

**Children Served
by MaineCare, 2006**

Survey Findings

March 2007



UNIVERSITY OF
SOUTHERN MAINE

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Nathaniel Anderson
Deborah Thayer
Catherine Ormond

University of Southern Maine
Muskie School of Public Service
Institute for Health Policy

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Additional copies of this report are available from
Nathaniel Anderson
(207) 228-8187
nanderso@usm.maine.edu
Muskie School of Public Service
University of Southern Maine
P.O. Box 9300
Portland, ME 04104-9300

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Executive Summary

This report presents findings from a random telephone survey of children currently enrolled in or recently disenrolled from MaineCare, the State's Medicaid and State Children's Health Insurance Program (SCHIP). The sample was stratified to include children enrolled in MaineCare through the Medicaid eligibility category, and through two SCHIP eligibility categories, Medicaid Expansion and the Separate Child Health Program (CHP).¹ These three eligibility categories include children ages 18 or under living in households with income up to 200% of the Federal Poverty Level. Income eligibility limits are lowest for the Medicaid eligibility category, followed by the Medicaid Expansion and the Separate Child Health Program categories.² Between April and July 2006 telephone interviews were completed with 1,846 parents of enrolled children and parents of disenrolled children.

This annual survey was commissioned by Maine's Department of Health and Human Services. Findings from this report will be used to improve understanding of the needs of this population, to develop quality improvement initiatives to better serve these children, and to satisfy reporting requirements of the federal SCHIP program.

Study Findings and Implications

Parents of children enrolled in MaineCare through all three eligibility categories continue to be overwhelmingly satisfied with the MaineCare benefit, with their children's providers, and with the quality of care. Virtually all respondents said their child has a usual source of care. Only a small proportion of current and of new enrollees (5 and 7 percent, respectively) reported having had difficulty obtaining needed care in the past 6 months. And only 2 percent of respondents caring for a child with a limiting condition said their child *rarely or never* received the care and services they need. Given the challenges of providing health care services to a low-income population in a rural state, these findings reflect extremely well on the work of MaineCare administrators and providers.

Several findings, however, point to areas of concern and potential intervention. First, among the minority of respondents who did express dissatisfaction with MaineCare, the most common specific complaint was about dental services, both the lack of dental providers who accept MaineCare and the attitude of dental providers.

A second area of concern was the high prevalence of both asthma and mental health conditions that we found among children on MaineCare. Fifteen percent of all respondents reported that their child is affected by asthma. Environmental tobacco smoke (ETS) may be a contributing

¹ Both the Medicaid Expansion and the separate child health program categories are funded by the federal SCHIP program (Title XXI).

² Income eligibility limits for the Medicaid and Medicaid Expansion categories vary according to the age of the child. For children younger than 6, the Medicaid category includes children with family income up to 133% FPL, and Medicaid Expansion is 134% through 150% FPL. For children ages 6 through 18, the Medicaid category includes children with family income up to 125% FPL, and Medicaid Expansion is 126% through 150% FPL. For both age groups, the Separate Child Health Program category includes children in households with income between 151% and 200% FPL. See Appendix A for more details.

factor to the high rate of asthma, in that 43% of children with asthma live in households with one or more adult smokers. MaineCare could help reduce the burden of asthma through ongoing provider education efforts; most parents reported that their child's primary care provider (PCP) speaks to them regularly about the risks of second hand smoke, but 30 percent with children under age 5 said their PCP *rarely or never* talks to them about the topic. Mental health issues also disproportionately affect children on MaineCare. Twenty percent of respondents told us that their child has depression or anxiety problems. This rate is substantially higher than the 13% of low-income children in Maine found to have depression or anxiety in the 2003 National Survey of Children's Health. Furthermore, among parents of children with a limiting condition (n=451), 24% said their child has a mental or behavioral disorder.

A third issue highlighted by the survey is the exorbitant rates of overweight among children of all ages on MaineCare. Fully one quarter of all children in the study are estimated to be overweight³ and nearly half (45 percent) are overweight or at risk of overweight. Teens (13 – 18 years old) have lower rates of overweight than younger children on MaineCare, but are still much more likely to be overweight than high-school students in the general population in Maine.

Survey findings also indicate that a substantial minority of parents do not accurately identify when their child is overweight, with 38 percent of respondents with an overweight child describing that child as being 'normal weight'. Parental education is therefore one potential avenue for intervention. Reports of diet and exercise all decline with the age of children on MaineCare. Infants and toddlers are reported to exercise and consume vegetables the most, and teens exercise and consume vegetables the least. The reverse is true for soda consumption. Coupled with the high rates of overweight and its associated health risks, these findings suggest that children on MaineCare would benefit from providers' advice on exercise and healthy eating habits.

Outreach through providers holds the most promise for reaching children on MaineCare with health and nutrition information. More than two-thirds of those interviewed told us they usually get information about health issues from a healthcare provider. However, our results also suggest that the internet may be an effective supplementary tool for this purpose. Almost one-third of respondents said they use the internet to get information about health issues. And more than two-thirds of all current and new enrollees reported using the internet at least once per week.

From parents of children who recently disenrolled from MaineCare (n=295), we learned that most left the program because of an increase in income which meant they were no longer eligible (45%) or because their child obtained other coverage and no longer needed MaineCare (29%). More than half (57%) of all disenrolled children were enrolled in employer-sponsored insurance at the time of the interview. But a discouraging finding is that one-third of disenrolled children (n=96) were uninsured at the time of the interview. Children of parents who said they disenrolled because they had not filled out a renewal application were more than twice as likely to be uninsured (72%). This finding points to an ongoing need for monitoring of the MaineCare reapplication process, to ensure that eligible children are not dropped from the program.

³ BMI in the 95th percentile or higher for their age/sex

Among new MaineCare enrollees (n=313), over two-thirds had some form of coverage in the year before the child enrolled in the program, and more than half (56%) had employer-sponsored insurance through a parent's employer. In addition, we found that seventeen percent of all new enrollees had access to employer-sponsored insurance at the time of the interview but were not enrolled – primarily because it is not affordable. Rates of declined coverage were highest among new CHP (28%) and Expansion (25%) enrollees.

The survey results show that some substitution of MaineCare coverage for employer-sponsored coverage is occurring, but do not reveal how much of this substitution is caused by the existence of MaineCare—commonly referred to as “crowd out”. External factors such as manufacturing job losses and continued double-digit annual increases in employer-sponsored insurance (ESI) premiums over the past several years have led to loss of ESI, and to unaffordable premiums for many low-income families who have access to ESI.⁴ For most low-income families, MaineCare serves as a safety net to protect children from spells of uninsurance and associated reduction in access to medical and dental care.⁵ Further, the availability of MaineCare has kept the uninsurance rate among children in Maine (7%) among the lowest of any state in the nation.⁶

⁴ O'Hara, F. and Pohlmann, L. (2005). *Maine Small Business Insurance: A 2004 Survey*. Augusta, ME: Maine Center for Economic Policy. ; Medical Expenditure Panel Survey, 2000 – 2004 Insurance Component Results for Maine. Available at: http://www.meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp. Accessed March 20, 2007.

⁵ Institute of Medicine. (2002). *Health Insurance is a Family Matter*. Washington, DC: National Academies Press.

⁶ Kaiser State Health Facts Online. <http://www.statehealthfacts.org>. Accessed March 20, 2007.

Purpose

The purpose of this study is to examine the experiences of parents of children enrolled in MaineCare, the State's Medicaid and SCHIP program. From this review we hope to understand the unmet needs, satisfaction levels, health behaviors of this population, and access to employer-sponsored insurance. Though all children enrolled in MaineCare receive the same benefits, children are enrolled through different eligibility categories, depending upon their age and household income. We included children in three eligibility categories for this survey to understand any differences that may occur among them. The three categories are:

1. **Medicaid**, which covers children under age 6 with household income up to 133% of the Federal Poverty Level (FPL), and children ages 6 through 18 up to 125% of the FPL;
2. **Medicaid Expansion**, which covers children under 6 years of age with household income between 134% and 150% of the FPL, and children ages 6 through 18 with income between 126% and 150% of the FPL; and
3. **Separate Child Health Program (CHP)**, which covers children up to 18 years of age who live in households with income from 151% to 200% of the FPL.

Note that both the Separate Child Health Program and Medicaid Expansion eligibility categories are part of the federal SCHIP program. A key distinction between these two categories is that parents of CHP enrollees pay monthly premiums of \$8 to \$64, depending on their family income, whereas there are no premiums charged for Medicaid Expansion enrollees. Appendix A summarizes the income eligibility guidelines, premium payments, and funding source for all three eligibility categories included in this report.

Data on service use, expenditures, and service providers are available from MaineCare claims data for this population; however, staff at the Department of Health and Human Services (DHHS) requested this survey to understand this information within the context of the experience, concerns, and satisfaction from the family's point of view. Survey respondents were also selected to include recently enrolled and recently disenrolled children. The survey includes questions on satisfaction with MaineCare and with providers, parental employment status, health status, healthy behaviors, and access to health services.

The goals of the study are to:

- Learn about concerns specific to parents of new MaineCare enrollees
- Clarify any differences in satisfaction or unmet needs among the three benefit categories
- Learn about health behaviors of this population
- Examine access to employer-sponsored insurance and substitution of public for private coverage
- Understand reasons parents disenrolled their children from MaineCare

Methodology

Target Population and Respondent Characteristics

Children who were enrolled at least nine months in any of the three MaineCare eligibility categories (Medicaid, Medicaid Expansion and CHP) were selected for the ‘*current enrollee*’ group so that the survey would reflect the perspective of families with substantial experience under a particular category. In addition, children who were enrolled within the past three to five months of survey administration were selected for the ‘*new enrollee*’ group. Children who had disenrolled from any eligibility category within the past five months were selected and reported as the ‘*disenrollee*’ group. One child per household was randomly selected so that no family would be interviewed about the experience of more than one child. Only children living in households with a parent (birth, foster or adoptive) or guardian were included. A screening question confirmed the status and eligibility category of the identified child. We over-sampled children receiving benefits through the CHP category to ensure a large enough sample size for this group of MaineCare enrollees.

Overall, a total of 1,846 responses were collected. This number includes 1,238 interviews with parents of children currently enrolled in MaineCare, 313 interviews of new enrollees and 295 parents of children who were recently disenrolled.⁷ Table 1 displays a summary of the numbers of completed interviews by age, gender, and eligibility category.

Table 1: Characteristics of Survey Respondents

Characteristic	Number and Percent of Respondents		New Enrollee	Current Enrollee	Disenrollee
Total	1846		313	1238	295
Age of Children					
0-5	473	25.6%	100	315	58
6-12	686	37.1%	123	468	95
13-18	687	37.2%	90	455	142
Gender					
Female	900	48.8%	153	598	149
Male	946	51.2%	160	640	146
MaineCare Eligibility					
Medicaid	866	46.9%	152	602	112
Expansion	494	26.8%	75	336	83
CHP	486	26.3%	86	300	100

⁷ Note: An additional 132 individuals were interviewed whose child/dependent was identified as having been enrolled in the MaineCare eligibility file, but when contacted said their child was never enrolled. These interviews were discontinued and the cases dropped from the analysis.

The regional distribution of the completed interviews is as follows:

23.5 %	Region I: York and Cumberland counties,
45.4%	Region II: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo counties
31.0%	Region III: Aroostook, Hancock, Penobscot, Piscataquis, and Washington counties.

Survey Instrument and Administration

The telephone survey instrument and administration methods were adapted from three separate surveys that had been conducted for this population in 2002 through 2004. In consultation with DHHS staff, the instrument was revised in 2005 to add questions regarding health behaviors such as tobacco use and exercise and experiences with providers pertaining to those behaviors.⁸ The current (2006) survey is essentially unchanged from the 2005 version; the only exceptions are a small change in the sampling design⁹ and the addition of questions about where respondents get health information and whether they have internet access. The complete 2006 questionnaire is included below as Appendix B.

The instrument was designed to be administered to all respondents. The complete instrument was administered to current and newly enrolled respondents; however, skip patterns were used to ask disenrollees only questions pertaining to employment and insurance status and reasons for disenrolling. The instrument, protocols, and confidentiality procedures were reviewed by the University of Southern Maine's Institutional Review Board (IRB) for human subject research. Professional interviewers at the Survey Research Center at the Muskie School of Public Service in Portland, Maine administered the survey. All project staff are trained in HIPAA compliance and confidentiality protocols.

Survey Research Center interviewers were thoroughly trained prior to call administration. In addition to 15 hours of general interviewing techniques training, all staff also completed four hours of training for this survey instrument. Survey training included an explanation of the intent and objectives of all questions, practice interviewing with the instrument, and a final review of all survey questions on this instrument.

The survey was administered using a computer-assisted telephone interviewing instrument (CATI) developed by Muskie School staff to collect and enter data directly from respondents. Upon reaching one of the randomly selected households, the interviewers explained the purpose of the survey and offered to give the respondents the name and telephone number of a

⁸ For more information about the development of the 2005 survey instrument and changes from prior years see: Ormond, C. and Thayer, D..(2006). *Children Served by MaineCare 2005.: Survey Findings*. Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.

⁹ In 2005, respondents identified as disenrollees in the MaineCare eligibility data who self-reported that they had re-enrolled were routed through the survey and asked questions targeted to current and new enrollees. In 2006, disenrollees who reported they had re-enrolled were discontinued from the survey because they were ineligible.

Department of Health and Human Services contact to verify the validity of the survey. The interviewer then asked to speak to the parent most knowledgeable about the child's needs and explained that they could skip any question they did not want to answer.

Contact with 2,522 households yielded 1,978 respondents who agreed to participate in the interview. Interviewers confirmed eligibility by asking a screening question explaining that the survey was about children recently disenrolled from or currently enrolled in MaineCare. 132 respondents were found to be not eligible because when contacted, they said their child/dependent had never enrolled in MaineCare, yielding a final sample of 1,846 respondents. The child's parent was the respondent in 96% of the cases, and in remaining cases the respondent was a grandparent (2%), foster parent (1%) or other relative. (Because the vast majority of respondents were the child's parent, throughout the report we often refer to respondents as "parents".) The interview took an average of 20 minutes; it was in the field from April through July 2006. Overall, the effective response rate¹⁰ for the survey was 78% for new enrollees, 79% for current enrollees, and 78% for disenrollees.

File Construction and Data Analysis

Staff at the Muskie School reviewed the survey for response validity, coded open-ended questions, and imported the data into SAS for analysis. This report presents primarily descriptive data, although some questions have been analyzed for differences based on the characteristics or eligibility category of the respondents. For the most part, subgroup comparisons are presented only when there was a statistically significant difference ($p < .05$) between the groups.

Study Limitations

Because the percentages and counts contained in this report are based on samples of the population, rather than direct responses from every parent of every child enrolled in MaineCare, they are estimates only. It should also be noted that the survey was administered to the adult in the household who reported on the health care use, needs, and services of the child. Therefore, the reliability of the responses is dependent upon the parents', guardians', or other family members' familiarity with all the child's behaviors, needs, and health care use.

For example, parents' reports of whether children use tobacco may be suspect; parents may not know if their children have begun to use tobacco or they may be reluctant to confirm it. Reports of smoking in the home may be underreported as a result of social bias. Reports of parents' perception of the frequency of providers' advice on topics such as weight, nutrition, or emotional development are limited by the length of the recall period. Parents were asked to report on their children's last check up; the recall period was, therefore, different for each respondent.

¹⁰ Effective Response Rate = Total Completed Interviews / Total Possible Contacts. Note that total possible contacts excludes sampled households that could not be contacted because the phone number was not in service, there was a wrong number, or no number listed.

Analysis and Presentation

We analyzed survey results by age groupings, enrollment status (newly enrolled or current), and by MaineCare eligibility category (Medicaid, Medicaid Expansion, or CHP). We included in the report the analysis of the measure that offers the most variation. Most frequently this was the eligibility category distribution. In addition, when there were identical questions included in the 2005 survey¹¹, we compared the results with those from 2006 and note where we found substantive changes in survey responses between 2005 and 2006.

Often, there was little variation between the current enrollees (enrolled for nine months or more) and the newly enrolled (enrolled within the past three to five months). We combined these groups for analysis unless there was sufficient variation between the two groups. Reports of disenrollees are limited to reasons for disenrolling, current insurance, and employment status.

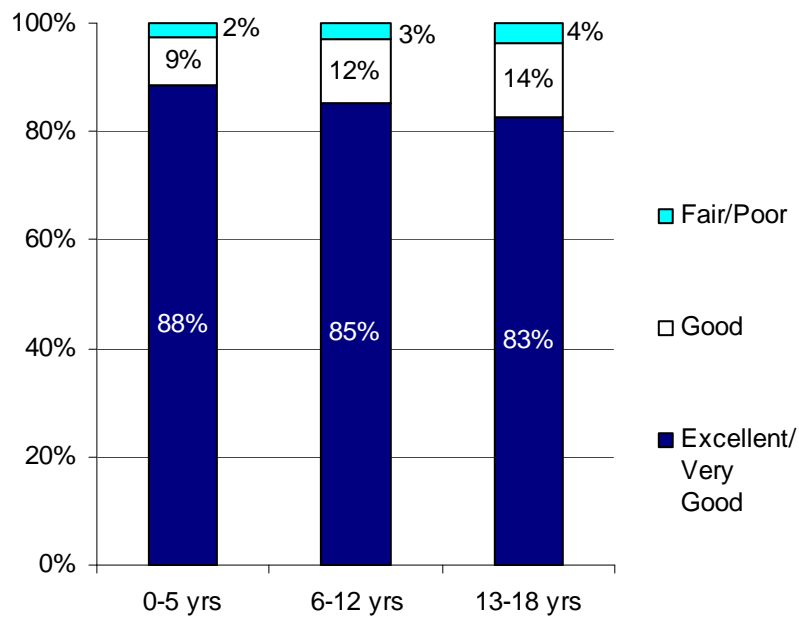
¹¹ Ormond, C. and Thayer, D..(2006). *Children Served by MaineCare 2005: Survey Finding*. Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.

Children's Health and Services

Children's Health Status

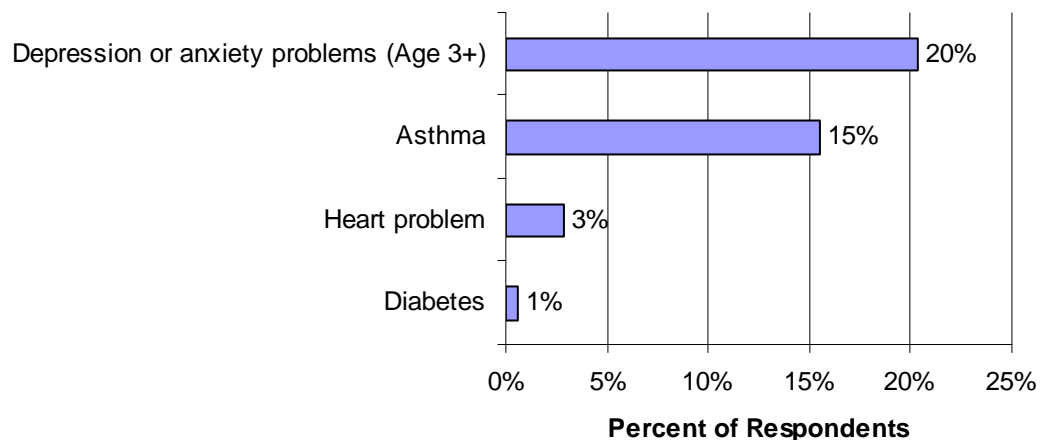
We asked each parent to describe their child's health status. Parents of younger children were more likely to report that their children's health was excellent or very good (88%), compared to parents of older children (83%). There was no significant variation in reports of health status by eligibility category (not shown).

**Figure 1. Health Status of Children Enrolled in MaineCare
N=1,550**



We also asked parents if their child had one or more of the following specific health conditions: depression or anxiety problems, asthma, a heart problem, or diabetes. More than twenty percent told us that their child has depression or anxiety problems¹², and 15 percent said their child has asthma. Heart problems and diabetes were less prevalent, at 3 percent and 1 percent respectively. Also notable is the fact that reports of depression or anxiety problems are more prevalent among children in the Medicaid eligibility category (24%), versus Medicaid Expansion (19%) or CHP (16%).

Figure 2. Prevalence of Specific Health Conditions
(Does your child have...)
N=1,549



How does the health of children in the MaineCare program compare with other children in Maine? To answer this question, we compared selected measures of health from this survey against results from two sub-samples of children living in Maine drawn from the 2003 National Survey of Children’s Health, conducted by the Centers for Disease Control and Prevention (CDC).¹³ A low-income comparison group, drawn from families with income below 200% of the Federal Poverty Level, approximates the general population of children in Maine who are eligible for MaineCare. We also include a higher-income comparison group (200% FPL and above) as a benchmark to highlight the relationship between family income and children’s health outcomes in Maine.

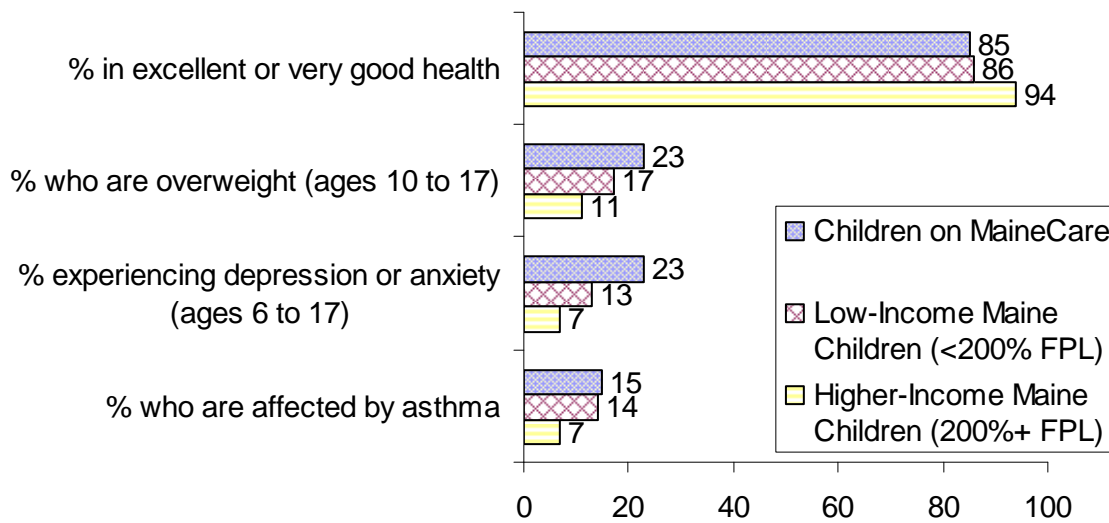
We found that, across all measures of health, children living in higher income families are healthier than both their low-income counterparts and children on MaineCare (Figure 3). 94 percent of higher-income children are in excellent or very good health, and they have the lowest rates of overweight (11%), depression or anxiety (7%), and asthma (7%). Low-income children

¹² This question was asked only if the child was age 3 or older.

¹³ The National Survey of Children’s Health (NSCH), funded by the Maternal and Child Health Bureau, includes information on over 102,000 children under age 18, with roughly 2000 children per state. Households were selected through a random-digit-dial sample, and one child was randomly selected in each household. All measures are based on responses of the parent or guardian in the household who was most knowledgeable about the sampled child’s health. Information was collected via a computer-assisted telephone interview. For more information on the NSCH, see <http://www.cdc.gov/nchs/about/major/slits/nsch.htm>.

in Maine and children on MaineCare are very similar in both reports of excellent/very good health (about 85 %) and asthma (15%). However, children on MaineCare appear to be faring particularly poorly on measures of overweight and depression, even relative to other economically disadvantaged children in Maine. An estimated 23 percent of children on MaineCare are overweight¹⁴, more than one-third higher than other low-income children in Maine (17%) and more than double the rate of higher-income children (11%). And reports of depression or anxiety among children on MaineCare (23%) are nearly double those of other low-income children (13%) and more than three times those of higher-income children (only 7%).¹⁵

Figure 3. Comparison of Children on MaineCare with Low-Income and Higher-Income Children in Maine



Note: Comparison group data are from Child Trends analysis of the 2003 National Survey of Children’s Health (<http://www.kidscount.org>)

¹⁴ A BMI classification of “overweight” indicates that the child’s BMI is equal or greater to the 95th percentile among children of the same sex and age, based on CDC BMI-for-age growth charts (for either girls or boys). For more information, see http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm.

¹⁵ Note that the depression and asthma measures in the NCSH are not strictly comparable to our survey because of a slight difference in the question wording. In the MaineCare Child Health survey, respondents are asked, “To the best of your knowledge, does [your child] currently have... [list of conditions] ?” (See questions 64 to 68 in Appendix B). In the NCSH, respondents are asked: “Has a doctor or health professional ever told you that [your child] has any of the following conditions?...[list of conditions]”

Usual Source of Care

Ninety-nine percent of parents of current and new enrollee (n=1,533) reported that their child has a regular source of health care. The fifteen remaining respondents without a regular source of health care mentioned a variety of different reasons why they did not have a usual source of care, including difficulty finding a provider who would accept MaineCare (n=2), that they don't go to a healthcare provider unless they are sick or have an accident (n=3), or that they recently moved and were looking for a new PCP (n=2).

Type of Provider

Eighty-nine percent (n=1,371) of current and new enrollees see a primary care physician for well-child visit or annual exams. Nine percent obtain these services from a nurse practitioner or physician assistant, and the remaining 4% go to specialists for their primary care.

Unmet needs

Interviewers asked respondents if they had difficulty obtaining care within the past six months. Five percent (n=61) of current enrollees and 7% of new enrollees (n=22) stated that they had difficulty finding a health care service. The most common unmet need was for dental care (n=25). The remainder reported a number of specialty services including mental health services; 19 respondents stated they had difficulty receiving routine primary care (n=4) or urgent care (n=15) when needed.

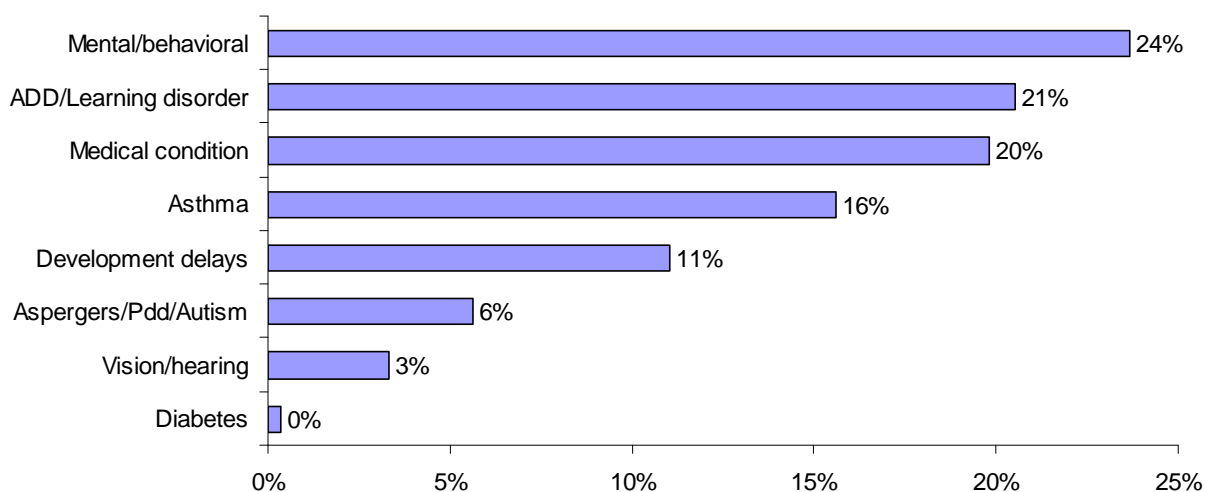
Limiting Conditions

In 2003 and 2004 when similar surveys were administered to current enrollees, 20% of those respondents stated that their children had a limiting condition.¹⁶ In 2005 and 2006, interviewers asked respondents whether or not the child in their care had 'an emotional, developmental, physical or behavioral condition that limits his or her ability to do what other children his/her age can do'. In 2006, 26% of new enrollees and 30% of current enrollees were reported to have a limiting condition. Reports of limiting conditions are higher than in 2005, when only 19% of new enrollees and 26% of current enrollees had a limiting condition.

The vast majority (92%) of parents of children with a limiting condition reported that they *always* or *usually* received the care and services needed to treat the condition. Five percent reported that they *sometimes* receive all the care and services for the condition and only 2% (n=11) reported that they *rarely* or *never* received services. The graph below shows the types of conditions that both new and current enrollees are reported to have. Mental or behavioral conditions are the most prevalent, followed by ADD/Learning disorders and medical conditions.

¹⁶ Ziller, E. C., & Loux, S. L. (2003, May). *Satisfaction with children's health care: Families' evaluation of Medicaid and the State Children's Health Insurance Program (SCHIP), FY 2003*. Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy..

Figure 4. Distribution of Limiting Conditions for Children Reported to Have a Limiting Condition (N=451)



Reports of ‘medical condition’ include heart, blood, pulmonary, and kidney diseases, among others. Over 21% reported having more than one condition that limited the child’s activities. The age distribution of children with limiting conditions is as follows: 18% of children age five or younger, 33% of children aged six through twelve, and 34% of children 13 or older.

Respondents also reported ‘overweight’ and obesity as limiting (medical) conditions. Six of the nine children reported to have diabetes have Type I and three have Type II¹⁷, the type of diabetes often associated with obesity.

Weight

To determine the weight status of this population, we asked respondents to report the height and weight of their children; we then used CDC guidelines to calculate their body mass index (BMI) and their BMI-for-age percentile ranking based on growth charts for both boys and girls.¹⁸

The CDC classifies weight status according to the following table:

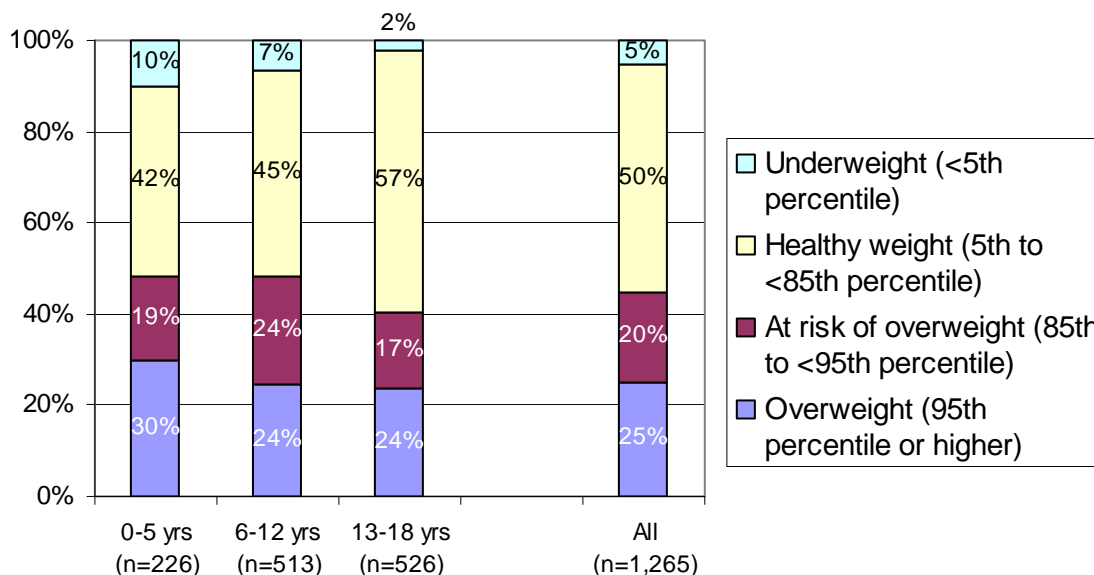
Weight status category	BMI age and sex-specific percentile range
Underweight	Less than the 5 th percentile
Healthy weight	5 th percentile to less than the 85 th percentile
At risk of overweight	85 th to less than the 95 th percentile
Overweight	Equal to or greater than the 95 th percentile

¹⁷ The presence of Type II diabetes was identified using the question: “Does he/she use insulin?”

¹⁸ Centers for Disease Control and Prevention. (2006). *About Body Mass Index for Children and Teens*. http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm#My%20two%20children. Accessed November 17, 2006.

Figure 5 shows the weight status, by age, of current and new enrollees in our MaineCare sample. Overall, one fourth of children on MaineCare are calculated to be overweight, and 45 percent are overweight or at risk of overweight. Rates of overweight are highest among the youngest children; nearly one-third of 0 to five year olds are overweight, and fully one half these children are overweight or at risk of overweight. Also notable is the fact that rates of underweight decline with age. Ten percent of 0 to 5 year olds are underweight, falling to 7 percent of elementary and middle-school children, and only 2 percent of teens.

Figure 5. Weight Variation of New and Current Enrollees
N= 1,276



While teens on MaineCare are less likely to be overweight than the younger MaineCare cohorts, they are much more likely to be overweight than the general population of teenagers in Maine. Twenty four percent of teens in the survey are estimated to be overweight and 16% are estimated to be at risk of overweight. The combined total, 40%, is considerably higher than estimates from the most recent (2005) Centers for Disease Control (CDC) report for Maine that indicates 25% of high school students in the state are overweight or at risk for being overweight.¹⁹

¹⁹ Centers for Disease Control and Prevention. (2006, June 9). *Youth Risk Behavior Surveillance – United States 2005*. (MMWR Surveillance Summaries 55, No. SS-5). <http://www.cdc.gov/mmwr/PDF/ss/ss5505.pdf>

Parents' Perception of Children's Weight

We also asked parents to describe their children's weight in order to understand the parents' perception of their children's weight status. Interviewers asked parents to describe their children's weight using the following descriptors: *underweight*, *slightly underweight*, *about right*, *slightly overweight* or *overweight*.

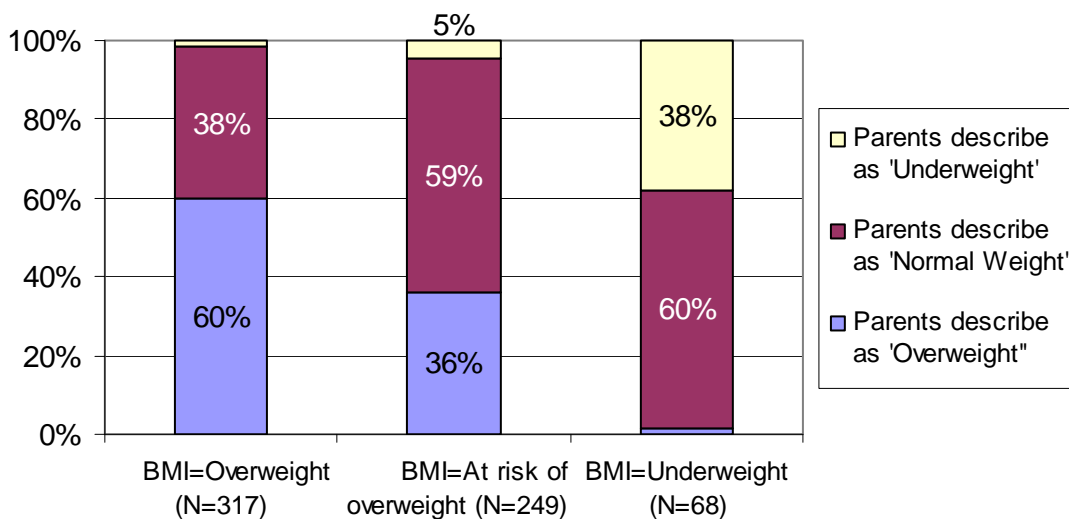
Of the 317 children whose reported height and weight were used to calculate their body mass index (BMI) and were determined to be overweight, 60% of their parents indicated that they believed their child was *overweight*. However, 38% of parents of overweight children described their child's weight as *normal*.

Similarly, 36% of parents of children whose height and weight were calculated to be at risk of overweight, described their children as *overweight or slightly overweight* and 59% described them as *normal weight*.

These results indicate a need for greater education directed toward both children and parents, particularly in light of increasing risk for Type II diabetes, sleep apnea and poor self-esteem among overweight children.²⁰

At the other end of the weight spectrum, parents of children on MaineCare also seem to have difficulty accurately identifying when their child is underweight. Among children calculated to be underweight, more than half of parents described them as being *normal weight*.

Figure 6. Parents' Perception of Children's Weight Status



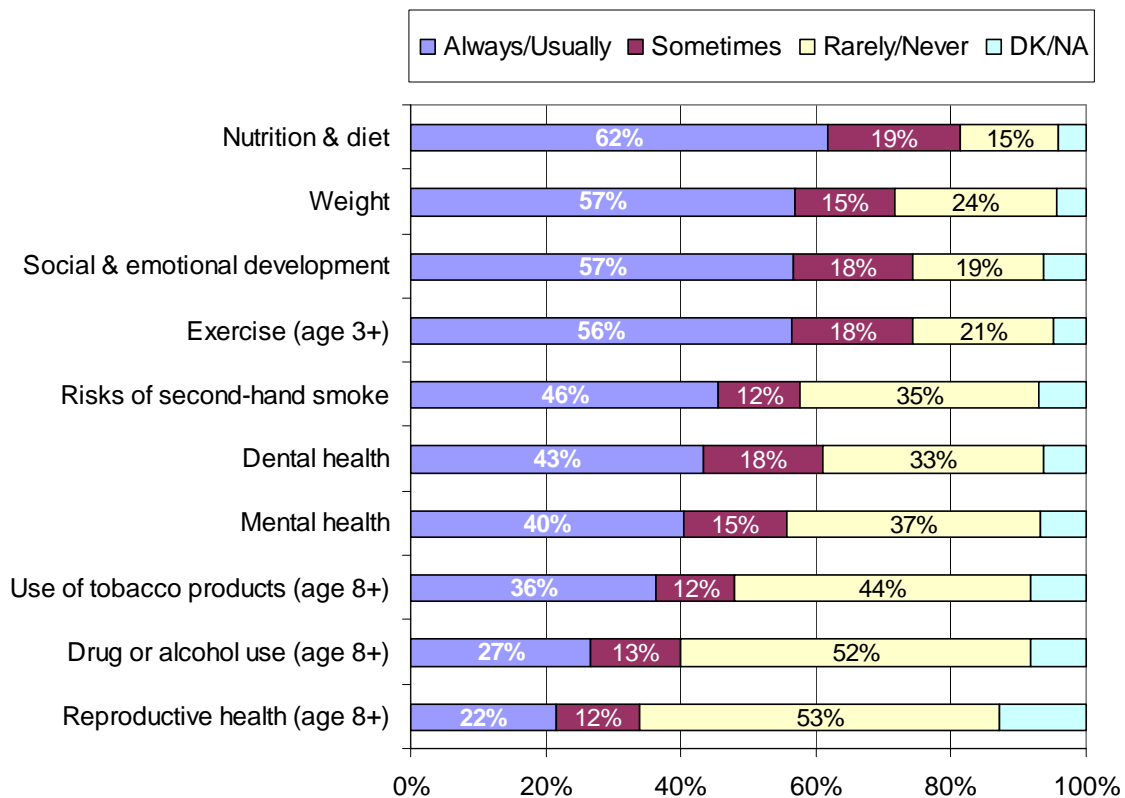
²⁰ Must, A and Anderson, SE. (2003). Effects of obesity on morbidity in children and adolescents. *Nutrition in Clinical Care* 6(1):4-12.

Well-child Visit Topics

We asked parents the frequency with which their children’s primary care provider (PCP) talks with them or their child about selected health care issues during the annual well-child visit. We also asked if they needed more information on these topics. Due to little variation in responses, we combined reports from members enrolled within the past three to five months with responses from members enrolled for nine months or more. Parents of newly enrolled children may have recently had a well-child visit and may be reporting on that visit; whereas parents of longer term enrollees may be recalling multiple, past well child visits. Interviewers also reported that some respondents, particularly parents of teenagers, did not always know what the provider discussed with the child because they were not present during the exam. The following results regarding provider discussions with patients may therefore underreport some topics, especially among older children.

Overall, respondents reported that their child’s PCP talks about nutrition and diet, weight, social and emotional development, and exercise most often (Figure 7). More than half of parents said the PCP *always* or *usually* discusses each of these four topics. Drug or alcohol use and reproductive health were least likely to be mentioned by respondents. For the latter two topics, more than half of respondents said their child’s PCP *rarely* or *never* talks to them or their child about each topic.

Figure 7. How often does the PCP talk to you or your child about...



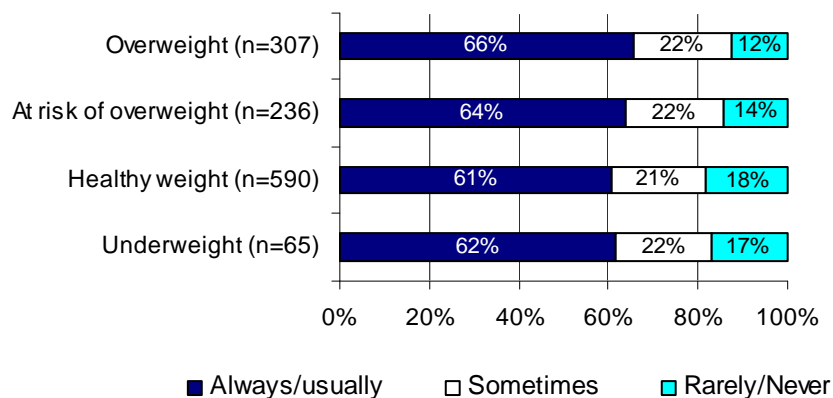
Risks of Second Hand Smoke

A new survey item was added in 2006 where the interviewers asked respondents how often their child's PCP discussed the risks of second hand smoke. Overall, 46% of all parents said that PCPs *always or usually* talk to them about second hand smoke. 62 percent of parents of infants and toddlers (age 5 or under) reported having a discussion *always or usually* about second hand smoke, higher than parents of older children. There was also a difference in reports of PCPs discussing second hand smoke according to whether or not there were any smokers living in the household. In households with an adult smoker present, 55% of respondents reported that their child's PCP *always or usually* speaks with them about the risks of second hand smoke, versus only 44% in households with no smokers.

Differences in Well-child Visit Topics by Weight Status

We also looked at the well-child visit discussions about nutrition & diet, exercise, and weight by the weight status of the child – expecting to find that the frequency with which providers speak about these topics is greater if the child is overweight or at risk of overweight. The results fit the expected pattern.

Figure 8. How often does the PCP talk to you or your child about Nutrition or Diet — by Weight Status



Among overweight children, 66 percent of parents reported that their PCP *always or usually* talks with them about nutrition and diet, versus only 61 percent among children of healthy weight and 62 percent among underweight children. About 13 percent of respondents whose children are overweight or at risk of overweight said their PCP *rarely or never* discussed nutrition or diet. Also notable is the fact that almost one in five respondents whose child is underweight said their provider *rarely or never* talks about nutrition or diet with them or their child.

Results are similar for the topics of exercise and weight (not shown). Among parents of children who are overweight or at risk of overweight, 65% reported that their PCP always or usually discusses exercise at well-child visits. Among parents of healthy weight children, this percentage

drops to 56%. But again, PCPs of a significant minority of overweight (18%) and at risk of overweight children (17%) in MaineCare *rarely or never* discuss exercise with the child or their parent.

In terms of the more general topic of the child’s weight, 65 percent of parents of overweight children report speaking about weight with PCPs always or usually, versus only 57 percent of children at risk of overweight and 53 percent of those who are healthy weight.

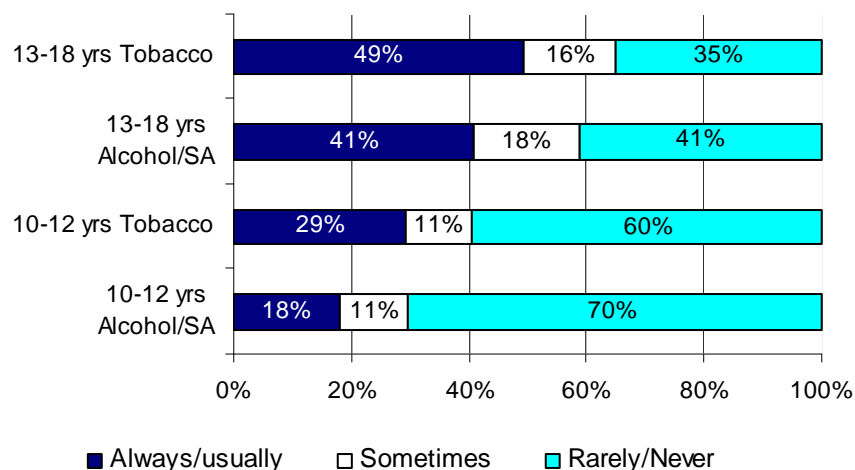
Differences in Well-child Visit Topics by Age

For most well-child visit topics, parents of younger children reported more frequent PCP discussions of the topic. For example, parents of infants and toddlers said that their PCP *always* or *usually* discusses social and emotional development at a rate of 71 percent. This percentage decreases with age, to 58% for 6-12 year olds, and 51% for teens. However, as noted above, it is not clear from our survey data whether this relationship is due to the fact that PCPs of older children are actually less likely to discuss the topic, or if it is an artifact of the data that arises because of underreporting among parents of older children (who are less likely to be present for well-child exams, or are less likely to hear about what the PCP discusses with their child).

But there were three topic areas that run counter to the general pattern: 1) tobacco use, 2) alcohol or drug use, and 3) reproductive health.

The percentage of PCP’s who are reported to discuss alcohol, drug, or tobacco use increases dramatically with age. Twenty-nine percent of parents of 10 to 12 year olds report that PCPs *always* or *usually* discuss tobacco use with their children at the annual exam; this percentage jumps to 49% among parents of teens. The percentage that is reported to *sometimes* discuss this topic increases slightly with age from 11% to 16% for teens.

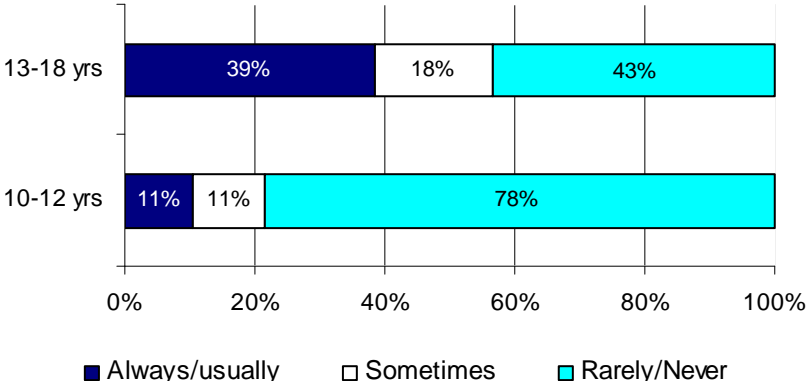
Figure 9. How often does the PCP talk to you or your child about Tobacco, Drug or Alcohol? N= 730



Discussions of alcohol and substance abuse (SA) also have a strong, positive relationship with age. According to respondents, 41% of PCPs *always or usually* talk about alcohol or substance abuse with their teens; this is more than double the rate of reporting among parents of pre-teens.

Reproductive health is another topic that PCPs appear to address much more often with older children; parents of teenagers were more than three times as likely to report that PCPs discussed reproductive health (39% *always or usually*) than pre-teens (11%).

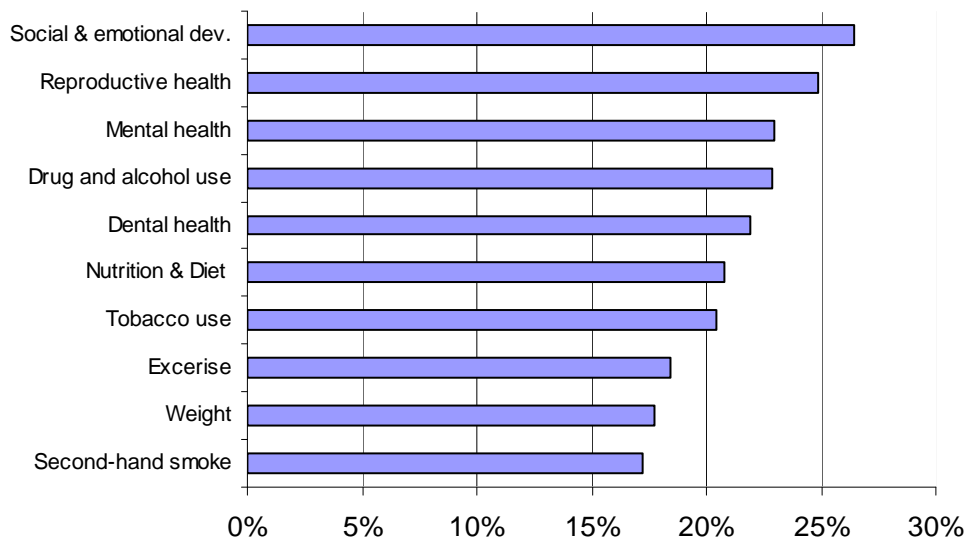
Figure 10. How often does the PCP talk to you or your child about Reproductive Health? N= 689



Information needed by Parents about their Children's Health

Interviewers asked respondents if it would be helpful if their child's provider gave them more information about each wellness topic. The most common topics mentioned were social & emotional development, at 26% of respondents, and reproductive health, at 25%. And more than one in five respondents said it would be helpful to receive information about mental health, drug and alcohol use, dental health, and nutrition.

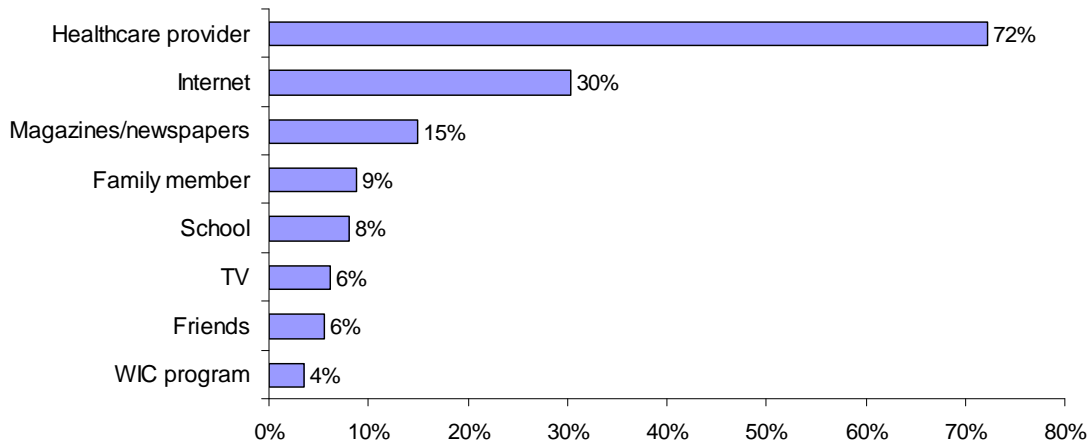
Figure 11. Would it be helpful if [your child's] provider gave you more information about this topic?



Sources of Health Information and Internet Access

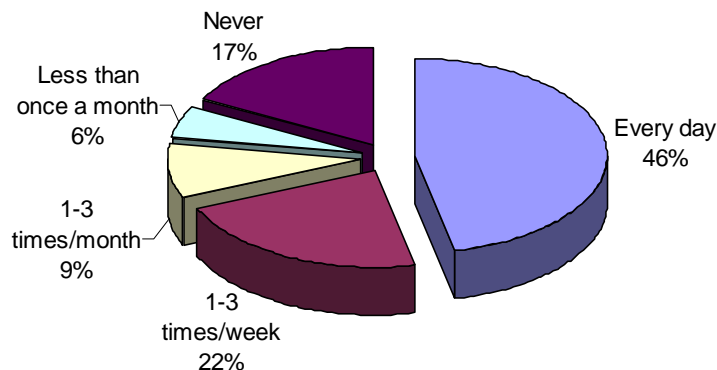
We added questions in 2006 about where respondents usually get information about health issues and about internet access.²¹ When asked about sources of health information, respondents mentioned their healthcare provider most often, at 72%. Almost a third of respondents said they get health information from the internet. (Respondents could mention more than one item.)

Figure 12. Where do you usually get information about health issues?



Interviewers also asked respondents if they have internet access at home or at work. Overall, 80 percent of current and new enrollees reported having internet access. Not surprisingly, access is more prevalent among families with higher income; 88% of CHP enrollees reported having internet access at home or at work, followed by 82% of Medicaid Expansion enrollees, and 74% of Medicaid enrollees. In addition, 46% of all current and new enrollees said that they use the internet on a daily basis, and two-thirds use the internet at least once a week (Figure 13).

Figure 13. How often do you use the internet? (n=1,539)



²¹ Because of the placement of the health information question in the survey instrument, some of the respondents may have interpreted this question as asking specifically about where they get information about reproductive health issues. This was evident from several open-ended responses, which referred to abstinence-only education programs and reproductive health centers. The results should therefore be interpreted with caution.

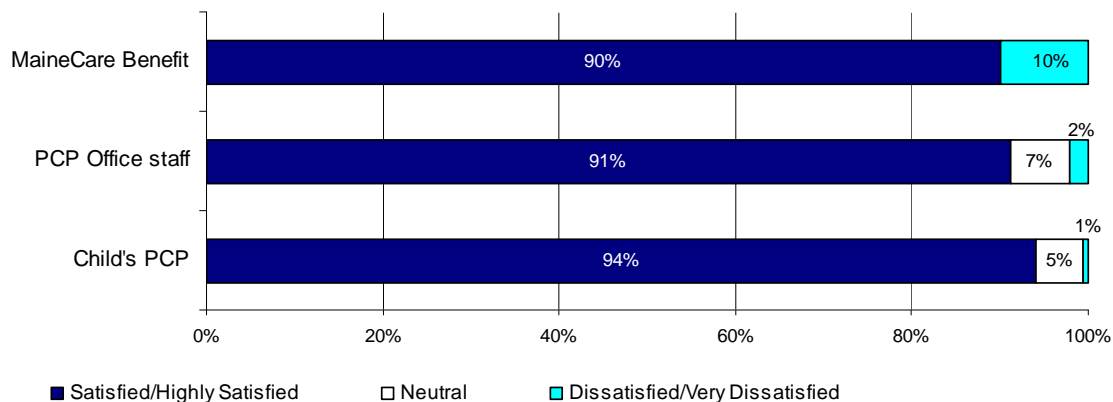
Satisfaction

Satisfaction with Providers and with Benefits

Interviewers asked respondents about their level of satisfaction or dissatisfaction with their children’s primary providers, with the office staff at their primary providers’ offices, and with MaineCare benefits. The results are presented below. Only one percent of respondents reported being dissatisfied or very dissatisfied with their child’s PCP, 2% reported they were unhappy with the PCP’s office staff, and 10% were dissatisfied or very dissatisfied with the MaineCare benefit.

Reasons for dissatisfaction varied from concerns about prior authorization requirements for certain medications or services, to the limited number of providers who participate in MaineCare, to difficulty finding a provider, and hassles with billing and eligibility paperwork. However, the largest number of reasons for dissatisfaction with MaineCare centered on dental services – both the lack of dental providers who accept MaineCare and the attitude of dental providers.

Figure 14. Satisfaction of MaineCare and MaineCare Providers
N=1,532



* Note: when asked about satisfaction with MaineCare in 2006, respondents did not have an option for a neutral response.

There were many more reports of respondents who were satisfied or very satisfied with MaineCare services (89%). When asked about the reasons for this satisfaction, most respondents mentioned the coverage or benefits that MaineCare offers their child (58%), and about one quarter said the affordability of the program is the reason they are satisfied.

Parents also commented on the following when asked about aspects of the program with which they were particularly satisfied:

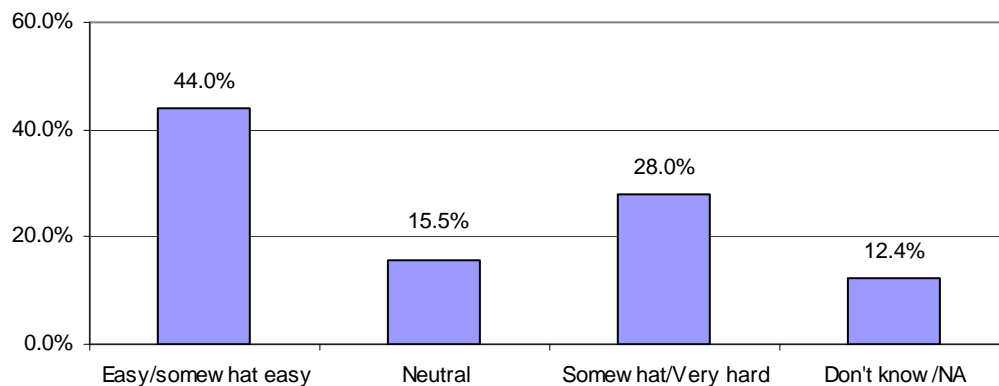
- Reminders about check ups
- Ability to keep the same provider
- Good quality care
- Health and financial information provided by MaineCare.

We also asked respondents to tell us the two most important reasons for having enrolled their child in MaineCare. Parents overwhelmingly said they could not afford insurance without it (n=1,040). Access to preventive care (n=444) and ‘peace of mind’ (n=373) were also frequently cited as important reasons for enrolling their child.

Separate Child Health Program Premiums

Parents whose children are enrolled in MaineCare through the CHP eligibility category pay monthly premiums between \$8 and \$64, depending upon family income and number of children. State policymakers wanted to know the extent to which this premium was burdensome to the parents. In 2006, about 44% stated that it was *easy* or *somewhat easy* to pay the premium for their children. Another 15% responded that it was neither easy nor hard to pay the premium. However, more than a quarter of respondents said that it was *hard* or *very hard* to pay the premium each month. The percent of CHP parents who found it easy to pay the premium has dropped from 2005 to 2006, from 57% down to 44%.

Figure 15. Paying CHP Premiums
N= 386



Healthy Behaviors

Health Behavior Reports

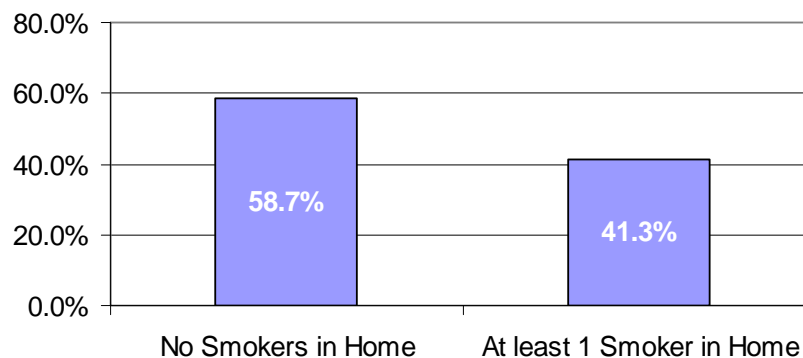
Department of Health and Human Services staff were interested in learning more about the level of exercise children are receiving in order to better focus outreach information to this population. We asked respondents about exercise their children participate in at school and at home. We also asked about tobacco use, both by the children and in the home by others. Due to space limitations we asked only two questions about diet.

Tobacco Use

Parents of children aged 8 or older (n=971) were asked whether their child used tobacco products. Five percent (n=46) reported that their child used tobacco. One percent of respondents reported that they did not know whether their children used tobacco.

We also asked how many people smoke or use tobacco products in the home (other than the child, if the child smokes). Forty-one percent of respondents' homes have at least one smoker. This rate is almost double the tobacco use rate for the State of Maine (20.8%)²². On the positive side, the rate has declined from the 45% of households with smokers found in the 2005 survey. But we also found that 43% of children on MaineCare who have asthma live in homes with one or more adult smokers. This is a disturbing finding given that researchers have established that environmental tobacco smoke (ETS) increases the likelihood of asthma exacerbations in pre-school children.²³

**Figure 16. Percentage of Households with at Least One Smoker
N= 1,549**



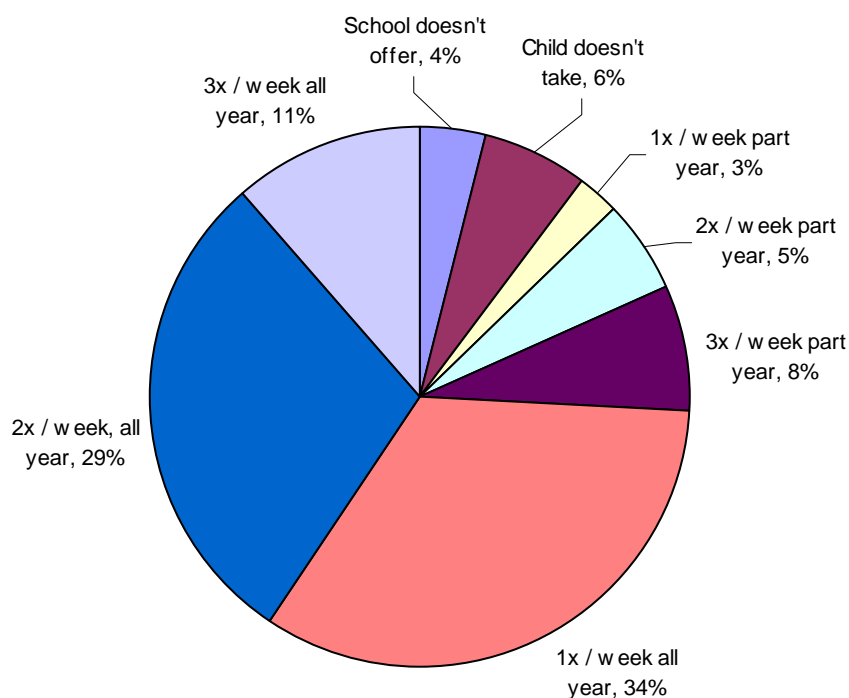
²² Centers for Disease Control and Prevention (2005). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. <http://apps.nccd.cdc.gov/brfss/>. Accessed March 21, 2007.

²³ Institute of Medicine. (2000). *Clearing the Air: Asthma and Indoor Air Exposures*. Washington, D.C.: National Academy Press, p. 438.

Exercise

Department of Health and Human Services staff wanted to know how often school children receiving MaineCare participated in organized physical education classes. There is great variation in the frequency and availability of physical education classes among the school districts in the State of Maine. Some schools offer classes once per week throughout the school year, others offer it once per week for a third or one half of the school year. The figure below shows the frequency with which surveyed children participate in school-sponsored physical education. Three quarters (74%) have physical education classes at least once per week for the entire school year. Approximately 4% of the schools do not offer these classes and 6% elect not to take physical education.

Figure 17. Frequency of Physical Education Classes of Children Enrolled in Maine Schools
N= 1,068

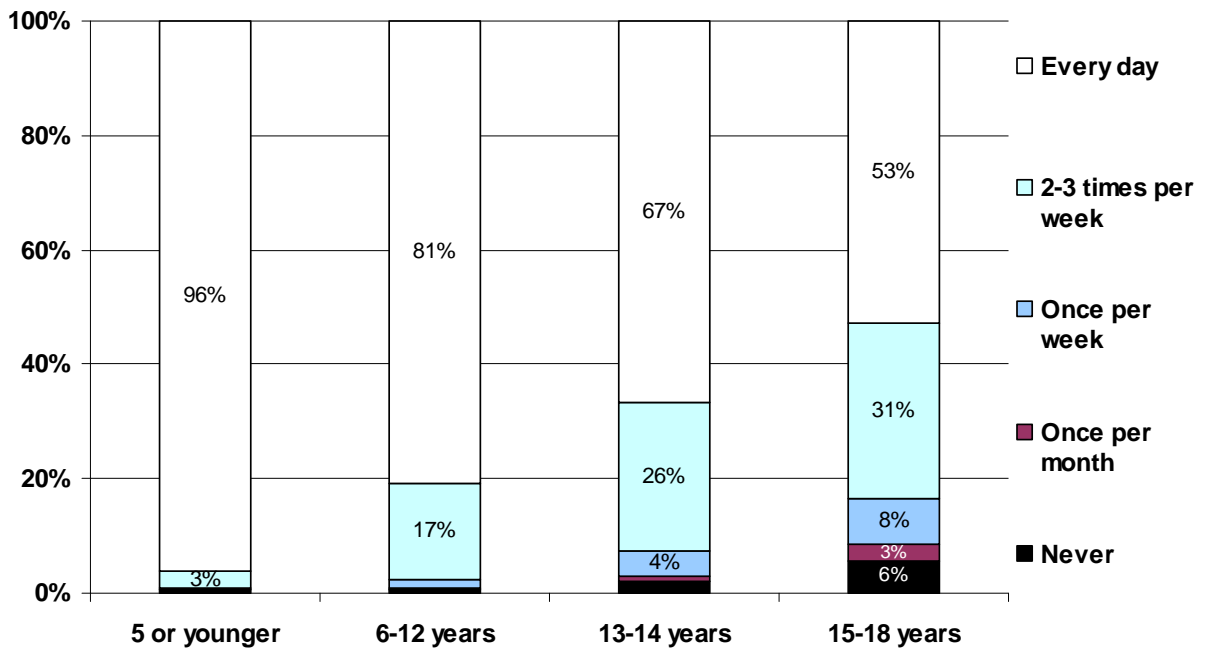


State policymakers also wanted to learn about exercise outside of school. We asked parents to tell us the kind of exercise in which their children participate, the frequency, and duration of the exercise. Two percent report that their children never exercise. Of those who did exercise, 64% report that their children exercise for at least an hour or more at a time. Another 27% of parents report that their children exercise 30-45 minutes in duration. The types of exercise parents mentioned included active play (44%), extra-curricular team sports (14%), walking (13%), bicycling (12%), running (5%), swimming (2%), work-related exercise (1%), and a range of other activities including martial arts, dance, horseback riding, etc. We specifically asked the

type of exercise to distinguish passive exercises, such as fishing or snowmobiling, from active exercises that include cardiovascular activity.

The graph below shows that exercise decreases with age in this population. Ninety-six percent of children five years old and younger participate in some sort of exercise *every day*; that percentage decreases to 53% by the time children reach 15 years old. Similarly, 6% of teens aged 15-18 are reported to *never* exercise, while only 2 % of 13-14 year olds never exercise and only 1% of 6-12 year olds are reported to never exercise.

Figure 18. Frequency of Exercise
N= 1,549

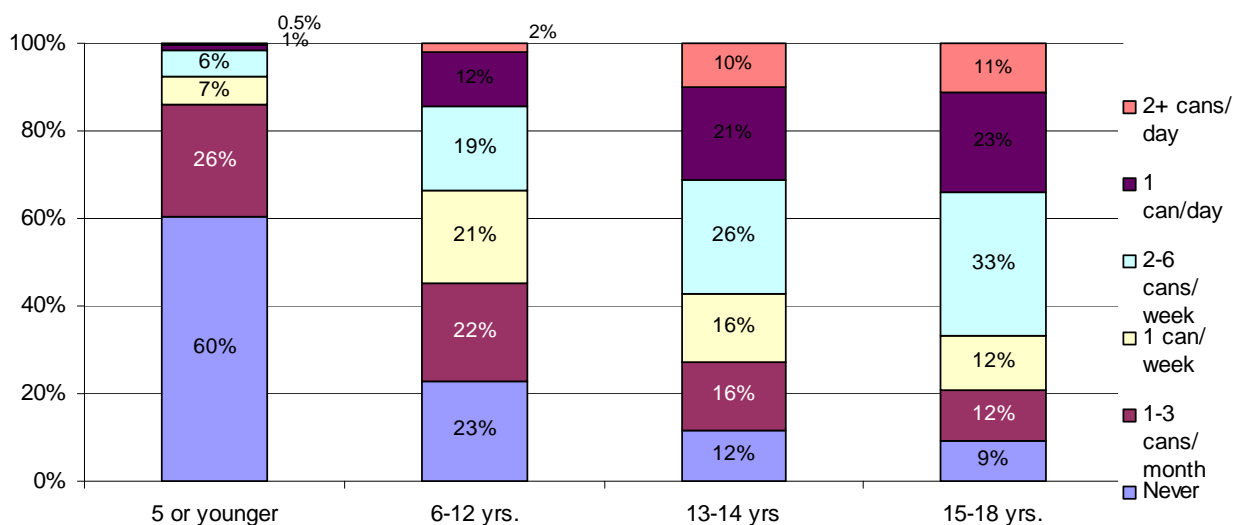


Nutrition

Soda consumption has been linked to weight gain and poor nutrition. The graph below shows the increase in soda consumption by age with 2% of children less than five years drinking one can of soda per day to 34% of teens aged 15 to 18 years drinking one or more cans of soda per day. Conversely, the percentage of children reported to never drink soda decreases from 60% for those under five years to 9% by the time children reach fifteen years.

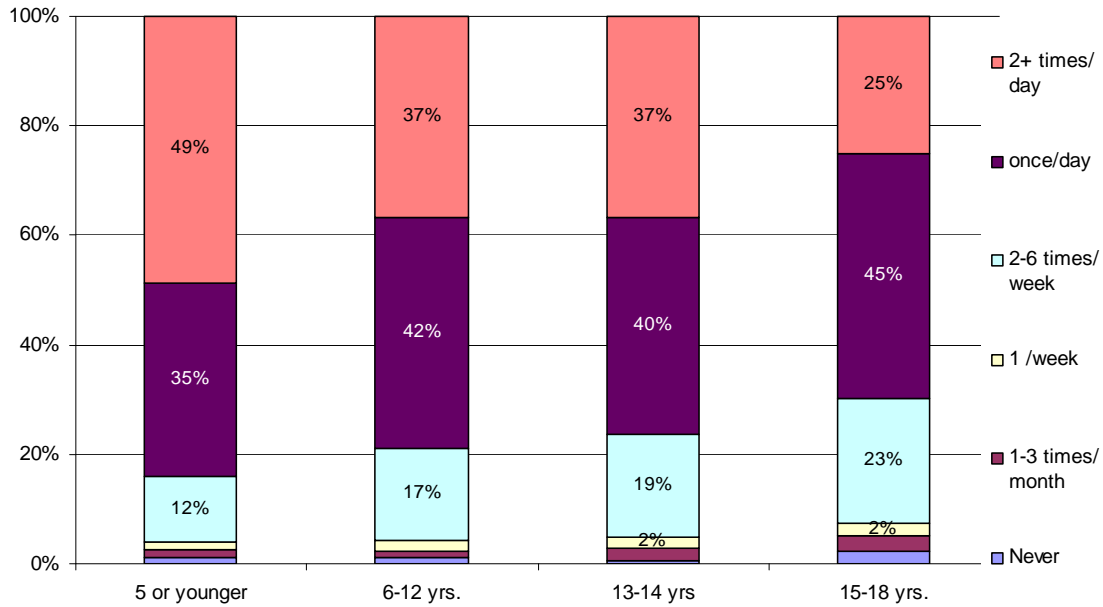
Comparison to the 2005 results suggests that there has been a small decline in soda consumption among 15 to 18 year olds (not shown). 41% of children in this age group consumed at least one can per day in 2005, versus only 34% in 2006.

Figure 19. Frequency of Soda Consumption
N= 1,549



We also asked parents about the frequency of vegetable consumption (and asked that they not include French fries when answering). The results from that question are presented below. A similar trend is seen with twice daily vegetable consumption reducing from 49% in children five years or younger to 25% for fifteen to eighteen year olds.

Figure 20. Frequency of Vegetable Consumption
N= 1,549



Substitution of Public for Private Coverage

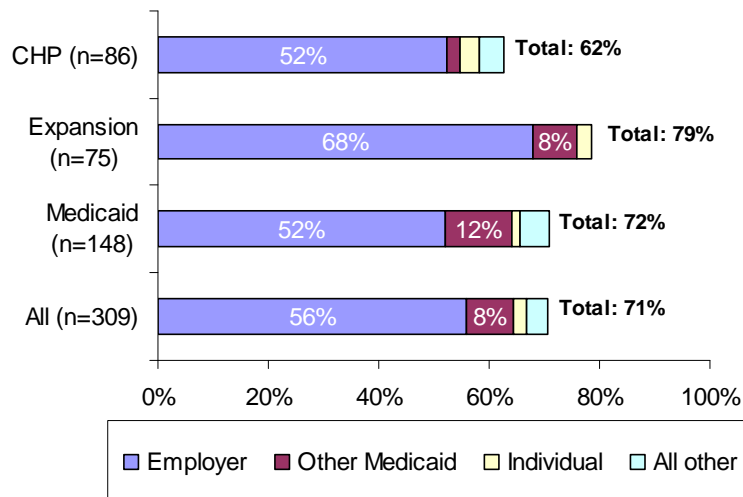
One concern of policymakers at the federal and state level is the possibility that expansions to the MaineCare program have caused the substitution of private coverage for public – sometimes referred to as “crowd-out”. There are three possible pathways by which crowd-out can occur.

- 1) An individual or family drops or does not purchase private coverage in order to enroll in a public program;
- 2) An enrollee in a public program refuses an offer of private coverage; or
- 3) Employers induce crowd-out by dropping coverage or increasing premiums to unaffordable levels.

A crucial point to remember is that, in order to be considered crowd-out, these actions must be taken by an individual or employer because of the existence of the public program. If the private coverage would have been dropped even in the absence of the program—leading to the child becoming uninsured in that case--then it is not crowd-out.²⁴

To examine the question of coverage substitution, we asked parents of new enrollees (n=313) whether their child was covered by any other health care plan during the year before they enrolled in MaineCare, and if so, what type of coverage their child had. Seventy one percent of new enrollees had coverage at some point during the previous 12 months, and 29 percent did not. There were significant differences in prior coverage by eligibility category. Children newly enrolled in MaineCare through the separate Child Health Program were the least likely to have had prior coverage—at only 62 percent. The other SCHIP eligibility category, Medicaid Expansion, had the highest rate of prior coverage, at 79 percent of new enrollees. The difference in coverage rates between these two groups is statistically significant (Chi-square $p < .05$).

Figure 21. Percent of New Enrollees with Coverage in Previous Year, by Eligibility Category



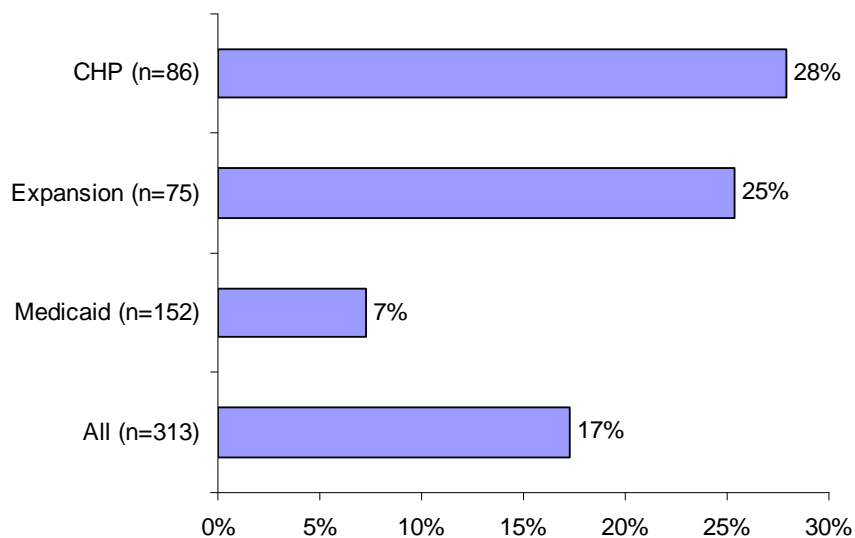
²⁴ Davidson, G., Blewett, L., and Call, KT. (2004). *Public Program Crowd-out of Private Coverage: What Are the Issues?* (Research Synthesis Report No. 5). Princeton, NJ: The Synthesis Project, Robert Wood Johnson Foundation,.

Figure 21 also outlines the prevalence of difference types of coverage among new enrollees in the year before they came on to MaineCare. Most new enrollees with prior coverage were covered through a parent or guardian's employer sponsored insurance. Among all new enrollees, 56 percent had prior coverage through their parent's employer. The next most common response was that the child had lived in another state and was covered by that state's Medicaid program (8 percent). New Medicaid expansion enrollees were the most likely to have had employer-sponsored coverage before coming on to MaineCare, at 68%, versus only 52% of both Medicaid and CHP enrollees. Very few (less than 3%) of children had individual policies purchased directly from an insurance company.

Taken together, the results showing that that more than two-thirds of newly enrolled children on MaineCare had prior coverage and that most with prior coverage had health insurance through an employer, suggests that some proportion of parents may be electing to drop employer coverage in favor of enrolling their child in MaineCare. Our results do not, however, shed light on how much of that substitution is crowd-out, because we do not know if the availability of MaineCare caused the substitution. Many parents may have been forced to drop employer-sponsored coverage for their children anyway, for example because they lost their job that provided benefits, or they experienced a financial shock that made their share of the monthly premium unaffordable.

There is also evidence in our results that the second pathway for coverage substitution is occurring, in which parents on a public program are offered but refuse private coverage for their child (Figure 22). After identifying the main wage earner in the household, interviewers asked a series of questions to determine if that person is employed, if their employer offers insurance coverage, if their child on MaineCare is also eligible for that coverage, and if their child is enrolled. Out of all new enrollees in our sample (n=313), 17 percent had access to employer sponsored coverage through the main wage earner but were not enrolled. The proportion of respondents who reported declining employer-sponsored coverage for their child was highest among new Medicaid Expansion and CHP enrollees, at more than 1 in 4. The reason given by almost all (92%) of these parents is that the available employer coverage is too expensive. If we assume that “too expensive” means that the family would refuse that coverage for their child even if MaineCare were not available, then only a small fraction of this type of coverage substitution we observed is crowd-out. In most cases, new enrollees would have become uninsured if MaineCare were not available.

Figure 22. Percent of New Enrollees Eligible But Not Enrolled in Employer Coverage by Eligibility Category



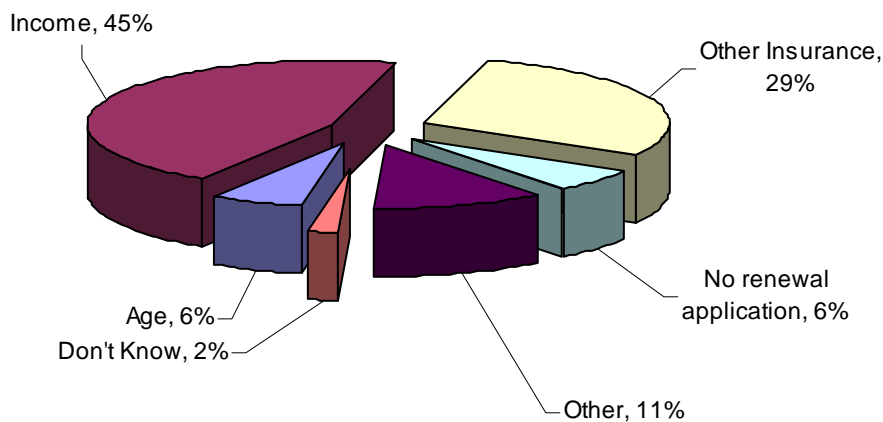
Disenrollees

Reasons for Disenrolling from MaineCare

We identified children from all eligibility categories who had been disenrolled from MaineCare five months before the survey was administered. This was to ensure selection of children who were not in the process of re-enrolling for MaineCare or other health services. Interviewers asked parents the reasons they had disenrolled their children from MaineCare in order to learn if parents were dissatisfied with MaineCare services. We found that increase in household income was the primary reason for disenrolling; 45% reported that their income had increased and they were no longer eligible. Obtaining other health insurance for their children was the second most reported reason; 29% reported that their child had other coverage and no longer needed MaineCare.

Six percent were over the age of 18 (and therefore no longer eligible) and another 6% did not fill out a renewal application. In the 'other' responses, three parents stated that CHP premiums were too difficult to pay and twelve said the child moved. The remainder stated a variety of reasons including that they thought the child would no longer qualify due to increased income or age.

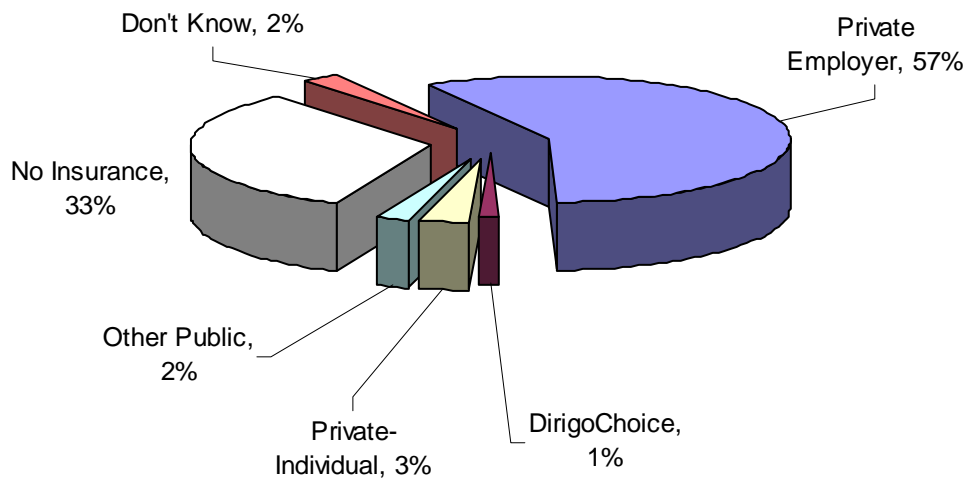
Figure 23. Reasons for Disenrolling from MaineCare
N= 295



Current Health Insurance Status

We asked whether the children disenrolled from MaineCare currently had health coverage and inquired about the type of coverage. The graph below shows that more than half currently had employer-sponsored health insurance; however, 33% of the disenrolled children were uninsured at the time of the interview. The rate of uninsurance was more than double (72%) among children who had disenrolled from MaineCare because a renewal application was not filled out, and because the child had aged out of the program.

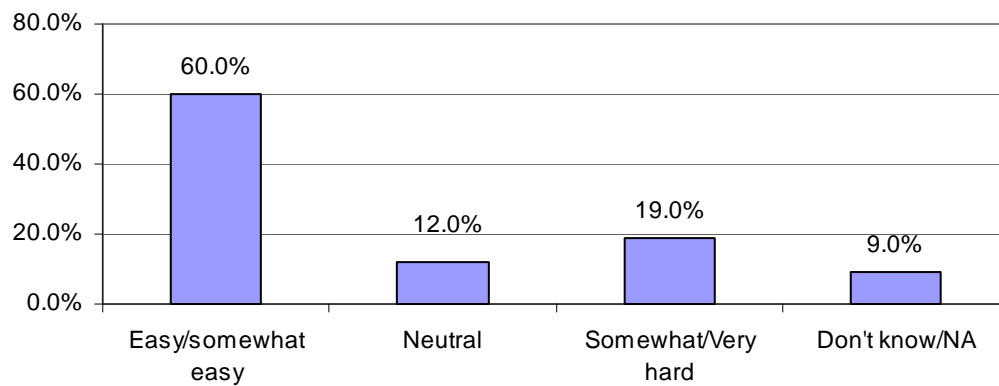
**Figure 24. Current Insurance Status of Children Disenrolled from MaineCare
N= 293**



Separate Child Health Program Premiums

Thirty-four percent of the disenrollees were formerly enrolled in MaineCare through the CHP eligibility category. Interviewers asked whether they had experienced any difficulty paying the premiums when their children had been enrolled. The results of that question are presented below. The majority (60%) of the CHP disenrollees did not have any difficulty; however 19% stated that it was somewhat or very difficult to pay the monthly premiums.

Figure 25. CHP Disenrollees Difficulty Paying Premiums
N= 100

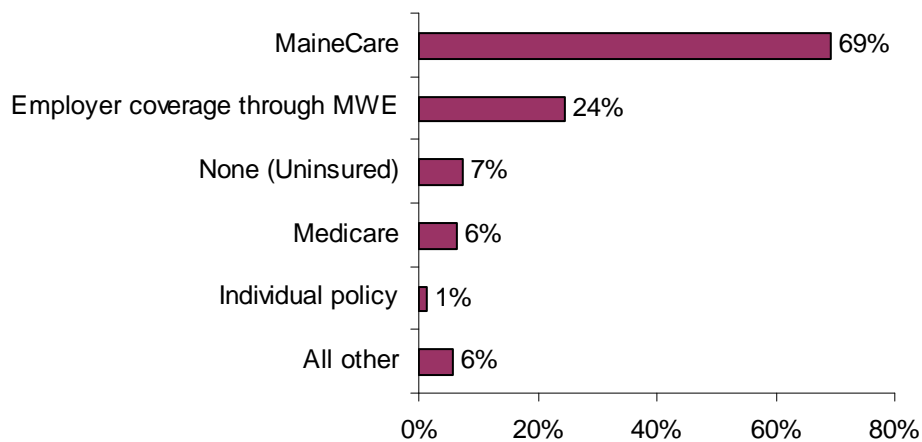


Parent's Status

Current Insurance Status

Several studies have shown that children with uninsured parents are less likely to use health care services, even when the children are insured.²⁵ Another study showed that children are more likely to use preventive services and seek care when needed when their parents are insured.²⁶ Because of the importance of parental insurance to the care received by children on MaineCare, we asked respondents about their current insurance status. More than two-thirds of respondents are also on MaineCare, and one-fourth have employer sponsored coverage through the main wage earner in the household. Seven percent reported that they are currently uninsured.

Figure 26. Insurance Status of Current and New Enrollee Parents (n=1,550)



(Note: Percentages do not add to 100% because respondents could report more than one type of coverage).

²⁵ Hanson, K. L. (2001). Patterns of insurance coverage within families with children. *Health Affairs*, 20(1), 240-246. ; Minkovitz, C. S., O'Campo, P. J., Chen, Y.-H., & Grason, H. A. (2002). Association between maternal and child health status and patterns of medical care use. *Ambulatory Pediatrics*, 2(2), 85-92.; Newacheck, P. W. (1992). Characteristics of children with high and low usage of physician services. *Medical Care*, 30(1), 30-42.

²⁶ Davidoff, A., Dubay, L., Kenney, G. et al.(2003). The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children, *Inquiry*, 40(3), 254-68.

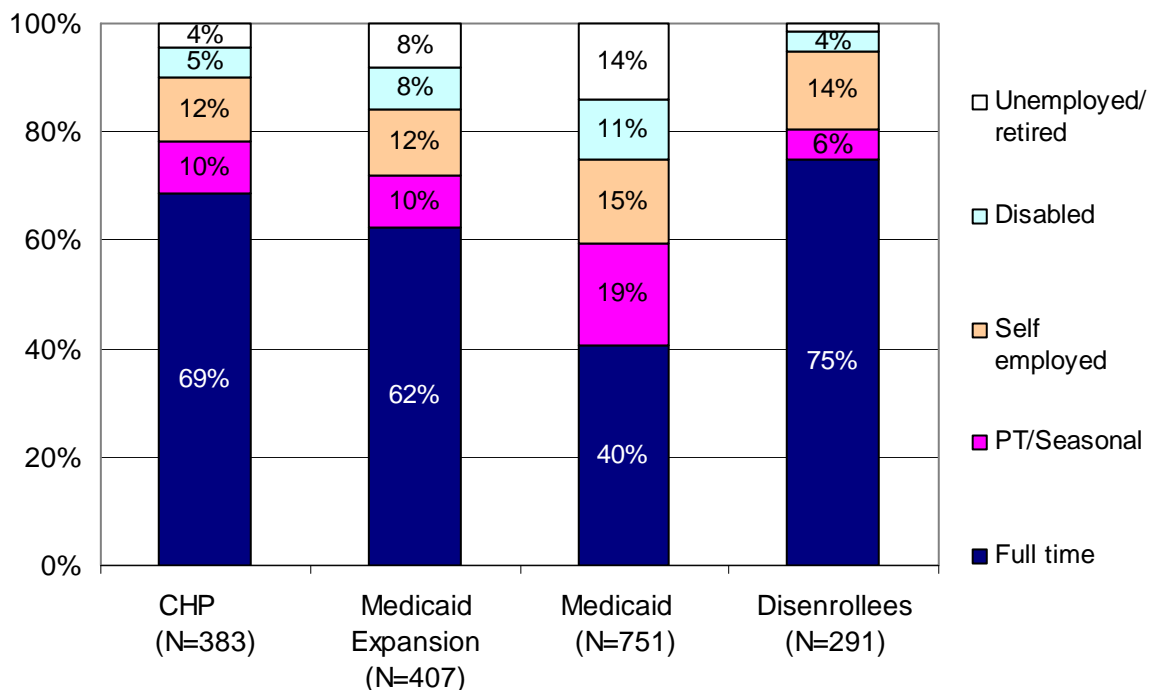
Employment Status

Interviewers asked respondents to identify the main wage earner in the household²⁷, and then asked for the employment status of that person. Fifty nine percent of respondents said they were the main wage earner, and 39 percent identified their spouse or unmarried partner.

Respondents from the lowest income households in our sample—those with a child enrolled in MaineCare under the Medicaid eligibility category—were more likely to identify the principal wage earner in the household as unemployed, disabled, or engaged in part-time or seasonal employment. The graph below illustrates similarities in the employment status between the CHP (150-200% FPL) and Medicaid Expansion (125-150% or 133-150% FPL) enrollees compared to that of the Medicaid enrollees. While 5% and 8% of CHP and Medicaid Expansion households, respectively, identify the primary wage earner as disabled, 11% of Medicaid households report that the main wage earner is disabled. Similarly, the unemployment rate among the Medicaid group (14%) is more than triple the unemployment rate of CHP households, (4%) and nearly doubles that of Medicaid Expansion households (8%).

It is interesting to note the difference in employment status of recent disenrollees as compared to current enrollees. Recent disenrollees were far more likely to be engaged in full time employment and less likely to have a disability. This group is comprised of former CHP enrollees (34%), former Expansion enrollees (28%), and former Medicaid enrollees (38%).

Figure 27. Employment Status of Main Wage Earner in Household



²⁷ When necessary, interviewers explained that main wage earner refers to, "...the adult living in your home who works and earns the most each week, or if no one is working, the adult who owns or rents your home."

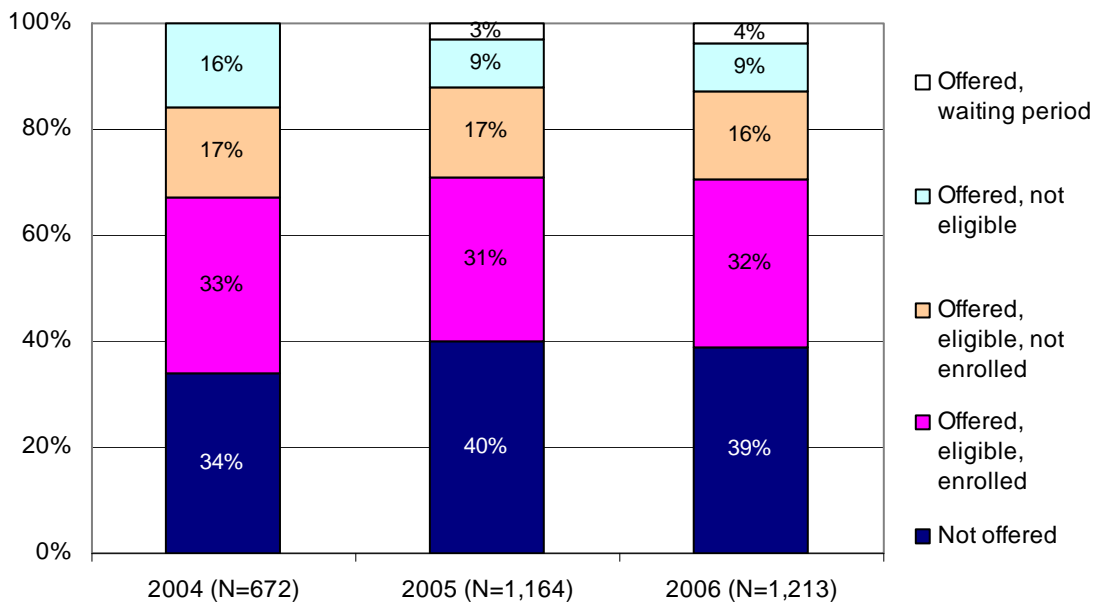
Access to Employer Sponsored Insurance (ESI)

Of the 81% of this population that was employed, we found that 39% were employed by companies that did not offer any kind of health insurance. This proportion is similar to findings from the past several surveys.²⁸ The graph below shows that in 2004, 34% of main wage earners who were employed, were employed by firms that did not offer any health insurance and in 2005, 40% were employed by companies that did not offer health insurance to employees.

Results from 2006 show that 32% of employed respondents were offered and enrolled in their employer's insurance plan. Similar to last year's results, 16% are employed in firms that offer insurance, they are eligible for that insurance, but are not enrolled. The primary reason given for not enrolling in available insurance is the high cost of premiums.

In 2006, 9% of the employed, primary wage earners were employed in firms that offer insurance but they are not eligible--most likely because they are employed part time. Finally, 4% of the employed primary wage earners will be eligible for insurance after a waiting period.

Figure 28. Distribution of Employed Main Wage Earner's ESI Status

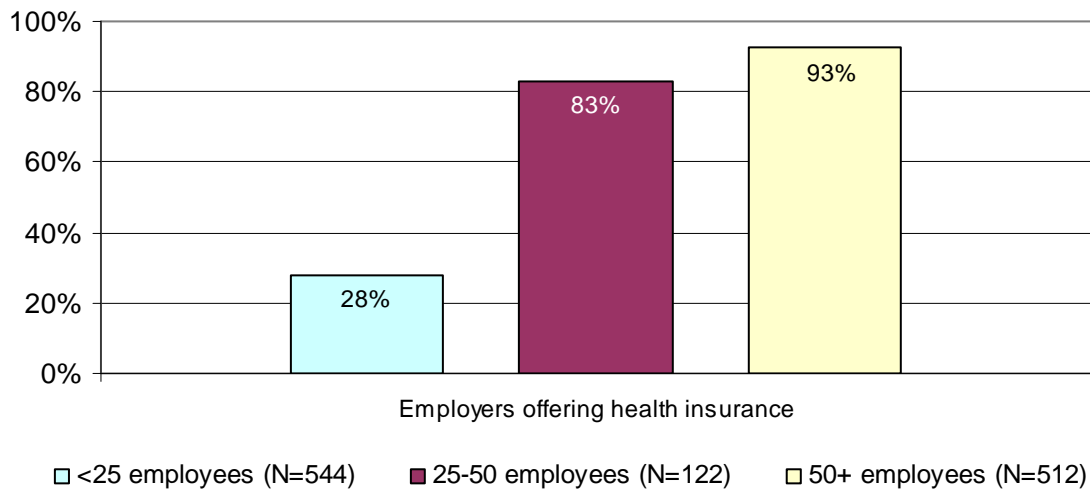


²⁸ Ormond, C., & Thayer, D. (2006, January). *Children served by MaineCare, 2005: Survey findings*. Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy.

ESI Access by Size of Employer

Our results confirm past work showing that large firms are more likely than smaller ones to offer health coverage. Companies with 50 or more employees, were very likely (93%) to offer health insurance to employees. Medium sized companies, those with 25-50 employees, offered health insurance at the rate of 83%. However, of the small firms, less than one third offer health insurance according to survey respondents.

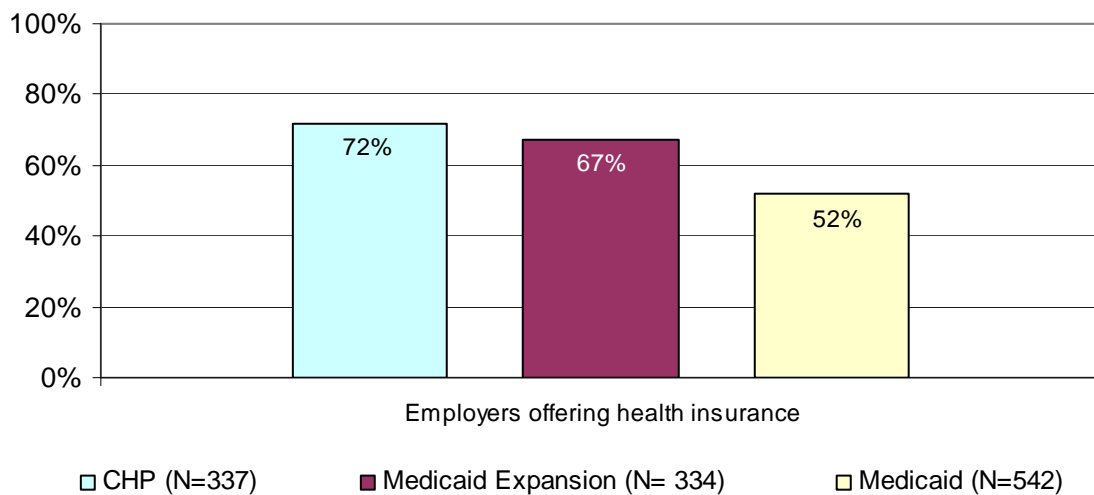
Figure 29. Percentage of Employers Offering Health Insurance by Size of Firm



ESI Access by Eligibility Category

We then looked at the same information as above (firms offering employer-sponsored health insurance) and analyzed it by MaineCare members' eligibility categories. The graph below shows that members enrolled in MaineCare through the CHP or Medicaid Expansion categories are more likely (72% and 67%) to have access to employer-sponsored health insurance, than are members enrolled through Medicaid (52%).

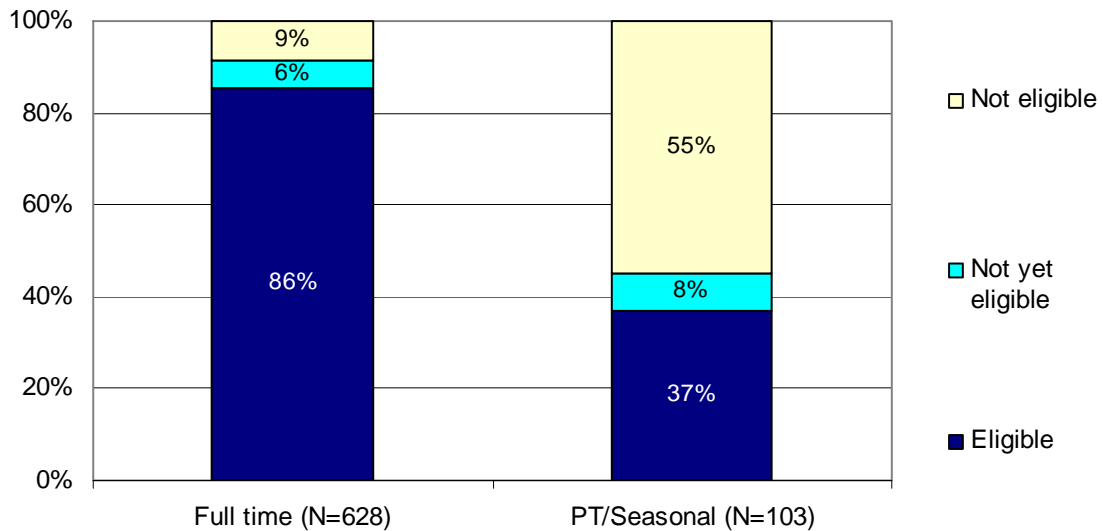
Figure 30. MaineCare Members' Access to Employer-Sponsored Health Insurance
N= 1,213



ESI Eligibility by Full or Part-time Status

Members who are engaged in full time employment are more likely to be eligible for employer-sponsored health insurance. The graph below shows that of the employed respondents who work in firms that offer health coverage, 86% of the respondents are eligible for employer-sponsored insurance. Another 6% are in a waiting period to become eligible and 9% are in positions for which insurance is not available. Only 37% of part-time, employed respondents are eligible for insurance in firms that offer insurance. The majority, 55%, are ineligible.

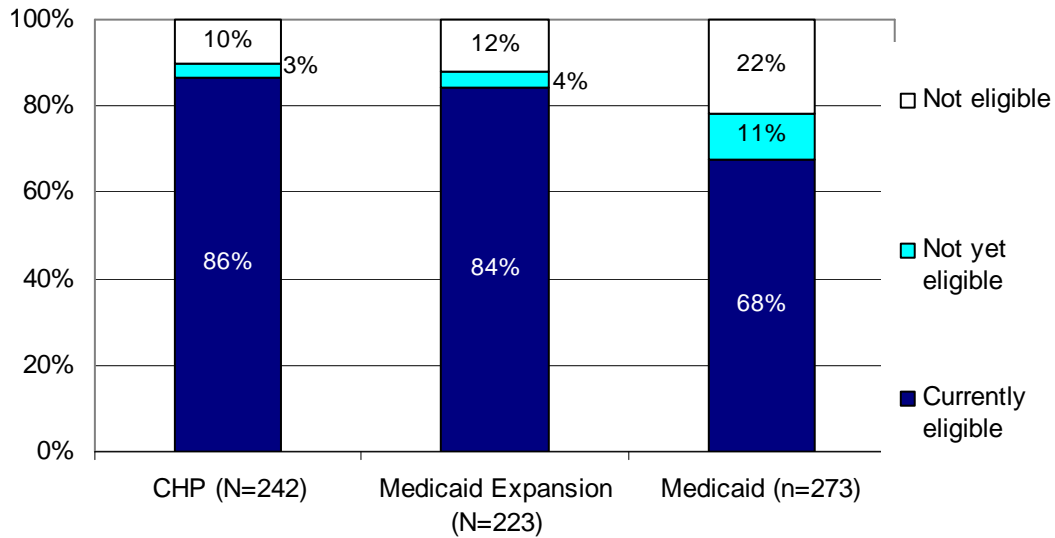
Figure 31. Eligibility for Health Insurance in Firms Offering Health Insurance: Full and Part-time



ESI Eligibility by MaineCare Eligibility Category

Similar to previous findings, respondents who are enrolled through Medicaid in households with less than 133% (125% for ages 6-18) of FPL, are more likely to be ineligible for employer-sponsored insurance (22%), compared with both CHP (10%) and Expansion populations (12%).

Figure 32. Eligibility for Health Insurance in Firms Offering Health Insurance by MaineCare Eligibility Category



Study Implications

Parents of children enrolled in MaineCare through all three eligibility categories continue to be overwhelmingly satisfied with the MaineCare benefit, with their children's providers, and with the quality of care. Virtually all respondents said their child has a usual source of care. Only a small proportion of current and of new enrollees (5 and 7 percent, respectively) reported having had difficulty obtaining needed care in the past 6 months. And only 2 percent of respondents caring for a child with a limiting condition said their child *rarely or never* received the care and services they need. Given the challenges of providing health care services to a low-income population in a rural state, these findings reflect extremely well on the work of MaineCare administrators and providers.

Several findings, however, point to areas of concern and potential intervention. First, among the minority of respondents who did express dissatisfaction with MaineCare, the most common specific complaint was about dental services, both the lack of dental providers who accept MaineCare and the attitude of dental providers.

A second area of concern was the high prevalence of both asthma and mental health conditions that we found among children on MaineCare. Fifteen percent of all respondents reported that their child is affected by asthma. Environmental tobacco smoke (ETS) may be a contributing factor to the high rate of asthma, in that 43% of children with asthma live in households with one or more adult smokers. MaineCare could help reduce the burden of asthma through ongoing provider education efforts; most parents reported that their child's primary care provider (PCP) speaks to them regularly about the risks of second hand smoke, but 30 percent with children under age 5 said their PCP *rarely or never* talks to them about the topic. Mental health issues also disproportionately affect children on MaineCare. Twenty percent of respondents told us that their child has depression or anxiety problems. This rate is substantially higher than the 13% of low-income children in Maine found to have depression or anxiety in the 2003 National Survey of Children's Health. Furthermore, among parents of children with a limiting condition (n=451), 24% said their child has a mental or behavioral disorder.

A third issue highlighted by the survey is the exorbitant rates of overweight among children of all ages on MaineCare. Fully one quarter of all children in the study are estimated to be overweight²⁹ and nearly half (45 percent) are overweight or at risk of overweight. Teens (13 – 18 years old) have lower rates of overweight than younger children on MaineCare, but are still much more likely to be overweight than high-school students in the general population in Maine.

Survey findings also indicate that a substantial minority of parents do not accurately identify when their child is overweight, with 38 percent of respondents with an overweight child describing that child as being 'normal weight'. Parental education is therefore one potential avenue for intervention. Reports of diet and exercise all decline with the age of children on MaineCare. Infants and toddlers are reported to exercise and consume vegetables the most, and

²⁹ BMI in the 95th percentile or higher for their age/sex

teens exercise and consume vegetables the least. The reverse is true for soda consumption. Coupled with the high rates of overweight and its associated health risks, these findings suggest that children on MaineCare would benefit from providers' advice on exercise and healthy eating habits.

Outreach through providers holds the most promise for reaching children on MaineCare with health and nutrition information. More than two-thirds of those interviewed told us they usually get information about health issues from a healthcare provider. However, our results also suggest that the internet may be an effective supplementary tool for this purpose. Almost one-third of respondents said they use the internet to get information about health issues. And more than two-thirds of all current and new enrollees reported using the internet at least once per week.

From parents of children who recently disenrolled from MaineCare (n=295), we learned that most left the program because of an increase in income which meant they were no longer eligible (45%) or because their child obtained other coverage and no longer needed MaineCare (29%). More than half (57%) of all disenrolled children were enrolled in employer-sponsored insurance at the time of the interview. But a discouraging finding is that one-third of disenrolled children (n=96) were uninsured at the time of the interview. Children of parents who said they disenrolled because they had not filled out a renewal application were more than twice as likely to be uninsured (72%). This finding points to an ongoing need for monitoring of the MaineCare reapplication process, to ensure that eligible children are not dropped from the program.

Among new MaineCare enrollees (n=313), over two-thirds had some form of coverage in the year before the child enrolled in the program, and more than half (56%) had employer-sponsored insurance through a parent's employer. In addition, we found that seventeen percent of all new enrollees had access to employer-sponsored insurance at the time of the interview but were not enrolled – primarily because it is not affordable. Rates of declined coverage were highest among new CHP (28%) and Expansion (25%) enrollees.

The survey results show that some substitution of MaineCare coverage for employer-sponsored coverage is occurring, but do not reveal how much of this substitution is caused by the existence of MaineCare—commonly referred to as “crowd out”. External factors such as manufacturing job losses and continued double-digit annual increases in employer-sponsored insurance (ESI) premiums over the past several years have led to loss of employer-sponsored insurance, and to unaffordable premiums for many low-income families who have access to ESI.³⁰ For most low-income families, MaineCare serves as a safety net to protect children from spells of uninsurance and associated reduction in access to medical and dental care.³¹ Further, the availability of MaineCare has kept the uninsurance rate among children in Maine (7%) among the lowest of any state in the nation.³²

³⁰ O'Hara, F. and Pohlmann, L. (2005). *Maine Small Business Insurance: A 2004 Survey*. Augusta, ME: Maine Center for Economic Policy. ; Medical Expenditure Panel Survey, 2000 – 2004 Insurance Component Results for Maine. Available at: http://www.meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp Accessed March 20, 2007.

³¹ Institute of Medicine. (2002). *Health Insurance is a Family Matter*. Washington, DC: National Academies Press.

³² Kaiser State Health Facts Online. <http://www.statehealthfacts.org> Accessed March 20, 2007.

Appendix A: MaineCare Coverage for Children

Eligibility Group	Family Income Eligibility Limits		Premium Payments	Funding Source
	<i>Children Ages 1 through 5</i>	<i>Children Ages 6 through 18</i>		
Medicaid	<ul style="list-style-type: none"> Family income up to 133% FPL 	<ul style="list-style-type: none"> Family income up to 125% FPL 	No monthly premiums	Medicaid (Title XIX)
Medicaid Expansion	<ul style="list-style-type: none"> Family income between 134% and 150% FPL 	<ul style="list-style-type: none"> Family income between 126% and 150% FPL 	No monthly premiums	SCHIP (Title XXI)
Separate Child Health Program (CHP)	<ul style="list-style-type: none"> Family income between 151% and 200% FPL 		Monthly premiums of \$8 to \$64, on sliding scale	SCHIP (Title XXI)

Appendix B: MaineCare Child Health Survey Instrument 2006

Q1 DISENROLLEES ONLY Option

The Department of Health and Human Services records indicate that \0 is NO LONGER ENROLLED in MaineCare. Is this correct?

IF "NO" OR "UNSURE", PROBE: MaineCare is a health insurance sponsored by the state. If \0 were enrolled, you would have a plastic ID card for \G2 MaineCare health insurance.

Q1	1 YES, \0 IS NO LONGER ENROLLED	Q5
Q1	2 YES, AFTER PROBE	Q5
Q1	3 NO, STILL ENROLLED/RE-ENROLLED	NEXT
Q1	8 DK/UNSURE	END
Q1	9 NA	END

Q2 DISENROLLEES ONLY Option

Was there a period in the past year when \0 was NOT enrolled in MaineCare?

(IWER NOTE: COUNT ANY PERIOD OF DISENROLLMENT AS A BREAK IN ENROLLMENT, EVEN IF IT IS LESS THAN ONE MONTH)

Q2	1 YES, \0 HAD A BREAK IN \G2 MAINECARE ENROLLMENT	NEXT
Q2	2 NO, \0 HAS BEEN CONTINUOUSLY ENROLLED IN MAINECARE	END
Q2	8 DK/UNSURE	END
Q2	9 NA	END

Q3 DISENROLLEES ONLY Multiple Check

Why was \0 disenrolled from MaineCare for a time?

Q3	5 DHHS PAPERWORK PROCESSING DELAY	NEXT
Q3	1 CHILD WAS NOT ELIGIBLE DUE TO FAMILY INCOME LEVEL	END
Q3	2 CHILD WAS ENROLLED IN another HEALTH INSURANCE PLAN	END
Q3	3 I DID NOT SUBMIT A RENEWAL APPLICATION	END
Q3	6 OTHER (SPECIFY)	END
Q3	7 Other	END
Q3	9 NA	END
Q3	8 DK	END
Q3	4 THE RENEWAL APPLICATION WAS DENIED	END

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Q4 **NEW & CURRENT ENROLLEES**

Option

The Department of Health and Human Services records indicate that \0 IS ENROLLED in MaineCare. Is this correct? IF "NO" OR "UNSURE", PROBE: MaineCare is health insurance provided by DHHS. They give you a plastic ID card if you are eligible.

Q4	1 YES	Q10
Q4	2 YES, AFTER PROBE	Q10
Q4	3 NO	NEXT
Q4	8 DK/UNSURE	END
Q4	9 NA	END

Q5

Option

Why is \0 NO LONGER on MaineCare?

Q5	1 \0 WAS NO LONGER ELIGIBLE DUE TO AGE	Q9
Q5	2 \0 WAS NO LONGER ELIGIBLE DUE TO FAMILY INCOME LEVEL	Q9
Q5	3 \0 WAS ENROLLED IN ANOTHER HEALTH INSURANCE PLAN	Q9
Q5	4 I DID NOT SUBMIT RENEWAL APPLICATION	Q7
Q5	5 OTHER	NEXT
Q5	8 DK	Q9
Q5	9 NA	Q9

Q6

Text Entry

What is that other reason?

Q6	0 REASON (98=DK, 99=NA)	Q9
----	-------------------------	----

Q7

Option

What is the main reason you did not send in the renewal application?
(DO NOT READ; SELECT FIRST REASON R MENTIONS.)

- | | | |
|----|--|------|
| Q7 | 1 DID NOT RECEIVE APPLICATION | Q9 |
| Q7 | 2 APPLICATION TOO DIFFICULT TO FILL OUT | Q9 |
| Q7 | 3 PREMIUMS TOO HIGH | Q9 |
| Q7 | 4 HEALTH CARE AVAILABLE FOR FREE AT SCHOOL | Q9 |
| Q7 | 5 MAINECARE WAS TOO MUCH OF A HASSLE | Q9 |
| Q7 | 6 DISSATISFIED WITH THE PROGRAM | Q9 |
| Q7 | 7 DIDN'T KNOW I NEEDED TO REAPPLY | Q9 |
| Q7 | 8 DIDN'T THINK CHILD WOULD QUALIFY | Q9 |
| Q7 | 9 GOT OTHER INSURANCE | Q9 |
| Q7 | 11 OTHER | NEXT |
| Q7 | 98 DK | Q9 |
| Q7 | 99 NA | Q9 |
| Q7 | 10 JUST DIDN'T GET AROUND TO IT | Q9 |

Q8

Text Entry

What is that other reason?

- | | | |
|----|-------------------------|------|
| Q8 | 0 REASON (98=DK, 99=NA) | NEXT |
|----|-------------------------|------|

Q9

Multiple Check

What kind of health insurance, if any, does \0 have now?

- | | | |
|----|---|-----|
| Q9 | 1 PRIVATE INS. FROM AN EMPLOYER | Q80 |
| Q9 | 2 DIRIGO CHOICE (THEY GIVE YOU A PLASTIC ID-SAYS DIRIGO/ANTHEM) | Q80 |
| Q9 | 3 PRIVATE INS. YOU BUY DIRECTLY FROM INSUR. CO | Q80 |
| Q9 | 4 OTHER PUBLIC HEALTH INSUR. (SUCH AS SSI/MEDICARE)-SPECIFY | Q80 |
| Q9 | 8 DK | Q80 |
| Q9 | 9 NA | Q80 |
| Q9 | 6 NONE | Q80 |
| Q9 | 5 Other Public Health Insurance | Q80 |

Q10

Option

Is this the only health insurance \0 has?

- | | | |
|-----|-------|------|
| Q10 | 1 YES | Q12 |
| Q10 | 2 NO | NEXT |
| Q10 | 8 DK | Q12 |
| Q10 | 9 NA | Q12 |

Q11

Multiple Check

What other type of health insurance does \0 have?

(IWER NOTE: IF R MENTIONS A PRIVATE INSURANCE COMPANY, PROBE TO SEE IF IT IS FROM AN EMPLOYER OR IF THEY BOUGHT IT DIRECTLY FROM THE INSURANCE COMPANY.)

- | | | |
|-----|--|------|
| Q11 | 1 PRIVATE INSURANCE FROM AN EMPLOYER | NEXT |
| Q11 | 2 DIRIGO CHOICE (PROBE: THEY GIVE YOU A PLASTIC ID CARD THAT SAYS DIRIGO/ANTHEM) | NEXT |
| Q11 | 3 PRIVATE INSURANCE YOU BUY DIRECTLY FROM INSUR CO | NEXT |
| Q11 | 4 OTHER PUBLIC HEALTH INSURANCE (SUCH AS SSI OR MEDICARE)-SPECIFY | NEXT |
| Q11 | 5 Other Public Health Insurance | NEXT |
| Q11 | 8 DK | NEXT |
| Q11 | 9 NA | NEXT |

Q12

Option

NEW ENROLLEES ONLY:

During the year before \0 enrolled in MaineCare, was \G0 covered by any other health care plan?

- | | | |
|-----|-------|------|
| Q12 | 1 YES | NEXT |
| Q12 | 2 NO | Q14 |
| Q12 | 8 DK | Q14 |
| Q12 | 9 NA | Q14 |

Q13 **NEW ENROLLEES ONLY:** Multiple Check

What plan was that?

- | | | |
|-----|---|------|
| Q13 | 1 PRIVATE INSURANCE FROM AN EMPLOYER | NEXT |
| Q13 | 2 DIRIGO CHOICE (PROBE: THEY GIVE YOU A PLASTIC CARD THAT SAYS DIRIGO/ANTHEM) | NEXT |
| Q13 | 3 PRIVATE INSURANCE YOU BUY DIRECTLY FROM THE INSUR CO. | NEXT |
| Q13 | 4 OTHER PUBLIC HEALTH INSURANCE (SUCH AS SSI OR MEDICARE)-SPECIFY | NEXT |
| Q13 | 5 Other Public Health Insurance | NEXT |
| Q13 | 8 DK | NEXT |
| Q13 | 9 NA | NEXT |

Q14 Option
 Now I'm going to ask some questions about the health care \0 receives through MaineCare.
 Does \0 have a regular place to go to get health care?

Q14	1 YES	NEXT
Q14	2 NO	Q17
Q14	8 DK	Q17
Q14	9 NA	Q17

Q15 Option
 How long has \0 gone to the same place for regular health care?
 (PROBE: The same clinic or doctor's office or health center?)

Q15	1 LESS THAN 6 MONTHS	NEXT
Q15	2 6 MONTHS TO 1 YEAR	Q19
Q15	3 1-3 YEARS	Q19
Q15	4 3-5 YEARS	Q19
Q15	5 OVER 5 YEARS	Q19
Q15	6 DOESN'T GO TO THE SAME PLACE	Q17
Q15	8 DK	Q19
Q15	9 NA	Q19

Q16 Option
 Where did \0 go before that?

Q16	1 EMERGENCY ROOM AT HOSPITAL	Q19
Q16	2 URGENT CARE CENTER AT HOSPITAL	Q19
Q16	3 A DIFFERENT HEALTH CENTER OR DOCTOR'S OFFICE	Q19
Q16	4 SCHOOL	Q19
Q16	5 DIDN'T GET HEALTH CARE	Q19
Q16	8 DK	Q19
Q16	9 NA	Q19
Q16	6 NEWBORN/ WASN'T BORN YET	Q19

Q17

Option

What is the main reason that \0 does not have a regular place to go to get health care?
(DO NOT READ)

- | | | |
|-----|---|------|
| Q17 | 1 DIFFICULT TO FIND A HEALTH CARE PROVIDER WHO WILL TAKE NEW PATIENTS | Q41 |
| Q17 | 2 DIFFICULT TO FIND A HEALTH CARE PROVIDER WHO WILL TAKE MAINECARE PATIENTS | Q41 |
| Q17 | 3 DON'T GO TO THE HEALTH CARE PROVIDER UNLESS SICK OR HAVE AN ACCIDENT | Q41 |
| Q17 | 4 PREFER TO GO TO THE EMERGENCY ROOM | Q41 |
| Q17 | 5 CHILD IS BASICALLY HEALTHY/DOESN'T NEED A REGULAR HEALTH CARE PROVIDER | Q41 |
| Q17 | 6 TRANSPORTATION | Q41 |
| Q17 | 7 OTHER | NEXT |
| Q17 | 8 DK | Q41 |
| Q17 | 9 NA | Q41 |

Q18

Text Entry

What is the other reason?

- | | | |
|-----|-------------------------|-----|
| Q18 | 0 REASON (98=DK, 99=NA) | Q41 |
|-----|-------------------------|-----|

Q19

Option

What kind of provider does \0 see at the place \G0 regularly goes for well-child visits or annual exams?
(PROBE: Not for sick or urgent care.)

- | | | |
|-----|--|------|
| Q19 | 1 PCP (PRIMARY CARE PROVIDER/REGULAR DOCTOR) | Q21 |
| Q19 | 2 NURSE PRACTITIONER | Q21 |
| Q19 | 3 SPECIALIST | Q21 |
| Q19 | 5 OTHER | NEXT |
| Q19 | 8 DK | Q21 |
| Q19 | 9 NA | Q21 |
| Q19 | 4 PHYSICIAN'S ASSISTANT (PA) | Q21 |

Q20

Text Entry

OTHER PROVIDER:

- | | | |
|-----|---------------------------|------|
| Q20 | 0 PROVIDER (98=DK, 99=NA) | NEXT |
|-----|---------------------------|------|

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Q21 Option
 How often does \0's provider talk about any of the following to you or your child?
 Nutrition and diet- would you say . . .

Q21	1 always	NEXT
Q21	2 usually	NEXT
Q21	8 DK	NEXT
Q21	9 NA	NEXT
Q21	3 sometimes	NEXT
Q21	4 rarely, or	NEXT
Q21	5 never	NEXT

Q22 **AGE 3 +** Option
 (How often does \0's provider talk about . . .)
 Exercise- would you say . . .

Q22	1 always	NEXT
Q22	2 usually	NEXT
Q22	8 DK	NEXT
Q22	9 NA	NEXT
Q22	3 sometimes	NEXT
Q22	4 rarely, or	NEXT
Q22	5 never	NEXT

Q23 **AGE 8 +** Option
 (How often does \0's provider talk about . . .)
 Drug or alcohol use- would you say . . .

Q23	1 always	NEXT
Q23	2 usually	NEXT
Q23	8 DK	NEXT
Q23	9 NA	NEXT
Q23	3 sometimes	NEXT
Q23	4 rarely, or	NEXT
Q23	5 never	NEXT

Q24 Option
 (How often does \0's provider talk about . . .)
 Weight - would you say . . .

Q24	1 always	NEXT
Q24	2 usually	NEXT
Q24	8 DK	NEXT
Q24	9 NA	NEXT
Q24	3 sometimes	NEXT
Q24	4 rarely, or	NEXT
Q24	5 never	NEXT

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Q25 **AGE 8 +** Option
 (How often does \0's provider talk about . . .)
 Use of tobacco products- would you say . . .

Q25	1 always	NEXT
Q25	2 usually	NEXT
Q25	8 DK	NEXT
Q25	9 NA	NEXT
Q25	3 sometimes	NEXT
Q25	4 rarely, or	NEXT
Q25	5 never	NEXT

Q26 Option
 (How often does \0's provider talk about . . .)
 Risks of second hand smoke- would you say . . .

Q26	1 always	NEXT
Q26	2 usually	NEXT
Q26	3 sometimes	NEXT
Q26	4 rarely, or	NEXT
Q26	5 never	NEXT
Q26	8 DK	NEXT
Q26	9 NA	NEXT

Q27 Option
 (How often does \0's provider talk about . . .)
 Dental health- would you say . . .

Q27	1 always	NEXT
Q27	2 usually	NEXT
Q27	8 DK	NEXT
Q27	9 NA	NEXT
Q27	3 sometimes	NEXT
Q27	4 rarely, or	NEXT
Q27	5 never	NEXT

Q28 Option
 (How often does \0's provider talk about . . .)
 Social and emotional development- would you say . . .

Q28	1 always	NEXT
Q28	2 usually	NEXT
Q28	8 DK	NEXT
Q28	9 NA	NEXT
Q28	3 sometimes	NEXT
Q28	4 rarely, or	NEXT
Q28	5 never	NEXT

Q29 Option
 (How often does \0's provider talk about . . .)
 Mental health- would you say . . .

Q29	1 always	NEXT
Q29	2 usually	NEXT
Q29	3 sometimes	NEXT
Q29	4 rarely, or	NEXT
Q29	5 never	NEXT
Q29	8 DK	NEXT
Q29	9 NA	NEXT

Q30 **AGE 8 +** Option
 (How often does \0's provider talk about . . .)
 Reproductive health- would you say . . .

Q30	1 always	NEXT
Q30	2 usually	NEXT
Q30	8 DK	NEXT
Q30	9 NA	NEXT
Q30	3 sometimes	NEXT
Q30	4 rarely, or	NEXT
Q30	5 never	NEXT

Q31 Option
 Would it be helpful if \0's provider gave you more information about nutrition and diet for \0?

Q31	1 YES	NEXT
Q31	2 NO	NEXT
Q31	8 DK	NEXT
Q31	9 NA	NEXT

Q32 **AGE 3 +** Option
 (Would it be helpful if \0's provider gave you more information about . . .)
 exercise for \0 . . .

Q32	1 YES	NEXT
Q32	2 NO	NEXT
Q32	8 DK	NEXT
Q32	9 NA	NEXT

Q33 **AGE 8 +** Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 drug or alcohol use . . .

Q33	1 YES	NEXT
Q33	2 NO	NEXT
Q33	8 DK	NEXT
Q33	9 NA	NEXT

Q34 Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 weight . . .

Q34	1 YES	NEXT
Q34	2 NO	NEXT
Q34	8 DK	NEXT
Q34	9 NA	NEXT

Q35 **AGE 8 +** Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 use of tobacco products . . .

Q35	1 YES	NEXT
Q35	2 NO	NEXT
Q35	8 DK	NEXT
Q35	9 NA	NEXT

Q36 Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 risks of second hand smoke . . .

Q36	1 YES	NEXT
Q36	2 NO	NEXT
Q36	8 DK	NEXT
Q36	9 NA	NEXT

Q37 Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 dental health . . .

Q37	1 YES	NEXT
Q37	2 NO	NEXT
Q37	8 DK	NEXT
Q37	9 NA	NEXT

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Q38 Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 social and emotional development . . .

Q38	1 YES	NEXT
Q38	2 NO	NEXT
Q38	8 DK	NEXT
Q38	9 NA	NEXT

Q39 Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 mental health . . .

Q39	1 YES	NEXT
Q39	2 NO	NEXT
Q39	8 DK	NEXT
Q39	9 NA	NEXT

Q40 **AGE 8 +** Option
 (Would it be helpful if \0's provider gave you more information about. . .)
 reproductive health . . .

Q40	1 YES	NEXT
Q40	2 NO	NEXT
Q40	8 DK	NEXT
Q40	9 NA	NEXT

Q41 Multiple Check

Where do you usually get information about health issues?
 (CHECK ALL THAT APPLY)

Q41	1 HEALTHCARE PROVIDER	NEXT
Q41	2 MAGAZINES/NEWSPAPERS	NEXT
Q41	3 TV	NEXT
Q41	5 FAMILY MEMBER	NEXT
Q41	6 FRIENDS	NEXT
Q41	7 SCHOOL	NEXT
Q41	9 OTHER (SPECIFY)	NEXT
Q41	10 Other	NEXT
Q41	98 DK	NEXT
Q41	99 NA	NEXT
Q41	4 INTERNET	NEXT
Q41	8 WIC PROGRAM (WOMEN/INFANTS/CHILDREN)	NEXT

Q42 Option

Do you have internet access either at home or at work?

Q42	1 YES	NEXT
Q42	2 NO	NEXT
Q42	8 DK	NEXT
Q42	9 NA	NEXT

Q43 Option

How often do you use the internet? Would you say . . .

Q43	1 every day	NEXT
Q43	2 1-3 times a week	NEXT
Q43	3 1-3 times a month	NEXT
Q43	4 less than once a month, or	NEXT
Q43	5 never	NEXT
Q43	8 DK	NEXT
Q43	9 NA	NEXT

Q44 Option

In the last 6 months, was there a time \0 needed health care but did NOT get it?

Q44	1 YES	Q46
Q44	2 NO	NEXT
Q44	8 DK	Q49
Q44	9 NA	Q49

Q45 Option

Do you mean \G0 didn't need any care (CHECK 1), or \G0 needed care and got it? (CHECK 2)

Q45	1 DID NOT NEED CARE	Q49
Q45	2 NEEDED CARE AND GOT IT	Q49
Q45	8 DK	Q49
Q45	9 NA	Q49

Q46

Multiple Check

What type of care did \0 need but did not receive? Please tell me all the types of care you can think of. (DO NOT READ; CHECK ALL THAT APPLY)

- Q46 1 ROUTINE DENTAL CARE NEXT
- Q46 4 MENTAL HEALTH SERVICES OR COUNSELING NEXT
- Q46 5 EYE CARE/GLASSES NEXT
- Q46 7 SICK CHILD/ URGENT CARE (NON-LIFE THREATNG-EVEN IF SEEN IN E.R.) NEXT
- Q46 8 WELL CHILD/ REGULAR CHECK UP NEXT
- Q46 6 SPEECH THERAPY NEXT
- Q46 3 PRESCRIPTION MEDICINE NEXT
- Q46 9 SPECIALIST CARE NEXT
- Q46 2 BRACES OR SPECIAL DENTAL SERVICES NEXT
- Q46 10 OTHER TYPE NEXT
- Q46 11 Other NEXT
- Q46 98 DK NEXT
- Q46 99 NA NEXT

Q47

Option

Please tell me the main reason you could not get the care for \0 that \G0 needed. Was it because . . . (READ OPTIONS, CHOOSE ONLY ONE)

- Q47 2 you couldn't find a provider Q49
- Q47 3 you couldn't find a provider who would take MaineCare Q49
- Q47 4 you couldn't find a provider who would make an appointment soon enough Q49
- Q47 6 some other reason NEXT
- Q47 8 DK Q49
- Q47 9 NA Q49
- Q47 5 you thought \G0 would get better anyway, or Q49
- Q47 1 \0 was not covered by MaineCare at that time Q49

Q48

Text Entry

What was that other reason?

- Q48 0 REASON (98=DK, 99=NA) NEXT

Q49

SKIP IF Q14 >1- NO REGULAR PROVIDER

Text Entry

We want to know your rating of \0's usual health care provider. On a scale of 0 to 10 where 0 is the worst provider possible and 10 is the best provider possible, how would you rate your child's provider?

- Q49 0 RATING (98=DK, 99=NA) NEXT

Q50 **SKIP IF Q14 >1- NO REGULAR PROVIDER** Text Entry

We also want to know your rating of the office staff at \0's usual health care provider's office. On a scale of 0 to 10 where 0 is rude and unhelpful and 10 is professional and efficient, how would you rate your child's provider's office

Q50 0 RATING (98=DK, 99=NA) NEXT

Q51 Multiple Check

Now I have a few questions about MaineCare.

Overall, what are the two most important reasons for having \0 enrolled in MaineCare?
(DO NOT READ; ONLY RECORD FIRST 2 RESPONSES)

Q51	1 PEACE OF MIND/SECURITY/NO WORRY	NEXT
Q51	5 COVERS SPECIALISTS	NEXT
Q51	2 NOT HAVING TO GO TO EMERGENCY ROOM FOR ROUTINE CARE	NEXT
Q51	3 COULDN'T AFFORD/WOULDN'T HAVE HEALTH CARE W/O IT	NEXT
Q51	7 PRESCRIPTIONS PROVIDED	NEXT
Q51	6 DENTAL COVERAGE	NEXT
Q51	4 COVERS PREVENTIVE CARE (CHECKUPS & ROUTINE CARE FROM PCP)	NEXT
Q51	8 COVERS other SERVICES WE NEED	NEXT
Q51	9 OTHER REASON	NEXT
Q51	98 DK/NA	NEXT
Q51	10 Other	NEXT

Q52 Option

In general, how satisfied are you with MaineCare as a health insurance plan? Are you . . .

Q52	1 very satisfied	NEXT
Q52	2 somewhat satisfied	NEXT
Q52	3 somewhat dissatisfied, or	Q54
Q52	4 very dissatisfied	Q54
Q52	8 DK	Q55
Q52	9 NA	Q55

Q53

Multiple Check

Could you tell me why you're satisfied?
(DO NOT READ; CHECK ALL THAT R MENTIONS)

- Q53 1 AFFORDABILITY/COST/PRICE Q55
- Q53 2 COVERAGE/BENEFITS Q55
- Q53 3 EFFICIENT Q55
- Q53 4 OTHER REASON Q55
- Q53 5 Other Q55
- Q53 8 DK Q55
- Q53 9 NA Q55
- Q53 6 NO PROBLEMS, NO HASSLES Q55

Q54

Multiple Check

Could you tell me why you're dissatisfied?
(DO NOT READ; CHECK ALL THAT R MENTIONS)

- Q54 4 PRIOR AUTHORIZATION REQUIRED FOR EVERYTHING NEXT
- Q54 3 GENERAL HASSLE NEXT
- Q54 8 THE WAY WE'RE TREATED BY PROVIDERS OFFICES NEXT
- Q54 6 THE WAY WE'RE TREATED BY MAINECARE NEXT
- Q54 2 COVERAGE LIMITATION NEXT
- Q54 7 LIMITED PCPs AVAILABLE (MAINECARE NETWORK PCP ONLY) NEXT
- Q54 9 DISTANCE TO MAINECARE PCP NEXT
- Q54 5 CAN'T FIND PROVIDER WHO WILL TAKE MAINECARE NEXT
- Q54 10 OTHER REASON NEXT
- Q54 11 Other NEXT
- Q54 98 DK NEXT
- Q54 99 NA NEXT
- Q54 1 LACK OF DENTAL PROVIDERS/NONE TAKE MAINECARE PATIENTS NEXT

Q55

Option

Now I'm going to ask you about your child's health.

In general, how would you rate \0's overall health now? This would be \G2 overall, general health; not if \G0 currently has a cold or other short term problem. Would you say it is . . .

- Q55 1 excellent NEXT
- Q55 2 very good NEXT
- Q55 3 good NEXT
- Q55 4 fair, or NEXT
- Q55 5 poor NEXT
- Q55 8 DK NEXT
- Q55 9 NA NEXT

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Q56

Option

Does \0 have any kind of condition that limits \G2 ability to do what other kids \G2 age can do? This condition might be emotional, developmental, physical or behavioral.

- Q56 1 YES NEXT
- Q56 2 NO Q59
- Q56 8 DK Q59
- Q56 9 NA Q59

Q57

Multiple Check

What is the condition?
(DO NOT READ LIST, CHECK ALL THAT APPLY)

- Q57 1 LEARNING DISORDER LIKE ADD OR ADHD NEXT
- Q57 2 ASTHMA NEXT
- Q57 3 DEVELOPMNTL DELAY (INCL. SPEECH/MOTOR IMPAIRMNT) NEXT
- Q57 4 MENTAL/ BEHAVIORAL COND LIKE DEPRESSION/ANXIETY/BIPOLAR DIS. NEXT
- Q57 5 VISION /HEARING COND THAT CAN'T BE CORRECTED W/GLASSES/HEARING AID NEXT
- Q57 6 AUTISM OR ASPERGER SYNDROME NEXT
- Q57 7 DIABETES NEXT
- Q57 9 SOME OTHER CONDITION (SPECIFY) NEXT
- Q57 10 Other condition NEXT
- Q57 98 DK/NA NEXT
- Q57 8 MEDICAL COND LIKE A HEART/LUNG/KIDNEY PROBLEM NEXT

Q58

Option

Does \0 get the care and services \G0 needs for this condition? Would you say \G0 . . .
(READ OPTIONS)

- Q58 1 always gets the care and services \G0 needs NEXT
- Q58 2 usually NEXT
- Q58 3 sometimes NEXT
- Q58 4 rarely, or NEXT
- Q58 5 never gets the care and services \G0 needs NEXT
- Q58 8 DK NEXT
- Q58 9 NA NEXT

Q59

Text Entry

What is your child's height?
(PROBE: Your best guess is fine.)
FEET:

- Q59 0 HEIGHT/FEET (98=DK, 99=NA) NEXT

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Q60 Text Entry

INCHES:

Q60 0 INCHES (98=DK, 99=NA) NEXT

Q61 Text Entry

What is your child's weight?
(IF ASKED; WEIGHT WITHOUT CLOTHES) (PROBE: Your best guess is fine.)
LBS:

Q61 0 WEIGHT (98=DK, 99=NA) NEXT

Q62 Option

How would you describe \0's weight . . . Would you say that \G0 is:
(READ OPTIONS, CHECK ONLY ONE)

Q62 1 underweight NEXT

Q62 2 slightly underweight NEXT

Q62 3 about the right weight NEXT

Q62 4 slightly overweight, or NEXT

Q62 5 overweight NEXT

Q62 8 DK NEXT

Q62 9 NA NEXT

Q63 Option

Does \0 need help with diet or exercise?
(IWER NOTE: THIS MEANS ANY KIND OF HELP AT ALL)

Q63 1 YES NEXT

Q63 2 NO NEXT

Q63 8 DK NEXT

Q63 9 NA NEXT

Q63 3 NOT SURE NEXT

Q64 Option

To the best of your knowledge, does \0 currently have diabetes?

Q64 1 YES NEXT

Q64 2 NO Q66

Q64 8 DK Q66

Q64 9 NA Q66

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Q65 Option

Does \0 use insulin?

Q65	1 YES	NEXT
Q65	2 NO	NEXT
Q65	8 DK	NEXT
Q65	9 NA	NEXT

Q66 **AGE 3+** Option

To the best of your knowledge, does \0 currently have depression or anxiety problems?

Q66	1 YES	NEXT
Q66	2 NO	NEXT
Q66	8 DK	NEXT
Q66	9 NA	NEXT

Q67 Option

(To the best of your knowledge . . .)

Does \0 currently have a heart problem, including congenital heart disease?

Q67	1 YES	NEXT
Q67	2 NO	NEXT
Q67	8 DK	NEXT
Q67	9 NA	NEXT

Q68 Option

(To the best of your knowledge . . .)

Does \0 currently have asthma?

Q68	1 YES	NEXT
Q68	2 NO	NEXT
Q68	8 DK	NEXT
Q68	9 NA	NEXT

Q69

Option

{\5<4}{During the past month, how often did \0 exercise? Was it . . .
 (IWER NOTE: ANY KIND OF EXERCISE COUNTS, FOR EX. ACTIVE PLAY, WALKING TO SCHOOL, AFTER SCHOOL SPORTS, GOING OUT TO PLAY, RUNNING AROUND, ETC.)}{During the past month, other than in gym class at school, how often did \0 exercise? Was it . . . (IWER NOTE: ANY KIND OF EXERCISE COUNTS, FOR EX. ACTIVE PLAY, WALKING TO SCHOOL, AFTER SCHOOL SPORTS, GOING OUT TO PLAY, RUNNING AROUND, ETC.)}

- Q69 1 everyday NEXT
- Q69 2 2-3 times a week NEXT
- Q69 3 once a week NEXT
- Q69 4 once a month, or NEXT
- Q69 5 never Q73
- Q69 8 DK Q73
- Q69 9 NA Q73

Q70

Option

How much exercise does \G0 do each time (usually)? Is it . . .

- Q70 1 15 minutes NEXT
- Q70 2 30 minutes NEXT
- Q70 3 45 minutes, or NEXT
- Q70 4 1 hour or more NEXT
- Q70 8 DK NEXT
- Q70 9 NA NEXT

Q71

Option

What kind of exercise was it?
 (DO NOT READ: IF MORE THAN ONE, CHOOSE THE ONE THAT \G0 DOES MOST OFTEN)

- Q71 2 WALK Q73
- Q71 5 RUN Q73
- Q71 6 SWIM Q73
- Q71 4 BICYCLE Q73
- Q71 7 EXERCISE/ DANCE/ MARTIAL ARTS CLASS Q73
- Q71 9 HORSEBACK RIDING Q73
- Q71 3 TEAM SPORTS (SOCCER, BASEBALL, HOCKEY, ETC.) Q73
- Q71 10 PASSIVE EXERCISE (SNOWMOBILING, FISHING, HUNTING, ATV), ETC. Q73
- Q71 11 OTHER TYPE NEXT
- Q71 98 DK Q73
- Q71 99 NA Q73
- Q71 1 ACTIVE PLAY Q73
- Q71 8 WORK RELATED Q73

Q72 Text Entry

OTHER TYPE OF EXERCISE:

Q72 0 EXERCISE (98=DK, 99=NA) NEXT

Q73 AGE 4+ Option

Does \0's school offer physical education classes?

Q73 3 DOESN'T GO TO SCHOOL Q76
Q73 1 YES NEXT
Q73 2 NO Q76
Q73 8 DK Q76
Q73 9 NA Q76

Q74 AGE 4+ Option

Are the physical education classes given throughout the school year, or just part of the year?

Q74 1 ALL SCHOOL YEAR NEXT
Q74 2 PART OF YEAR NEXT
Q74 8 DK NEXT
Q74 9 NA NEXT

Q75 AGE 4+ Option

How many times a week does \0 have physical education at school?

Q75 1 ONCE A WEEK NEXT
Q75 2 2 TIMES PER WEEK NEXT
Q75 3 3 OR MORE TIMES PER WEEK NEXT
Q75 8 DK NEXT
Q75 9 NA NEXT
Q75 4 CHILD DOESN'T TAKE IT NEXT

Q76

Option

How often does \0 drink a can or a glass of soda?

(IWER: IF \G0 DRINKS ONE CAN OF SODA 2-3 TIMES PER WEEK, THEN THE ANSWER WOULD BE 2-6 CANS PER WEEK.)

Q76	1 NEVER	NEXT
Q76	2 1-3 CANS PER MONTH	NEXT
Q76	3 1 CAN PER WEEK	NEXT
Q76	4 2-6 CANS PER WEEK	NEXT
Q76	5 1 CAN A DAY	NEXT
Q76	6 2 OR MORE CANS A DAY	NEXT
Q76	8 DK	NEXT
Q76	9 NA	NEXT

Q77

Option

How often does \0 eat vegetables?

(PROBE: "Vegetables are all cooked and uncooked vegetables; salads; and boiled baked and mashed potatoes. Do not count french fries or chips.")

Q77	1 NEVER	NEXT
Q77	2 1-3 TIMES A MONTH	NEXT
Q77	3 ONCE A WEEK	NEXT
Q77	4 2-6 TIMES A WEEK	NEXT
Q77	5 ONCE A DAY	NEXT
Q77	6 2 OR MORE TIMES A DAY	NEXT
Q77	8 DK	NEXT
Q77	9 NA	NEXT

Q78 **AGE 8+**

Option

Does \0 smoke or use tobacco products?

Q78	1 YES	NEXT
Q78	2 NO	NEXT
Q78	8 DK, NOT SURE	NEXT
Q78	9 NA	NEXT

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Q79

Option

How many people in your household smoke or use tobacco products?
(PROBE: "Even if they go outside to smoke, please count them.")

Q79	1 1	NEXT
Q79	2 2	NEXT
Q79	3 3 OR MORE	NEXT
Q79	4 NONE	NEXT
Q79	5 SOMEBODY SMOKES, UNKNOWN #	NEXT
Q79	8 DK	NEXT
Q79	9 NA	NEXT

Q80 **SKIP IF NOT CUB CARE**

Option

The last few questions are about you.

{Q1=1 OR Q1=2}{MaineCare requires a premium to be paid every month. When \0 was enrolled, how easy or hard was it to afford to pay the premium? Was it . . .}{MaineCare requires a premium to be paid every month. How easy or hard has it been to afford to pay the premium? Is it . . .}

Q80	1 very easy	NEXT
Q80	2 somewhat easy	NEXT
Q80	3 neither easy nor hard	NEXT
Q80	4 somewhat hard, or	NEXT
Q80	8 DK	NEXT
Q80	9 NA	NEXT
Q80	5 very hard	NEXT

Q81

Option

{Q80>0}{What is the highest grade or level of school that you have completed so far?}{The last few questions are about you. What is the highest grade or level of school that you have completed so far?}

Q81	1 8TH GRADE OR LESS	NEXT
Q81	2 SOME HIGH SCHOOL, BUT DID NOT GRADUATE	NEXT
Q81	3 HIGH SCHOOL GRADUATE OR GED	NEXT
Q81	4 SOME COLLEGE OR 2 YEAR DEGREE	NEXT
Q81	5 4 YEAR COLLEGE DEGREE	NEXT
Q81	6 MORE THAN 4 YEAR COLLEGE DEGREE	NEXT
Q81	8 DK	NEXT
Q81	9 NA	NEXT

Q82 Option

How are you related to V0?

Q82	1 PARENT/STEP PARENT	Q84
Q82	2 GRANDPARENT	Q84
Q82	3 LEGAL GUARDIAN	Q84
Q82	4 OTHER RELATIVE	NEXT
Q82	8 DK	Q84
Q82	9 NA	Q84
Q82	5 FOSTER PARENT	Q84
Q82	6 PARTNER/BOYFRIEND/GIRLFRIEND OF PARENT	Q84

Q83 Text Entry

How are you related?

Q83	0 RELATED (98=DK, 99=NA)	NEXT
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Q84 Option

The last few questions are about the main wage earner in your household.

Who is the main wage earner?

(IWER NOTE: IF NECESSARY, EXPLAIN "The main wage earner is the adult living in your home who works and earns the most each week, or if no one is working, the adult who owns or rents your home.")

(PROBE IF NECESSARY: "How are you related to that person? So he/she's your . . .")

Q84	1 I AM/ SELF (THE RESPONDENT)	Q86
Q84	2 MY SPOUSE	Q86
Q84	4 MY CHILD (R IS MWE'S PARENT)	Q86
Q84	5 MY PARENT (R IS MWE'S CHILD)	Q86
Q84	6 MY OTHER RELATIVE	Q86
Q84	7 MY ROOMMATE	Q86
Q84	8 OTHER	NEXT
Q84	99 NA	Q86
Q84	98 DK	Q86
Q84	3 MY UNMARRIED PARTNER (BOYFRIEND/GIRLFRIEND)	Q86

Q85 Text Entry

R'S RELATIONSHIP TO MAIN WAGE EARNER:

(PROBE IF NECESSARY: "So he/she's your.. .")

Q85	0 MAIN WAGE EARNER (98=DK, 99=NA)	NEXT
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Q86

Option

{Q84=1}{Which of the following best describes your current work status?}{Which of the following best describes the work status of the main wage earner in your household?}

- Q86 1 works full-time NEXT
- Q86 2 works 1 part-time job NEXT
- Q86 3 works more than 1 part-time job NEXT
- Q86 4 works seasonally NEXT
- Q86 5 self-employed NEXT
- Q86 6 disabled, not working NEXT
- Q86 7 retired, not working NEXT
- Q86 8 unemployed, looking for work, or NEXT
- Q86 9 not working NEXT
- Q86 98 DK NEXT
- Q86 99 NA NEXT

Q87 **SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED** Option

{Q84=1}{Approximately how many employees are in the company or organization where you work?}{Approximately how many employees are in the company or organization where he/she works?}

- Q87 1 LESS THAN 25 NEXT
- Q87 2 25 TO 50 EMPLOYEES NEXT
- Q87 3 MORE THAN 50 EMPLOYEES NEXT
- Q87 8 DK NEXT
- Q87 9 NA NEXT

Q88 **SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED** Option

Does the company or organization currently offer health insurance to any of its employees?

- Q88 1 YES NEXT
- Q88 2 NO Q95
- Q88 8 DK Q95
- Q88 9 NA Q95

Q89 **SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED** Option

{Q84=1}{Are you eligible to receive that health insurance?}{Is he/she eligible to receive that health insurance?}

- Q89 1 YES NEXT
- Q89 2 NO Q95
- Q89 8 DK Q95
- Q89 9 NA Q95
- Q89 3 NOT YET Q95

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Q90 SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED Option

{Q84=1}{Are you enrolled in the employer's health insurance program?}{Is he/she enrolled in the employer's health insurance program?}

Q90	1 YES	Q92
Q90	2 NO	NEXT
Q90	8 DK	Q92
Q90	9 NA	Q92

Q91 SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED Option

{Q84=1}{Now I'll read a list of possible reasons why you may not be enrolled in the insurance offered by that employer. Is it because . . .}{Now I'll read a list of possible reasons why he/she may not be enrolled in the insurance offered by that employer. Is it because . . .}

Q91	1 it is too expensive	NEXT
Q91	2 the coverage is too limited	NEXT
Q91	3 MaineCare offers better coverage	NEXT
Q91	4 MaineCare is less expensive, or	NEXT
Q91	5 SOME OTHER REASON	NEXT
Q91	6 Other	NEXT
Q91	8 DK	NEXT
Q91	9 NA	NEXT

Q92 SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED Option

Can that insurance cover \0?

Q92	1 YES	NEXT
Q92	2 NO	Q95
Q92	8 DK	Q95
Q92	9 NA	Q95

Q93 SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED Option

Is \0 enrolled in that insurance?

Q93	1 YES	Q95
Q93	2 NO	NEXT
Q93	8 DK	Q95
Q93	9 NA	Q95

Q94 **SKIP IF Q86>5- MAIN WAGE EARNER NOT EMPLOYED** Multiple Check

Now I'll read a list of possible reasons why \0 may not be enrolled in the insurance offered by that employer. Is it because . . .

Q94	1 it is too expensive	NEXT
Q94	2 the coverage is too limited	NEXT
Q94	3 MaineCare offers better coverage	NEXT
Q94	4 MaineCare is less expensive, or	NEXT
Q94	5 SOME OTHER REASON	NEXT
Q94	6 Other	NEXT
Q94	8 DK	NEXT
Q94	9 NA	NEXT

Q95 Multiple Check

{Q84=1}{Finally, I'm going to read a list of different types of health insurance. Please tell me which, if any, you have:}{Finally, I'm going to read a list of different types of health insurance. Please tell me which, if any, the main wage

Q95	2 Medicare	NEXT
Q95	7 Health insurance through the military (TriCare, CHAMPUS, Veteran's Services)	NEXT
Q95	4 Dirigo Choice (CARD FROM ANTHEM)	NEXT
Q95	5 Health insurance through someone else's work or union	NEXT
Q95	6 Health insurance bought directly from an insurance company	NEXT
Q95	1 MaineCare	NEXT
Q95	3 Health insurance through main wage earner's work or union	NEXT
Q95	8 Some OTHER health insurance, or	NEXT
Q95	98 DK	NEXT
Q95	99 NA	NEXT
Q95	9 No health insurance?	NEXT
Q95	10 Other	NEXT

Q96 Option

Those are all the questions I have for you today. Thank you very much for your time.
(IWER: ALWAYS CHECK 1 HERE)

Q96	1 END	END
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