Children Served by MaineCare, 2007

Survey Findings

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Executive Summary

This report presents findings from a 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 randomly selected, and 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 May and September 2007 telephone interviews were completed with 1,531 parents of enrolled children and 259 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 continue to be overwhelmingly satisfied with the MaineCare benefit, with their children's MaineCare providers, and with the quality of care their children receive. Parents rated their child's MaineCare provider an average of 8.9 (out of a best possible score of 10), and rated the office staff an average of 8.8. Ninety five percent of parents interviewed said they are *very or somewhat* satisfied with MaineCare as a health insurance plan.

Among the minority of respondents who did express dissatisfaction with MaineCare, the most common specific complaint was the lack of dental providers who accept MaineCare coverage or who have a practice in the area. A number of respondents also expressed dissatisfaction about coverage limitations, such as lack of coverage for a specific prescription drug.

Most children with MaineCare coverage are in good health. Eighty five percent of parents surveyed said that their child was in *very good or excellent* health. Only three percent reported having a child in *fair or poor* health. However, several conditions and health risk factors are more prevalent among children with MaineCare coverage than in the general population, including asthma, mental health conditions, and being overweight.

[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.

Parental reports from the survey indicate that 12% of children with MaineCare coverage currently have asthma. This rate is comparable to the 14% of low-income children in Maine found to have asthma in the 2003 National Survey of Children's Health, but substantially higher than the 7% of higher-income (>200% FPL) children who have asthma in the 2003 NSCH. Environmental tobacco smoke (ETS) may be a contributing factor to the high rate of asthma among children on MaineCare, in that almost half of the children with asthma live in households with one or more adult smokers. MaineCare could help reduce the burden of asthma and the impact of ETS through greater 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 38 percent said their PCP *rarely* or *never* talks to them about the topic.

Almost one in five (18%) children with MaineCare coverage has a current diagnosis of ADD/ADHD, anxiety, or depression. Looking at these three conditions separately, we found that 11% have ADD/ADHD, 10% have an anxiety disorder, and 7% have depression. The prevalence of anxiety or depression among children with MaineCare coverage (13%) is similar to other low-income children in Maine, but much higher than high-income children (7%) according to the 2003 NSCH.

A third health issue highlighted by the survey is the exorbitant rates of overweight among children of all ages on MaineCare. More than one quarter of all children age 2 to 18 in the study are estimated to be overweight[3] and an additional 18 percent are at risk of overweight. Teens (13 – 18 years old) have lower rates of overweight than younger children with MaineCare coverage, but are still much more likely to be overweight than high-school students in the general population in Maine. These findings regarding childhood overweight in the 2007 MaineCare survey are essentially unchanged from a similar study conducted in 2006.

Survey findings also indicate that a substantial minority of parents do not accurately identify when their child is overweight. Only 51 percent of respondents with an overweight child – as measured by BMI calculated from reported height and weight -- described that child as being 'overweight'. Parents of younger children appear to have a more difficult time identifying their child as being overweight. Only 15 percent of parents with overweight children age 6-12 rated their child as being *overweight*, compared with 43 percent of parents with overweight children age 13-18. Overweight children on MaineCare could potentially benefit from educational interventions designed to increase parental awareness of BMI status and the health risks of their children being overweight.

Reports of health behaviors associated with being overweight are more prevalent in older than younger children with MaineCare coverage. Toddlers and young children are reported to exercise and consume vegetables the most, whereas teens exercise and consume vegetables the least. Conversely, teens tend to consume more soda and spend more time watching television or playing video games. Coupled with the high rates of overweight and its associated health risks, these findings suggest that older children with MaineCare coverage would benefit from increased provider advice on exercise and healthy eating habits.

Outreach through providers holds the most promise for reaching children with MaineCare coverage with health and nutrition information. Eighty percent of parents interviewed told us they usually get information about health issues from a healthcare provider. Our results also suggest that the internet may be an effective supplementary tool for this purpose. Four out of five parents use the internet at least occasionally, and almost one half (45%) said they use the internet specifically to get

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

information about health issues. Internet use for health information appears to be on the rise, as the comparable figure from 2006 was only 30 percent.

There has been a growing consensus among health care professionals and families over the past several years around what constitutes the ideal characteristics of medical care for children. The American Academy of Pediatrics codified this consensus in a 2002 policy statement that defined the concept of a medical home.[4] Access to a medical home has been shown to improve health outcomes for individuals and populations, reduce the cost of care, and reduce disparities between socially advantaged and disadvantaged populations.[5]

The 2007 MaineCare survey includes a subset of questions from the 2007 National Survey of Children's Health that are designed to measure five components of the medical home concept: 1) having a usual place for sick/well care; 2) having a personal doctor or nurse who knows the child well and is familiar with their health history; 3) experiences no difficulty in obtaining needed referrals; 4) receives needed care coordination; 5) receives family-centered care.

Virtually every child in our sample (98%) has a usual place where they receive sick- or well-child care, and the vast majority (93%) have a personal doctor or nurse who knows them well and is familiar with their health history. Among parents who said their child needed a referral for medical services in the past 12 months, 85 percent said that there was "not a problem" getting a referral. Among parents who said they used or needed assistance with coordinating care for their child in the past 12 months, 73 percent told us that they "usually" received all the assistance they wanted, and that they were satisfied with the communication among their child's health care providers. Overall, we found that 81 percent of children with MaineCare coverage receive family-centered care. Finally, we created a summary measure to indicate whether or not the child received all of the medical home measures for which they were eligible. According to this measure, 73 percent of all children in our sample have a medical home.

We identified Children with Special Health Care Needs (CSHCN) in the survey using a sub-set of questions drawn from the CSHCN Screener developed by Bethell, et al (2002). Children who have functional limitations due to a medical, behavioral or other health condition that has lasted or is expected to last 12 months or longer are classified as CSHCN. We found 191 parents, or 12.5% of all current and new enrollees, who identified their child as having special health care needs. The prevalence of every health condition measured in the survey was significantly higher among CSHCN compared with other children with MaineCare coverage. Fifty three percent of CSHCN were reported to have a developmental delay, and just under half have one or more of the three mental health conditions (ADD/ADHD, anxiety or depression). In addition, twenty eight percent of CSHCN currently have asthma, 20 percent have autism, and 2 percent have diabetes.

According to the survey, CSHCN on MaineCare are less likely to get the care they need. Thirty six percent of parents with a CSHCN reported that their child had an unmet need for health care in the last 12 months, versus only 15 percent among all other children. CSHCN also scored lower on several of the medical home measures. CSHCN were more likely to report having problems getting referrals, less likely to receive care coordination, and less likely to receive family-centered care

[4] Medical Home Initiatives for Children With Special Needs Project Advisory Committee (1 Jul 2002) The Medical Home. *Pediatrics* 110 (1) : 184-186.
[5] Starfield, B., Shi, L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. Pediatrics Volume 113, Number 5: 1943-1498, May 2004.

relative to other children with MaineCare coverage. In addition, only 58 percent of CSHCN were reported to meet all the medical home criteria, as compared with 73 percent of all children.

Many children with MaineCare coverage are not receiving recommended dental care; 28 percent of parents reported that their child had not seen a dentist for a preventive appointment in the last twelve months. Lack of preventive dental care was highest among children enrolled through the Medicaid eligibility category, with 36 percent having no visits in the past 12 months, versus only 21 percent from the Expansion and CHP eligibility categories. Unmet need for dental care also varied regionally, with 15 percent of respondents living in Region II (mid-coast and western parts of Maine) reporting unmet need for dental care, 11 percent in Region I (southern Maine), and only 7 percent in Region III (downeast and northern Maine).

From parents of children who recently disenrolled from MaineCare (n=259), we learned that most left the program because of an increase in income which meant they were no longer eligible (39%) or because their child obtained other coverage and no longer needed MaineCare (36%). More than half (60%) of all disenrolled children were enrolled in employer-sponsored insurance (ESI) at the time of the interview. But a discouraging finding is that almost one-third of disenrolled children (29%) were uninsured at the time of the interview.

Among new MaineCare enrollees (n=290), sixty percent had some form of coverage in the year before the child enrolled in the program, and just under half (47%) had employer-sponsored insurance (ESI) through a parent's employer. In addition, we found that nineteen percent of all new enrollees had access to ESI at the time of the interview but were not enrolled – primarily because it is not affordable. The percentage of new enrollees who declined available employer-sponsored insurance was highest among new CHP (34%) and Expansion (18%) 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 premiums over the past several years have caused increasing numbers of employers to either drop coverage for their employees altogether, or to pass on a higher share of the premium to their employees resulting in unaffordable premiums for many low-income families who have access to ESI.[6] 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.[7] Further, the availability of MaineCare has kept the uninsurance rate among children in Maine (7%) among the lowest of any state in the nation.[8]

[6] 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.
[7] Institute of Medicine. (2002). *Health Insurance is a Family Matter*. Washington, DC: National Academies Press.
[8] Kaiser State Health Facts Online. http://www.statehealthfacts.org Accessed January 11, 2008.

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 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 newly enrolled within the past six to eleven months prior to survey administration were selected for the *'new enrollee'* group.[9] 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. To reduce respondent burden, children from the current enrollee group living in households that participated in the 2006 survey of children with MaineCare coverage were excluded from the sample. 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 and Expansion categories to ensure a large enough sample size for this group of MaineCare enrollees.

Overall, a total of 1,790 responses were collected. This number includes 1,199 interviews with parents of children currently enrolled in MaineCare, 332 interviews of new enrollees and 259 parents of children who were recently disenrolled. Table 1 displays a summary of the numbers of completed interviews by age, gender, region of residence and eligibility category.

[9] The initial sample of "new enrollees" included only 61 children in the MaineCare Expansion, and 81 in the CHP eligibility categories; these children enrolled in MaineCare between October 2006 and January 2007. To increase the number of new enrollee respondents in these two eligibility categories, a second sample of new enrollees was pulled in September 2007. This follow-up sample included children in the MaineCare Expansion and CHP categories who enrolled in MaineCare between February and June 2007.

Table 1: Characteristics of Survey Respondents

	All Respondents N= 1,790		New Enrollee 332	Current Enrollee 1199	Disenrollee 259
Characteristic	#	%	#	#	#
Age of Child					
0 - 5	473	26%	90	325	58
6-12	651	36%	116	445	90
13-18	666	37%	126	429	111
Gender					
Female	875	49%	168	572	135
Male	915	51%	164	627	124
MaineCare Eligibility					
Medicaid	816	46%	150	552	114
Expansion	511	29%	91	343	77
CHP	463	26%	91	304	68
Region of Residence					
Region I (York and Cumberland)	410	23%	63	273	74
Region II (Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo)	738	41%	106	527	105
Region III (Aroostook, Hancock, Penobscot, Piscataquis and Washington)	538	30%	60	399	79
Unknown*	103	6%	103	0	0

* A follow-up sample of new enrollees in the Expansion and CHP eligibility categories was drawn in September 2007. County of residence information was not available for these respondents.

Survey Instrument and Administration

The survey was administered between June and September 2007 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[10] explained the purpose of the survey and offered to give the respondents the name and telephone number of a 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

[10] Professional interviewers at the Survey Research Center at the Muskie School of Public Service in Portland, Maine administered the survey. 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. All project staff are trained in HIPAA compliance and confidentiality protocols.

about the child's needs and explained that they could skip any question they did not want to answer.

Contact with 2,314 households yielded 1,946 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. 156 cases were deemed not eligible and dropped from the analysis because their enrollment status could not be confirmed[11], yielding a final analysis sample of 1,790 respondents. The child's parent or step-parent was the respondent in 96 percent of the cases, and in remaining cases the respondent was a grandparent (3%), foster parent or other relative (< 1%). (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. Overall, the effective response rate[12] for the survey was 79 percent for new enrollees, 83 percent for current enrollees, and 84 percent for disenrollees.

The survey instrument used by the Muskie School to collect information about children with MaineCare coverage has evolved and expanded over the past several years. Three separate surveys were conducted for children with MaineCare coverage from 2002 through 2004. In 2005, the surveys of new enrollees, current enrollees, and disenrollees were combined into a single instrument; skip patterns in the CATI program were used to ask disenrollees a more limited set of questions pertaining to employment, insurance status, and reasons for disenrolling. Current and new enrollees are asked the full complement of questions on the survey. In consultation with DHHS staff, questions were added in 2005 regarding health behaviors such as tobacco use and exercise, height and weight (used to compute Body Mass Index) and provider education practices.[13] In 2006, questions were added about internet access and sources of health information.[14]

Revisions to the 2007 instrument were more extensive. To facilitate comparisons between children with MaineCare coverage and populations of children nationally and of children within Maine, we altered the wording of a number of questions to match items included in the 2007 National Survey of Children's Health (NSCH 2007). The NSCH is a survey of more than 80,000

[11] These cases were determined to be not eligible for the following reasons:

- There were 133 individuals 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.
- There were 16 interviews conducted with parents of children who were identified as having recently disenrolled from MaineCare, but when contacted said their child was actually still enrolled or had re-enrolled by the date of the interview. These interviews were also discontinued.
- Seven cases were deemed ineligible because the respondent ended the interview before completing a sufficient number of questions. (Current and new enrollees were dropped if they did not complete at least through Question 52. Disenrollees were dropped if they did not complete all the questions.)

[12] 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.

[13] 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.

[14] Anderson, N., Thayer, D., & Ormond, C. (2007, March). *Children Served by MaineCare, 2006: Survey Findings.* Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.

children conducted by National Center for Health Statistics of the Centers for Disease Control. [15] The 2007 NSCH is currently being fielded, with data collection scheduled for completion in February 2008. As a result, comparative data from the 2007 NSCH is not currently available, so in this report we instead use comparison information from the 2003 NSCH.

The following topic areas were included in past surveys of children with MaineCare coverage, but question wording was altered in 2007 survey to match the 2007 NSCH.

- Usual source of care
- Unmet need for health care services
- Child with special health care need indicator (CSHCN)
- Child's height and weight / Body Mass Index
- Prevalence of asthma and diabetes (ever had condition and currently has condition)
- Health behaviors: frequency of physical activity and consumption of soda/sugar-sweetened beverages

Strictly speaking, by altering the survey items noted above, we lose the ability to directly compare results from the 2007 MaineCare survey to prior MaineCare surveys. However, where question wording did not change significantly, we do present some data from 2005 and 2006 that suggest a trend.

Survey items were also added to the 2007 MaineCare survey targeting areas of operational interest identified by DHHS staff. All of these items were also drawn from the 2007 NSCH:

- Utilization of medical and dental services in the past 12 months
- Medical home questions: referrals, care coordination, provider communication, family-centered care
- Prevalence of ADD/ADHD, depression, anxiety problems, autism and developmental delay (ever had condition and currently has condition)

The complete 2007 MaineCare Child Health questionnaire is included below as Appendix B.

[15] http://www.cdc.gov/nchs/about/major/slaits/nsch07.htm

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. During a debriefing, one interviewer mentioned that parents of younger children generally seemed more aware of their child's medical care needs and daily activities, whereas parents of older children tended to express more uncertainty in their responses.

There are also certain topics that may be subject to social bias. For example, parents may not know or may be reluctant to confirm that their child smokes or uses drugs, leading to underreporting of these items. Similarly, 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.

Most interviews took place in July and August, when children were on summer break from school. This may have had an impact on reports of children's television viewing and exercise habits, which can change during the summer months. Interviewers also reported that some respondents had difficulty answering questions about their child's participation in physical education at school, since their child was not in school at the time of the interview.

Finally, there were roughly twenty households contacted where no English-speaker was present. Due to a lack of translation services, interviews could not be conducted with these households. Consequently, children with MaineCare coverage living in families where English is not spoken are not represented in our analytic sample or in the results that follow.

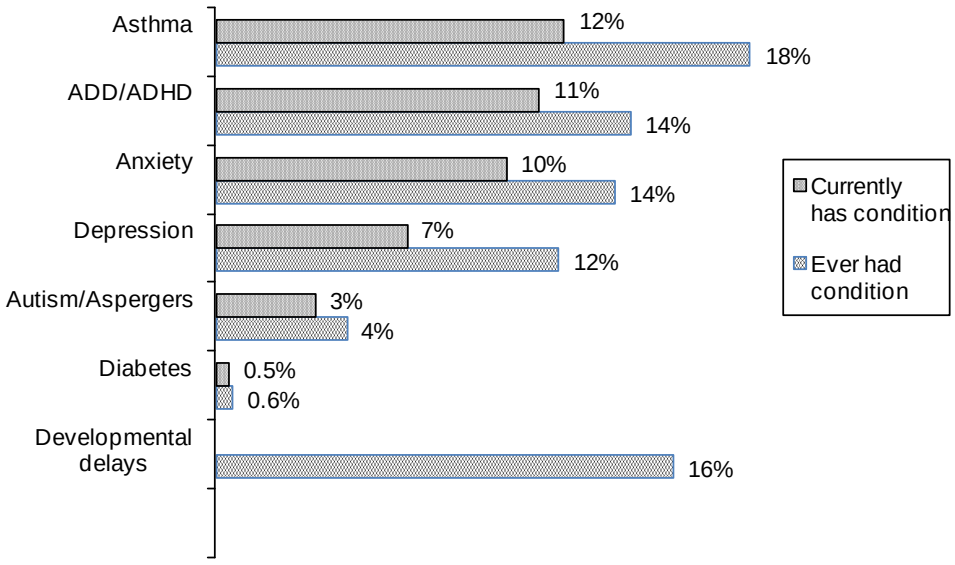
Health Status and Health Conditions

We asked each parent to describe their child's overall health status. Eighty five percent of parents reported that their child's health was excellent or very good, twelve percent said it was good, and only three percent said their child was in fair or poor health. There was no significant variation in reports of health status by the age of the child or their MaineCare eligibility category (not shown).

We also asked parents if a doctor or other health care provider had ever told them that their child had one or more of the following specific health conditions, and if their child currently has the condition: asthma, Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder (ADD or ADHD), anxiety, depression , autism or Asperger's Disorder, diabetes, and any developmental delay that affects their ability to learn.

Asthma is the most prevalent of these conditions among children with MaineCare coverage. Twelve percent of respondents said their child currently has asthma. Mental health conditions are also quite prevalent. According to the parental reports, 11 percent have ADD/ADHD, 10 percent have an anxiety disorder, and 7 percent have depression. Eighteen percent were reported to have one or more of these three mental health conditions (not shown). The survey also indicated that 3 percent of children with MaineCare coverage have an Autism spectrum disorder, and that less than 1 percent currently has diabetes. Lifetime reports of developmental delays were also fairly common, at 16 percent.

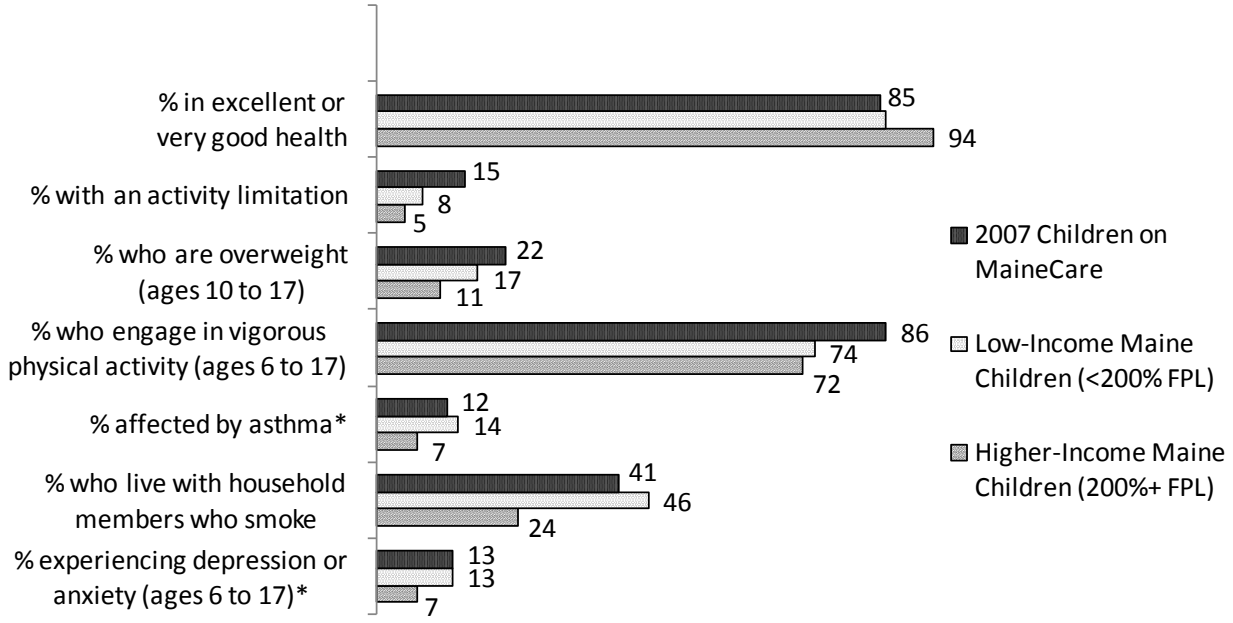
Figure 1. Prevalence of Specific Health Conditions
(Has a doctor or other health care provider ever told you that your child had…)
N=1,515



When we compared the prevalence of health conditions across the three eligibility categories, we found that lifetime prevalence of ADD/ADHD, Autism spectrum disorders, and developmental delay were all significantly higher among children enrolled in the Medicaid eligibility category, relative to those enrolled in the Expansion or CHP categories (not shown).

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).[16] A low-income comparison group, drawn from families with income below 200 percent 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.

Figure 2. Comparison of Children with MaineCare coverage with Low-Income and Higher-Income Children in Maine



* Note: There are minor differences between the 2007 MaineCare survey and the 2003 NSCH on these measures.

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

[16] 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://ww.cdc.gov/nchs/about/major/slaits/nsch.htm.

We found that, across almost all measures of health, children living in higher income families are healthier than both their low-income counterparts and children with MaineCare coverage (Figure 2). Ninety four percent of higher-income children are in excellent or very good health, and they have the lowest rates of activity limitations (5%), overweight (11%), asthma (7%), and depression or anxiety (7%). Low-income children in Maine and children with MaineCare coverage are very similar on reports of excellent/very good health (about 85 %), asthma (12 and 14%), and depression or anxiety (13%). However, children with MaineCare coverage appear to be faring poorly, even relative to other economically disadvantaged children in Maine, on measures of activity limitations (15% versus 8%) and weight problems. An estimated 22 percent of children with MaineCare coverage are overweight[17], more than one-third higher than other low-income children in Maine (17%) and double the rate of higher-income children (11%). Given the higher than average rates of weight problems, it is surprising finding that children with MaineCare coverage appear to be more physically active than other children in Maine. Eighty six percent of parents reported that their child engages in vigorous physical activity at least 3 days per week. (As noted previously, this may be due to the fact that most of the MaineCare interviews were conducted during the summer months.) Children with MaineCare coverage are also slightly less likely to live with an adult who smokes than other low-income children in the State (41 versus 46 percent).

The prevalence of parental reports of diagnosed autism in our MaineCare sample, though low in an absolute sense, is extremely high when compared with the prevalence of autism nationally. CDC estimates indicated a prevalence of 5.5 per 1,000 children ages 4 to 17 in the 2003 NSCH.[18] In the MaineCare survey, 48 out of 1,260 parents with children in this age group reported their child currently has autism, a prevalence of 38.1 per 1,000 – more than six times higher than the prevalence of autism in the general population.

Children with Special Health Care Needs (CSHCN)

A group of particular interest is children with special health care needs (CSHCN)—defined as children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[19] Several federal and state programs target CSHCN, including children in the foster care or adoption assistance programs (Title IV-E), Supplemental Security Income (SSI), Title V-funded care coordination services[20], or services under a 1903(3)(3) option, known as the Katie Beckett option.

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[17] 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.

[18] Centers for Disease Control and Prevention. *Mental Health in the United States: Parental Report of Diagnosed Autism in Children Aged 4--17 Years --- United States, 2003--2004.* MMWR 2006; 55(17):481-486. http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5517a3.htm

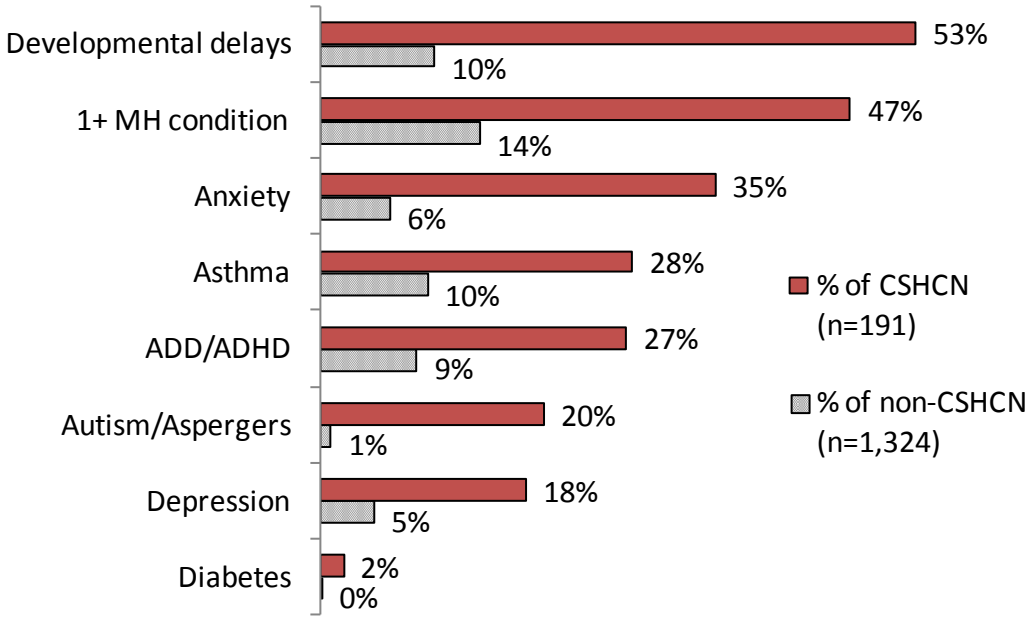
[19] McPherson, M., et al. A new definition of children with special health care needs. Pediatrics 102: 137-40, 1998.

[20] The Title V Program is funded by the federal Maternal and Child Health block grant and supports children with the following conditions: blood disorders, cardiac defects, childhood oncology, craniofacial anomalies, gastrointestinal disorders, metabolic disorders, ophthalmologic diseases, orthopedic, neurological neurosensory, neuromuscular, or respiratory conditions.

We identified CSHCN in our survey sample using a sub-set of questions drawn from the CSHCN Screener developed by Bethell, et al (2002).[21] Children who have functional limitations due to a medical, behavioral or other health condition that has lasted or is expected to last 12 months or longer are classified as CSHCN. Using this measure we found 191 parents, or 12.5% of all current and new enrollees, who identified their child as having special health care needs. There were no significant differences in the prevalence of CSHCN by eligibility category, age of the child, or region of residence.

Not surprisingly, the prevalence of every health condition measured in the survey instrument is significantly higher among children with special health care needs, compared with other children with MaineCare coverage (Figure 3). Fifty three percent of CSHCN in our sample are reported to have a developmental delay, and just under half have one or more of the three mental health conditions (ADD/ADHD, anxiety or depression). In addition ,twenty eight percent of CSHCN currently have asthma, 20 percent have autism, and 2 percent have diabetes.

Figure 3. Health Conditions of CSHCN



[21] Due to respondent burden considerations, the complete five-item CSHCN Screener could not be included in the 2007 survey. The complete CSHCN screener identifies children who experience one of five different health consequences: 1) Use or need of prescription medication, 2) Above average use or need of medical, mental health or educational services, 3) Functional limitations compared with others of same age, 4) Use or need of specialized therapies, and 5) Treatment or counseling for emotional or developmental problems. Our survey includes only questions related to functional limitations, and as a result will not capture children who would otherwise be classified as a CSHCN under one of the remaining areas. For more information, see Bethell, C.D., Read, D., Neff, J., et al. Identifying children with special health care needs: development and evaluation of a short screening instrument. *Ambulatory Pediatrics*. 2002;2:49-57.
http://www.markle.org/resources/facct/doclibFiles/documentFile_446.pdf

Access to a Medical Home

There has been a growing consensus among health care professionals and families over the past several years around what constitutes the ideal characteristics of medical care for children. The American Academy of Pediatrics codified this consensus in a 2002 policy statement that defined the concept of a medical home. The definition includes 39 elements that can be summed up as care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.[22] Access to a medical home has been shown to improve health outcomes for individuals and populations, reduce the cost of care, and reduce disparities between socially advantaged and disadvantaged populations.[23] Having a medical home is particularly important for CSHCN; in fact, goals were included in the national health objectives of Healthy People 2010 to ensure that all states have systems of services for CSHCN, and to ensure that all CSHCN have access to a medical home.[24]

The 2007 MaineCare survey includes a subset of questions from the 2007 National Survey of Children's Health that are designed to measure five components of the medical home concept: 1) having a usual place for sick/well care; 2) having a personal doctor or nurse who knows the child well and is familiar with their health history; 3) experiences no difficulty in obtaining needed referrals; 4) receives needed care coordination; 5) receives family-centered care.[25] Figure 4 presents the results of all five medical home measures and a summary measure for all new and current enrollees and for children with special health care needs.

Virtually every child in our sample (98%) had a usual place where they receive sick- or well-child care. (Children who used the emergency room--0.66 percent--were not considered to have a usual source of care.) The vast majority (93%) have a personal doctor or nurse who knows them well and is familiar with their health history. There were no significant differences between CSHCN and non-CSHCN on either of these medical home measures.

Among parents who said their child needed a referral for medical services in the past 12 months, 85 percent said that there was "not a problem" getting a referral. For CSHCN this percentage was significantly lower, at only 74 percent.

Among parents who said they used or needed assistance with coordinating care for their child in the past 12 months, 73 percent told us that they "usually" received all the assistance they wanted, and that they were very or somewhat satisfied with the communication among their child's health care providers. Children identified as CSHCN again fared worse on this measure; only 64 percent of those who used or needed care coordination usually received it.

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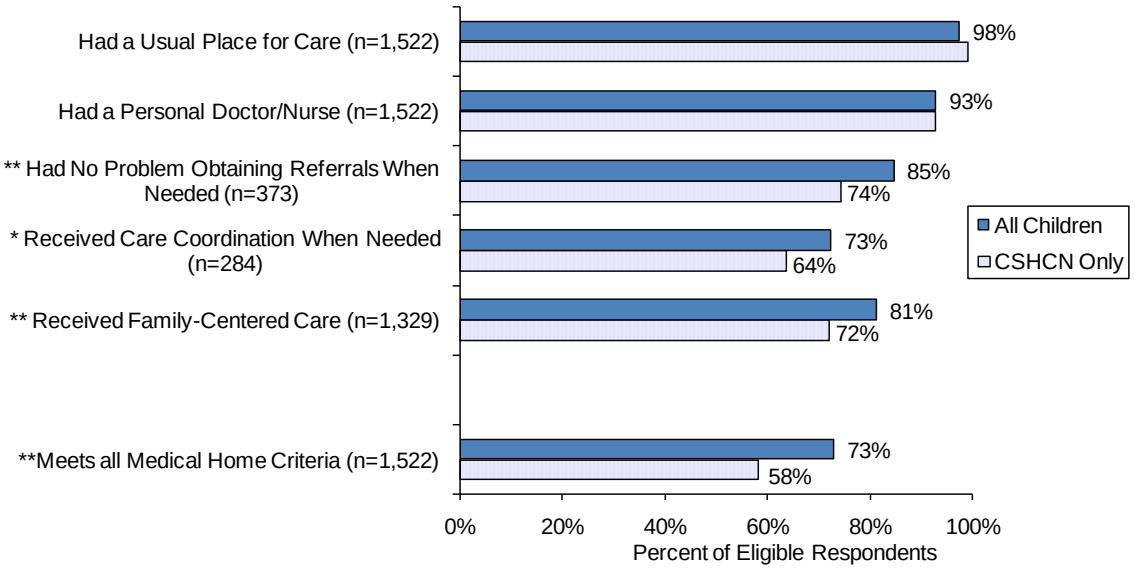
[22] Medical Home Initiatives for Children With Special Needs Project Advisory Committee (1 Jul 2002) The Medical Home. *Pediatrics* 110 (1) : 184-186.

[23] Starfield, B., Shi, L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. Pediatrics Volume 113, Number 5: 1943-1498, May 2004.

[24] U.S. Department of Health and Human Services. *Healthy People 2010.* Conf ed. Washington, DC: U.S. Department of Health and Human Services; 2000.

[25] This five-component operationalization of the medical home is borrowed from: Strickland, B, McPherson, M, Weissman, G, van Dyck, P, Huang ZJ, and Newacheck, P. Access to the Medical Home: Results of the National Surveyh of Children With Special Health Care Needs. *Pediatrics* 113 (5):1485-1492.

Figure 4. Medical home measures: All Children and CSHCN



* Difference between CSHCN and non-CSHCN is significant at p<.05;
** Difference is significant at p<.01

The family-centered care measure is a composite of three items that ask about care received during the past 12 months. If a parent said the child's health care providers "usually" or "always": 1) spent enough time with the child, 2) listened carefully, and 3) provided specific information about the causes and care of the child's health problems, then the child is considered to have received family-centered care. Overall, we found that 81 percent of children with MaineCare coverage receive family-centered care. The comparable figure for CSHCN was only 72 percent, again significantly lower than other children with MaineCare coverage.

The summary measure indicates whether or not the child received each of the medical home measures for which they were eligible.[26] According to the survey, 73 percent of all children in our sample have a medical home, whereas only 58 percent of children with special health care needs have a medical home.

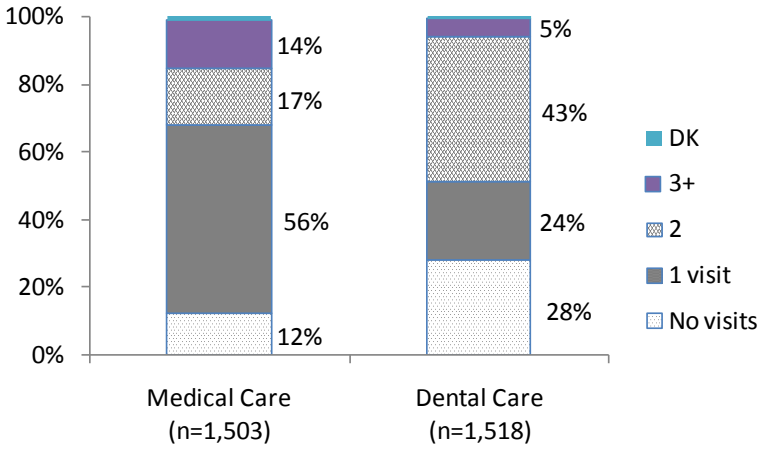
In addition to the disparities in medical home outcomes between CSHCN and non-CSHCN, we also found significant differences by age and by eligibility category (not shown). Children ages 13 and older were less likely to have a medical home (using the summary measure) than younger children (68% versus 76%), and children enrolled through the Medicaid eligibility category were less likely to have a medical home than children in the Expansion or CHP categories (70% versus 76%).

[26] Only respondents who said they needed a referral in the past 12 months were eligible for the referral measure; only respondents who said they used or needed care coordination were eligible for the care coordination measure; and only respondents who said they had visited their health care provider in the past 12 months were eligible for the family-centered care measure. The summary measure could therefore be coded based on as few as two, and on as many as five different measures.

Utilization of Services

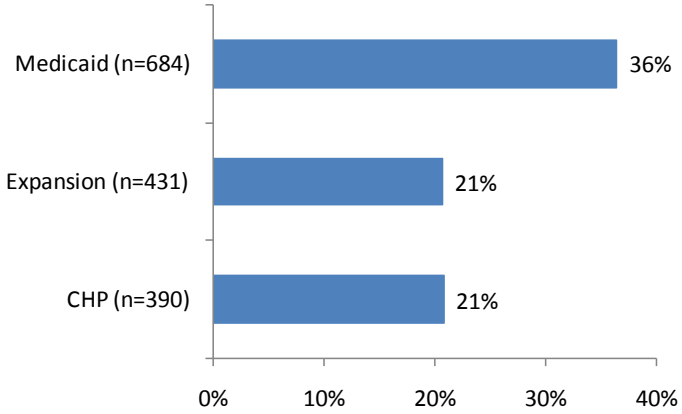
Interviewers asked respondents how many times their child saw a health care provider for preventive medical care and for preventive dental care in the past 12 months. We found that children with MaineCare coverage are more likely to receive physical exams or well-child check-ups than they are to receive dental cleanings or check-ups (Figure 5). Only 12 percent of current and new enrollees had no preventive medical visits in the past year, versus 28 percent who had no preventive dental care.

Figure 5. Number of Preventive Medical and Dental Visits in the past 12 Months



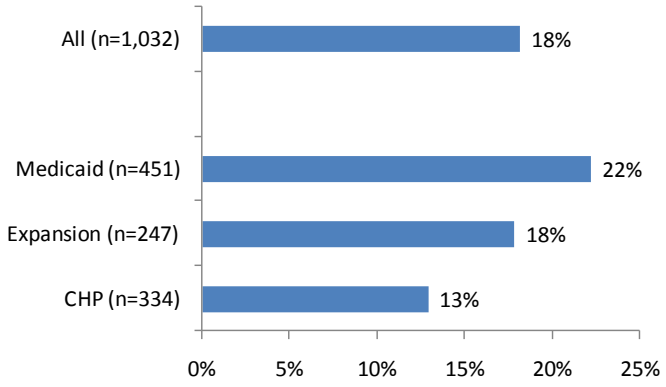
Access to preventive dental care is particularly problematic for children enrolled in MaineCare under the traditional Medicaid eligibility category (Figure 6). More than one-third (36%) of children in the Medicaid category had no preventive dental visits according to the survey, significantly higher than the 21 percent of Expansion and CHP enrollees.

Figure 6. No Preventive Dental Care in past 12 Months by MaineCare Eligibility Category



Mental health service use is less common than medical or dental care among children with MaineCare coverage, but is still quite prevalent (Figure 7). For children ages 6 and older, almost one in five (18%) received treatment or counseling in the past 12 months from a mental health professional . The proportion of children who received mental health services varied significantly across eligibility categories. The poorest children (i.e. those in the Medicaid eligibility category) were the most likely to use mental health services, followed by children in the Medicaid Expansion category, and those in CHP.

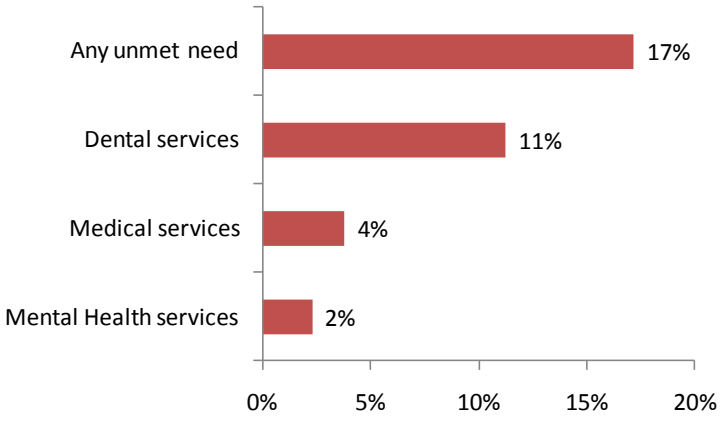
Figure 7. Mental Health Treatment or Counseling in Past 12 Months by Eligibility Category (Age 6+ only)



Unmet needs

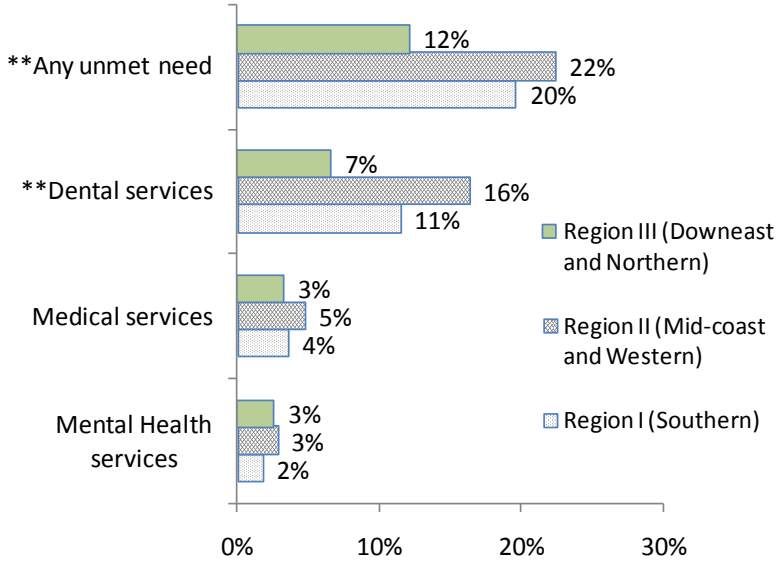
An important measure of access to health care services is whether or not children with MaineCare coverage received all the services they needed in a timely manner. Interviewers asked respondents if there was a time in the past 12 months when their child needed health care, but that care was delayed or not received. If so, the parent was asked to identify what type of care was not received (Figure 8). Seventeen percent of current and new enrollees had an unmet need for health care in the past 12 months. The most prevalent unmet need was for dental care, at 11 percent, followed by unmet need for medical services (4%) and mental health services (2%).

Figure 8. Unmet Need for Health Care Services (n=1,519)



We found significant geographic variation in patterns of unmet need among children with MaineCare coverage (Figure 9). Children living in Region III (downeast and northern Maine) were significantly less likely to report having delayed or unmet need for health care services in the past year; only 12 percent reported any unmet need, versus more than 20-22 percent of children living in other parts of the state. Unmet need for dental services was highest for children living in Region II (mid-coast and western Maine), and lowest for those living in Region III. There were no significant geographic differences in unmet need for medical or mental health services.

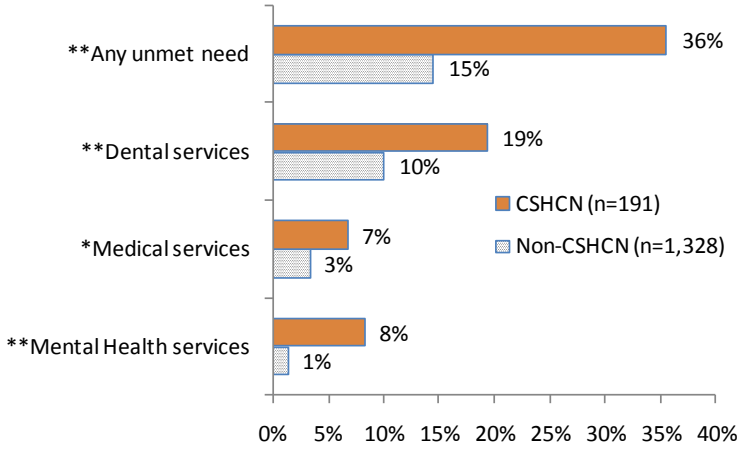
Figure 9. Unmet Need for Health Care Services by Region of Residence (n=1,348)



** Regional differences on this measure are significant at p<.01

Children with special health care needs on MaineCare are at higher risk of going without needed health care services (Figure 10). CSHCN are more than twice as likely to have had delayed or unmet need for care in the past year relative to non-CSHCN (36 percent versus 15 percent). Similarly, CSHCN were twice as likely to have had unmet dental (19% versus 10%) and medical care (7% versus 3%). Unmet need for mental health services among CSHCN was actually more prevalent than unmet need for medical services.

Figure 10. Unmet Need for Health Care Services by CSHCN Status



Childhood Overweight

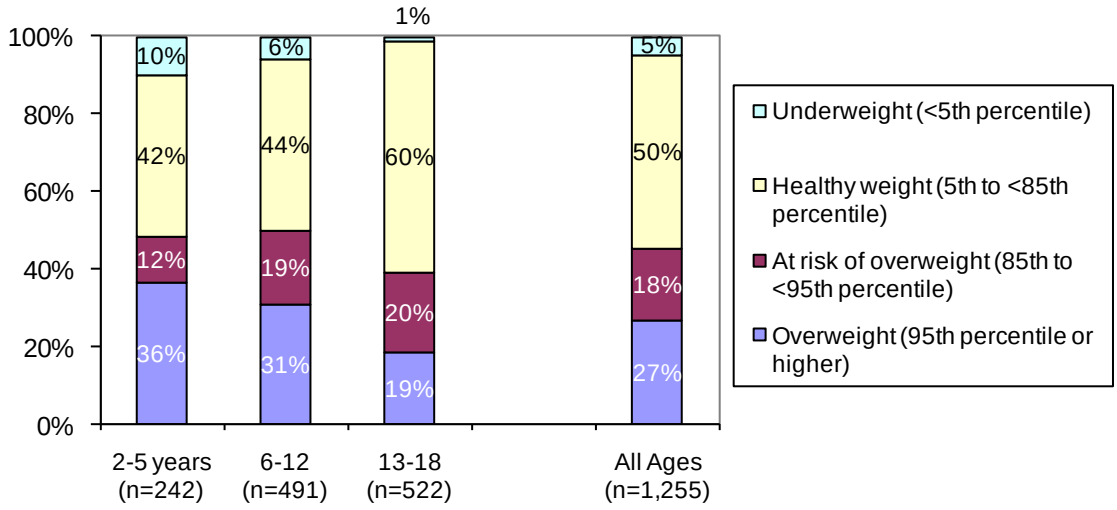
To determine the weight status of children with MaineCare coverage, we asked parents to report the height and weight of their children; we then used CDC guidelines to calculate the body mass index (BMI) and their BMI-for-age percentile ranking based on growth charts for both boys and girls.[27]

The CDC classifies weight status according to the following table:

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

Figure 11 shows the weight status, by age, of current and new enrollees between the ages of 2 and 18 in our MaineCare sample. Overall, more than one fourth of children with MaineCare coverage (27%) are calculated to be overweight, and 45 percent are overweight or at risk of overweight. Rates of overweight are highest among the youngest children; more than one-third of two to five year olds are overweight, and almost half of all children in this age range are overweight or at risk of overweight. Also notable is the fact that rates of underweight decline with age. Ten percent of 2 to 5 year olds are underweight, falling to 6 percent of elementary and middle-school children, and only 1 percent of teens.

Figure 11. Weight Status of New and Current Enrollees
N= 1,255



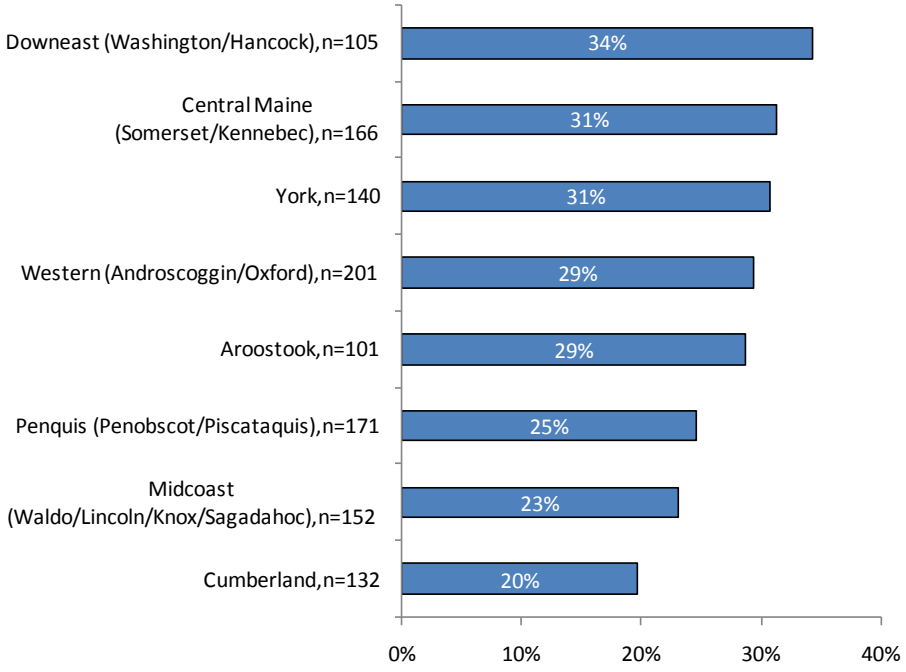
[27] Centers for Disease Control and Prevention. (2006). *About Body Mass Index for Children and Teens.* http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm#My%20two%20children. Accessed November 17, 2006.

While teens on MaineCare are less likely to be overweight than their younger MaineCare counterparts, they are much more likely to be overweight or at risk of overweight than the general population of teenagers in Maine. Nineteen percent of teens in the survey are estimated to be overweight and 20 percent are estimated to be at risk for being overweight. The combined total, 39 percent, is considerably higher than estimates from the most recent (2005) Centers for Disease Control (CDC) report for Maine that indicates 25 percent of high school students in the state are overweight or at risk for being overweight.[28]

These findings confirm our results from 2006, when we found that 25 percent of children with MaineCare coverage were overweight, and nearly half (45 percent) were at risk of overweight.[29]

There is also considerable geographic variation in weight problems among children on MaineCare. We examined rates of overweight according to the DHHS health district[30] in which the child lives (Figure 12). The Downeast and Central Maine districts have the highest percentage of children who are overweight – at 34 and 31 percent, respectively. The lowest rates of overweight are in the Cumberland health district, the most urban part of Maine, and in the Midcoast health district.

Figure 12. Overweight Status by DHHS Health District
N=1,168



[28] Centers for Disease Control and Prevention. (2006, June 9). *Youth Risk Behavior Surveillance – United States 2005*. (MMWR Surveillance Summaries55,No. SS-5). http://www.cdc.gov/mmwr/PDF/ss/ss5505.pdf
[29] Anderson, N., Thayer, D., & Ormond, C. (2007, March). *Children Served by MaineCare, 2006: Survey Findings.* Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.
[30] For more information on Maine DHHS Health Districts, see: http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm

Children with MaineCare coverage in general, and young children and those living in more rural areas in particular, are clearly at higher risk of childhood overweight than the general population. This finding is of particular concern in light of increasing risk for Type II diabetes, sleep apnea and poor self-esteem among overweight children.[31] Further, several recent studies in the New England Journal of Medicine indicate that higher BMI during childhood is associated with increased risk of coronary heart disease in adulthood.[32,33]

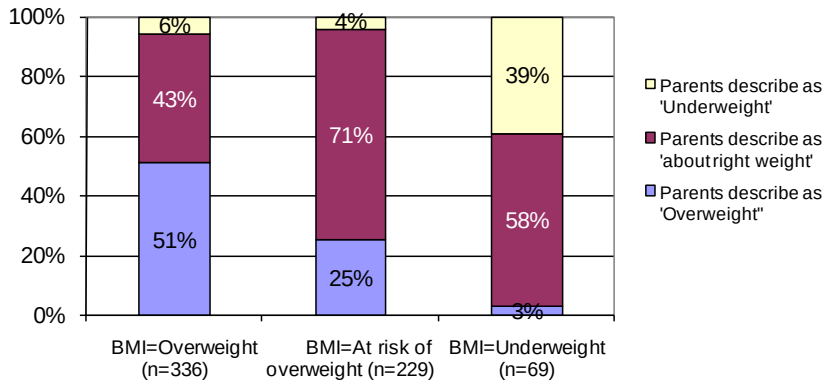
Parents' Perception of Children's Weight and Need for Help

To assess how well parents are able to recognize that their child is overweight, interviewers asked parents to describe their children's weight using the following descriptors: *underweight, slightly underweight, about right, slightly overweight* or *overweight.*

Of the 336 children whose body mass index (BMI) was classified as overweight, 51 percent of their parents also believed their child was *overweight* (Figure 13). However, 43 percent of parents of overweight children described their child's weight as *about right.* Parents with children at risk of being overweight were even less likely to describe their children as being overweight. Only 25 percent of parents of children with a BMI classified as being at risk of overweight described their children as *overweight or slightly overweight,* and 71 percent described their child's weight as *about right.*

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

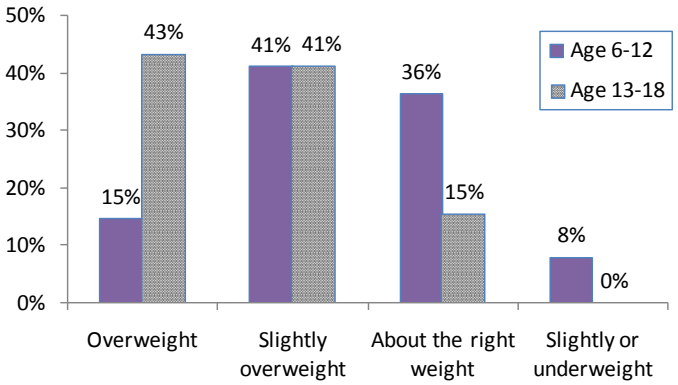
Figure 13. Parents' Perception of Children's Weight by BMI Status



[31] Must, A and Anderson, SE. (2003). Effects of obesity on morbidity in children and adolescents. *Nutrition in Clinical Care 6*(1):4–12.
[32] Bibbins-Domingo, Kirsten, Coxson, Pamela, Pletcher, Mark J., Lightwood, James, Goldman, Lee (2007). *Adolescent Overweight and Future Adult Coronary Heart Disease.* N Engl J Med 357: 2371-2379
[33] Baker, Jennifer L., Olsen, Lina W., Sorensen, Thorkild I.A. (2007). *Childhood Body-Mass Index and the Risk of Coronary Heart Disease in Adulthood.* N Engl J Med 357: 2329-2337

Parents of younger children appear to have a more difficult time identifying weight problems in their child. Only 15 percent of parents with overweight children age 6-12 rated their child as being *overweight*, compared with 43 percent of parents with overweight children age 13-18. (Figure 14). Similarly, only 28 percent of parents with overweight children age 6-12 said that there child needs help with diet or exercise, versus 53 percent of parents with overweight children age 13 or older (not shown).[34]

Figure 14. Parents' Perception of Children's Weight for Children Age 6 – 18 Who are Overweight



Taken together, these findings point to a mismatch between the actual weight status of children and parental perceptions. This problem is particularly acute among parents of children ages 6 to 12. Overweight children with MaineCare coverage could potentially benefit from educational interventions designed to increase parental awareness of BMI status and of the health risks of overweight for their children.

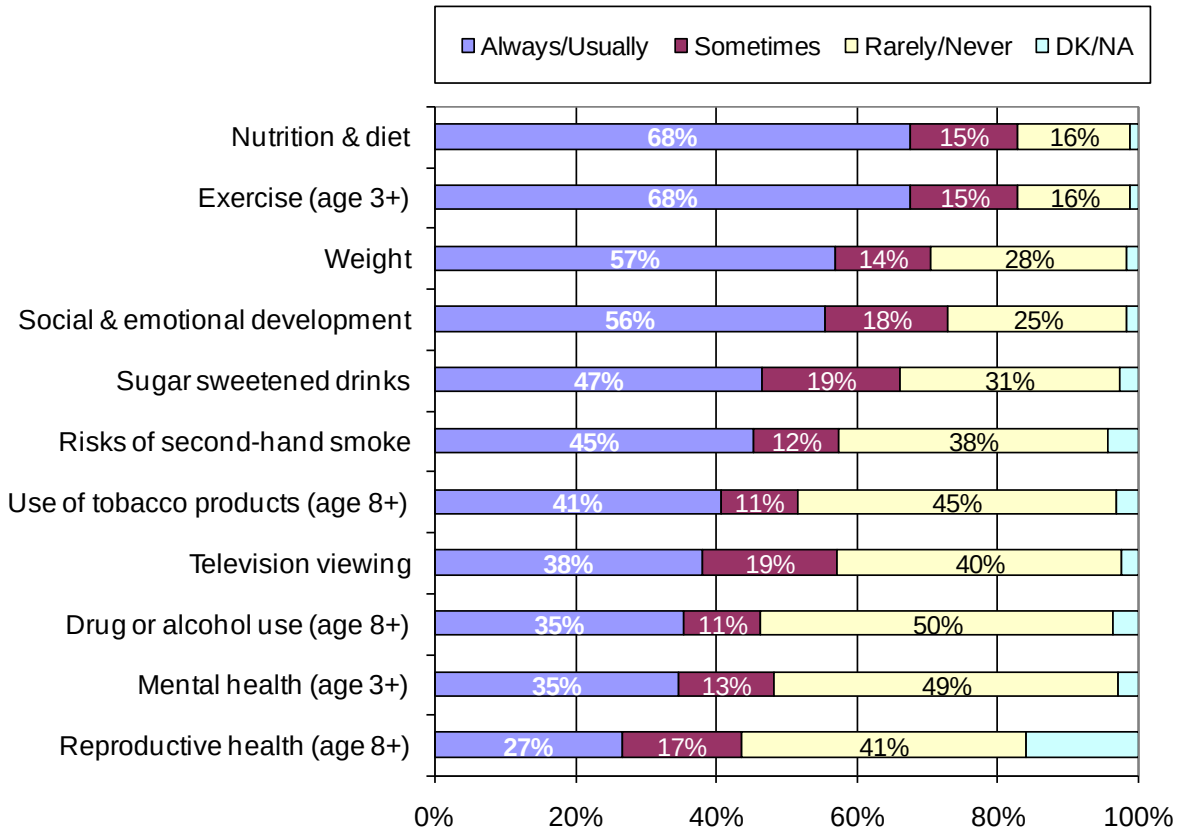
[34] Our findings are also consistent with the C.S. Mott Children's Hospital National Poll on Children's Health, conducted in August 2007, which showed that parents of overweight children ages 6-11 were less likely to identify their child as overweight compared with parents of overweight teens. See: http://www.med.umich.edu/mott/research/chearbmi.html Downloaded December 27, 2007

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.[35] We also asked if they needed more information on these topics. 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.

Overall, respondents reported that their child's PCP talks about nutrition and diet, exercise, weight, and social and emotional development most often (Figure 15). More than half of parents said the PCP *always* or *usually* discusses each of these four topics. Drug or alcohol use, mental health, and reproductive health were least likely to be discussed by MaineCare providers.

Figure 15. How often does the PCP talk to you or your child about...

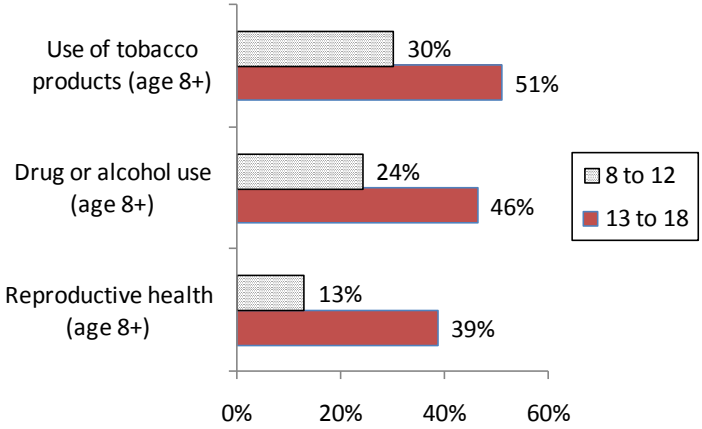


[35] A screening question was used to identify how often the respondent goes with their child to well-child visits. Respondents who said they "rarely" or "never" went with the child were not asked this series of questions.

Differences in Well-child Visit Topics by Age

According to the survey results, MaineCare providers emphasize different topics depending on the age of the child. Parents of teenage children were much more likely to report that their child's provider *always or usually* discussed use of tobacco products, drug or alcohol use, and reproductive health, compared with parents of younger children (Figure 16).

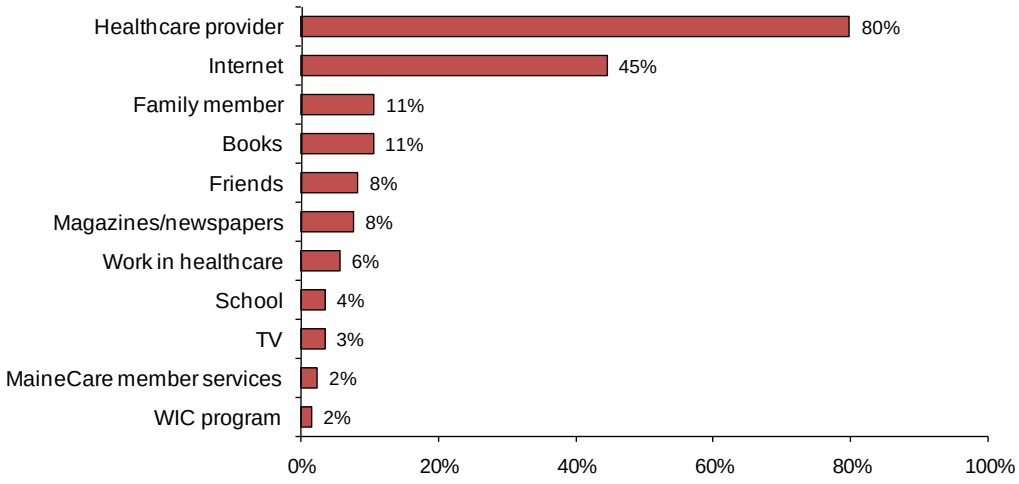
Figure 16. Selected Well-child visit topics by age of the child: PCP "Always" or "Usually" talks about…



Sources of Health Information and Internet Access

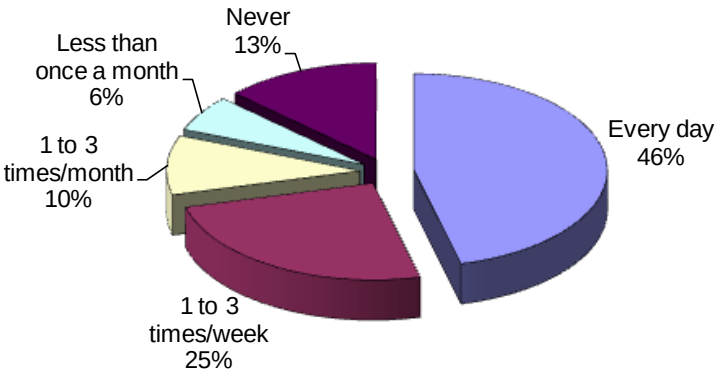
When asked about sources of health information, parents of children with MaineCare coverage most commonly relied on their healthcare provider (80%). A large and growing proportion of parents said they access health information on the internet. In 2007, nearly half (45%) of all MaineCare parents mentioned the internet specifically as a source of health information. Internet use for health information appears to be on the rise, as the comparable figure from 2006 was only 30 percent.

Figure 17. Where do you usually get information about health issues?



Interviewers also asked respondents if they have internet access at home or at work. Overall, 81 percent of current and new enrollees reported having internet access. Not surprisingly, access is more prevalent among families with higher income; 88 percent of CHP enrollees reported having internet access at home or at work, followed by 84 percent of Medicaid Expansion enrollees, and 75 percent of Medicaid enrollees. In addition, 46 percent 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 18).

Figure 18. How often do you use the internet? (n=1,521)



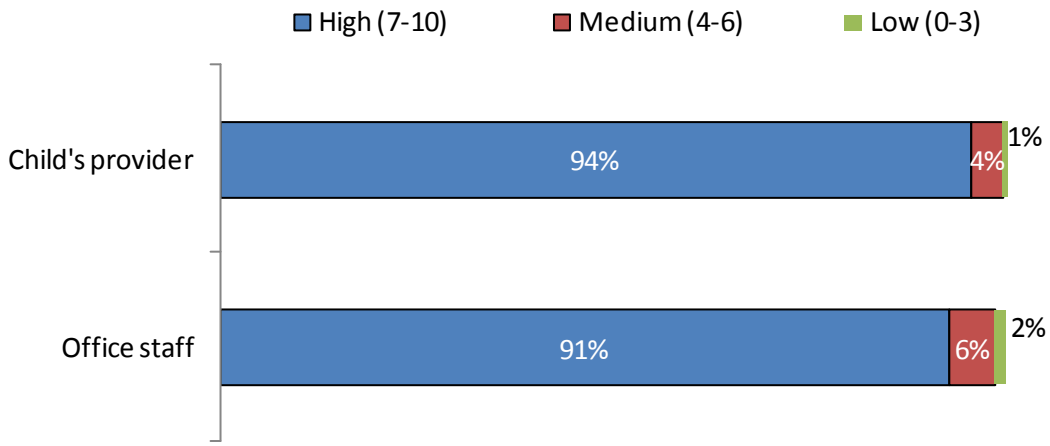
Finally, MaineCare managers wanted to verify that members are receiving the health information and materials that are periodically sent to members' homes. According to the survey, 62 percent of parents with children with MaineCare coverage had received health information materials from the MaineCare agency in the past 12 months, 30 percent did not, and 8 percent were not sure.

Satisfaction

Satisfaction with Providers and with Benefits

For the past several years, survey results have shown that parents of children with MaineCare coverage are generally very satisfied with providers, office staff, and MaineCare benefits. The 2007 results continue this positive trend. Interviewers asked respondents to rate their MaineCare provider and the office staff on a scale from 0 to 10, where 0 is the worst and 10 is the best possible score (Figure 19). On average, parents rated their child's provider an 8.9 (out of 10), and the office staff an 8.8. 94 percent of parents rated their child's provider 7 or higher, and 91 percent rated office staff at 7 or higher. Only one percent of respondents rated their child's provider less than a 4.

Figure 19. Parent's Rating of MaineCare providers and office staff (0 to 10 Scale) N=1,460



In addition, we found that 95 percent of parents were *very* or *somewhat* satisfied with the MaineCare as a health insurance plan. When asked about the reasons for this satisfaction, most respondents mentioned the coverage or benefits that MaineCare offers their child (54%), and about one third said the affordability of the program.

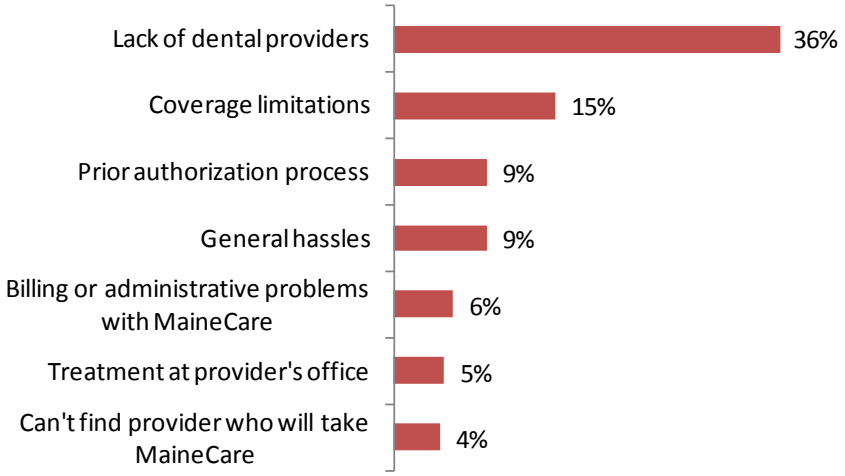
Parents also commented on the following when asked about aspects of the MaineCare program with which they were particularly satisfied:

- No problems or hassles in getting needed care
- Good quality care
- MaineCare is widely accepted – gives access to providers
- Reminders about check-ups from MaineCare are helpful
- Ability to keep the same provider

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=1,062). Access to preventive care (n=400) and 'peace of mind' (n=327) were also frequently cited as important reasons for enrolling their child.

Among respondents who expressed dissatisfaction with MaineCare (n=477), the most common complaint was a lack of dental providers in their area or lack of dental providers who accept MaineCare members (Figure 20). Dissatisfaction over coverage limitations, such as lack of coverage for specific prescription drugs, was also expressed by a number of parents.

Figure 20. Reasons for Dissatisfaction with MaineCare
N=477



Health Behaviors

The health of children with MaineCare coverage is impacted not only by the care they receive from providers, but also by their personal health behaviors. For example, the health risks of smoking are well-known, and environmental tobacco smoke (ETS) has been shown to increase the likelihood of asthma exacerbations in pre-school children.[36] Childhood obesity, identified as a particularly prevalent issue in the MaineCare population by this and prior MaineCare surveys, is associated with poor eating habits and decreased physical activity.[37] Questions designed to measure these behaviors are included in the 2007 MaineCare survey to assess the potential for behavioral interventions in improving the health of children with MaineCare coverage.

Tobacco Use and Environmental Tobacco Smoke

Parents of children aged 8 or older (n=987) were asked whether their child used tobacco products. Four percent (n=35) 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%)[38]. This figure is unchanged from the 2006 survey.

A notable finding is that, among children with MaineCare coverage who currently have asthma (n=180), almost half live in homes where one or more adults smoke. Given the risks of exposure to ETS for children with asthma, targeting the adults living in these families for smoking cessation programs would likely lead to improved health for these children.

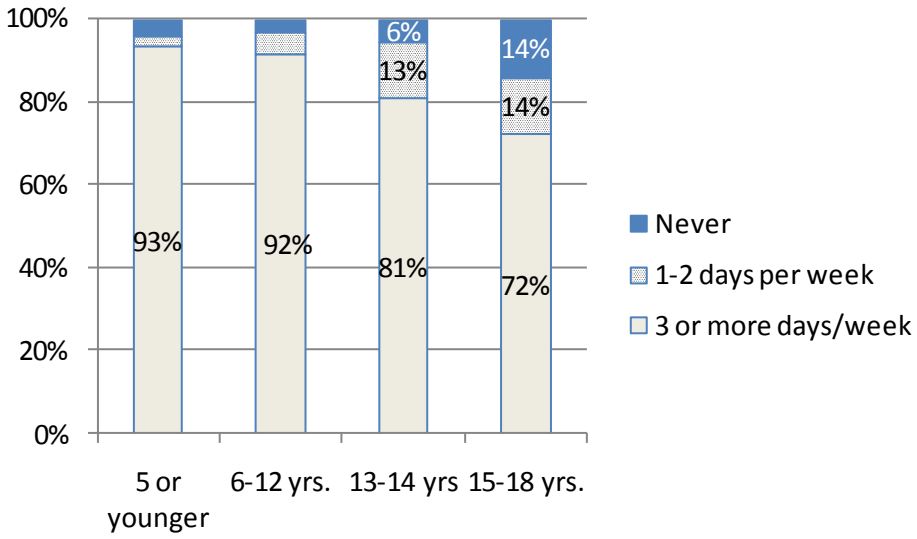
[36] Institute of Medicine. (2000). *Clearing the Air: Asthma and Indoor Air Exposures*. Washington, D.C.: National Academy Press, p. 438.
[37] For a review of evidence concerning the causes of obesity and methods to increase the public health, see: *Final Report of the Commission to Study Public Health*, January 2005. Presented to the State of Maine, 121st Legislature. http://www.maine.gov/legis/opla/reports2.htm Accessed January 3 2008.
[38] 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.

Behaviors that Impact Childhood Overweight

The 2007 MaineCare survey includes several items that measure four key behaviors known to be risk factors for children being overweight: lack of physical activity, excessive time spent watching television or playing video games, inadequate consumption of fruits and vegetables, and consumption of sugar-sweetened beverages.[39]

To assess the level of physical activity, parents were asked: "During the past week, on how many days did your child exercise, play a sport, or participate in physical activity for at least 20 minutes that made him/her sweat and breathe hard?" Survey results show that physical activity decreases with age (Figure 21). Ninety-three percent of children age five and younger are physically active three or more days per week; that percentage is only 72 percent among children who are 15 to 18 years old. Similarly, fewer than 4 percent of young children are reported to *never* be physically active while this figure rises to 14 percent for teens age 15 to 18.

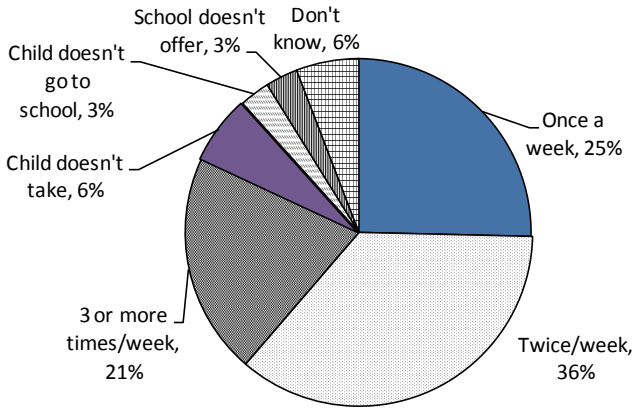
Figure 21. Frequency of Vigorous Physical Activity
N=1,375



Interviewers also asked about participation in organized physical education classes in schools. There is great variation in the frequency and availability of physical education classes among the school districts in the State of Maine. The figure below shows the frequency with which surveyed children participate in school-sponsored physical education. Four out of five parents (82%) reported that their child participates in physical education classes at least once per week. Approximately 3 percent said their child's school does not offer physical education classes, and 6 percent elect not to take physical education.

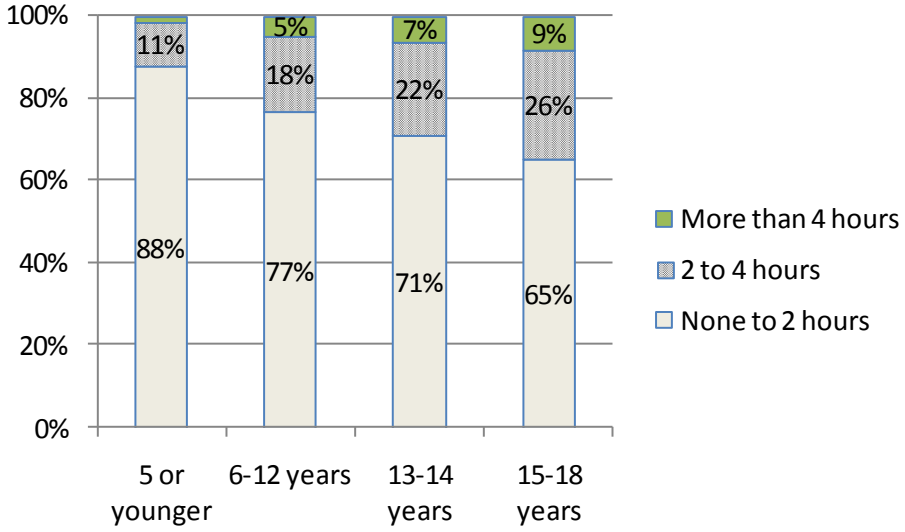
[39] These four behaviors were targeted by the Maine Youth Overweight Collaborative (MYOC), a project of the Maine Center for Public Health and Maine chapter of the American Academy of Pediatrics that focused on improving systems in primary care practices to assess childhood overweight and promote behavior change in families and patients. For more information, see: Polacsek, M. July, 2006. *The Maine Youth Overweight Collaborative: Final Report.* http://www.maineaap.org/project_youthoverweight.htm

Figure 22. Frequency of Physical Education in Schools
Children Age 6 or older, N= 1,096



Time spent watching television or playing video games may play a role in the high rates of weight problems among children with MaineCare coverage, both by displacing general physical activity and by exposing children to food advertising, which typically promotes foods with high sugar and/or fat content.[40] We asked parents: "On an average weekday, about how many hours does your child usually watch TV, watch videos, or play video games?" Their responses indicate that screen time increases markedly with the age of the child (Figure 23). Only 12 percent of children age 5 of under have more than 2 hours of screen time each day, rising to 23 percent for 6 to 12 year olds, 29 percent for 13 to 14 year olds, and 35 percent for teens age 15 to 18.

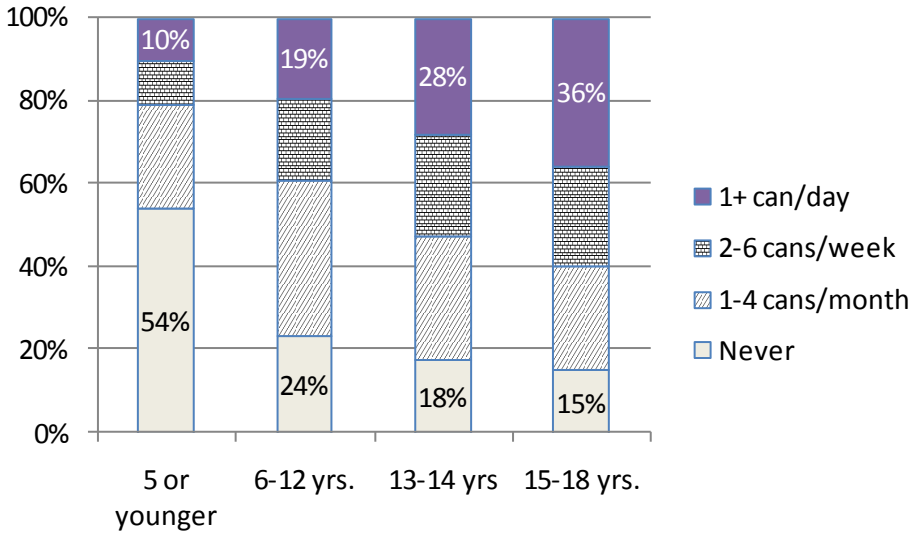
Figure 23. Average hours of TV or Screen Time
N=1,497



[40] Dietz WH, Strasburger VC. Children, adolescents, and television. *Current Problems in Pediatrics*. 1991;20:8-31.

Consumption of soda or sugar-sweetened drinks has been linked to weight gain and poor nutrition. Soda consumption is fairly common among children with MaineCare coverage (Figure 24). Again, we find that soda consumption is significantly associated with age, with more than one third (36%) of older teens drinking soda every day, and less consumption among younger children. But even among the youngest children in our sample, more than 10 percent were reported to drink one or more sweetened drinks every day.

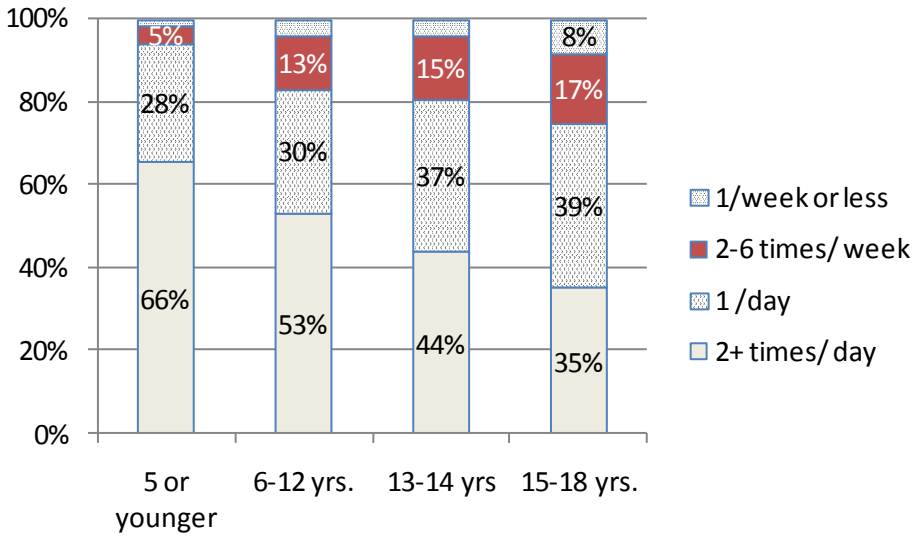
Figure 24. Consumption of Soda or Sweetened Fruit Drinks
N= 1,504



The American Academy of Pediatrics recommends that children eat fruits and vegetables every day.[41] To assess how many children with MaineCare coverage are able to meet this recommendation, we asked parents how often their child eats fruits and vegetables (Figure 25). Two-thirds of young children with MaineCare coverage are reported to eat fruits and vegetables at least twice a day, and 94 percent of this age group eats fruits and vegetables at least once a day. But the frequency of fruit and vegetable consumption falls off among the older cohorts. Just over half of children age 6 to 12 eat fruits and vegetables two or more times per day and the same is true of only one third of teens age 15 to 18.

[41] American Heart Association, Gidding SS, Dennison BA, Birch LL, Daniels SR, Gilman MW, Lichtenstein AH, Rattay KT, Steinberger J, Stettler N, and Van Horn L (1 Feb 2006) Dietary Recommendations for Children and Adolescents: A Guide for Practitioners**.** *Pediatrics* 117 (2) : 544-559.

Figure 25. Consumption of Fruits and Vegetables
N= 1,510



Surprisingly, when we compared the prevalence of each of these four behavioral risk factors (physical activity, screen time, consumption of soda, consumption of fruits and vegetables) between children who were overweight, at-risk of overweight, and healthy weight, we found no statistically significant differences. A follow-up multivariate analysis of the survey data is planned to more closely examine the relationship between BMI and these risk factors, controlling for other demographic characteristics such as age and gender.

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 public coverage for private– 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.[42]

To discourage crowd-out, there is a three month waiting period for children who are dropped from health insurance provided through an employer. Note that the waiting period applies only to children eligible for MaineCare through the Separate Child Health Program (formerly CubCare). The waiting period is waived for CHP applicants if: the person who dropped coverage does not live with the child; the family pays 50 percent or more of the cost of the child's coverage; the family pays more than 10 percent of all family income for family coverage (including coverage for the child); or the person had good cause for terminating insurance coverage (such as the loss of employment.)[43]

To examine the question of coverage substitution, we asked parents of new enrollees[44] (n=290) 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 (Figure 26). Sixty percent of new enrollees had coverage at some point during the previous 12 months, and 40 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 54 percent. The other SCHIP eligibility category, Medicaid Expansion, had the highest rate of prior coverage, at 72 percent of new enrollees. The difference in coverage rates between these two groups is statistically significant (Chi-square $p < .05$).

[42] 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,.

[43] MaineCare Eligibility Manual, Section 9000.02-III. http://www.maine.gov/sos/cec/rules/10/ch332.htm

[44] There were a total of 332 parents of new enrollees who initially responded survey. Due to a CATI programming error the set of questions about prior coverage were not asked, so follow-up calls were attempted to all new enrollees to collect this information. The results presented in this section only reflect that responses of the 290 new enrollees who were successfully reached by interviewers during these follow-up calls.

Figure 26. Percent of New Enrollees with Coverage in Previous Year by Eligibility Category

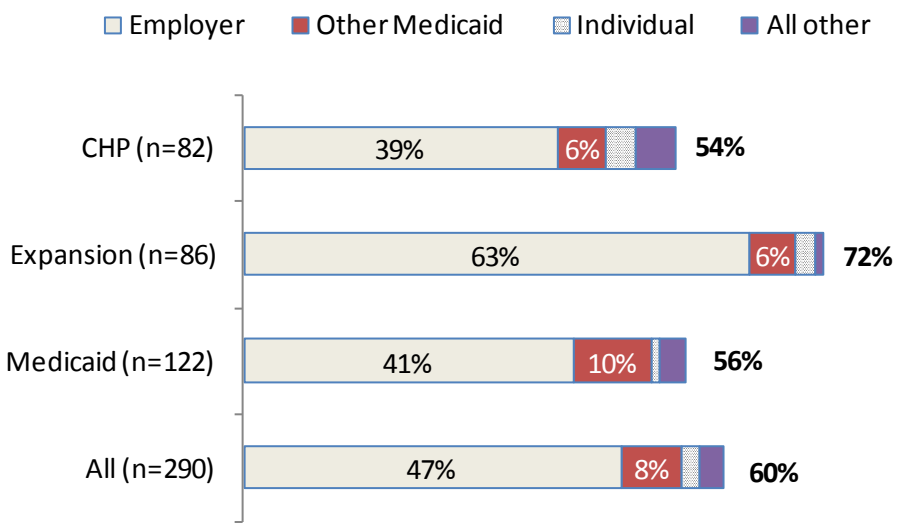
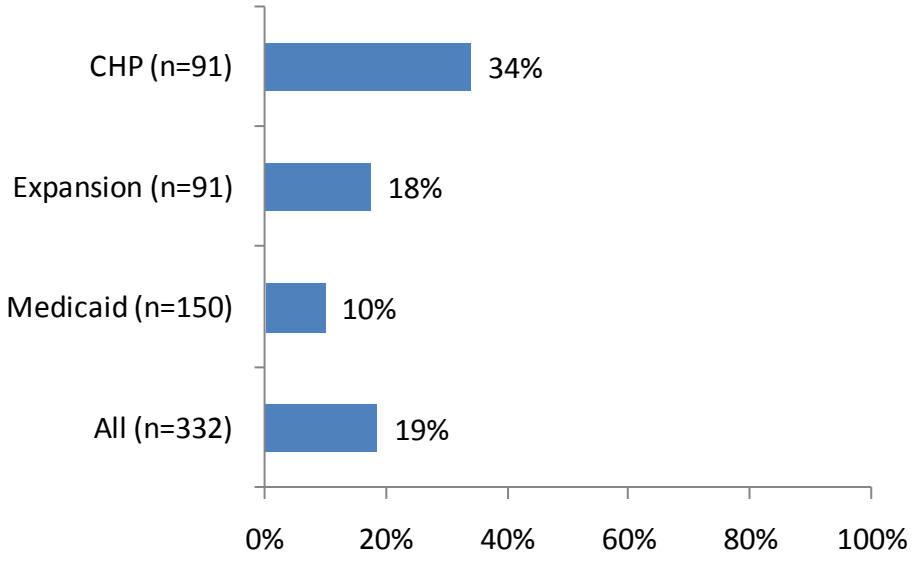


Figure 26 also indicates the different types of coverage new enrollees had in the year before they enrolled in MaineCare. Most new enrollees with prior coverage were covered through a parent or guardian's employer sponsored insurance. Among all new enrollees, 47 percent had prior coverage through their 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 63 percent, versus only 39 percent and 41 percent CHP and Medicaid enrollees, respectively. The lower rates of previous employer coverage for new CHP enrollees are most likely a result of the three-month waiting period for applicants with prior access to employer coverage. There is no analogous waiting period for new Medicaid Expansion or Medicaid enrollees. Lastly, very few (less than 3%) children had individual policies purchased directly from an insurance company.

Taken together, the results showing that six out of every ten newly enrolled children with MaineCare coverage 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.

We also examined the possibility 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 27). 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=332), 19 percent had access to employer sponsored coverage through the main wage earner but were not enrolled. The proportion of respondents who reported declining available employer-sponsored coverage for their child was highest among new Medicaid Expansion (18%) and CHP enrollees (34%). The reason given by almost all (97%) of these parents is that the 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 tiny fraction of this type of coverage substitution we observed can be considered crowd-out. In most cases, new enrollees would have become uninsured if MaineCare were not available.

Figure 27. Percent of New Enrollees Eligible But Not Enrolled in Employer Coverage by Eligibility Category



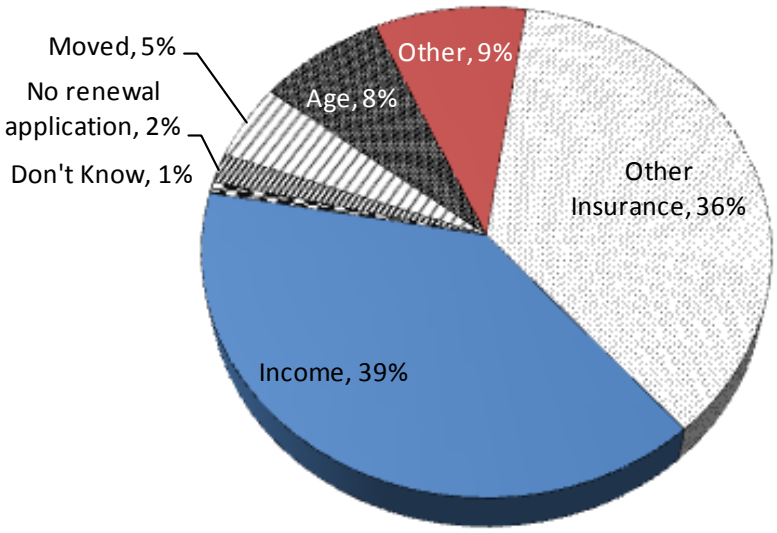
Disenrollees

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; 39 percent 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; 36 percent reported that their child had other coverage and no longer needed MaineCare. Five percent were over the age of 18 (and therefore no longer eligible) and another 2 percent did not fill out a renewal application. Among the "other" reasons for disenrolling, respondents mentioned:

- Child moved in with the other parent or out of state (6 respondents)
- Failed to show proof of income documentation (2)
- Too many hassles and red tape (2)
- Not sure why child was dropped by MaineCare (2)
- Fell behind on CHP premium payments (1)

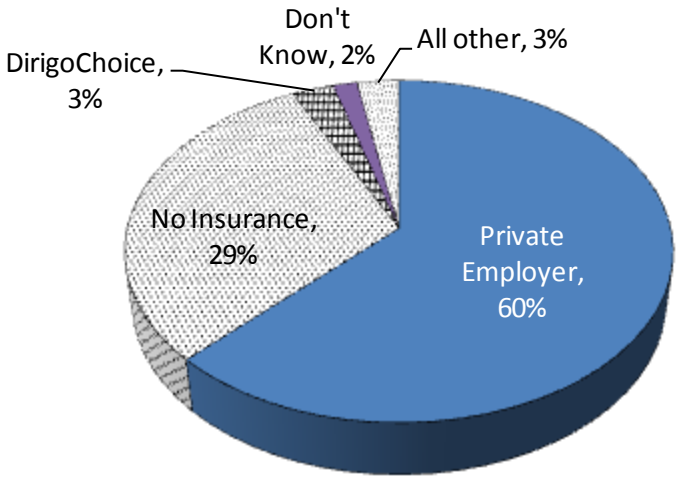
Figure 28. Reasons for Disenrolling from MaineCare
N= 259



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, 29 percent of the disenrolled children were uninsured at the time of the interview. Among the 75 respondents with uninsured children, most (53%) said they had disenrolled from MaineCare because their income was too high, and one fourth (23%) said their child was no longer eligible because of their age. Only 5 percent (n=4) said their child had disenrolled because they did not fill out a renewal application.

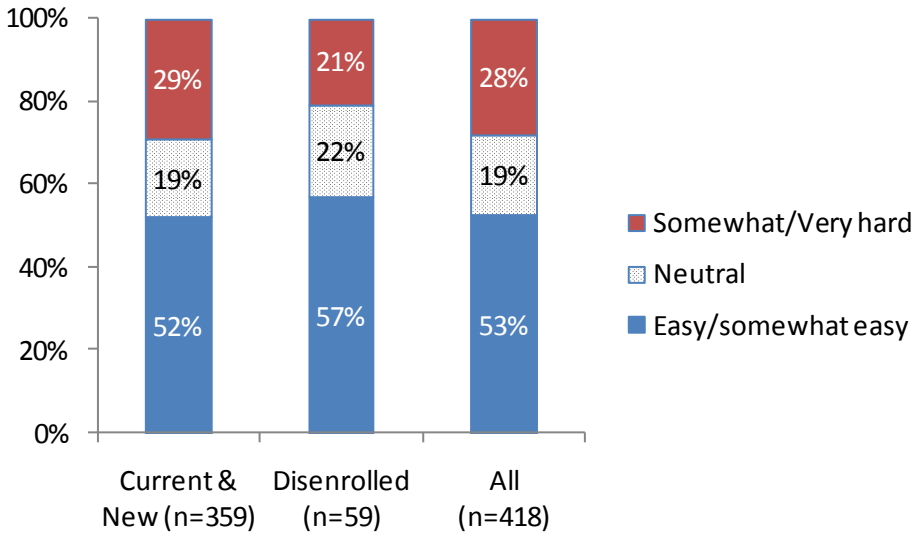
Figure 29. Current Insurance Status of Children Disenrolled from MaineCare
N= 259



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 are interested in monitoring the extent to which this premium is burdensome to parents, both among parents of children who disenrolled as well as those still on the program. (Figure 30). The survey showed that over half of all parents of CHP-eligible children said it was *easy or somewhat easy* to pay the premium. Twenty eight percent expressed difficulty paying the premium. Parents of disenrolled children were actually less likely to say that paying the CHP premium was *somewhat or very hard* relative to parents of children still on MaineCare, but the difference was not statistically significant. We also compared the proportion of CHP parents who reported difficulty paying the premium from 2005 through 2007 and found no discernable trend (not shown).

Figure 30. How easy or hard is it to pay the CHP premium? By enrollment type



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.[45] Another study showed that children are more likely to use preventive services and seek care when needed when their parents are insured.[46] Because of the importance of parental insurance to the care received by children with MaineCare coverage, we asked respondents about their own insurance status.

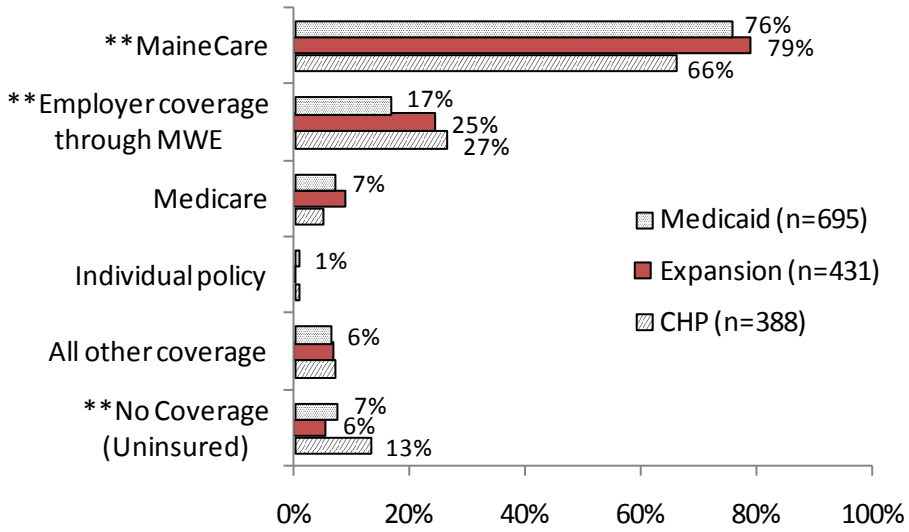
The vast majority of respondents do have some sort of health insurance. Almost three-fourths have MaineCare, and one-fourth have employer sponsored coverage through the main wage earner (MWE) in the household. Eight percent reported they have both MaineCare and employer sponsored insurance. (In these cases, the person's employer coverage serves as the primary insurer, and MaineCare provides supplementary coverage for co-insurance and benefits not covered by the primary insurance.) A significant minority of parents in our survey--eight percent--reported that they are currently uninsured.

There is significant variation in the insurance coverage of parents depending on the MaineCare enrollment category of the child. Parents of CHP children are less likely to have MaineCare coverage (66% versus 76%) and are more likely to have employer sponsored coverage through the main wage earner (27% versus 17%) relative to parents of Medicaid children. However CHP parents are also almost twice as likely to be uninsured compared to the other eligibility categories (13% versus 7%).

[45] 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.

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

Figure 31. Insurance Status of Current and New Enrollee Parents (n=1,514)



** Difference between eligibility categories is significant at p<.01
(Note: Percentages do not add to 100% because respondents could report more than one type of coverage).

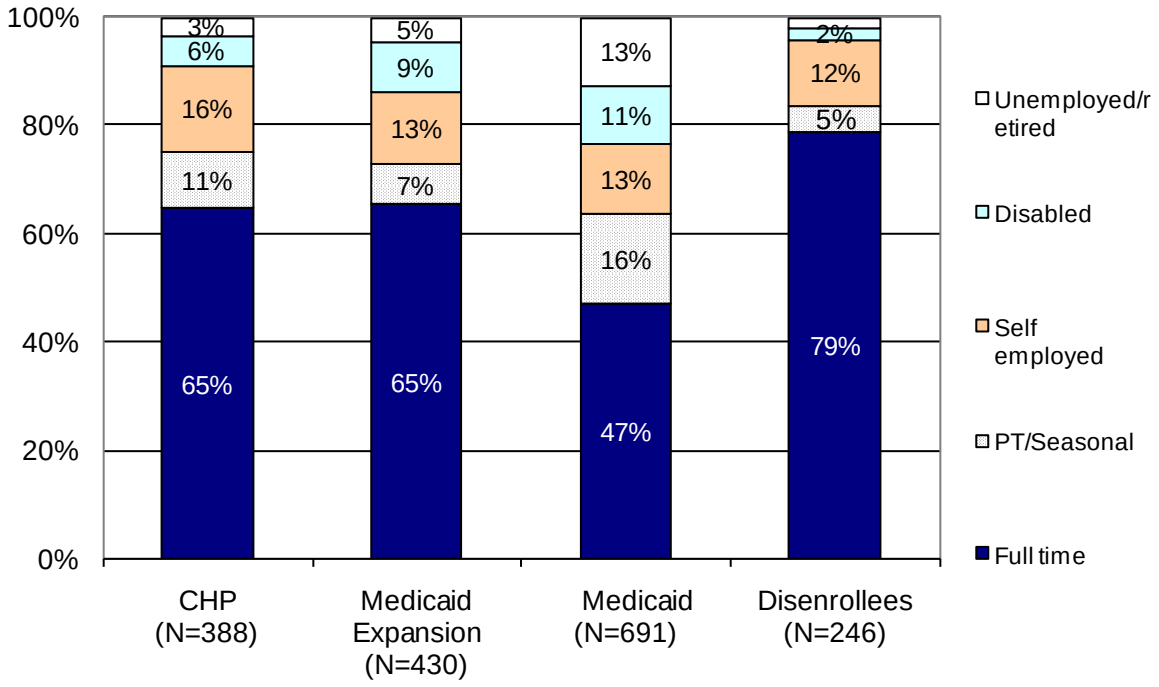
Employment Status

Interviewers asked respondents to identify the main wage earner in the household[47], and then asked for the employment status of that person. Fifty seven percent of respondents said they were the main wage earner, and 42 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 6 percent and 9 percent of CHP and Medicaid Expansion households, respectively, identify the primary wage earner as disabled, 11 percent of Medicaid households report that the main wage earner is disabled. Similarly, the unemployment rate among the Medicaid group (13%) is more than four times the unemployment rate of CHP households (3%) and more than twice the unemployment rate among Medicaid Expansion households (5%).

It is also interesting to note the difference in employment status of parents 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.

Figure 32. Employment Status of Main Wage Earner in Household



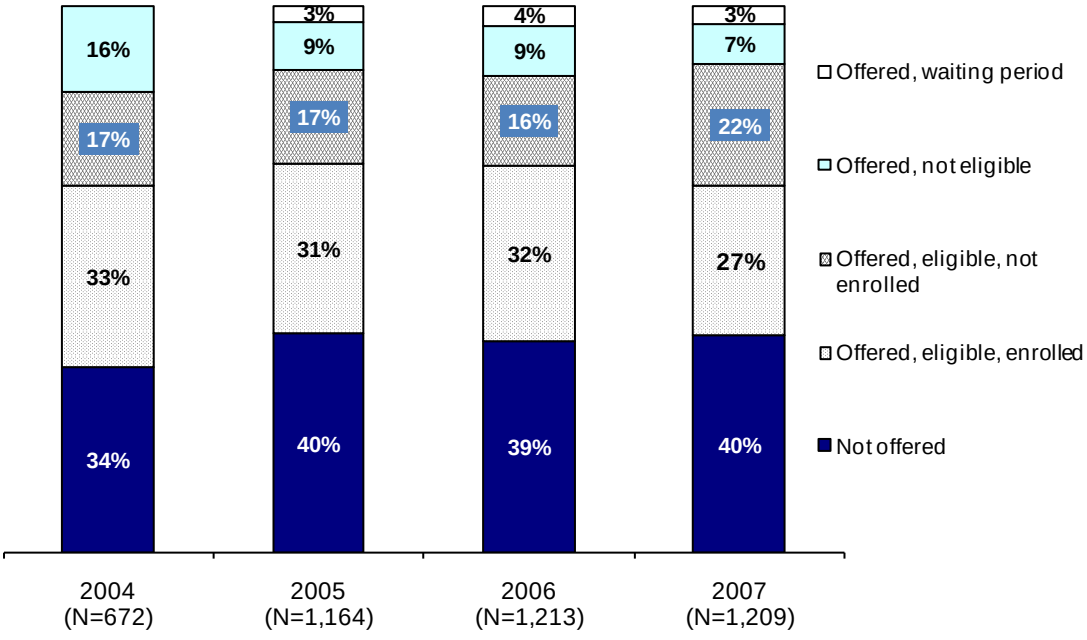
[47] When necessary, interviewers explained that main wage earner refers to, "…the adult living in your home who works and earns the most each week, or if no one is working, the adult who owns or rents your home."

Access to Employer Sponsored Insurance (ESI)

Taking a closer look at the availability of employer sponsored insurance to parents of children with MaineCare coverage, we found that among parents of current and new enrollees who were employed (n=1,209), 40 percent were employed by companies that did not offer any kind of health insurance, 7 percent were not eligible for coverage through their employer, and 3 percent reported their employer only offers coverage after a waiting period (Figure 33). About half of the employed parents reported that they are eligible for coverage, but only 27 percent are actually enrolled in these employer sponsored programs. The primary reason given by the 22 percent of respondents who did not enroll in available coverage was the high cost of premiums.

Figure 33 shows the trend in availability of employer sponsored insurance among employed MaineCare parents from 2004 through 2007, based on survey results from these years. ESI offer rates by employers have remained roughly constant over the past three years. However, MaineCare parents' eligibility for ESI offered is declining as is the percentage of those eligible that actually enroll. In 2004, 17% of employed MaineCare parent employed wage earners were not eligible for ESI coverage offered by their employer, but by 2007, 22% were not eligible. Similarly, in 2004, 33% of employed wage earners were eligible and enrolled in ESI, whereas only 27% were eligible and enrolled in 2007. These figures are consistent with national trends and reflect continuing double-digit increases in private health insurance premiums in Maine and nationally, which have resulted in employers increasing employee cost-sharing.

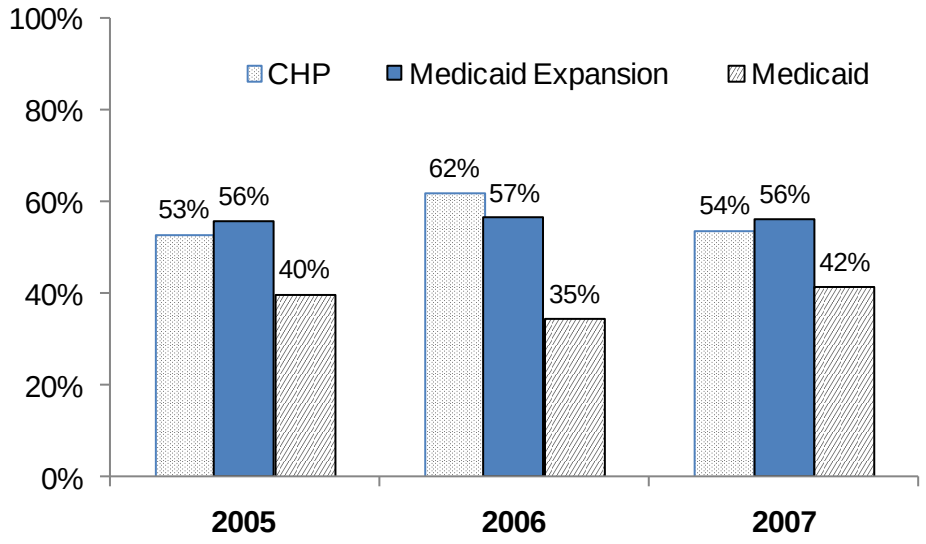
Figure 33. Distribution of Employed Main Wage Earner's ESI Status



ESI Access by Eligibility Category

Employed parents of children enrolled in MaineCare through the CHP and Expansion eligibility categories are more likely to have access to employer coverage than for those in the Medicaid category (Figure 34). In 2007, 54 percent of employed CHP parents reported that they were offered and eligible for health insurance coverage through their employer, versus only 42 percent of employed Medicaid parents. The figure also shows that there has been no significant trend in the availability of employer coverage to parents of children with MaineCare coverage over the past three survey years.

Figure 34. Percent of employed respondents offered and eligible for employer coverage By child's eligibility category, 2005 - 2007



Summary & Implications

Parents of children enrolled in MaineCare continue to be overwhelmingly satisfied with the MaineCare benefit, with their children's MaineCare providers, and with the quality of care their children receive. Parents rated their child's MaineCare provider an average of 8.9 (out of a best possible score of 10), and rated the office staff an average of 8.8. Ninety five percent of parents interviewed said they are *very or somewhat* satisfied with MaineCare as a health insurance plan.

Among the minority of respondents who did express dissatisfaction with MaineCare, the most common specific complaint was the lack of dental providers who accept MaineCare coverage or who have a practice in the area. A number of respondents also expressed dissatisfaction about coverage limitations, such as lack of coverage for a specific prescription drug.

Most children with MaineCare coverage are in good health. Eighty five percent of parents surveyed said that their child was in *very good or excellent* health. Only three percent reported having a child in *fair or poor* health. However, several conditions and health risk factors are more prevalent among children with MaineCare coverage than in the general population, including asthma, mental health conditions, and being overweight.

Parental reports from the survey indicate that 12% of children with MaineCare coverage currently have asthma. This rate is comparable to the 14% of low-income children in Maine found to have asthma in the 2003 National Survey of Children's Health, but substantially higher than the 7% of higher-income (>200% FPL) children who have asthma in the 2003 NSCH. Environmental tobacco smoke (ETS) may be a contributing factor to the high rate of asthma among children on MaineCare, in that almost half of the children with asthma live in households with one or more adult smokers. MaineCare could help reduce the burden of asthma and the impact of ETS through greater 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 38 percent said their PCP *rarely* or *never* talks to them about the topic.

Almost one in five (18%) children with MaineCare coverage has a current diagnosis of ADD/ADHD, anxiety, or depression. Looking at these three conditions separately, we found that 11% have ADD/ADHD, 10% have an anxiety disorder, and 7% have depression. The prevalence of anxiety or depression among children with MaineCare coverage (13%) is similar to other low-income children in Maine, but much higher than high-income children (7%) according to the 2003 NSCH.

A third health issue highlighted by the survey is the exorbitant rates of overweight among children of all ages on MaineCare. More than one quarter of all children age 2 to 18 in the study are estimated to be overweight[48] and an additional 18 percent are at risk of overweight. Teens (13 – 18 years old) have lower rates of overweight than younger children with MaineCare

[48] BMI in the 95th percentile or higher for their age/sex

coverage, but are still much more likely to be overweight than high-school students in the general population in Maine. These findings regarding childhood overweight in the 2007 MaineCare survey are essentially unchanged from a similar study conducted in 2006.

Survey findings also indicate that a substantial minority of parents do not accurately identify when their child is overweight. Only 51 percent of respondents with an overweight child – as measured by BMI calculated from reported height and weight -- described that child as being 'overweight'. Parents of younger children appear to have a more difficult time identifying their child as being overweight. Only 15 percent of parents with overweight children age 6-12 rated their child as being *overweight*, compared with 43 percent of parents with overweight children age 13-18. Overweight children on MaineCare could potentially benefit from educational interventions designed to increase parental awareness of BMI status and the health risks of their children being overweight.

Reports of health behaviors associated with being overweight are more prevalent in older than younger children with MaineCare coverage. Toddlers and young children are reported to exercise and consume vegetables the most, whereas teens exercise and consume vegetables the least. Conversely, teens tend to consume more soda and spend more time watching television or playing video games. Coupled with the high rates of overweight and its associated health risks, these findings suggest that older children with MaineCare coverage would benefit from increased provider advice on exercise and healthy eating habits.

Outreach through providers holds the most promise for reaching children with MaineCare coverage with health and nutrition information. Eighty percent of parents interviewed told us they usually get information about health issues from a healthcare provider. Our results also suggest that the internet may be an effective supplementary tool for this purpose. Four out of five parents use the internet at least occasionally, and almost one half (45%) said they use the internet specifically to get information about health issues. Internet use for health information appears to be on the rise, as the comparable figure from 2006 was only 30 percent.

There has been a growing consensus among health care professionals and families over the past several years around what constitutes the ideal characteristics of medical care for children. The American Academy of Pediatrics codified this consensus in a 2002 policy statement that defined the concept of a medical home.[49] Access to a medical home has been shown to improve health outcomes for individuals and populations, reduce the cost of care, and reduce disparities between socially advantaged and disadvantaged populations.[50]

The 2007 MaineCare survey includes a subset of questions from the 2007 National Survey of Children's Health that are designed to measure five components of the medical home concept: 1) having a usual place for sick/well care; 2) having a personal doctor or nurse who knows the child well and is familiar with their health history; 3) experiences no difficulty in obtaining needed referrals; 4) receives needed care coordination; 5) receives family-centered care.

[49] Medical Home Initiatives for Children With Special Needs Project Advisory Committee (1 Jul 2002) The Medical Home. *Pediatrics* 110 (1) : 184-186.
[50] Starfield, B., Shi, L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. Pediatrics Volume 113, Number 5: 1943-1498, May 2004.

Virtually every child in our sample (98%) has a usual place where they receive sick- or well-child care, and the vast majority (93%) have a personal doctor or nurse who knows them well and is familiar with their health history. Among parents who said their child needed a referral for medical services in the past 12 months, 85 percent said that there was "not a problem" getting a referral. Among parents who said they used or needed assistance with coordinating care for their child in the past 12 months, 73 percent told us that they "usually" received all the assistance they wanted, and that they were satisfied with the communication among their child's health care providers. Overall, we found that 81 percent of children with MaineCare coverage receive family-centered care. Finally, we created a summary measure to indicate whether or not the child received all of the medical home measures for which they were eligible. According to this measure, 73 percent of all children in our sample have a medical home.

We identified Children with Special Health Care Needs (CSHCN) in the survey using a sub-set of questions drawn from the CSHCN Screener developed by Bethell, et al (2002). Children who have functional limitations due to a medical, behavioral or other health condition that has lasted or is expected to last 12 months or longer are classified as CSHCN. Using this measure we found 191 parents, or 12.5% of all current and new enrollees, who identified their child as having special health care needs. The prevalence of every health condition measured in the survey was significantly higher among CSHCN compared with other children with MaineCare coverage. Fifty three percent of CSHCN were reported to have a developmental delay, and just under half have one or more of the three mental health conditions (ADD/ADHD, anxiety or depression). In addition, twenty eight percent of CSHCN currently have asthma, 20 percent have autism, and 2 percent have diabetes.

According to the survey, CSHCN on MaineCare are less likely to get the care they need. Thirty six percent of parents with a CSHCN reported that their child had an unmet need for health care in the last 12 months, versus only 15 percent among all other children. CSHCN also scored lower on several of the medical home measures. CSHCN were more likely to report having problems getting referrals, less likely to receive care coordination, and less likely to receive family-centered care relative to other children with MaineCare coverage. In addition, only 58 percent of CSHCN were reported to meet all the medical home criteria, as compared with 73 percent of all children.

Many children with MaineCare coverage are not receiving recommended dental care; 28 percent of parents reported that their child had not seen a dentist for a preventive appointment in the last twelve months. Lack of preventive dental care was highest among children enrolled through the Medicaid eligibility category, with 36 percent having no visits in the past 12 months, versus only 21 percent from the Expansion and CHP eligibility categories. Unmet need for dental care also varied regionally, with 15 percent of respondents living in Region II (mid-coast and western parts of Maine) reporting unmet need for dental care, 11 percent in Region I (southern Maine), and only 7 percent in Region III (downeast and northern Maine).

From parents of children who recently disenrolled from MaineCare (n=259), we learned that most left the program because of an increase in income which meant they were no longer eligible (39%) or because their child obtained other coverage and no longer needed MaineCare (36%). More than half (60%) of all disenrolled children were enrolled in employer-sponsored insurance

(ESI) at the time of the interview. But a discouraging finding is that almost one-third of disenrolled children (29%) were uninsured at the time of the interview.

Among new MaineCare enrollees (n=290), sixty percent had some form of coverage in the year before the child enrolled in the program, and just under half (47%) had employer-sponsored insurance (ESI) through a parent's employer. In addition, we found that nineteen percent of all new enrollees had access to ESI at the time of the interview but were not enrolled – primarily because it is not affordable. The percentage of new enrollees who declined available employer-sponsored insurance was highest among new CHP (34%) and Expansion (18%) 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 premiums over the past several years have caused increasing numbers of employers to either drop coverage for their employees altogether, or to pass on a higher share of the premium to their employees resulting in unaffordable premiums for many low-income families who have access to ESI.[51] 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.[52] Further, the availability of MaineCare has kept the uninsurance rate among children in Maine (7%) among the lowest of any state in the nation.[53]

[51] 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.
[52] Institute of Medicine. (2002). *Health Insurance is a Family Matter*. Washington, DC: National Academies Press.
[53] Kaiser State Health Facts Online. http://www.statehealthfacts.org Accessed January 11, 2008.

Appendix A: MaineCare Coverage for Children

Eligibility Group	Family Income Eligibility Limits		Premium Payments	Funding Source
	Children Ages 1 through 5	*Children Ages 6 through 18*		
Medicaid	• Family income up to 133% FPL	• Family income up to 125% FPL	No monthly premiums	Medicaid (Title XIX)
Medicaid Expansion	• Family income between 134% and 150% FPL	• Family income between 126% and 150% FPL	No monthly premiums	SCHIP (Title XXI)
Separate Child Health Program (CHP)	• 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 2007

QUESTIONS

Q1 Option **[if Respondent Type doesn't equal Dis Enroll]**

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	END
Q1	9	NA	END

Q2 Option

Was there a period in the past year when \0 was NOT enrolled in MaineCare? **[if Respondent Type doesn't equal Dis Enroll]**
(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 Multiple Check Entry

Why was \0 disenrolled from MaineCare for a time? **[if Respondent Type doesn't equal Dis Enroll]**

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	4	THE RENEWAL APPLICATION WAS DENIED	END
Q3	5	DHHS PAPERWORK PROCESSING DELAY	END
Q3	6	OTHER (SPECIFY)	END
Q3	7	other	END
Q3	8	DK	END
Q3	9	NA	END

Q4 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	6	NEVER ENROLLED	END
Q5	7	MOVED OUT OF STATE	END
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	10	JUST DIDN'T GET AROUND TO IT	Q9
Q7	11	OTHER	NEXT
Q7	98	DK	Q9
Q7	99	NA	Q9

Q8 Text Entry

What is that other reason?

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

Q9 Multiple Check Entry

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

Q9	1	PRIVATE INS. FROM AN EMPLOYER	Q91
Q9	2	DIRIGO CHOICE (THEY GIVE YOU A PLASTIC ID-SAYS DIRIGO/ANTHEM)	Q91
Q9	3	PRIVATE INS. YOU BUY DIRECTLY FROM INSUR. CO.	Q91
Q9	4	OTHER PUBLIC HEALTH INSUR. (SUCH AS SSI/MEDICARE)-SPECIFY	Q91
Q9	5	TRICARE/CHAMPUS/VA (other MILITARY COVERAGE)	Q91
Q9	6	other Public Health Insurance	Q91
Q9	7	NONE	Q91
Q9	8	DK	Q91
Q9	9	NA	Q91

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 Entry

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 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 TRICARE/CHAMPUS/VA (other MILITARY COVERAGE)	NEXT
Q11	6 other Public Health Insurance	NEXT
Q11	8 DK	NEXT
Q11	9 NA	NEXT

Q12 Option

Was \0 covered by any health insurance at any time during the 12 months before \G0 was enrolled in MaineCare? **[If Respondent type equals New Enroll]**

Q12	1 YES	NEXT
Q12	2 NO	Q19
Q12	8 DK	Q19
Q12	9 NA	Q19

Q13 Option

What kind of insurance was it? **[If Respondent type equals New Enroll]**
(READ OPTIONS IF NECESSARY)
(IWER NOTE: IF CHILD WAS COVERED BY MORE THAN ONE INSURANCE, ASK ABOUT THE ONE JUST BEFORE STARTING ON MAINECARE.)

Q13	1 PRIVATE INSURANCE FROM AN EMPLOYER	Q15
Q13	2 DIRIGO CHOICE (PROBE: THEY GIVE YOU A PLASTIC CARD THAT SAYS DIRIGO/ANTHEM)	Q15
Q13	3 PRIVATE INSURANCE YOU BUY DIRECTLY FROM THE INSUR CO	Q15
Q13	4 OTHER PUBLIC HEALTH INSURANCE (SUCH AS SSI OR MEDICARE)	Q15
Q13	5 CHAMPUS/TRICARE/VA, OTHER MILITARY COVERAGE	Q15
Q13	6 OTHER PUBLIC HEALTH INSURANCE	NEXT
Q13	8 DK	Q15
Q13	9 NA	Q15

Q14 Text Entry

What is that other public health insurance? **[If Respondent type equals New Enroll]**

Q14	0 PUBLIC INSURANCE (98=DK, 99=NA)	NEXT

Q15 Option

Is \0 still covered by this health insurance? **[If Respondent type equals New Enroll]**

Q15	1 YES	NEXT
Q15	2 NO	NEXT
Q15	8 DK	NEXT
Q15	9 NA	NEXT

Q16 Option

How long was \0 covered by this insurance before \G0 was enrolled in MaineCare? **[If Respondent type equals New Enroll]**

Q16	1 1 TO 6 MONTHS	NEXT
Q16	2 6 MONTHS TO 1 YEAR	NEXT
Q16	3 1 TO 2 YEARS	NEXT
Q16	4 2 TO 4 YEARS	NEXT
Q16	5 4 YEARS OR MORE	NEXT
Q16	8 DK	NEXT
Q16	9 NA	NEXT

Q17 Option

Which one of the following reasons best describes why \0 is no longer covered by this insurance? Was it because . . . **[If Q15 doesn't equal 2]**

(READ OPTIONS UNTIL R SELECTS ONE.)

Q17	1	You dropped coverage because it had too many rules/restrictions	Q19
Q17	2	You dropped coverage because it was too expensive	Q19
Q17	3	You dropped coverage in order to get MaineCare or because your child was eligible for MaineCare	Q19
Q17	4	The coverage was dropped because of a divorce	Q19
Q17	5	The coverage was dropped by employer or association	Q19
Q17	6	The coverage was no longer available- left or changed job	Q19
Q17	7	Other	NEXT
Q17	8	STILL COVERED	Q19
Q17	98	DK	Q19
Q17	99	NA	Q19

Q18 Text Entry

What is that other reason? **[If Q15 doesn't equal 2]**

Q18	0	REASON (98=DK, 99=NA)	NEXT

Q19 Option

USUAL PLACE FOR CARE

Now I'm going to ask some questions about the health care \0 receives through MaineCare.
Is there a place that \0 USUALLY goes when \G0 is sick or you need advice about \G2 health?
(IF R SAYS YES, ASK: And is there ONE place \G0 goes or is there more than 1 place?)

Q19	1	YES	NEXT
Q19	2	NO	Q22
Q19	3	THERE IS MORE THAN ONE PLACE	NEXT
Q19	8	DK	Q22
Q19	9	NA	Q22

Q20 Option

{Q19=1}{What kind of place is it? Is it a doctor's office, emergency room, hospital outpatient department, clinic, or some other place?}{What kind
of place does \0 go to most often? Is it a doctor's office, emergency room, hospital outpatient clinic, or some other place?}

Q20	1	DOCTOR'S OFFICE	Q22
Q20	2	HOSPITAL EMERGENCY ROOM	Q22
Q20	3	HOSPITAL OUTPATIENT DEPARTMENT	Q22
Q20	4	CLINIC OR HEALTH CENTER	Q22
Q20	5	SCHOOL (NURSE'S OFFICE, ATHLETIC TRAINER'S OFFICE, ETC.)	Q22
Q20	6	FRIEND/RELATIVE	Q22
Q20	7	CANADA/ OTHER LOCATION OUT OF U.S.	Q22
Q20	8	SOME OTHER PLACE	NEXT
Q20	9	DOES NOT GO TO ONE PLACE MOST OFTEN	Q22
Q20	98	DK	Q22
Q20	99	NA	Q22

Q21 Text Entry

{Q19=1}{What kind of place is it?(IWER: RECORD VERBATIM RESPONSE)}{Q19=3}{What kind of place does \0 go to most often?(IWER: RECORD VERBATIM RESPONSE)}

Q21	0	PLACE (98=DK, 99=NA)	NEXT

Q22 Option

A personal doctor or nurse is a health professional who knows your child well and is familiar with your child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of
as \0's personal doctor or nurse?
IF R SAYS YES, ASK: Is there ONE person you think of as \0's personal doctor or is there more than one person?

Q22	1	YES, ONE PERSON	NEXT
Q22	2	YES, MORE THAN ONE PERSON	NEXT
Q22	3	NO	NEXT
Q22	8	DK	NEXT
Q22	9	NA	NEXT

Q23 Option

UTILIZATION OF SERVICES

During the past 12 months, how many times did \0 see a doctor, nurse, or other health care provider for preventive medical care such as a physical exam or well-child check-up?

Q23	1	1	NEXT
Q23	2	2	NEXT
Q23	3	3	NEXT
Q23	4	4	NEXT
Q23	5	5	NEXT
Q23	6	6 - 10	NEXT
Q23	7	11 OR MORE	NEXT
Q23	8	NONE	NEXT
Q23	9	DK	NEXT
Q23	10	NA	NEXT

Q24 Text Entry

During the past 12 months, how many times did \0 see a dentist for preventive dental care, such as check-ups and dental cleanings?

Q24	0	TIMES (98=DK, 99=NA)	NEXT

Q25 Option

Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers. During the past 12 months, has \0 received any treatment or counseling from a mental health professional? **[Age is less than 3]**

Q25	1	YES	NEXT
Q25	2	NO	NEXT
Q25	8	DK	NEXT
Q25	9	NA	NEXT

Q26 Option

UNMET NEED

Sometimes people have difficulty getting health care when they need it. By health care, I mean medical care as well as other kinds of care like dental care and mental health services. During the past 12 months, was there any time when \0 needed health care but it was delayed or not received?

Q26	1	YES	NEXT
Q26	2	NO	Q28
Q26	8	DK	Q28
Q26	9	NA	Q28

Q27 Multiple Check Entry

What type of care was delayed or not received? Was it medical care, dental care, mental health services, or something else?

Q27	1	MEDICAL CARE	NEXT
Q27	2	DENTAL CARE	NEXT
Q27	3	MENTAL HEALTH SERVICES	NEXT
Q27	4	OTHER (SOMETHING ELSE)	NEXT
Q27	8	DK	NEXT
Q27	9	NA	NEXT
Q27	5	other	NEXT

Q28 Option

REFERRALS

During the past 12 months, did \0 need a referral to see any doctors or receive any services? **[If Q23 equals 8]**

Q28	1	YES	NEXT
Q28	2	NO	Q30
Q28	8	DK	Q30
Q28	9	NA	Q30

Q29 Option

Was getting referrals a big problem, a small problem, or not a problem? **[If Q23 equals 8]**

Q29	1	BIG PROBLEM	NEXT
Q29	2	SMALL PROBLEM	NEXT
Q29	3	NOT A PROBLEM	NEXT
Q29	8	DK	NEXT
Q29	9	NA	NEXT

Q30 Option

CARE COORDINATION

Does anyone help you arrange or coordinate \0's care among the different doctors or services that \G0 uses? **[If Q23 equals 8]**

(IWER READ IF NECESSARY: "By "arrange and coordinate", I mean: Is there anyone who helps you make sure that \0 gets all the health care and services \G0 needs, that health care providers share information, and that these services fit together and are paid for in a way that works for you?" "Anyone" means anyone.)

Q30	1	YES	NEXT
Q30	2	NO	NEXT
Q30	3	NO COORDINATION NEEDED OR WANTED	Q33
Q30	8	DK	NEXT
Q30	9	NA	Q33

Q31 Option

During the past 12 months, have you felt that you could have used extra help arranging or coordinating \0's care among the different health care
providers or services? **[If Q23 equals 8]**

Q31	1	YES	NEXT
Q31	2	NO	Q33
Q31	8	DK	Q33
Q31	9	NA	Q33

Q32 Option

During the past 12 months, how often did you get as much help as you wanted with arranging or coordinating \0's care? Would you say . . . **[If Q23 equals 8]**

Q32	1	never	NEXT
Q32	2	sometimes, or	NEXT
Q32	3	usually	NEXT
Q32	8	DK	NEXT
Q32	9	NA	NEXT

Q33 Option

PROVIDER COMMUNICATION

Overall, are you very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied with the communication among \0's doctors and other health care providers? **[If Q23 equals 8]**

Q33	1	VERY SATISFIED	NEXT
Q33	2	SOMEWHAT SATISFIED	NEXT
Q33	3	SOMEWHAT DISSATISFIED	NEXT
Q33	4	VERY DISSATISFIED	NEXT
Q33	5	NO COMMUNICATION NEEDED OR WANTED	NEXT
Q33	8	DK	NEXT
Q33	9	NA	NEXT

Q34 Option

COMPASSIONATE CARE **[If Q23 equals 8]**

During the past 12 months, how often did \0's doctors and other health care providers spend enough time with \G1? Would you say . . .

Q34	1	never	NEXT
Q34	2	sometimes	NEXT
Q34	3	usually, or	NEXT
Q34	4	always	NEXT
Q34	8	DK	NEXT
Q34	9	NA	NEXT
Q34	5	HASN'T BEEN TO DR. IN PAST 12 MONTHS	Q37

Q35		Option

During the past 12 months, how often did \0's doctor and other health care providers listen carefully to you? **[If Q34 equals 5 or Q23 equals 8]**
Would you say . . .
(IWER NOTE: IF MORE THAN ONE PROVIDER, ASK ABOUT THE "REGULAR" PROVIDER OR PROVIDER THAT CHILD SEES MOST OFTEN.)

Q35	1	never	NEXT
Q35	2	sometimes	NEXT
Q35	3	usually, or	NEXT
Q35	4	always	NEXT
Q35	5	HASN'T BEEN TO DR. IN PAST 12 MONTHS	Q37
Q35	8	DK	NEXT
Q35	9	NA	NEXT

Q36		Option

Information about a child's health or health care can include things such as the causes of any health problems, how to care for a child now, and
what changes to expect in the future. During the past 12 months, how often did you get the specific information you needed from \0's doctors and
other health care providers? Would you say . . . **[If Q34 equals 5 or Q23 equals 8]**

Q36	1	never	NEXT
Q36	2	sometimes	NEXT
Q36	3	usually, or	NEXT
Q36	4	always	NEXT
Q36	5	HASN'T BEEN TO DR. IN PAST 12 MONTHS	NEXT
Q36	8	DK	NEXT
Q36	9	NA	NEXT

Q37		Option

PROVIDER EDUCATION PRACTICES

How often do you, personally, go with \0 to \G2 physical exams or well-child check-ups? Would you say . . . **[If Q23 equals 8]**

Q37	1	always	NEXT
Q37	2	usually	NEXT
Q37	3	sometimes	NEXT
Q37	4	rarely, or	Q51
Q37	5	never	Q51
Q37	8	DK	Q51
Q37	9	NA	Q51

Q38		Option

At those exams or check-ups, how often does \0's provider talk about any of the following to you or your child? **[If Q23 equals 8]**
Nutrition and diet- would you say . . .

Q38	1 always	NEXT
Q38	2 usually	NEXT
Q38	3 sometimes	NEXT
Q38	4 rarely, or	NEXT
Q38	5 never	NEXT
Q38	8 DK	NEXT
Q38	9 NA	NEXT

Q39		Option

(At those exams or check-ups, how often does \0's provider talk about any of the following to you or your child?)

Physical activity or exercise- would you say . . . [**If Q23 equals 8 or age is less than 3]**

Q39	1 always	NEXT
Q39	2 usually	NEXT
Q39	3 sometimes	NEXT
Q39	4 rarely, or	NEXT
Q39	5 never	NEXT
Q39	8 DK	NEXT
Q39	9 NA	NEXT

Q40		Option

(At those exams or check-ups, how often does \0's provider talk about any of the following to you or your child?)

Drug or alcohol use- would you say . . . [**If Q23 equals 8 or age is less than 8]**

Q40	1 always	NEXT
Q40	2 usually	NEXT
Q40	3 sometimes	NEXT
Q40	4 rarely, or	NEXT
Q40	5 never	NEXT
Q40	8 DK	NEXT
Q40	9 NA	NEXT

Q41	Option	
(How often does \0's provider talk about . . .) Weight- would you say . . .		**[If Q23 equals 8]**
Q41	1 always	NEXT
Q41	2 usually	NEXT
Q41	3 sometimes	NEXT
Q41	4 rarely, or	NEXT
Q41	5 never	NEXT
Q41	8 DK	NEXT
Q41	9 NA	NEXT

Q42	Option	
(How often does \0's provider talk about . . .) Use of tobacco products- would you say . . .		[**If Q23 equals 8 or age is less than 8]**
Q42	1 always	NEXT
Q42	2 usually	NEXT
Q42	3 sometimes	NEXT
Q42	4 rarely, or	NEXT
Q42	5 never	NEXT
Q42	8 DK	NEXT
Q42	9 NA	NEXT

Q43	Option	
(How often does \0's provider talk about . . .) Risks of second hand smoke- would you say . . .		**[If Q23 equals 8]**
Q43	1 always	NEXT
Q43	2 usually	NEXT
Q43	3 sometimes	NEXT
Q43	4 rarely, or	NEXT
Q43	5 never	NEXT
Q43	8 DK	NEXT
Q43	9 NA	NEXT

Q44		Option	

(How often does \0's provider talk about . . .)

Social and emotional development- by this we mean how \G0 interacts with other children \G2 age; would you say . . . **[If Q23 equals 8]**

Q44	1	always	NEXT
Q44	2	usually	NEXT
Q44	3	sometimes	NEXT
Q44	4	rarely, or	NEXT
Q44	5	never	NEXT
Q44	8	DK	NEXT
Q44	9	NA	NEXT

Q45		Option	

(How often does \0's provider talk about . . .)
Mental health- would you say . . . [**If Q23 equals 8 or age is less than 3]**

Q45	1	always	NEXT
Q45	2	usually	NEXT
Q45	3	sometimes	NEXT
Q45	4	rarely, or	NEXT
Q45	5	never	NEXT
Q45	8	DK	NEXT
Q45	9	NA	NEXT

Q46		Option	

(How often does \0's provider talk about . . .)
Reproductive health- would you say . . . [**If Q23 equals 8 or age is less than 8]** Q46 1 always NEXT

Q46	2	usually	NEXT
Q46	3	sometimes	NEXT
Q46	4	rarely, or	NEXT
Q46	5	never	NEXT
Q46	8	DK	NEXT
Q46	9	NA	NEXT
Q46	6	DOESN'T APPLY- CHILD TOO YOUNG	NEXT

Q47 Option

(How often does \0's provider talk about . . .)
Television viewing or other screen time- would you say . . . **[If Q23 equals 8]**

Q47	1	always	NEXT
Q47	2	usually	NEXT
Q47	3	sometimes	NEXT
Q47	4	rarely, or	NEXT
Q47	5	never	NEXT
Q47	8	DK	NEXT
Q47	9	NA	NEXT

Q48 Option

(How often does \0's provider talk about . . .)
Sugar-sweetened drinks- would you say . . . **[If Q23 equals 8]**

Q48	1	always	NEXT
Q48	2	usually	NEXT
Q48	3	sometimes	NEXT
Q48	4	rarely, or	NEXT
Q48	5	never	NEXT
Q48	8	DK	NEXT
Q48	9	NA	NEXT

Q49 Option
Are there any topics related to \0's health or health care that you need MORE information about from \G2 provider? **[If Q23 equals 8]**

Q49	1	YES	NEXT
Q49	2	NO	Q51
Q49	8	DK	Q51
Q49	9	NA	Q51

Q50 Multiple Check Entry
What topics do you need more information about? **[If Q23 equals 8]**
(CHECK ALL THAT APPLY)

Q50	1	NUTRITION AND DIET	NEXT
Q50	2	PHYSICAL ACTIVITY OR EXERCISE	NEXT
Q50	3	DRUG OR ALCOHOL USE	NEXT
Q50	4	WEIGHT	NEXT
Q50	5	OTHER (SPECIFY)	NEXT
Q50	6	other	NEXT
Q50	8	DK	NEXT
Q50	9	NA	NEXT

Q51 Multiple Check Entry

ACCESS TO HEALTH INFORMATION

Next we have some questions about access to health information.
Where do you usually get information about health issues?
(CHECK ALL THAT APPLY.)

Q51	1	HEALTHCARE PROVIDER	NEXT
Q51	2	MAGAZINES/ NEWSPAPERS	NEXT
Q51	3	TV	NEXT
Q51	4	INTERNET	NEXT
Q51	5	FAMILY MEMBER	NEXT
Q51	6	FRIENDS	NEXT
Q51	7	SCHOOL	NEXT
Q51	8	WIC PROGRAM (WOMEN/INFANTS/CHILDREN)	NEXT
Q51	9	BOOKS	NEXT
Q51	10	WORK IN HEALTHCARE	NEXT
Q51	11	MAINECARE MEMBER SERVICES/ NEWSLETTER/ 800 NUMBER	NEXT
Q51	12	OTHER (SPECIFY)	NEXT
Q51	13	other	NEXT
Q51	98	DK	NEXT
Q51	99	NA	NEXT

Q52 Option

In the last 12 months, have you received any health information materials from MaineCare? It may have come as a newsletter or in a separate mailing.

Q52	1	YES	NEXT
Q52	2	NO	NEXT
Q52	8	DK	NEXT
Q52	9	NA	NEXT

Q53 Option

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

Q53	1	YES	NEXT
Q53	2	NO	NEXT
Q53	8	DK	NEXT
Q53	9	NA	NEXT

Q54 Option

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

Q54	1	every day	NEXT
Q54	2	1-3 times a week	NEXT
Q54	3	1-3 times a month	NEXT
Q54	4	less than once a month, or	NEXT
Q54	5	never	NEXT
Q54	8	DK	NEXT
Q54	9	NA	NEXT

Q55 Text Entry

SATISFACTION WITH PROVIDER AND MAINECARE

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? **[If Q19 equals 2 or Q19 equals 8 or Q19 equals 9]**

Q55	0	RATING (98=DK, 99=NA)	NEXT

Q56 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 staff? **[If Q19 equals 2 or Q19 equals 8 or Q19 equals 9]** Q56 0 RATING (98=DK, 99=NA) NEXT

Q57 Multiple Check Entry

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.)

Q57	1	PEACE OF MIND/SECURITY/NO WORRY	NEXT
Q57	2	NOT HAVING TO GO TO EMERGENCY ROOM FOR ROUTINE CARE	NEXT
Q57	3	COULDN'T AFFORD/WOULDN'T HAVE HEALTH CARE WITHOUT IT	NEXT
Q57	4	COVERS PREVENTIVE CARE (CHECKUPS & ROUTINE CARE FROM PCP)	NEXT
Q57	5	COVERS SPECIALISTS	NEXT
Q57	6	DENTAL COVERAGE	NEXT
Q57	7	PRESCRIPTIONS PROVIDED	NEXT
Q57	8	COVERS other SERVICES WE NEED	NEXT
Q57	9	OTHER REASON	NEXT
Q57	10	other	NEXT
Q57	98	DK	NEXT
Q57	99	NA	NEXT

Q58 Option

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

Q58	1	very satisfied	NEXT
Q58	2	somewhat satisfied	NEXT
Q58	3	somewhat dissatisfied, or	Q60
Q58	4	very dissatisfied	Q60
Q58	8	DK	Q61
Q58	9	NA	Q61

Q59 Multiple Check Entry

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

Q59	1	AFFORDABILITY/COST/PRICE	NEXT
Q59	2	COVERAGE/BENEFITS	NEXT
Q59	3	EFFICIENT	NEXT
Q59	4	OTHER REASON	NEXT
Q59	5	other	NEXT
Q59	6	NO PROBLEMS/NO HASSLES	NEXT
Q59	8	DK	NEXT
Q59	9	NA	NEXT

Q60 Multiple Check Entry

{Q58=2}{Is there anything you are dissatisfied with? IF YES ASK: "What is that ?"(DO NOT READ; CHECK ALL THAT R MENTIONS)}{Could you tell me why you're dissatisfied?(DO NOT READ; CHECK ALL THAT R MENTIONS)} **[If Q58 equals 1]**

Q60	1	LACK OF DENTAL PROVIDERS/NONE TAKE MAINCARE PATIENTS	NEXT
Q60	2	COVERAGE LIMITATION	NEXT
Q60	3	GENERAL HASSLE	NEXT
Q60	4	PRIOR AUTHORIZATION REQUIRED FOR EVERYTHING	NEXT
Q60	5	CAN'T FIND PROVIDER WHO WILL TAKE MAINECARE	NEXT
Q60	6	THE WAY WE'RE TREATED BY MAINECARE	NEXT
Q60	7	LIMITED PCP'S AVAILABLE (MAINECARE NETWORK PCP ONLY)	NEXT
Q60	8	THE WAY WE'RE TREATED BY PROVIDERS OFFICES	NEXT
Q60	9	DISTANCE TO MAINECARE PCP	NEXT
Q60	10	OTHER REASON	NEXT
Q60	11	other	NEXT
Q60	98	DK	NEXT
Q60	99	NA	NEXT
Q60	12	NOTHING	NEXT

Q61 Option

CHILD HEALTH STATUS

Now I'm going to ask you about your child's health.
In general, how would you describe \0's health? Would you say \G2 health is . . .

Q61	1	excellent	NEXT
Q61	2	very good	NEXT
Q61	3	good	NEXT
Q61	4	fair, or	NEXT
Q61	5	poor	NEXT
Q61	8	DK	NEXT
Q61	9	NA	NEXT

Q62 Option

Is \0 LIMITED OR PREVENTED in any way in \G2 ability to do the things most children of the same age can do?
(IWER NOTE: A CHILD IS LIMITED OR PREVENTED WHEN THERE ARE THINGS THE CHILD CAN'T DO AS MUCH OR CAN'T DO AT ALL THAT MOST CHILDREN THE SAME AGE CAN.)

Q62	1	YES	NEXT
Q62	2	NO	Q65
Q62	8	DK	Q65
Q62	9	NA	Q65

Q63 Option

Is \G2 limitation in abilities because of ANY medical, behavioral, or other health condition?

Q63	1	YES	NEXT
Q63	2	NO	Q65
Q63	8	DK	Q65
Q63	9	NA	Q65

Q64 Option

Is this a condition that has lasted or is expected to last 12 months or longer?

Q64	1	YES	NEXT
Q64	2	NO	NEXT
Q64	8	DK	NEXT
Q64	9	NA	NEXT

Q65 Text Entry

BMI/OBESITY

How tall is \0 now?
(PROBE: "Your best guess is fine.")
FEET:

Q65	0	HEIGHT/FEET (98=DK, 99=NA)	NEXT

Q66 Text Entry

INCHES:

Q66	0 INCHES (98=DK, 99=NA)	NEXT

Q67 Text Entry

How much does \0 weigh now?
(IF ASKED; WEIGHT WITHOUT CLOTHES) (PROBE: "Your best guess is fine.")
LBS:

Q67	0 WEIGHT (998=DK, 999=NA)	NEXT

Q68 Option

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

Q68	1 underweight	NEXT
Q68	2 slightly underweight	NEXT
Q68	3 about the right weight	NEXT
Q68	4 slightly overweight, or	NEXT
Q68	5 overweight	NEXT
Q68	8 DK	NEXT
Q68	9 NA	NEXT

Q69 Option

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

Q69	1 YES	NEXT
Q69	2 NO	NEXT
Q69	8 DK	NEXT
Q69	9 NA	NEXT

Q70 Option

CHILD HEALTH CONDITIONS- SEE SEPARATE INFO SHEET!

Now I am going to read you a list of conditions. For each condition, please tell me if a doctor or other health care provider ever told you that \0 had
the condition, even if \G0 does not have the condition now.
Has a doctor or other health care provider ever told you that \0 had . . .
ADD or ADHD, that is Attention Deficit Disorder or Attention Deficit Hyperactive Disorder?

Q70	1 YES	NEXT
Q70	2 NO	NEXT
Q70	8 DK	NEXT
Q70	9 NA	NEXT

Q71		Option

Has a doctor or other health care provider ever told you that \0 had . . .
Depression?

Q71	1 YES	NEXT
Q71	2 NO	NEXT
Q71	8 DK	NEXT
Q71	9 NA	NEXT

Q72		Option

(Has a doctor or other health care provider ever told you that \0 had . . .)
Anxiety problems?

Q72	1 YES	NEXT
Q72	2 NO	NEXT
Q72	8 DK	NEXT
Q72	9 NA	NEXT

Q73		Option

(Has a doctor or other health care provider ever told you that \0 had . . .)
Autism, Asperger's Disorder, pervasive developmental disorder, or other autism spectrum disorder?

Q73	1 YES	NEXT
Q73	2 NO	NEXT
Q73	8 DK	NEXT
Q73	9 NA	NEXT

Q74		Option

(Has a doctor or other health care provider ever told you that \0 had . . .)
Any developmental delay that affects \G2 ability to learn?

Q74	1 YES	NEXT
Q74	2 NO	NEXT
Q74	8 DK	NEXT
Q74	9 NA	NEXT

Q75		Option

(Has a doctor or other health care provider ever told you that \0 had . . .)
Asthma?

Q75	1 YES	NEXT
Q75	2 NO	NEXT
Q75	8 DK	NEXT
Q75	9 NA	NEXT

Q76		Option

(Has a doctor or other health care provider ever told you that \0 had . . .)
Diabetes?

Q76	1 YES	NEXT
Q76	2 NO	NEXT
Q76	8 DK	NEXT
Q76	9 NA	NEXT

Q77		Option

Does \0 currently have ADD or ADHD? **[If Q70 is greater than 1]**

Q77	1 YES	NEXT
Q77	2 NO	Q79
Q77	8 DK	Q79
Q77	9 NA	Q79

Q78		Option

Is \0 currently taking medication for ADD or ADHD? **[If Q70 is greater than 1]**

Q78	1 YES	NEXT
Q78	2 NO	NEXT
Q78	8 DK	NEXT
Q78	9 NA	NEXT

Q79		Option

Does \0 currently have depression? **[If Q71 is greater than 1]**

Q79	1 YES	NEXT
Q79	2 NO	NEXT
Q79	8 DK	NEXT
Q79	9 NA	NEXT

Q80		Option

Does \0 currently have anxiety problems? **[If Q72 is greater than 1]**

Q80	1 YES	NEXT
Q80	2 NO	NEXT
Q80	8 DK	NEXT
Q80	9 NA	NEXT

Q81 Option

Does \0 currently have autism or ASD? **[If Q73 is greater than 1]**

Q81	1	YES	NEXT
Q81	2	NO	NEXT
Q81	8	DK	NEXT
Q81	9	NA	NEXT

Q82 Option

Does \0 currently have asthma? **[If Q75 is greater than 1]**

Q82	1	YES	NEXT
Q82	2	NO	NEXT
Q82	8	DK	NEXT
Q82	9	NA	NEXT

Q83 Option

Does \0 currently have diabetes? **[If Q76 is greater than 1]**

Q83	1	YES	NEXT
Q83	2	NO	NEXT
Q83	8	DK	NEXT
Q83	9	NA	NEXT

Q84 Text Entry

CHILD EXERCISE, NUTRITION, AND SCREEN TIME

During the past week, on how many days did \0 exercise, play a sport, or participate in physical activity for at least 20 minutes that made \G1 sweat and breathe hard? \5<3

(IWER NOTE: INCLUDE ACTIVE SPORTS SUCH AS BASEBALL, SOFTBALL, BASKETBALL, SWIMMING, SOCCER, TENNIS, OR FOOTBALL; RIDING A BIKE OR ROLLERSKATING; WALKING OR JOGGING; JUMPING ROPE; GYMNASTICS; AND ACTIVE DANCE SUCH AS BALLET.)

Q84	0	NUMBER OF DAYS (98=DK, 99=NA)	NEXT

Q85 Option

How many times a week does \0 have physical education at school? **[Age is less than 4]**

Q85	1	ONCE A WEEK	NEXT
Q85	2	2 TIMES PER WEEK	NEXT
Q85	3	3 OR MORE TIMES PER WEEK	NEXT
Q85	4	CHILD DOESN'T TAKE IT	NEXT
Q85	5	SCHOOL DOESN'T OFFER PHYSICAL EDUCATION	NEXT
Q85	8	DK	NEXT
Q85	9	NA	NEXT
Q85	6	DOESN'T GO TO SCHOOL	NEXT

Q86 Option

How often does \0 drink a can or a glass of regular soda or sweetened fruit drinks?
(IWER NOTE: WE'RE ASKING ABOUT BEVERAGES WITH ADDED SUGAR ONLY, LIKE COKE, 7-UP OR SUNNY D. DO NOT COUNT DIET SODA OR 100% JUICE DRINKS. IF \G0 DRINKS 1 CAN OF SODA 2-3 TIMES PER WEEK, THEN THE ANSWER WOULD BE 2-6 CANS PER WEEK.)

Q86	1	NEVER	NEXT
Q86	2	1-3 CANS PER MONTH	NEXT
Q86	3	1 CAN PER WEEK	NEXT
Q86	4	2-6 CANS PER WEEK	NEXT
Q86	5	1 CAN A DAY	NEXT
Q86	6	2 OR MORE CANS A DAY	NEXT
Q86	8	DK	NEXT
Q86	9	NA	NEXT

Q87 Option

How often does \0 eat fruit or vegetables?
(PROBE: "Vegetables are all cooked and uncooked vegetables; salads; and boiled, baked and mashed potatoes. Do not count french fries or chips.")

Q87	1	NEVER	NEXT
Q87	2	1-3 TIMES A MONTH	NEXT
Q87	3	ONCE A WEEK	NEXT
Q87	4	2-6 TIMES A WEEK	NEXT
Q87	5	ONCE A DAY	NEXT
Q87	6	2 OR MORE TIMES A DAY	NEXT
Q87	8	DK	NEXT
Q87	9	NA	NEXT

Q88 Text Entry

On an average WEEKDAY, about how many hours does \0 usually watch TV, watch videos, or play video games?
(IWER NOTE: THIS INCLUDES MONDAY- FRIDAY, AM AND PM)

Q88	0	NUMBER OF HOURS (97=DON'T OWN A TV, VIDEO PLAYER OR VIDEO GAMES, 98=DK, 99=NA)	NEXT

Q89 Option

TOBACCO USE

Does \0 smoke or use tobacco products? **[Age is less than 8]**

Q89	1	YES	NEXT
Q89	2	NO	NEXT
Q89	8	DK, NOT SURE	NEXT
Q89	9	NA	NEXT

Q90 Option

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

Q90	1	1	NEXT
Q90	2	2	NEXT
Q90	3	3 OR MORE	NEXT
Q90	4	NONE	NEXT
Q90	5	SOMEBODY SMOKES, UNKNOWN #	NEXT
Q90	8	DK	NEXT
Q90	9	NA	NEXT

Q91 Option

The next few questions are about you. **[SCHIP/CUBCARE ENROLLEES ONLY]**

{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 . . .}

Q91	1	very easy	NEXT
Q91	2	somewhat easy	NEXT
Q91	3	neither easy nor hard	NEXT
Q91	4	somewhat hard, or	NEXT
Q91	5	very hard	NEXT
Q91	8	DK	NEXT
Q91	9	NA	NEXT

Q92 Option

{Q91>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?}

Q92	1	8TH GRADE OR LESS	NEXT
Q92	2	SOME HIGH SCHOOL, BUT DID NOT GRADUATE	NEXT
Q92	3	HIGH SCHOOL GRADUATE OR GED	NEXT
Q92	4	SOME COLLEGE OR 2 YEAR DEGREE	NEXT
Q92	5	4 YEAR COLLEGE DEGREE	NEXT
Q92	6	MORE THAN 4 YEAR COLLEGE DEGREE	NEXT
Q92	8	DK	NEXT
Q92	9	NA	NEXT

Q93 Option

How are you related to \0?
(PROBE IF NECESSARY: "So you're \0's . . . ")

Q93	1	PARENT/STEP PARENT	Q95
Q93	2	GRANDPARENT	Q95
Q93	3	LEGAL GUARDIAN	Q95
Q93	4	OTHER RELATIVE	NEXT
Q93	5	FOSTER PARENT	Q95
Q93	6	PARTNER/BOYFRIEND/GIRLFRIEND OF PARENT	Q95
Q93	8	DK	Q95
Q93	9	NA	Q95

Q94 Text Entry

How are you related?

Q94	0	RELATED (98=DK, 99=NA)	NEXT

Q95 Option

ACCESS TO EMPLOYER SPONSORED INSURANCE

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 . . . ")

Q95	1	I AM/ SELF (THE RESPONDENT)	Q97
Q95	2	MY SPOUSE	Q97
Q95	3	MY UNMARRIED PARTNER (BOYFRIEND/GIRLFRIEND)	Q97
Q95	4	MY CHILD (R IS MWE'S PARENT)	Q97
Q95	5	MY PARENT (R IS MWE'S CHILD)	Q97
Q95	6	MY OTHER RELATIVE	Q97
Q95	7	MY ROOMMATE	Q97
Q95	8	OTHER	NEXT
Q95	98	DK	Q97
Q95	99	NA	Q97

Q96 Text Entry

R'S RELATIONSHIP TO MAIN WAGE EARNER:
(PROBE IF NECESSARY: "So he/she's your . . . ")

Q96	0	MAIN WAGE EARNER (98=DK, 99=NA)	NEXT

Q97		Option	

{Q95=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?}

Q97	1	works full-time	NEXT
Q97	2	works 1 part-time job	NEXT
Q97	3	works more than 1 part-time job	NEXT
Q97	4	works seasonally	NEXT
Q97	5	self-employed	NEXT
Q97	6	disabled, not working	NEXT
Q97	7	retired, not working	NEXT
Q97	8	unemployed, looking for work, or	NEXT
Q97	9	not working	NEXT
Q97	98	DK	NEXT
Q97	99	NA	NEXT

Q98		Option	

{Q95=1}{Approximately how many employees are in the company or organization where you work?(IWER NOTE: IF MORE THAN ONE JOB, COUNT THE ONE WITH THE MOST HOURS.)}{Approximately how many employees are in the company or organization where he/she works?(IWER NOTE: IF MORE THAN ONE JOB, COUNT THE ONE WITH THE MOST HOURS.)} **[If Q97 is greater than 5]**

Q98	1	LESS THAN 25	NEXT
Q98	2	25 TO 50 EMPLOYEES	NEXT
Q98	3	MORE THAN 50 EMPLOYEES	NEXT
Q98	8	DK	NEXT
Q98	9	NA	NEXT

Q99		Option	

Does the company or organization currently offer health insurance to any of its employees? **[If Q97 is greater than 5]**

Q99	1	YES	NEXT
Q99	2	NO	Q106
Q99	8	DK	Q106
Q99	9	NA	Q106

Q100		Option	

{Q95=1}{Are you eligible to receive that health insurance?}{Is he/she eligible to receive that health insurance?}**[If Q97 is greater than 5]**

Q100	1	YES	NEXT
Q100	2	NO	Q106
Q100	3	NOT YET	Q106
Q100	8	DK	Q106
Q100	9	NA	Q106

Q101 Option

{Q95=1}{Are you enrolled in the employer's health insurance program?}{Is he/she enrolled in the employer's health insurance program?} **[If Q97 is greater than 5]**

Q101	1	YES	Q103
Q101	2	NO	NEXT
Q101	8	DK	Q103
Q101	9	NA	Q103

Q102 Multiple Check Entry

{Q95=1}{Now I'll read a list of possible reasons why you may not be enrolled in the insurance offered by that employer. Is one reason you're not enrolled because . . .(IWER: READ OPTIONS, CHECK ALL THAT APPLY)}{Now I'll read a list of possible reasons why he/she may not be enrolled in the insurance offered by that employer. Is one reason he/she isn't enrolled because . . . (IWER: READ OPTIONS, CHECK ALL THAT APPLY)} **[If Q97 is greater than 5]**

Q102	1	it is too expensive	NEXT	
Q102	2	the coverage is too limited	NEXT	
Q102	3	MaineCare offers better coverage	NEXT	
Q102	4	MaineCare is less expensive	NEXT	
Q102	5	you have other coverage (through spouse, military or other source), or	NEXT	
Q102	6	SOME OTHER REASON (SPECIFY)	NEXT	
Q102	7	other	NEXT	
Q102	8	DK	NEXT	
Q102	9	NA	NEXT	

Q103 Option

Can that insurance cover \0? **[If Q97 is greater than 5]**

Q103	1	YES	NEXT
Q103	2	NO	Q106
Q103	8	DK	Q106
Q103	9	NA	Q106

Q104 Option

Is \0 enrolled in that insurance? **[If Q97 is greater than 5]**

Q104	1	YES	Q106
Q104	2	NO	NEXT
Q104	8	DK	Q106
Q104	9	NA	Q106

Q105 Multiple Check Entry

Now I'll read a list of possible reasons why \0 may not be enrolled in the insurance by that employer. Is is because . . . **[If Q97 is greater than 5]**
(IWER: READ OPTIONS AND CHECK FIRST RESPONSE. THEN PROBE ONCE WITH "Anything else?")

Q105	1	It is too expensive	NEXT	
Q105	2	the coverage is too limited	NEXT	
Q105	3	MaineCare offers better coverage	NEXT	
Q105	4	MaineCare is less expensive	NEXT	
Q105	5	you have other coverage (through spouse, military, or other source), or	NEXT	
Q105	6	SOME OTHER REASON (SPECIFY)	NEXT	
Q105	7	other	NEXT	
Q105	8	DK	NEXT	
Q105	9	NA	NEXT	

Q106 Multiple Check Entry

{Q95=1}{Finally, I'm going to read a list of different types of health insurance. Please tell me which, if any, you have.(IWER: READ OPTIONS AND CHECK FIRST RESPONSE. THEN PROBE ONCE WITH "Anything else?")}{Finally, I'm going to read a list of different types of health insurance. Please tell me which, if any, the main wage earner has.(IWER: READ OPTIONS AND CHECK FIRST RESPONSE. THEN PROBE ONCE WITH "Anything else?")}

Q106	1	MaineCare	NEXT	
Q106	2	Medicare	NEXT	
Q106	3	Health Insurance through main wage earner's work or union	NEXT	
Q106	4	Dirigo Choice (CARD FROM ANTHEM)	NEXT	
Q106	5	Health insurance through someone else's work or union	NEXT	
Q106	6	Health insurance bought directly from an insurance company	NEXT	
Q106	7	Health insurance through the military (TriCare, CHAMPUS, Veteran's Services)	NEXT	
Q106	8	Some OTHER health insurance, or	NEXT	
Q106	9	No health insurance?	NEXT	
Q106	10	other	NEXT	
Q106	98	DK	NEXT	
Q106	99	NA	NEXT	

Q107 Option

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

Q107	1	END	END