

**ACCESS TO CARE IN EPO COMPARED TO HMO DELIVERY SYSTEMS**

**A REPORT PREPARED FOR THE  
HEALTHY KIDS BOARD OF DIRECTORS**

**Elizabeth Shenkman, PhD  
Principal Investigator**

**Nat Boyett, MA  
Institute for Child Health Policy**

**Christine A. Bono, MA  
Program Associate**

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**Institute for Child Health Policy**  
*Creative Vision in Research & Service*

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The Balanced Budget Act (BBA) of 1997 authorized Title XXI of the Social Security Act (SSA), also known as the State Children's health Insurance Program (SCHIP), to provide assistance to states to initiate or expand health benefits to uninsured, low-income children. During Federal Fiscal Year 2000 (October 1, 1999 through September 30, 2000), over 3 million children were enrolled in SCHIP nationally (Center for Medicare and Medicaid Studies, 2001). States had flexibility to design their SCHIP initiatives in various ways. In very broad terms, the program could be a Medicaid expansion, a separate program, or a combination of the two. However, within those broad categories, states also had to make many decisions about how the health care delivery system would be organized to provide services to the enrollees.

As of June 2000, 49 states and the District of Columbia had implemented SCHIP programs. Of these, 78% with separate SCHIP initiatives used some form of managed care arrangement to deliver health care services to their enrollees. For those states with Medicaid expansions, either as their sole program option or in combination with a separate program, 97% were using some type of managed care arrangement. These managed care arrangements were either 1) a risk-based program where health plans provided or arranged the agreed upon services for a set fee per enrollee per month or 2) a primary care case management model (PCCM) where primary care providers are paid fee-for-service (FFS) and receive a small additional fee for gate keeping and care coordination functions (Pernice, Wyses, Riley, & Kaye, 2001).

However, some sparsely populated states were using FFS delivery systems (West Virginia, Alabama, North Carolina, North Dakota, and Wyoming). In addition two states, Mississippi and Montana were using indemnity coverage for their SCHIP Programs and two other states, New York and Iowa were using indemnity coverage in part of their states.

While general information is available about the use of managed care or FFS arrangements, little information is available about the types of managed care arrangements that states are using. There may be wide variations both between states and within states. Moreover, little is known about the relationship between these various service delivery arrangements and children's access to care within SCHIP. Florida is one state operating a SCHIP Program that uses two different types of managed care arrangements to organize and deliver care. These two types are 1) health maintenance organizations (HMOs) and 2) exclusive provider organizations (EPOs).

Under the HMO arrangement, a family chooses a primary care provider (PCP) for their child. The PCP serves as a gatekeeper and is responsible for referring the child within the HMO's network for services that he or she cannot provide. In the HMOs, PCPs are paid many different ways, including salaries, capitation, FFS, and any combination of the three, depending on the contracts they negotiate. In contrast, the EPO does not use PCPs as gatekeepers. Families may choose to take their child to any provider in the network for any reason. Care provided by providers outside of the network is not reimbursed except in emergency cases. All of the providers are reimbursed a discounted FFS that is close to Florida Medicaid rates.

Florida chose these two options because of challenges associated with forming provider networks in those areas of the state that are sparsely populated and not adjacent to any major urban centers. Often there are shortages of health care providers in rural areas. In addition, the low population density makes it difficult for health plans to maintain a sufficient enrollment base to ensure their financial viability (Casey, Wellever, Moscovice, 1997). Providers in some Florida rural areas were willing to join an HMO network and serve as gatekeepers, others were not.

As states implement various managed care delivery systems, it is important to gain a better understanding of how these models affect the care that children receive. Children rapidly grow and develop and can be particularly vulnerable when they do not receive adequate primary and preventive care. Earlier studies on managed care typically included both adults and children, thereby providing limited information about children's unique experiences in managed care arrangements (Hurley, Freund, and Paul, 1993). Other studies focused uniquely on children. However these studies often included only children in Medicaid and usually compared managed care to traditional FFS arrangements, rather than assessing different types of managed care arrangements (Long and Coughlin, 2001). There are some studies examining the health care children received in subsidized children's health insurance programs that later become models for SCHIP (Lave, et al., 1998; Shenkman, et al., 1996; Shenkman et al., 1997). However, these studies did not examine the children's health care within the context of the managed care arrangements delivering that care.

The purpose of this study was to examine the relationship between the type of managed care arrangement used to deliver services and SCHIP enrollees' access to health care. Access was assessed by examining 1) the odds that children would use health care and for those children who used health care, their health care use rates, 2) the incidence of inpatient admissions for ambulatory care sensitive conditions (ACSCs), and 3) the incidence of emergency room use for ACSCs. Using person-level claims and encounter data provided by the Florida Healthy Kids Corporation, we compared children's access to care in the HMO and EPO models. Because children's care can be influenced by many factors, we included information about the child's health status, the child's sociodemographic characteristics, and local community characteristics in our analyses.

## BACKGROUND

### **THE FLORIDA HEALTHY KIDS PROGRAM**

This study was conducted with families whose children were enrolled in the Florida Healthy Kids

Program between July 1, 2000 and June 31, 2001. The Healthy Kids Program is the largest component of Florida's Title XXI SCHIP initiative, with over 187,000 enrollees as of September 2001. The program is available to children between the ages of 5 and 19 years. Those below 200% of the federal poverty level (FPL) receive subsidized health insurance premiums. The benefit package is comprehensive and covers preventive care with no copayment, and other outpatient care, inpatient care, rehabilitative services, mental health care, and emergency services with minimal copayments.

The Healthy Kids Corporation negotiates contracts with health plans to assume financial risk and to provide health care services. At the time of the study, there was one health plan operating in 64 of Florida's 67 counties for the Healthy Kids enrollees. The remaining three counties had two to three health plans available in each due to the size of the counties and the large numbers of enrollees. Twenty-one counties had a health plan that was characterized as an EPO and the remaining 46 counties had HMOs. Regardless of the managed care type (EPO versus HMO), care is delivered through private physicians' offices and clinics in the children's communities.

The two strongest distinguishing features between the EPO and the HMO models are 1) the use of a PCP as a gatekeeper and 2) the reliance on FFS versus a variety of provider payment mechanisms. The EPO model does not have PCPs function as gatekeepers and all providers are reimbursed on a FFS basis. All of the PCPs in the HMOs serve as gatekeepers, seeing the children in their panels and referring children to specialists and others for services as needed. None of the HMOs have financial penalties related to PCPs referral patterns. The PCPs and the specialists in the HMOs may be salaried, capitated, paid FFS, or paid some combination of the three methods depending on their contracts.

## ACCESS TO CARE

One essential component of health care quality is the extent to which children have access to needed health care services (Durch, 1994). Assessing access to care is particularly important when contracting with managed care plans because of the perception that financial and utilization review arrangements with providers may restrict the enrollees' access to needed health care (Newacheck, et. al., 1996). For example, HMOs typically require a physician to seek prior authorization before rendering certain types of services in an effort to reduce health care use and control costs. Concern has been raised that some of the reductions in use and costs may be excessive and possibly detrimental to the enrollee (Newacheck et. al., 1994).

For one of our access measures, we are assessing the odds that an enrollee will use health care services at least once during the time period under study. For those children who use health care services at least once, we then examine the amount of health care that they use. Whether a child uses health care and the amount that he or she uses is important. However, this does not tell us whether the child's use of services was appropriate or not.

Assessing the incidence of inpatient and emergency room use for ambulatory care sensitive conditions is one way to identify possible problems in access to care and to assess the performance of the primary care delivery system overall (Billings, Anderson, and Newman, 1996). ACSC are those conditions that should not result in a hospital admission or an emergency room (ER) visit if appropriate ambulatory health care is provided (Friedman, Jee and Bierman, 1999). There are variations in the types of conditions that are considered ambulatory care sensitive. However, generally conditions such as asthma, diabetes, urinary tract infections, pneumonia, otitis media, and mastoiditis are included. Hospitalizations or emergency room use for these conditions can signal poor access to ambulatory care and difficulties obtaining timely care.

## METHODS

### *Study Population and Data Sources*

A census of all children enrolled in the Florida Healthy Kids Program between July 1, 2000 and June 31, 2001 were included in the analysis (N=128,701). Three data sources were used for this study. First, the Healthy Kids Corporation provided child-specific enrollment information containing the child's enrolled program months, age, gender, and family income. Second, each health plan provided child-specific health care encounter data including Physician's Current Procedural Terminology (CPT) codes and International Classification of Diseases, 9th Revision (ICD 9-CM) codes. These files

contain information for all inpatient, outpatient, and emergency room uses. Encounter data from July 2000 through June 2001 were used in the analysis.

Third, Florida Statistical Abstract data was used to characterize each county on the following dimensions: 1) the percent of residents living below 100% FPL, 2) the number of managed care plans operating in the county, 3) the number of physician providers per 1,000 population, 4) the number of pediatricians per 1,000 population, and 5) the percent of low birthweight babies born in the county.

### *Ambulatory Care Sensitive Conditions*

A review of the literature was conducted examining the diagnoses considered to represent ACSC (Billings, Anderson, and Newman, 1996; Friedman et. al., 1999; Falik et al., 2001; Kaestner, Joyce, and Racine, 2001). The ICD-9 codes associated with these conditions were identified and the claims and encounter files were searched for inpatient admissions or emergency room visits that had at least one of these conditions as the primary diagnosis.

### *Data Analysis*

A detailed summary of the data analysis is available from the Institute for Child Health Policy.

#### SUMMARY OF RESULTS

- 10,964 Children Receive Care Within EPOs
- 117,737 Children Receive Care Within HMOs
- 13,497 Children Living in Rural Areas
- No differences in child age, household size or income noted between EPO and HMO enrollees
- When Considering the Likelihood that a Child Will Use Health Care Services:
  - Those in an EPO .81 times as likely as those in an HMO to have used health care services at least once.
  - Other factors also significant:
    - Those in counties with higher percentage of those below 100% FPL less likely to use health care
    - Fewer pediatricians 0.84 times as likely to use as counties with higher number pediatricians
    - Rural counties 0.80 times as likely to use as non-rural counties
    - Smaller household size 1.5 times as likely to use health care
    - Children under 11, 11 times more likely to use health care
    - Families under 200% FPL about .80 times as likely as families over 200% FPL to use health care
- Once a child used health care:
  - Higher use rates seen in EPO compared to HMO



- •Other factors important:
  - Lower use rates associated with more HMOs, fewer physicians
  - Lower use seen with lower family incomes
  - Health status variables related to use with highest coefficients
  
- Findings Related to Inpatient and Emergency Room Use for Ambulatory Care Sensitive Conditions:
  - <1% of inpatient admissions for ACSC for EPOs and HMOs
  - 2% of ER visits for ACSC in EPO versus 5% in HMO
  - EPO enrollees have statistically significant lower ER use for ACSC than HMO enrollees - .70 times that of HMO enrollees
  - Other factors important Related to ER Use for ACSC:
    - Lower family income greater odds of ER visit for ACSC
    - Several health status measures associated with greater odds of ER visit for ACSC
  - Important Factors Related to Inpatient Use for ACSC:
    - No statistically significant differences noted between EPO and HMO enrollees
    - Fewer providers in area associated with higher odds of inpatient stay for ACSC
    - Several health status variables important

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**A COMPARISON OF HEALTH STATUS AND FUNCTIONING AMONG NEW AND ESTABLISHED  
ENROLLEES, WITH AND WITHOUT ASTHMA WHO ARE ENROLLED  
IN THE FLORIDA HEALTH KIDS PROGRAM**

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## INTRODUCTION

This report provides the reader with:

- Demographic information about the child and family
- Information regarding child health status while enrolled in the Florida Healthy Kids program, as measured by parent report as well as various standardized instruments
- Detailed information gathered using Child Health Survey on Asthma

## SAMPLE AND INSTRUMENT

The *Family Caregiver Survey* contains several sections including: a household listing section that addresses both the health status and health insurance status of all household members; and a section on family demographics. In addition, the survey contains several standardized questionnaire components including: the Child Health Questionnaire Parent Form (CHQ-28); and the Child and Adolescent Health Measurement Initiative: Living With Illness Measure Screener for Children with Chronic Conditions (LWIM); and the Children's Health Survey for Asthma (CHSA).

To be eligible to participate in this study a family must have had a child that could be classified into one of the following four categories:

- 1) newly enrolled in the Florida Healthy Kids Program between January 2001 and March 2001 and have a diagnosis of asthma (NEWA); or
- 2) newly enrolled in the Florida Healthy Kids Program between January 2001 and March 2001 and have no diagnosis of asthma (NEWOA); or
- 3) have a child that was continuously enrolled in the Florida Healthy Kids Program for at least twelve months beginning in May 2000 and have a diagnosis of asthma (EEWA); or

- 4) have a child that was continuously enrolled in the Florida Healthy Kids Program for at least twelve months beginning in May 2000 and have no diagnosis of asthma (EEWOA).

Between April 2001 and September 2001 a total of 590 telephone interviews were completed; 347 surveys were completed by parents of newly enrolled children, and 243 surveys were completed by parents of established enrollees. Each telephone interview took approximately 35-45 minutes.

#### **RESPONDENT AND CHILD DEMOGRAPHIC CHARACTERISTICS**

The majority of the respondents in each of the four groups described above were white, of non-Hispanic origin, married, living in two-parent households, had at least a high school education, and earned between \$25,000 and \$34,999 annually. Similarly, most respondent's children were white, of non-Hispanic origin, and on average 9 years of age. Demographic characteristics of both parent and child can be found in Table 1 of this report.

#### **PARENT REPORTED CHILD HEALTH**

Approximately 44% of group NEWA parents report that their child's health is excellent or very good, whereas 50% of group EEWA parents report that their child's health is excellent or very good. Almost 4% of group NEWA parents report that their child is in "poor" health, and 3% of group EEWA parents report that their child is in "poor" health.

In comparison, approximately 63% of group NEWOA parents report that their child's health is excellent or very good, whereas 87% of group EEWOA parents report that their child's health is excellent or very good. Less than one percent of the parents of children without asthma report that their child is in "poor" health.

## CHILD'S HEALTH QUESTIONNAIRE (CHQ)<sup>1</sup>

The functional status of the respondents' children was assessed using the Child Health Questionnaire Parent Form (CHQ-28). This instrument was constructed to measure the physical and psychosocial well being of children five years of age and older. The CHQ-28 consists of 28 questions yielding 14 unique components (i.e., physical functioning, role/social functioning - emotional/behavioral, role/social functioning - physical, bodily pain, general behavior, mental health, self-esteem, general health perceptions, parental impact - time, parental impact - emotional, family activities, family cohesion, single item general health, a single item global health). This instrument also yields a summary health score and a summary psychosocial score. Higher average scores are more favorable than lower average scores. Higher scores indicate a healthier state.

The average scores and standard deviations for each of the components and summary scores of the CHQ-28 for each of the four comparison groups (NEWA, NEWOA, EEWA, and EEWOA) are presented in Table 2. The United States population sample is also presented in Table 2, for comparison purposes.

Children in group EEWOA score higher than the U.S. population on all fourteen CHQ components, while children in group NEWOA score higher than the U.S. population on twelve of the fourteen components. Thus, in summary, children without asthma who are enrolled in the Florida Healthy Kids Program are perceived by their parents to be healthier than the average child in the United States.

It is not surprising that both new enrollees and established enrollees with asthma (NEWA and EEWA) score lower than the U.S. population on the majority of the CHQ components. Although a difference is seen between these two groups on the physical

functioning and self esteem components, this difference is within one percentage point and is not statistically significant.

### **CHILDREN'S HEALTH SURVEY FOR ASTHMA<sup>2</sup>**

The Children's Health Survey for Asthma (CHSA) is a condition-specific, self-report, functional health measure for parents of children 5 to 12 years of age with chronic asthma. The CHSA includes 48 child and family focused items divided into five scales: physical health (15 items); activity of the child (5 items); activity of the family (6 items); emotional health of the child (5 items); and emotional health of the family (17 items). The CHSA also contains questions regarding health care utilization, asthma triggers and family demographics. All scale items are answered using a five-point Likert-type scale with higher scores indicating better or more positive outcomes.

As expected, children in group EEWA scored higher than children in group NEWA on each of the five CHSA scales. This finding indicates that children who are enrolled longer may have their asthma under better control than children who are newly enrolled. Since this instrument is in the early stages of development, no national estimates are available for comparison. The CHSA mean scale scores can be found in Table 3 of this report. The reader interested in more detail can refer to Tables 6 through 12 for answers to the individual questions in the CHSA.

### **LIVING WITH ILLNESS MEASURE SCREENER FOR CHILDREN WITH CHRONIC CONDITIONS (LWIM)<sup>3</sup>**

As part of this survey, children were screened in two ways to determine if they may have a special health care need. First, parents were simply asked if their children had a condition or health care need requiring ongoing medical care or supervision (see Table 1). Second, the 14-item Living With Illness Measure (LWIM) was administered. The results for each of these are described below.

On the first measure, 70% of the parents of newly enrolled children with asthma (NEWA) indicated that their child had a special health care need. A slightly higher percentage (78%) of the parents of established enrollees with asthma (EEWA) indicated that their child had a special health care need. This difference may be due to the increased awareness of asthma and its implications among the parents of established enrollees. Approximately 22% of the parents of group NEWOA indicated that their child had a special health care need, whereas only 18% of the parents of group EEWO indicated a special need.

The second screen involved the LWIM, which has recently been approved as the standard screening tool for special needs by the National Committee for Quality Assurance (NCQA). The LWIM, developed by the Foundation for Accountability (FACCT), is designed to reflect consensus definitions of children with chronic conditions. The tool is intended to be sensitive enough to capture children with a wide range of childhood chronic conditions, yet specific enough to disqualify children with non-chronic or very mild health problems. There are three components or domains within the screening tool: 1) functioning, 2) need and use for compensatory mechanisms, and 3) utilization of services. Children who meet with LWIM screener can do so by qualifying in any one or more of these domains. LWIM scores and responses to each item in the tool can be found in Table 4 of this report. Since this instrument is in the early stages of development, no national estimates are currently available for comparison.



Approximately 60% of the newly enrolled children with asthma (NEWA) fell into a least one of the three domains, and therefore can be said to have met the LWIM criteria to be classified as a child with a “chronic condition.” Over 64% of the established enrollees with asthma (EEWA) were classified with a chronic condition. Finally, 12% of newly enrolled children without asthma (NEWOA) had a chronic condition and 15% of established enrollees without asthma (EEWOA) had a chronic condition. The higher percentage of children with chronic conditions in the established enrollee group may be due to an increased awareness of chronic conditions. Children in both the NEWA and EEWA groups are most frequently fall into the “need and use for compensatory mechanism” domain, followed by the “utilization of services” domain, and finally the “functioning” domain.

This information is important for program planning purposes. Although children with the most severe health care needs are referred to Children’s Medical Services, the Florida Healthy Kids Program does have a significant percentage of children with more mild conditions. Historically, studies show that almost 25% of the program enrollees have some type of special health care need. Quality assurance and evaluation must continue to focus on these children to ensure that they continue to receive the excellent access to care they have been receiving.

### **BASIC CHILD HEALTH**

Children with asthma in both the newly enrolled group and the continuously enrolled group report missing more days of school than children without asthma. Seventy percent of group NEWA report that these missed school days were due to their special health care need; conversely, only 44% of group EEWA report that these missed school days was due to their

special health care need. This result suggest that perhaps children who are enrolled in the program for a longer period of time have their asthma under better control than newly enrolled children with asthma. Almost 20% of parents of children in group NEWA report that their child was unable to engage in his/her usual activities, with 85% indicating that this was due to the child's special health care need. For group EEWA, 16% of parents report that their child was unable to engage in usual activities, with two-thirds indicating this was due to the child's special health care need.

## SUMMARY AND RECOMMENDATIONS

- Children with asthma who are enrolled in Florida Healthy Kids for longer periods of time report missing school less frequently than children with asthma who are new to the program.
- Established enrollees report better overall health status than those newly enrolled as measured by both parental estimation of child's health status and standardized instruments for rating child's health status. This findings holds for both children with asthma and those without asthma.

<sup>1</sup> For component description see: Jeanne M. Landgraf, Linda Abetz, and John E. Ware (1996). Child Health Questionnaire (CHQ): A Users Manual. First Edition. Boston, MA: The Health Institute, New England Medical Center.

<sup>2</sup> Children's Health Survey for Asthma (CHSA). Center for Child Health Research, American Academy of Pediatrics, Elk Grove Village, Illinois; the Center of Health Services Research, and the Department of Immunology and Microbiology, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois.

<sup>3</sup> Living with Illness Screener and Supplemental Survey Module: Description and Summary of Development and Testing, Interim Report. Prepared by Christina Bethell and Debra Read, May, 1999.

Table 1: Demographic Characteristics of Respondents.

Question	New Enrollee				Established Enrollee			
	Asthma		Non-CSHCN		Asthma		Non-CSHCN	
	#	%	#	%	#	%	#	%
<b>Respondent's Race (may have more than one response)</b>								
White	75	73.53	180	77.55	84	73.68	96	74.42
Non-White	27	26.47	55	22.45	30	26.32	33	25.58
<b>Respondent of Hispanic Origin</b>								
Yes	31	30.39	104	42.62	32	28.32	37	28.68
No	71	69.61	140	57.38	81	71.69	92	71.32
<b>Child's Race (may have more than one response)</b>								
White	74	72.55	189	77.14	83	72.81	97	75.19
Non-White	28	27.45	56	22.86	31	27.19	32	24.81
<b>Child of Hispanic Origin</b>								
Yes	34	33.33	108	44.08	31	27.68	43	33.33
No	68	66.67	137	55.92	81	72.32	86	66.67
<b>Mean Age of Child (mean in # column, S.D. in % column)</b>	8.56	1.79	8.95	1.75	11.34	2.8528	8.71	1.63
<b>Child's Gender</b>								
Male	66	64.71	128	52.24	62	54.39	58	44.96
Female	36	35.29	117	47.76	52	45.61	71	55.04
<b>Marital Status</b>								
Married	69	67.65	165	67.62	73	64.04	90	69.77
Common Law	0	0.00	8	3.28	0	0.00	1	0.78
Divorced	12	11.76	35	14.28	19	16.67	18	13.95
Separated	5	4.90	14	5.74	5	4.39	6	4.65
Single	13	12.75	19	7.79	10	8.77	11	8.53
Widowed	3	2.40	3	1.23	7	6.14	3	2.33
<b>Household Type</b>								
Single Parent Household	29	28.43	67	27.46	43	37.72	38	29.46
Two Parent Household	73	71.57	177	72.54	71	62.28	91	70.54
<b>Education</b>								
8th grade or less	4	3.92	11	4.51	9	7.96	5	3.91
9th to 11th grade	13	12.75	27	11.07	5	4.42	12	9.38
12th grade	24	23.53	40	16.39	28	24.78	23	17.97
GED	1	0.98	4	1.64	0	0.00	3	2.34
High School Diploma	10	9.80	41	16.80	19	16.81	21	16.41
Some Voc/Tech/Business	3	2.94	4	1.64	5	4.42	1	0.78
Voc/Tech/Business Certificate or Diploma	4	3.92	13	5.33	2	1.77	4	3.13
Some College	22	21.57	41	16.80	19	16.81	23	17.97
Associate's Degree (AA; AS)	9	8.82	19	7.79	11	9.73	11	8.59
Bachelor's Degree (BA; BS)	9	8.82	33	13.52	12	10.62	20	15.63
Some Graduate/Professional School	0	0.00	4	1.64	0	0.00	2	1.56
Graduate/Professional Degree	3	2.94	7	2.87	3	2.65	3	2.34

Table 1: Demographic Characteristics of Respondents.

Question	New Enrollee				Established Enrollee			
	Asthma		Non-CSHCN		Asthma		Non-CSHCN	
	#	%	#	%	#	%	#	%
<b>Income</b>								
Less than \$4,999	1	1.04	6	2.71	2	1.83	2	1.64
\$5,000 to \$9,999	3	3.13	8	3.62	6	5.50	3	2.46
\$10,000 to \$14,999	10	10.42	28	12.67	11	10.09	15	12.30
\$15,000 to \$19,999	15	16.63	45	20.36	22	20.18	27	22.13
\$20,000 to \$24,999	21	21.88	40	18.10	25	22.94	24	19.67
\$25,000 to \$34,999	27	28.13	68	30.77	26	23.85	34	27.87
\$35,000 to \$44,999	12	12.50	15	6.79	14	12.84	13	10.66
\$45,000 to \$54,999	3	3.13	5	2.26	3	2.75	3	2.46
\$55,000 to \$64,999	2	2.08	4	1.81	0	0.00	1	0.82
\$65,000 to \$74,999	2	2.08	2	0.90	0	0.00	0	0.00
\$75,000 to \$84,999	0	0.00	0	0.00	0	0.00	0	0.00
\$85,000 to \$94,999	0	0.00	0	0.00	0	0.00	0	0.00
\$95,000 or more	0	0.00	0	0.00	0	0.00	0	0.00
<b>Child's Health Status</b>								
Excellent	15	14.71	90	37.04	22	19.47	77	59.69
Very Good	30	29.41	62	25.51	35	30.97	35	27.13
Good	36	35.29	74	30.45	37	32.74	14	10.85
Fair	17	16.67	16	6.58	16	14.16	2	1.55
Poor	4	3.92	1	0.41	3	2.65	1	0.78
<b>Special Needs Child (Parent Report)</b>								
Yes	72	70.59	55	22.45	90	78.95	23	17.83
No	30	29.41	190	77.55	24	21.05	106	82.17