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Access Gaps Among Uninsured Children in Los Angeles County:

Baseline Findings from the 2002/2003 Los Angeles County Health Survey

Children's Health Initiative of Greater Los Angeles

Prepared for:

The California Endowment

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A Baseline Analysis with the 2002/2003 Los Angeles County Health Survey

Executive Summary

Six out of 10 low-income, uninsured children in Los Angeles County had difficulty accessing needed medical care in 2002/2003. Based on the Los Angeles County Health Survey, it appears that L.A.'s Children's Health Initiative has the potential to improve access to health care services for these children if they enroll in public health programs. This analysis suggests that children enrolled in the Healthy Kids program would have fewer unmet health and dental needs and would be more likely to receive well-child and regular care.

Results

Health Access Measures for Low-Income, Uninsured Children

- ***Health Services.*** Nearly one-third of survey respondents did not see a doctor for needed check-ups and 30 percent did not go for illness because of cost concerns. However, any preventive care is an encouraging sign.
- ***Usual Source of Care.*** Nearly one-third did not have a regular health care provider. Of those who had a provider, most were very satisfied.
- ***Prescription Drugs.*** One-quarter did not receive needed medicine.
- ***Dental Care.*** More than half did not go to the dentist.

Access Comparison between Low-Income, Uninsured and Publicly Insured Children

- More than 60 percent of uninsured children had difficulty accessing health care compared to slightly more than 18 percent of publicly insured children.
- Uninsured children were nearly four times less likely to see a doctor for a regular exam than their publicly insured counterparts.
- Fully 30 percent of uninsured children did not see a doctor for a health problem compared to just more than 8 percent with public insurance.
- Uninsured children were more than twice as likely to not get needed prescription medicines than those with public insurance.
- Children with public coverage were more likely to receive well-child visits. For example, 95 percent of children age 5 or younger with public coverage had a visit in the past year compared to 88 percent of uninsured children.

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Access and Use of Low-Income Children Ages 0-17 in L.A. County, Overall and by Key Characteristics, 2002/2003

Outcome (Means)	Publicly Insured^	Uninsured
Unmet or delayed health needs[1]		
Difficulty accessing needed care for child	18.35%	60.67%***
Unable to afford to see doctor for checkup	8.22%	30.71%***
Unable to afford to see doctor for illness	6.98%	29.53%***
Unable to afford prescription drugs	11.18%	25.07%***
Unable to afford dental care[3]	15.00%	52.36%***
Unable to afford mental health care[3]	4.50%	11.42%***
Any unmet needs due to unaffordability	22.30%	59.73%***
Multiple unmet needs due to unaffordability	10.20%	38.05%***
Transportation barrier to medical care	10.33%	14.07%**
Language barrier to medical care[4]	16.99%	21.89%*
Service Use[1]		
Children receiving at least one visit for well-child in past year (0-5)	94.97%	88.37%*
Children receiving at least one visit for well-child in past two years (6-17)	93.17%	79.62%***
Usual source of care (USC)[1]		
Child has a usual source of care	93.54%	68.65%***
Receipt of health care by children with usual source of care[2]		
USC (Usual Source of Care) same place for physical exam	94.85%	85.12%***
USC same place for vaccination	95.86%	86.60%***
Received care at hospital ER	21.23%	9.06%***
Satisfaction with usual source of care[2]		
Among children with a usual source of care		
Caregiver satisfied with health care provided	93.77%	91.49%
Caregiver satisfied with guidance on how to care for child	91.97%	90.45%
Caregiver satisfied with USC helping to understand child growth/development	92.01%	91.71%
Caregiver satisfied with USC being easy to contact by phone	88.65%	87.73%
Caregiver satisfied with USC listening and answering questions	92.79%	95.54%**
Caregiver satisfied with USC scheduling appointments quickly	88.06%	89.59%

Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.
* p <.1, ** p <.05; ** p ≤ .01

Notes:
^ denotes reference category.
[1] The sample size is 1739 for Publicly Insured and 491 for Uninsured.
[2] The sample size is 1628 for Publicly Insured and 342 for Uninsured.
[3] Only respondents with a child age 3-17 received these questions.
[4] Only respondents who were interviewed in a non-English language received this question.

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I. Introduction

Los Angeles County is engaged in an ambitious effort to reduce rates of uninsurance among children in the county. Many prior studies have found that, without health insurance, children have lower access to care than to those who have insurance coverage, both nationally and in the state of California (Inkelas et al. 2003; Brown et al. 2004; Davidoff and Rubenstein 2006). In L.A. County, uninsured children were more than four times less likely to have a regular source of health care than children covered by public or private health insurance. Uninsured children were also less likely than insured children to have had a physical exam at the recommended interval (LA Health Department of Health Services 2004). To address the potential access problems experienced by children in L.A. County, the Healthy Kids program was introduced in July 2003. The Healthy Kids program included a coverage expansion to undocumented children and to uninsured children whose incomes were between 250 and 300 percent of the federal poverty level. It also included broader outreach and application assistance efforts aimed at increasing enrollment of uninsured citizen children who could qualify for the existing Medi-Cal and Healthy Families programs. It is hoped that the Healthy Kids Program will improve access to care among the children who gain coverage.

This brief uses the 2002/2003 L.A. County Health Survey (LACHS) to examine the extent to which uninsured children experienced access problems prior to the launch of the Healthy Kids Program and how much access could be improved by enrolling these children in public coverage. We first examine the extent of access problems reported for low-income, uninsured children in L.A. County and then compare those measures to those found for low-income children covered by Medi-Cal or Healthy Families in the baseline period. Because the composition of low-income children who were uninsured in 2002/2003 differed from that of those with public coverage, we examined access differences between uninsured and publicly insured children, controlling for observed characteristics of the two groups related to race/ethnicity, age, health status of the child and the socioeconomic characteristics of the family. Since these multivariate models yielded results that were comparable to the bivariate findings, we present the bivariate findings.[1] For all of the analyses in this brief, we define low-income children as children with family incomes below 200 percent of the federal poverty level (FPL).

This analysis is part of the Healthy Kids Program Evaluation, a four-year effort supported by The California Endowment and First 5 LA. A prior brief used the 2002/2003 survey to examine coverage gaps for children in the baseline period, and subsequent briefs will examine the 2005 LACHS data to assess the extent to which the new Healthy Kids program and renewed outreach efforts appear to be reducing uninsurance among children in L.A. County (Kenney et al. 2006 (a and b)). The evaluation has multiple components, including case studies, focus groups and a longitudinal survey of enrollees. For more information on the evaluation and these studies, see www.first5la.org/ourprojects/healthykids.php4 or www.urban.org.

II. Results

Access Measures Among Low-Income, Uninsured Children. In 2002/2003, low-income, uninsured children experienced higher levels of unmet health care needs than other children in L.A. County. Six of every 10 low-income families (61 percent) with uninsured children reported difficulty accessing needed medical care for their children. In terms of specific health services, 31 percent of uninsured children were unable to see the doctor for a needed medical checkup and 30 percent were unable see the doctor for illness because of cost concerns. Another 25 percent of low-income uninsured children did not receive needed prescription drugs and 52 percent did not get dental care because of cost (Table 1).

Table 1. Access and Use of Low-Income Children Ages 0-17 in L.A. County, Overall and by Key Characteristics, 2002/2003

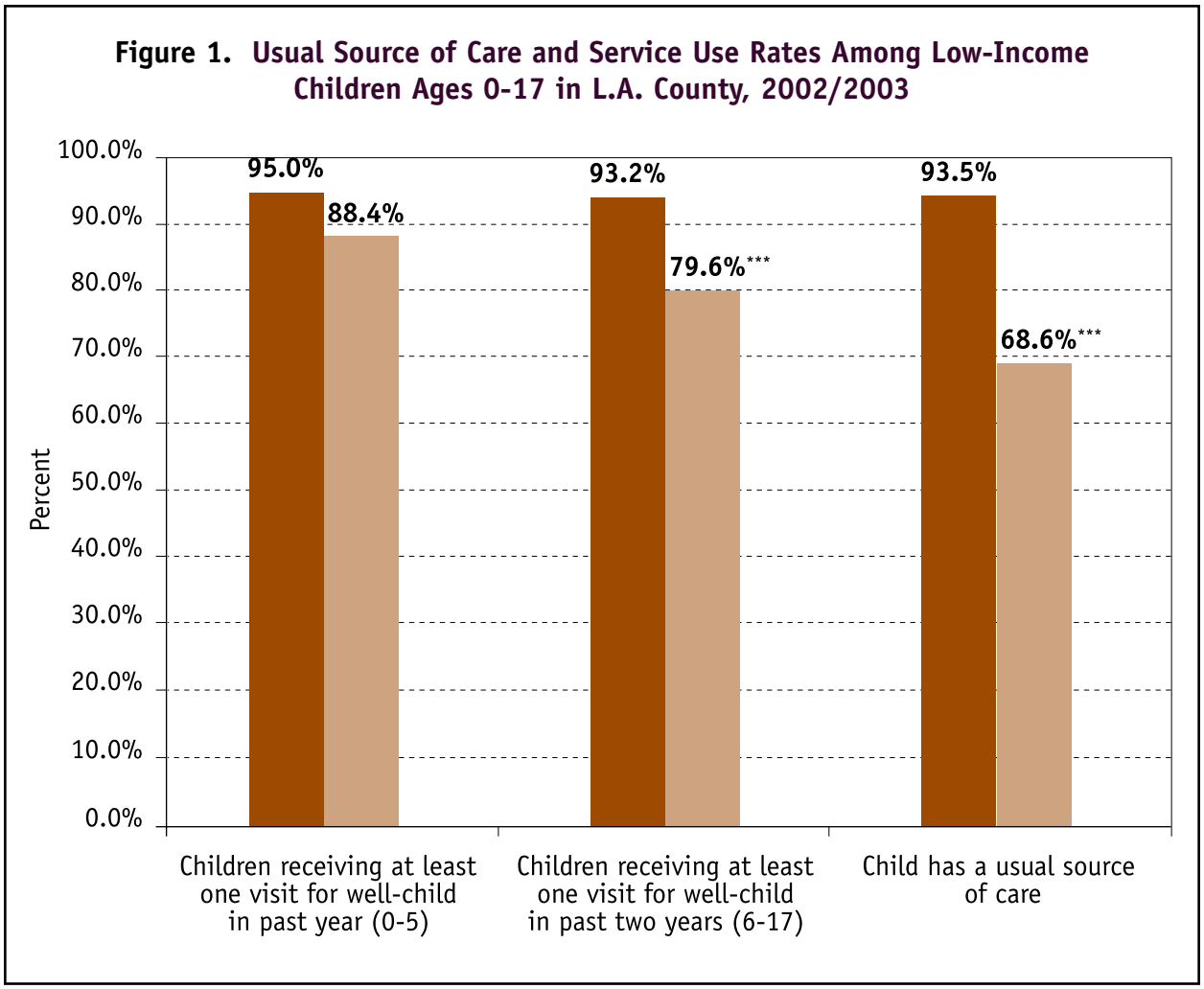
Outcome (Means)	Publicly Insured^	Uninsured
Unmet or delayed health needs[1]		
Difficulty accessing needed care for child	18.35%	60.67%***
Unable to afford to see doctor for checkup	8.22%	30.71%***
Unable to afford to see doctor for illness	6.98%	29.53%***
Unable to afford prescription drugs	11.18%	25.07%***
Unable to afford dental care[3]	15.00%	52.36%***
Unable to afford mental health care[3]	4.50%	11.42%***
Any unmet needs due to unaffordability	22.30%	59.73%***
Multiple unmet needs due to unaffordability	10.20%	38.05%***
Transportation barrier to medical care	10.33%	14.07%**
Language barrier to medical care[4]	16.99%	21.89%*
Service[1]		
Children receiving at least one visit for well-child in past year (0-5)	94.97%	88.37%*
Children receiving at least one visit for well-child in past two years (6-17)	93.17%	79.62%***
Usual source of care[1]		
Child has a usual source of care	93.54%	68.65%***
Receipt of health care by children with usual source of care[2]		
USC (Usual Source of Care) same place for physical exam	94.85%	85.12%***
USC same place for vaccination	95.86%	86.60%***
Received care at hospital ER	21.23%	9.06%***

Outcome (Means)	Publicly Insured^	Uninsured
Satisfaction with usual source of care[2]		
Among children with a usual source of care		
Caregiver satisfied with health care provided	93.77%	91.49%
Very satisfied	65.87%	57.76%
Somewhat satisfied	27.91%	33.73%
Somewhat dissatisfied	4.87%	4.86%
Very dissatisfied	1.36%	3.65%
Caregiver satisfied with guidance on how to care for child	91.97%	90.45%
Very satisfied	63.70%	59.44%
Somewhat satisfied	28.27%	31.00%
Somewhat dissatisfied	6.08%	7.45%
Very dissatisfied	1.95%	2.10%
Caregiver satisfied with USC helping to understand child growth/development	92.01%	91.71%
Very satisfied	66.69%	61.39%
Somewhat satisfied	25.32%	30.32%
Somewhat dissatisfied	6.29%	4.92%
Very dissatisfied	1.70%	3.37%
Caregiver satisfied with USC being easy to contact by phone	88.65%	87.73%
Very satisfied	59.48%	58.15%
Somewhat satisfied	29.17%	29.58%
Somewhat dissatisfied	7.45%	7.11%
Very dissatisfied	3.90%	5.16%
Caregiver satisfied with USC listening and answering questions	92.79%	95.54%**
Very satisfied	63.81%	64.73%
Somewhat satisfied	28.97%	30.81%
Somewhat dissatisfied	5.77%	3.78%
Very dissatisfied	1.44%	0.68%
Caregiver satisfied with USC scheduling appointments quickly	88.06%	89.59%
Very satisfied	61.33%	51.91%
Somewhat satisfied	26.73%	37.68%
Somewhat dissatisfied	8.03%	7.35%
Very dissatisfied	3.91%	3.06%

Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.
* p <.1, ** p <.05; ** p ≤ .01

Notes:
^ denotes reference category.
[1] The sample size is 1739 for Publicly Insured and 491 for Uninsured.
[2] The sample size is 1628 for Publicly Insured and 342 for Uninsured.
[3] Only respondents with a child age 3-17 received these questions.
[4] Only respondents who were interviewed in a non-English language received this question.

Figure 1. Usual Source of Care and Service Use Rates Among Low-Income Children Ages 0-17 in L.A. County, 2002/2003



Source: Urban Institute calculations of the 2002/2003 Los Angeles County Health Survey.
Notes: * p <.1, ** p <.05, *** p < .01. ^ Indicates the reference category.

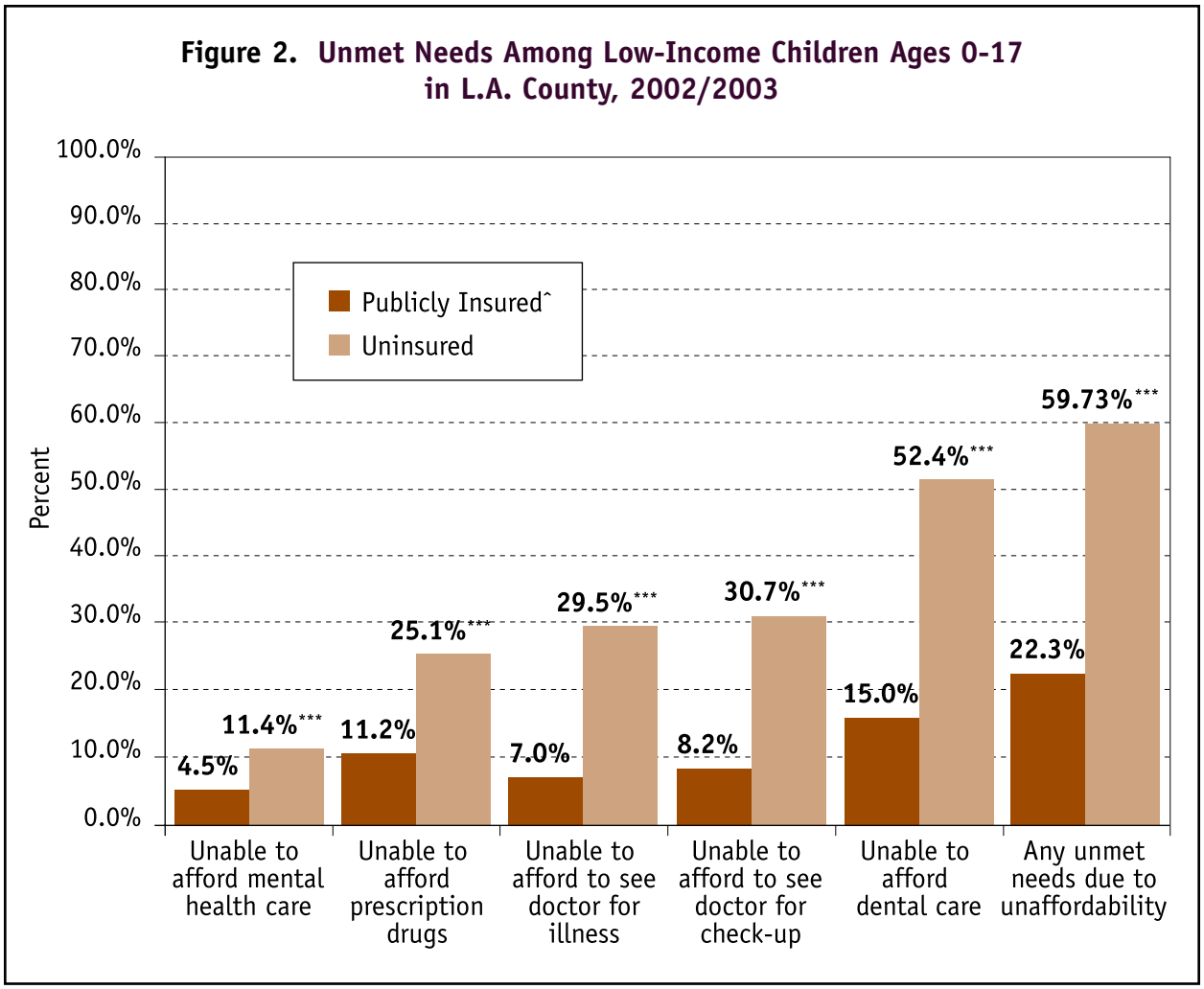
Receipt of well-child care fell short of the guidelines recommended by the American Academy of Pediatrics (AAP). Children 0 to 5 are supposed to receive 1 to 6 well-child visits each year, depending on the age of the child, but 11.6 percent did not receive any well-child care at all. Among children 6 to 17 who are supposed to get a checkup every year, 20 percent had not received any well-child care in the prior 2 years (Figure 1).

Slightly more than 31 percent of low-income uninsured children did not have a usual source of care. However, according to the 2002/2003 LACHS, when parents of low-income uninsured children did report having a usual source of care for their child, they expressed high levels of satisfaction with their health care provider. For example, 91.5 percent of parents indicated that they were satisfied with the health care provided by their children's usual source of care. Furthermore, the majority of these parents of low-income, uninsured children reported being very satisfied with their provider (Table 1).

Comparison of Access for Uninsured and Publicly Insured Children. These data indicate that uninsured children are experiencing more access problems than publicly insured children. Low-income publicly insured children were significantly less likely to have difficulty obtaining needed care. While 61 percent of low-income children were reported to have access difficulties, just 18.4 percent of publicly insured children were reported to have similar problems.

Although publicly covered children also experienced unmet health care needs, their rates of unmet needs were significantly lower than the uninsured. Low-income uninsured children were nearly four times less likely to see a doctor for a physical exam or checkup than their publicly insured counterparts (31 percent versus 8 percent). Thirty percent of low-income uninsured children did not see a doctor when they had an illness or other health problem compared to just 8 percent of low-income publicly insured children. Low-income, uninsured children were also more than twice as likely as low-income publicly insured children to report cost as a barrier to obtaining prescription medicines (25.1 percent versus 11.2 percent). Low-income, uninsured children were also two to three times less likely to report being able to afford mental health care or counseling (11.4 percent versus 4.5 percent) and more than three times less likely to report being able to afford dental care (52.4 percent versus 15.0 percent) (Figure 2).

Figure 2. Unmet Needs Among Low-Income Children Ages 0-17 in L.A. County, 2002/2003



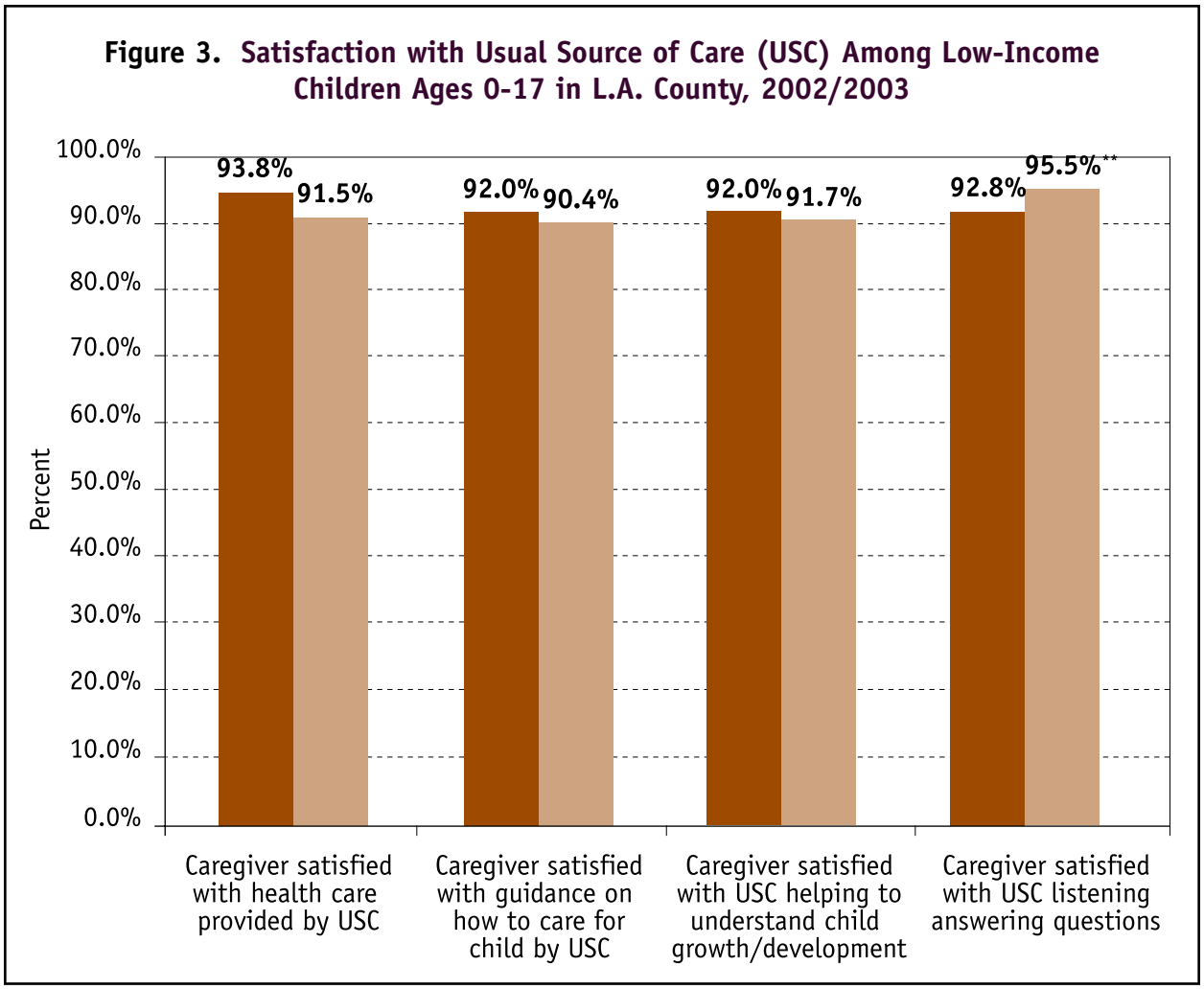
Source: Urban Institute calculations of the 2002/2003 Los Angeles County Health Survey.

Notes: * p <.1, ** p <.05, *** p < .01. ^ Indicates the reference category.
Only respondents with a child age 3-17 were asked whether they were unable to afford dental care.

While high proportions of both low-income, publicly insured and uninsured children received well-child visits, children with public coverage were significantly more likely to receive such care. For example, 95 percent of low-income children ages 0 to 5 with public coverage had a well-child visit in the past year compared to 88 percent of uninsured children. Similarly, 94 percent of low-income, publicly insured children had a usual source of care compared to just 69 percent of uninsured children (Figure 1). When caregivers do report a usual source of care for their child, they report high levels of satisfaction regardless of their insurance status. For example, 94 percent of caregivers with publicly insured children and 92 percent of caregivers with uninsured children were satisfied with the health care provided by their usual source of care (Figure 3).

Similar patterns were found in the multivariate analyses. Being publicly insured was associated with substantially lower reported levels of unmet health care needs relative to being uninsured, other things being equal. For example, low-income, publicly covered children were 38 percent less likely to have difficulty accessing needed medical care and 30 percent less likely to have an unmet dental need compared to low-income, uninsured children, controlling for the observed socioeconomic, demographic and health status of the children.

Figure 3. Satisfaction with Usual Source of Care (USC) Among Low-Income Children Ages 0-17 in L.A. County, 2002/2003



Source: Urban Institute calculations of the 2002/2003 Los Angeles County Health Survey.
Notes: * p <.1, ** p <.05, *** p < .01. ^ Indicates the reference category.

III. Policy Implications

Based on the information provided in the 2002/2003 LACHS, it appears that the Children's Health Initiative has the potential to improve access to health care services for low-income, uninsured children if they enroll in public programs. This brief indicates that, prior to the Healthy Kids program, low-income, uninsured children had unmet health care needs at much higher rates than children who had public health insurance coverage. Thus, reductions of uninsurance coupled with increases in public coverage should reduce the extent to which low-income children in the county have unmet health and dental needs. In addition, expansions in public coverage should also increase the share of children in the county that have a usual source of care, which is considered a necessary component of continuous primary care and, therefore, a key indicator of access (Starfield 1992).

While this analysis pointed to significant access problems for uninsured children living in L.A. County in 2002/2003, there were some signs that the safety net was working to meet some of their health care needs. In particular, many uninsured children had received preventive care at some point in the prior year or two — 90 percent of the uninsured children age 5 years or younger had at least one well-child visit in the 12 months before the survey. While these children may not have received the recommended levels of preventive care, that so many received any preventive care at all is a somewhat encouraging sign. Likewise, parents expressed high levels of satisfaction with their child's usual source of care, both for publicly insured and for uninsured children. This suggests that the providers who are serving these children are providing care that is at least satisfactory in the view of the parents.

In summary, uninsured children stand to experience improvements in access to care if they gain public health insurance coverage in L.A. County. In particular, this analysis suggests that they would have fewer unmet health and dental needs and that they would be more likely to receive well-child care and to have a usual source of care. Indeed, analyses of children enrolling in L.A.'s new Healthy Kids program suggest that children ages 1 to 6 years who were enrolled in Healthy Kids for one year were 17 percent more likely to have a usual source of medical care, 31 percent more likely to have a usual source of dental care, and 7 percent more likely to have had a physician or other health professional visit in the past six months than new enrollees prior to entering the program (Dubay and Howell 2006). While further analysis is needed to document the full impacts of the Healthy Kids program and the broader outreach efforts aimed at increasing participation in Medi-Cal and Healthy Families, this baseline analysis suggest that public coverage can reduce access problems for low-income children in L.A. County.

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Appendix: Data and Methods

The data source for this analysis is the 2002/2003 Los Angeles County Health Survey (LACHS). The LACHS is a random digit-dial survey of Los Angeles County, California. The survey has two components. One component is the Adult Survey where one randomly selected adult from a household is interviewed for the survey via telephone using an unrestricted random digit dialing methodology. The 2002/2003 Adult Survey had a total sample of 8,167 respondents. The response rate was 31.1 percent and the cooperation rate was 56.7 percent.

The second component is the Child Survey where a random telephone sample of parents of children under 18 was interviewed about their children. The survey was administered only to the mother of a selected child unless the child's mother did not reside in the household. If the mother did not reside in the household, then the father or other primary caregiver for the child was interviewed. There were two phases to the survey. The first phase involved interviewing 2,460 mothers or primary caregivers who had previously been interviewed for the Adult Survey and were identified as having at least one child under age 18 in their household. The second phase involved interviewing an additional sample of 3,535 mothers or primary caregivers from households with a child under age 18. In total, there were 5,995 respondents to the survey, a response rate of 33.9 percent, and a cooperation rate of 77.5 percent. For the Child Survey, the parent provided answers to the survey for only one randomly selected child even if the household contains more than one child.

The LACHS was designed to addresses potential biases caused by language barriers and by the exclusion of non-telephone households. To improve coverage of households where languages other than English and Spanish are spoken, the LACHS was conducted in other languages including Cantonese, Mandarin, Korean, and Vietnamese. Thus, this should reduce the bias associated with language barriers since U.S. Census data show that 98 percent of adults in Los Angeles County speak one of the six languages used by the survey (Field Research 2003). The LACHS excludes households who lack telephone landlines. However, the weights developed by the survey attempt to address this issue by collecting information on interruptions in telephone service. Data provided by respondents with intermittent telephone service are given more weight to compensate for households without telephones.

This brief focuses on comparing 1) access to health services, 2) the level of unmet health needs, 3) access to a usual source of care, and 4) receiving a medical checkup between low-income uninsured children and low-income, publicly insured children in Los Angeles County. The survey asks about the health insurance coverage status of a child at the time of the survey. There are three main categories of insurance coverage used in our analysis.[2] The categories are: 1) public coverage — a child is covered by Healthy Families (SCHIP) and Medi-Cal (Medicaid); 2) private insurance — a child is covered under an insurance plan, such as those provided by an employer, that is not publicly sponsored;[3] and 3) no insurance — a child does not have health insurance Parents were asked if

their child had health insurance coverage at the time of the survey. If the parents said their child had current health insurance, the parents were asked about different types of health insurance policies to determine their child's type of insurance coverage. If the parents said their child did not have health insurance, the parents were then asked about different types of health insurance policies to determine if their child may be covered by an insurance policy that the parents had not previously considered to be health insurance.[4] A child was determined to be uninsured if the parents initially said their child did not have insurance coverage or did not know if the child was insured, and did not indicate in subsequent questioning that the child had insurance coverage.

The child health insurance coverage variable was created based on the responses from the survey and a selection method to deal with parents who indicated that their children had more than one type of health insurance coverage.[5] The selection method used by the LACHS takes into account the types of insurance coverage mentioned by the parent, family income and the age of the children being studied to determine the appropriate coverage category. When parents indicated that their child had private coverage and either Healthy Families or Medi-Cal, and that the age and family income of the child show the child is eligible for public insurance, the child was assigned to either Healthy Families or Medi-Cal. Otherwise, the children who were reported to have both public and private coverage were assigned to private coverage.[6]

The survey also obtains information on family income. If a child's family income is below 200 percent of the federal poverty level (FPL), the child is considered to be low-income. Parents were asked about their annual pretax income. The survey then used income thresholds based on the household size of the family to determine if a family's income was 1) 0 to 99 percent of the FPL, 2) 100 to 199 percent of the FPL, 3) 200 to 299 percent of the FPL, or 4) 300 percent or more of the FPL.For this analysis, parents were asked a series of questions about their child's use of health care. Parents were asked if they had difficulty getting medical care for their child. Parents were also asked that if in the past year their child had unmet health needs because the family could not afford to pay for some health care services including: 1) medical exams when their child was sick or had a health problem; 2) prescription medicines; 3) dental care including dental check-ups; and 4) mental health care. The survey asked parents if they had one health care provider or a preferred health care provider to obtain care for the child, as a usual source of care. If parents indicated that their child had a usual source of care, they were asked about their satisfaction with several aspects of the provider including: 1) the overall quality of care received; 2) the quality of guidance given on how to care for their child; 3) the quality of assistance on understanding their child's growth and developmental needs; 4) the accessibility of the provider by telephone; 5) the provider's responsiveness to parents' questions and concerns; and 6) the availability of appointments when their child is sick or injured. Last, the parents indicated how recently their child had a medical checkup. There were different time options for children ages 0 to 5 (within last six months,

six to 12 months ago, one to two years ago, more than two years ago, never) than for children ages six to 17 (within the last two years, two or more years, never).

We examine how access to health care services, the level of unmet health needs, access to a usual source of care and frequency of a medical checkup were different between low-income, uninsured children and low-income, publicly insured children for a number of characteristics of the children and their family. Family characteristics included the responding parent's gender, martial status (married or not married); educational attainment (defined as: less than high school; high school; some college or trade school; college or postgraduate degree); employment status (working/non-working; part-time versus full-time) citizenship status (citizen versus noncitizen) and birthplace (United States or other country); the language in which the interview was conducted (English versus non-English); number of children in the household (two or less or three or more) and geographic location (defined according to the Service Planning Area (SPA) in which the child lived — Antelope Valley, San Fernando, San Gabriel, Metro, West, South, East, and South Bay). We also examined the mental health status of the parent (the parent is considered to be depressed if the parent said they often felt down, depressed, or hopeless or had little interest or pleasure in doing things), but this analysis is considered exploratory because the parent mental health questions for the 2002/2003 survey have not been validated. Child characteristics included: age (0 to 5; 6 to 11, 12 to 17), gender, race/ethnicity (Latino, White, African-American, Asian-Pacific Islander, Other), citizenship status (citizen versus noncitizen), health status (categories are excellent; very good; good; fair; poor), and the presence of a functional limitation or other special health need (defined as: having a chronic medical, health or behavioral condition requiring prescription medication; a chronic medical, health or behavioral condition requiring either a high level of care or specialized therapy for treatment; or an emotional, developmental or behavioral problem for which the child receives counseling).

In all analyses, we used survey weights in an attempt to make the survey data representative of all of Los Angeles County. We calculated standard errors that took into account the complex nature of the survey design related to the unequal probabilities of selection and other factors used in the creation of survey weights. We present bivariate and multivariate estimates of the access to health services, the level of unmet health needs, access to a usual source of care, and frequency of a medical checkup for low-income, uninsured children and low-income publicly insured children according the family and child-specific characteristics described above. We then compare results to determine the differences between the two groups of children coverage.

Study Limitations

All of the data are self-reported, and it is possible that some survey respondents may not have understood that they or their children have valid health insurance coverage, or may believe they or their children have valid health insurance coverage when they do not. For access to health care services, unmet health needs and having a usual source of care it is possible that parents under-reported the problems they have with obtaining health care for their children to not appear negligent. Likewise, parents may have claimed that their children received more frequent medical check-ups than the children actually received to avoid appearing negligent.

In addition, the reliance on a single question to define household income likely introduces downward bias into our estimates of income. Indeed the share of children under 200 percent FPL in the LACHS is higher than the U.S. Census and the California Health Interview Survey. Another limitation is that we do not have information that allows us to identify which children in the sample are undocumented. Our analysis therefore focuses on noncitizen children, which include both documented and undocumented children. There is a concern that the access and use differences found across publicly insured and uninsured children were due to unobserved differences in the children in the publicly insured and uninsured coverage categories that are not accounted for by the control variables included in the regression analyses. Finally, the low survey response rates could lead to inaccurate estimates of difficulty with accessing health services, unmet health care needs, having a usual source of care, and the frequency of having a medical checkup. It is possible that the portion of the sample that did not respond may be different from those who did respond in ways that are not accounted for by the weights.

Notes

1 Refer to the appendix for information on the 2002/2003 L.A. County Health Survey, including information on the access to care measures, health insurance measures, and characteristics of the child and their family included in this study. Results from multivariate regressions are available upon request from the authors.

2 There also are options if parents did not know if their children had health insurance or if parents refused to provide information.

3 Valid coverage for this category includes employer-sponsored insurance or union or trade association policies, military insurance programs, California Kaiser Kids or similar programs, or any non-group insurance policy.

4 The types of insurance policies mentioned included employer-sponsored insurance and other related insurance provided through a union or trade association, Medi-Cal and Healthy Families which are public insurance programs, military insurance, and California Kaiser Kids and other similar programs. If the parents did not indicate coverage for their children under any of these types of policies, they were asked if the children were covered under a non-group insurance policy.

5 Survey data indicated that 5 percent of children surveyed had more than one type of health insurance.

6 An exception is made if the children have military coverage or coverage through California Kaiser Kids or similar programs. Then the children are assigned to private insurance without regard to their age or family income.

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