

Los Angeles Healthy Kids Improves Access to Care and Health Status

Longitudinal Findings on the Impact of Healthy Kids

Embry Howell, Lisa Dubay, Sarah Benatar, Louise Palmer, and Ian Hill

Findings from a longitudinal survey of parents with children enrolled in the Los Angeles Healthy Kids program indicate that access to medical and dental care for enrolled children increased over time, while unmet needs for care decreased. In addition, parents report improvements in the perceived health status of their children.

Background

Launched in July 2003, the Healthy Kids program in Los Angeles aims to extend universal coverage to children in families with incomes below 300 percent of the federal poverty level who are ineligible for Medi-Cal or Healthy Families. With funding from First 5 LA, Healthy Kids initially covered children 0 through 5 years old. Additional funding enabled expansion of the program in May 2004 to include children 6 through 18 years old. Enrollment for this age group was rapid and funding limited, requiring that a hold be placed on enrollment of children 6 through 18 years old in June 2005. The hold remains in place today.

The Healthy Kids program includes intensive community-based outreach, enrollment assistance, and comprehensive coverage of preventive, primary, and specialty care benefits, including dental and vision services. Services are administered by L.A. Care Health Plan on a prepaid, capitated basis. Families with incomes above 133 percent of the federal poverty

level are required to pay an income-adjusted premium, and all enrollees are responsible for some co-payments at the point of service.

This brief presents results from two waves of parent surveys conducted as part of the Los Angeles Healthy Kids program evaluation designed to measure the impact of the Healthy Kids program on perceived and realized access to care for established and new enrollees. The findings summarized here are limited to parents of children age 1 to 5 and focus on how the program affects access to care and health status outcomes. First 5 LA contracts with the Urban Institute and its partners—the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc. (MPR), and Castillo and Associates—to conduct the evaluation.

Data and Methods

The analysis presented here uses data from parent surveys conducted by MPR under a subcontract with the Urban Institute. The first wave of data collection took place between April and December 2005, and the second wave occurred from May 2006 to January 2007. The sample included children 12 to 72 months old who were identified as either new enrollees (enrolled from March to July 2005) or established enrollees (enrolled from March to July 2004). Response rates for these surveys were

Healthy Kids has improved access to medical and dental services and reduced the use of emergency room care.

Funding for this brief provided by



Champions For Our Children

high, with 1,087 interviews (a response rate of 86 percent) at wave one and 975 interviews at wave two (90 percent of eligible respondents). Response rates were slightly higher among established enrollees than among new enrollees.

New and established enrollees and their families share similar demographic profiles. Both groups of children live in predominantly low-income families, they are mostly of Latino ethnicity, and a majority are not U.S. citizens. By and large, parents of enrollees have not graduated from high school. Most enrollees speak Spanish at home and live in households with either married parents or a parent and his or her partner. Established enrollees are older on average than new enrollees by just over half a year, and their parents have lived in Los Angeles County longer.

In this brief, we compare changes in new enrollees' access to care, use of services, and health outcomes over time with those changes for established enrollees. Using the parent surveys, impact estimates are derived using responses to questions designed to measure usual source of care, use of services, and unmet need. We also present impact estimates for changes in parent perception of their child's health status.

A quasi-experimental longitudinal design is used to measure the impact of enrollment in Healthy Kids based on the measures mentioned above. The design uses data from both waves to assess differences between the two groups in wave one, changes over time between the waves for new and established enrollees, and differences in their rates of change, determined by subtracting the change in outcomes between wave one and wave two for the established enrollees from changes in the same outcomes for new enrollees. This analysis removes the effect of non-program-related secular factors and aging that affect outcomes for both groups. This measure assumes that all program effects occur during the first year of the program and do not continue into the second year of enrollment, which may underestimate the impact over time.

Since enrollees differ in a number of characteristics associated with access to

and use of health care services, as well as health status, we use multivariate logistic regression to control for characteristics of the child and the child's family, and adjust for changes between groups and over time. The resulting regression-adjusted means compare outcomes in wave one between new and established enrollees, and compare outcomes over time for both new and established enrollees.

Results

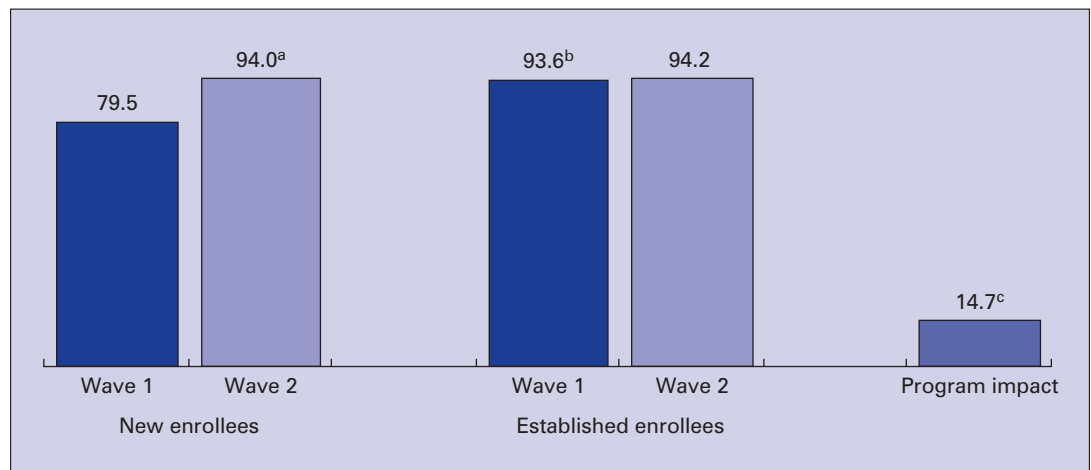
Usual Source of Care. Enrollment in Healthy Kids substantially improves children's access to care. As previously reported (Dubay and Howell 2006), after adjusting for age and demographic characteristics, the share of established enrollees with a usual source of care is substantially higher than that of new enrollees (93.6 percent versus 79.5 percent). By wave two, however, the share of new enrollees with a usual source of care has increased, so both cohorts have nearly identical rates (94.2 and 94.0 percent, respectively, as shown in figure 1).

During the first year, the program increases the likelihood of having a usual source of care by 14.7 percentage points, which is highly significant.

Even stronger patterns emerge for having a usual source of dental care, a measure evaluated for enrollees age 3 to 5. Enrollment in Healthy Kids results in a 27.5 percentage point increase in the likelihood of having a usual source of dental care (figure 2).

Use of Services. Use of preventive services increases as a result of enrollment in Healthy Kids among enrollees who have no usual source of care before enrolling in the program. New enrollees who have a usual source of care when enrolling demonstrate no increase in likelihood of having a preventive care visit. This contrasts with a 26.9 percentage point increase in the likelihood of having a preventive care visit for those who have no usual source of care before enrollment (figure 3).

FIGURE 1. Percent of Healthy Kids Enrollees with a Usual Source of Medical Care in Past Six Months



Note: Regression-adjusted percentages.

a. Difference between wave 1 new and wave 2 new is statistically significant at the $p < .01$ level.

b. Difference between wave 1 new and wave 1 established is statistically significant at the $p < .01$ level.

c. Program impact is statistically significant at the $p < .01$ level.

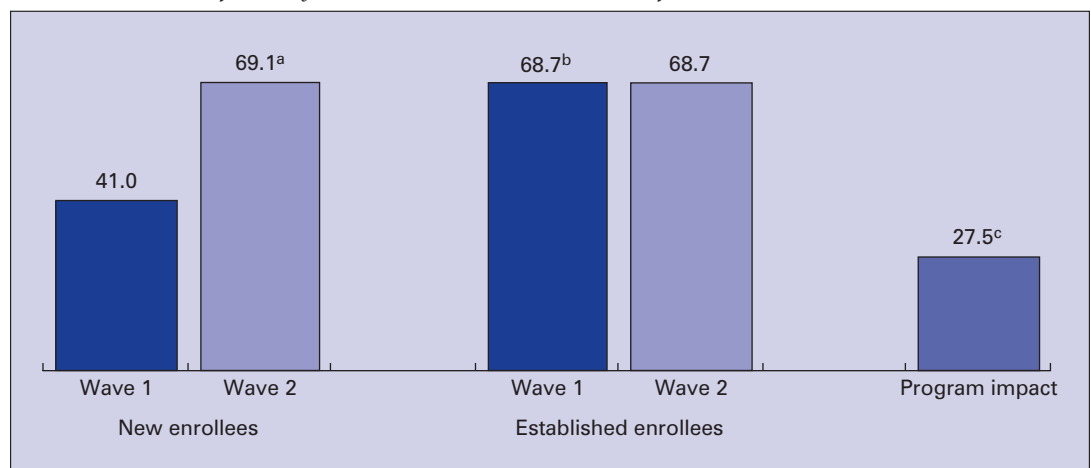
A decline in emergency room use is also associated with enrollment in Healthy Kids. While 24 percent of new enrollees report an emergency room visit in the six months before enrolling in the program, 14.4 percent report visits to the emergency room one year later. The program reduced emergency room use by 4.7 percentage points (figure 4).

Unmet Need. At wave one, significantly more new enrollee parents (5.9 percent)

report that their child required ambulatory care for an injury or illness in the past six months but did not receive it, compared with 2.5 percent of established enrollees. New enrollee parents report a significant decline in unmet need for ambulatory care one year later (1.4 percent), but the program impact was not statistically significant (data not shown).

Declines in unmet need for preventive care are both significant and substantial. Approximately 23 percent of new enrollee

FIGURE 2. Percent of Healthy Kids Enrollees with Usual Source of Dental Care



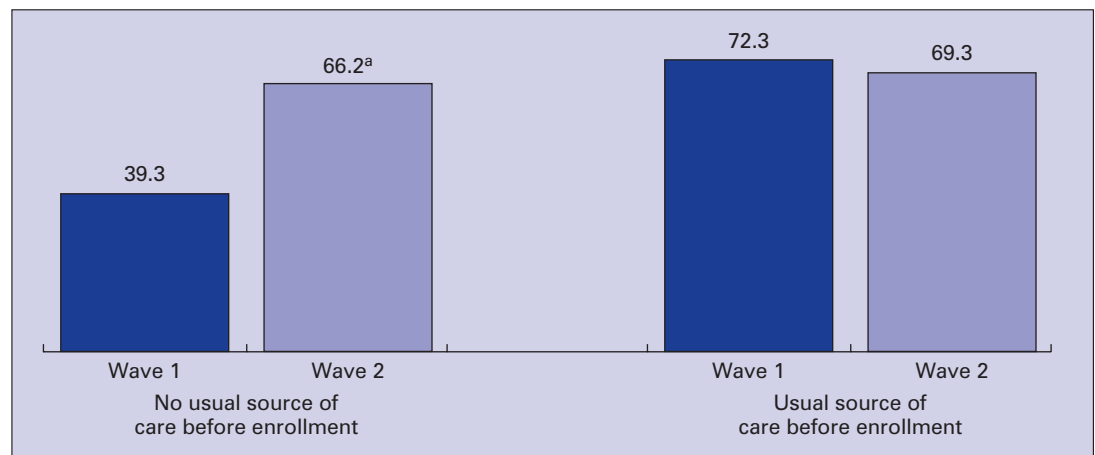
Note: Regression-adjusted percentages.

a. Difference between wave 1 new and wave 2 new is statistically significant at the $p < .01$ level.

b. Difference between wave 1 new and wave 1 established is statistically significant at the $p < .01$ level.

c. Program impact is statistically significant at the $p < .01$ level.

FIGURE 3. Percent of New Healthy Kids Enrollees with Any Preventive Care Visit in Past Six Months



Note: Regression-adjusted percentages.

a. Difference between wave 1 no usual source of care and wave 2 no usual source of care is statistically significant at the $p < .01$ level.

parents in wave one report that their child did not receive necessary preventive care when needed, compared with 8.8 percent in wave two. Further, the impact estimates suggest that enrollment in the program results in a 13.2 percentage point decline unmet need for preventive care (figure 5).

Similar declines in unmet need for specialist care are observed with enrollment in the program, resulting in a significant decrease in unmet need (figure 6).

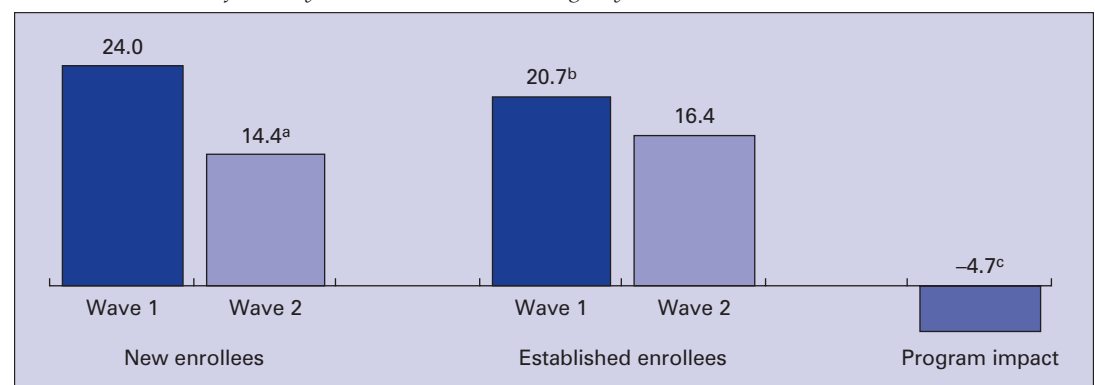
Health Status. The health of both new and established enrollees improved between wave one and wave two (figure 7). The positive trend in health status outcomes for both groups—coupled with a lack of

significance for the impact measure—suggests that health status continues to improve over time.

Conclusion

This analysis demonstrates that Healthy Kids has had a positive and significant impact on access to medical and dental services, and on the use of specialty care services. Preventive service use also improves greatly among children who do not have a usual source of care before enrolling in the program. There is also substantial evidence that Healthy Kids improves the health status of children in their first year of enrollment and that the effect continues into the second year.

FIGURE 4. Percent of Healthy Kids Enrollees with Emergency Room Visit in Past Six Months



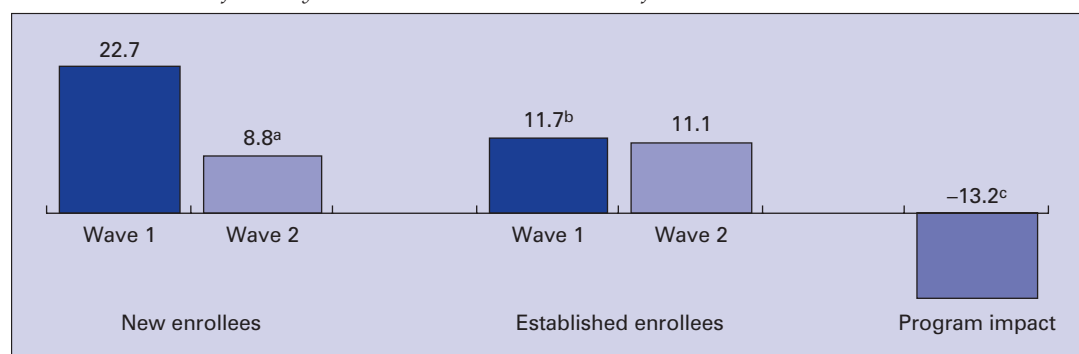
Note: Regression-adjusted percentages.

a. Difference between wave 1 new and wave 2 new is statistically significant at the $p < .01$ level.

b. Difference between wave 1 new and wave 1 established is statistically significant at the $p < .01$ level.

c. Program impact is statistically significant at the $p < .01$ level.

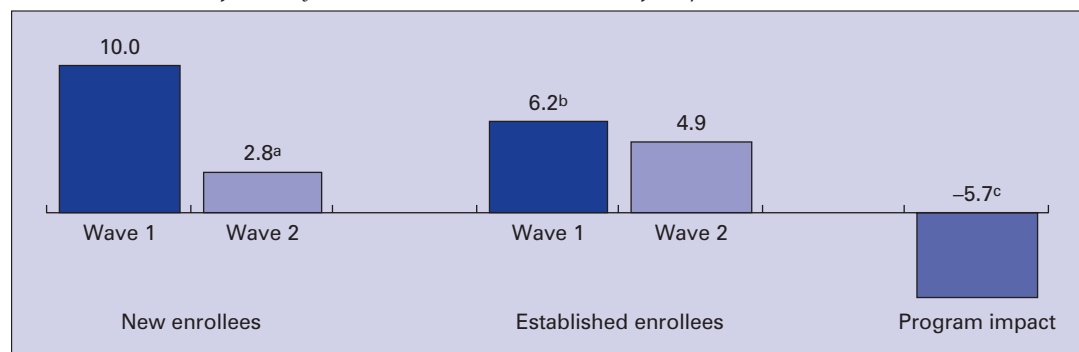
FIGURE 5. Percent of Healthy Kids Enrollees with Unmet Need for Preventive Care in Past Six Months



Note: Regression-adjusted percentages.

- a. Difference between wave 1 new and wave 2 new is statistically significant at the $p < .01$ level.
- b. Difference between wave 1 new and wave 1 established is statistically significant at the $p < .01$ level.
- c. Program impact is statistically significant at the $p < .01$ level.

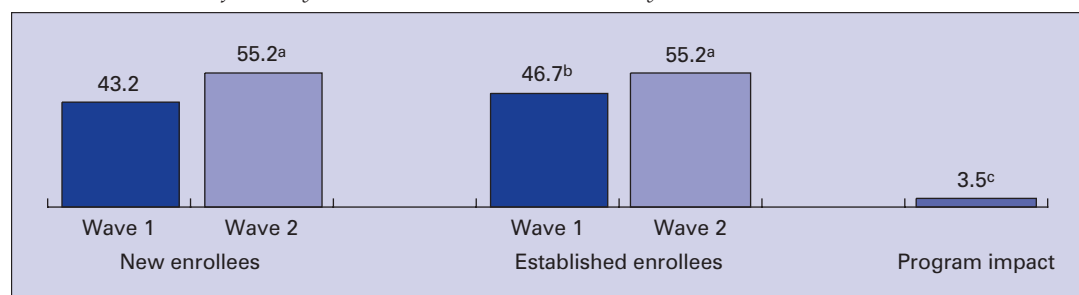
FIGURE 6. Percent of Healthy Kids Enrollees with Unmet Need for Specialist Care



Note: Regression-adjusted percentages.

- a. Difference between wave 1 new and wave 2 new is statistically significant at the $p < .01$ level.
- b. Difference between wave 1 new and wave 1 established is statistically significant at the $p < .01$ level.
- c. Program impact is statistically significant at the $p < .01$ level.

FIGURE 7. Percent of Healthy Kids Enrollees in Excellent or Very Good Health



Note: Regression-adjusted percentages of perceived health status.

- a. Difference between wave 1 and wave 2 is statistically significant at the $p < .01$ level.
- b. Difference between wave 1 new and wave 1 established is not statistically significant.
- c. Program impact is not statistically significant.

Though limited by the short time horizon of the study and a lack of clinical data, the results presented here provide strong evidence that the Healthy Kids program has improved access to care and enhances the health of enrollees.

Reference

Dubay, Lisa, and Embry Howell. 2006. "Los Angeles Healthy Kids Improves Access to Care for Young Children: Early Results from the Healthy Kids Evaluation." Washington, DC: The Urban Institute.

Address Service Requested

To order additional copies
of this publication, call
202-261-5687
or visit our online bookstore,
<http://www.uipress.org>.



The Urban Institute's Health Policy Center (HPC) was established in 1981 to study the public policy issues surrounding the dynamics of the health care market and health care financing, costs, and access. Research topics include health insurance coverage and costs, incentives for public and private provider reimbursement, reform of the long-term care system, and malpractice tort law and insurance. HPC researchers also examine Medicare and Medicaid benefits and proposals, assess proposed reforms in the private medical market, and study ways to expand health insurance coverage for children, among other issues.

The Health Policy Briefs series provides analysis and commentary on key health policy issues facing the nation. Topics include Medicare and Medicaid policy, changes in private health care markets, strategies for expanding health insurance, and the rising costs of health care. The series will include both data briefs and perspectives on national debates.

The views expressed are those of the authors and do not necessarily reflect those of the Urban Institute, its board, its sponsors, or other authors in this series. Permission is granted for reproduction of this brief, with attribution to the Urban Institute.

First 5 LA is a unique child-advocacy organization created by California voters to invest tobacco tax revenues in programs for improving the lives of children in Los Angeles County, from prenatal through age 5. First 5 LA champions health, education, and safety causes concerning young children and families. For additional information about First 5 LA, our partners, and projects, visit <http://www.first5la.org>.