keep children enrolled in the Florida Healthy Kids Programs versus having disruptions in program coverage.

VIII. CONCLUSIONS

It is difficult to assess the effectiveness of Project Pathfinder on renewal rates because the outreach effort coincided with the implementation of an active and more difficult renewal process. Disenrollment from the Florida Healthy Kids Program overall after the implementation of active redetermination is higher than what has been found in previous analyses in Florida (27 percent disenrollment versus 5 percent). With the existing data, it is not possible to determine to what extent disenrollment rates would have been even greater in the absence of the Healthy Kids program outreach efforts. However, Florida’s overall disenrollment rate appears to be lower than that compared to other states (27 percent compared to as high as 50 percent).

A smaller percentage of families who were targeted for household visits recall getting letters or phone calls from the Florida Healthy Kids Program about renewal compared to the Healthy Kids renewal population overall. For the household visits themselves, only 22 percent of families who renewed their children's coverage and 10 percent of families who did not renew coverage recall receiving this contact from the Florida Healthy Kids Program. These low rates suggest difficulties in locating and reaching these families. Among families who do recall receiving program contact, less than half report that their renewal decision was influenced by such contact. This is not altogether surprising, because some families choose not to renew coverage for reasons other than having difficulty with the renewal process. For example, 16 percent of families reported that they did not renew their children's coverage because they obtained another source of coverage. To make future outreach efforts most effective in reducing disenrollment of eligible children from the Florida Healthy Kids Program, efforts should be made to (1) identify additional ways to locate and maintain contact with enrollees and (2) identify which household will most benefit from outreach efforts.

Focusing on helping eligible families to complete the renewal process is important because 54 percent of the children whose coverage was not renewed were uninsured at the time of the survey. Uninsured children are at risk for poor access to needed health care services.

Endnotes

¹ When this policy change was enacted, redetermination occurred every six months. Effective January 1, 2005 the redetermination process was changed to occur every 12 months (HB 1843).

² The proof of income requirements specified in HB 1843, effective July 1, 2004, included copies of the prior year's federal income tax return, wages and earnings statements, and any other appropriate documents. These requirements were subsequently eased in December 2004 with the enactment of SB 28-A, which provides that proof of family income include a copy of the most recent federal income tax return; in the absence of a federal income tax return, families may submit wages and earning statements (pay stubs), W-2 forms, or other appropriate documents.

³ Neff, J.M., Sharp, V., Muldoon, J., Graham, J. Popalisky, J., Gay, J. 2001. "Identifying and Classifying Children with Chronic Conditions Using Administrative Data with the Clinical Risk Group Classification System." *Journal of Ambulatory Pediatrics*. 2(1): 72-29.

⁴ These analyses were conducted as part of the Child Health Insurance Research Initiative (CHIRI) and were published in A.W. Dick, R. A. Allison, S.G. Haber, C. Brach, E. Shenkman. 2002. "The Consequences of States' Policies for SCHIP Disenrollment." *Health Care Financing Review* 23(3): 65-88.

⁵ Olson, L., Suk-fong, S., Newacheck, P. "Children in the United States with Discontinuous Health Insurance Coverage." *The New England Journal of Medicine*. 353(4): 382-391.

⁶ Practice Management Information Incorporated. 2002. *Physician Fees*. Los Angeles, California: James B. Davis, Publisher.