Open Enrollment in the Florida Healthy Kids Program: Perspectives from Families and Participating Agencies

A Report Prepared for the
Florida Healthy Kids Corporation

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I. EXECUTIVE SUMMARY

In 2004, the Florida Legislature replaced year-round enrollment in the Florida Healthy Kids Program with limited open enrollment. The Institute for Child Health Policy (ICHP) was asked to address the following aspects of the open enrollment process: (1) enrollment outcomes of families who applied for coverage during the open enrollment period; (2) communication and outreach efforts during the open enrollment period and the preceding marketing period; and (3) families' satisfaction with the open enrollment process. The following data sources were used to conduct this study: (1) administrative enrollment data provided by the Healthy Kids Corporation; (2) surveys of health plans, hospitals, and community-based organizations who participated in the January 2005 open enrollment outreach activities; and (3) telephone survey data from a random sample of families who applied for coverage during the January 2005 open enrollment period.

Enrollment Outcomes

- Approximately 44 percent of children who had applied for coverage during the January 2005 open enrollment period were enrolled in Healthy Kids, MediKids, CMS, or Medicaid by May 2005.
- Of the 56 percent of applicants who were not enrolled by May 2005, 54 percent had incomplete application information, 19 percent had been referred to Medicaid and were still in process, and 17 percent did not meet eligibility requirements.
- Of the 9,879 children who were enrolled in Healthy Kids by May 2005, 35 percent received coverage in January, and 24 percent did not receive coverage until May.

Communication and Outreach Efforts

Organizations participating in the open enrollment outreach efforts indicated the following:

- The items used most frequently from the Healthy Kids Marketing and Public Relations Tool Kit were those that could be prepared quickly and at relatively low cost, such as the general brochure, application, application instructions, poster, and flier.
- The outreach strategies cited as most effective were distributing applications and participating in community events with an emphasis on coordinating with local partners, having direct contact with families, and providing application assistance.
- The least effective outreach strategies were those involving large expenses because of financial constraints and the short time period associated with limited open enrollment over which to spread those costs.

Family Surveys

- Children who did not become enrolled were more likely to be non-Hispanic black (20 percent) than those who became enrolled (13 percent). Children who were not enrolled were more likely to reside in a single parent household (47 percent) compared to enrolled children (38 percent).
- Families who completed the enrollment process were much more likely to report having a usual source of care for their child (91.5 percent) than those who did not complete the enrollment process (69.0 percent).
- Families whose children were not enrolled in Healthy Kids were much more likely to report problems in obtaining needed care during the past year. For example, 54.2%

of "not enrolled" children requiring specialty care reported that obtaining such care was a "problem" compared to 20.7% of "enrolled" children.

- Both groups had difficulty reaching someone at the call center, with the families who completed the enrollment process reporting more success in reaching someone (36 percent) than those who did not complete the process (27 percent). Significantly more of those in the enrolled group (66 percent) reported that the person they spoke to was helpful or very helpful compared to the non-enrolled group (38 percent).
- About 85 percent of children whose parents applied to the KidCare Program on their behalf but did not become enrolled were uninsured at the time of the telephone survey. Cost was cited as the primary reason for not having another source of health insurance coverage. Most also indicated that they are waiting to get into the Healthy Kids Program.

Implications

- Providing sufficient planning time, expanding call center capabilities, and enhanced application process capabilities are essential if set open enrollment periods are ever used in the future.
- Families with certain sociodemographic characteristics (e.g., single-parent households and non-Hispanic black families) may benefit from additional application assistance.
- Identifying strategies to help families complete the application process in a timely manner is essential to providing access to needed medical services for uninsured children.

II. BACKGROUND

In 2004, the Florida Legislature replaced year-round enrollment in the Florida Healthy Kids Program with limited open enrollment. The legislation provided for no more than two 30-day open enrollment periods, depending on available funding. The first open enrollment period occurred during the period starting January 1, 2005 and ending January 30, 2005. Because legislation was passed in 2005 to return to year-round enrollment, this was the only limited open enrollment period.[1]

As part of the 2005-2006 Healthy Kids Program evaluation, the Institute for Child Health Policy (ICHP) was asked to address the following aspects of the open enrollment process: (1) enrollment outcomes of families who applied for coverage during the open enrollment period; (2) communication and outreach efforts during the open enrollment period and the preceding marketing period; and (3) families' satisfaction with the open enrollment process. The following data sources were used:

1. Enrollment data provided by the Healthy Kids Corporation. These data contain information about the number of applications processed, application status, and application disposition. This information was used to identify which families applied for coverage for their children during the January 2005 open enrollment period, whether the children moved to coverage, and if so, in which KidCare program component.
2. Surveys of health plans, hospitals, and private and public community-based organizations who participated in communication and outreach efforts prior to and during the January 2005 open enrollment period.
3. Telephone survey data from a random sample of families who applied for coverage during the January 2005 open enrollment period and were eligible for the Florida Healthy

Kids Program. Samples were selected from the application and enrollment files provided by the Florida Healthy Kids Corporation and maintained at the Institute for Child Health Policy. The surveys were conducted from June 2005 through August 2005 in both English and Spanish. A total of 400 interviews were conducted with 200 interviews of families who had completed the enrollment process and 200 interviews of families whose children had not completed the process at the time of the interview.

III. Application Volume and Disposition

During the January 2005 open enrollment period, 64,170 unique applications were physically scanned on behalf of 123,891 children.[2] Approximately 44 percent, or 55,055 children, were enrolled in Healthy Kids, MediKids, CMS, or Medicaid by May 2005 and 56 percent were not enrolled in any of the four programs.[3] Table 1 shows how many children became enrolled in any of these programs in each month from January to May. For example, 24,491 of the 123,891 children, or 19.77 percent, became enrolled in one of the four programs during the month of January.

Table 1: Enrollment in any Program Component by Month January 2005 – May 2005

	Number	Percent	Cumulative Number	Cumulative Percent
January2005	24491	19.77	24491	19.77
February 20005	4503	3.63	28994	23.40
March 2005	6917	5.58	35911	28.98
April 2005	8168	6.59	44079	35.57
May 2005	10976	8.86	55055	44.43
Not Enrolled	68836	55.56	123891	100.00

Table 2 shows enrollment by program component. Of the 55,055 children who became enrolled in any program component by May 2005, approximately 75 percent were in Medicaid, 18 percent were in Healthy Kids, 3 percent were in MediKids, and 1 percent was in CMS. The remaining 3 percent were in multiple programs due to transfers between plans during the January to May 2005 period.

Table 2: Enrollment by Program Component
January 2005 – May 2005

	Number	Percent	Cumulative Number	Cumulative Percent
CMS	518	0.94	518	0.94
Healthy Kids	9879	17.94	10397	18.88
MediKids	1476	2.68	11873	21.57
Medicaid	41311	75.04	53184	96.6
Multiple Plans (reflects transfers)	1871	3.40	55055	100.00

As Table 3 shows, of the 9,879 children who were enrolled only in Healthy Kids (not including children who transferred into or out of Healthy Kids), approximately 35 percent of those received coverage in January, and 24 percent did not receive coverage until May.

Table 3: Enrollment by Month for Those Who Were Enrolled in Healthy Kids Only
January 2005 – May 2005

	Number	Percent	Cumulative Number	Cumulative Percent
January2005	3447	34.89	3447	34.89
February 20005	336	3.40	3783	38.29
March 2005	1534	15.53	5317	53.82
April 2005	2156	21.82	7473	75.65
May 2005	2406	24.35	9879	100.00

Table 4 shows Healthy Kids enrollment by month including children who transferred between programs. Approximately 41 percent of these children received coverage in January, and 21 percent did not receive coverage until May.

Table 4: Enrollment by Month for Those Who Were Enrolled in Healthy Kids at Any Point in Time (Includes Transfers between Programs) January 2005 – May 2005

	Number	Percent	Cumulative Number	Cumulative Percent
January 2005	4606	40.54	4606	40.54
February 20005	400	3.52	5006	44.06
March 2005	1675	14.74	6681	58.80
April 2005	2275	20.02	8956	78.82
May 2005	2406	21.18	11362	100.00

Significantly, 68,836 children (56 percent) of all children whose parents' submitted an application had not received coverage through any KidCare component by May 2005. Table 5 summarizes the application status of these children:

Table 5: Status of Children Not Enrolled in Any KidCare Component as of May 2005

	Number	Percent	Cumulative Number	Cumulative Percent
Referred to Medicaid and Still in Process	13139	19.09	13139	19.09
Ineligible (application rejected)	11807	17.15	24946	36.24
Completed Application (Waiting for Supporting Documentation)	11300	16.42	36246	52.66
Major Error on Application	25870	37.58	62116	90.24
Other	6720	9.76	68836	100.00

Approximately 17 percent of children did not meet the eligibility requirements, and 19 percent had been referred to Medicaid and were still in process. Notably, more than half (54 percent) had not received coverage because families submitted incomplete application information: 37.58

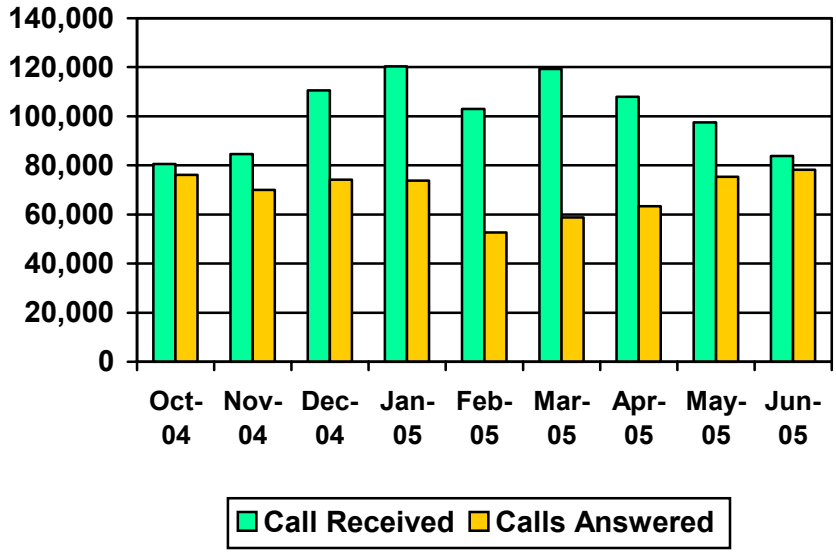
percent had a major error on the application (omitting critical information) and an additional 16.42 percent correctly filled out their application but still needed to submit supporting documentation. In addition to examining ways to reduce the processing time for applications, it also may be important to identify ways to facilitate families' completion of the application process.

IV. Communication and Outreach Prior to and During the Open Enrollment Period

A. Call Volume and Dispositions

Telephone call volume data for the period surrounding open enrollment was provided by the Florida Healthy Kids Corporation. The call volume experienced by the Florida Healthy Kids Program increased considerably during the open enrollment period. The number of calls received increased by 49 percent from October 2004 (80,608 calls received) to the January 2005 open enrollment period (120,262 calls received) with a marked increase occurring in December 2004, immediately preceding the open enrollment period. Figure 1 provides a summary of the monthly call volume. The call volume remained relatively high through April 2005 after which it declined and returned to the October 2004 and November 2004 levels.

Figure 1: Healthy Kids Monthly Call Volume
October 2004 - June 2005



The increased call volume in the months surrounding the open enrollment period resulted in a smaller percentage of calls being answered, a greater percentage of calls being abandoned, and longer waits (Figures 2 and 3). For example, 94 percent of calls were answered in October 2004 compared to 61 percent in January 2005, falling to and remaining below 60 percent from February through April. The average time in which a call was answered increased from 1 minute and 53 seconds in October 2004 to 26 minutes and 8 seconds in January 2005 and remained above 20 minutes through April 2005. These numbers did not return to their October 2004 levels until June 2005 when the average percentage of calls answered was 93 percent and the average time in which calls were answered was 2 minutes and 23 seconds.

Figure 2:
Percentage of Calls Answered and Abandoned
October 2004 - June 2005

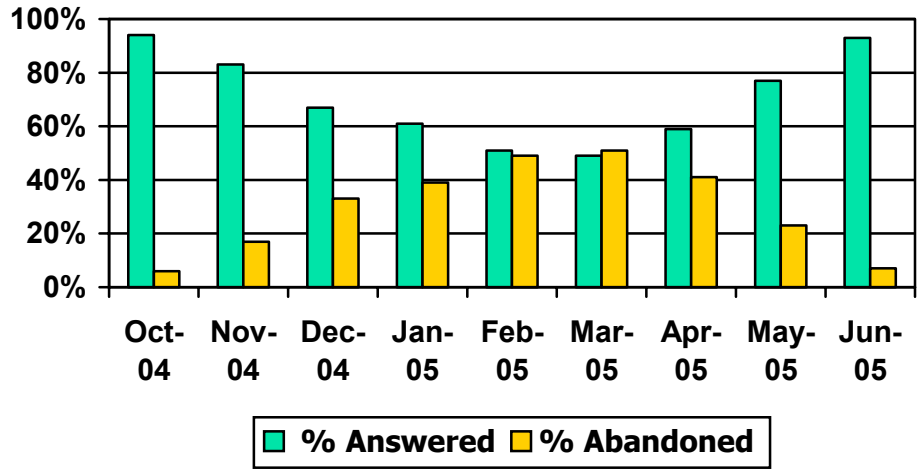
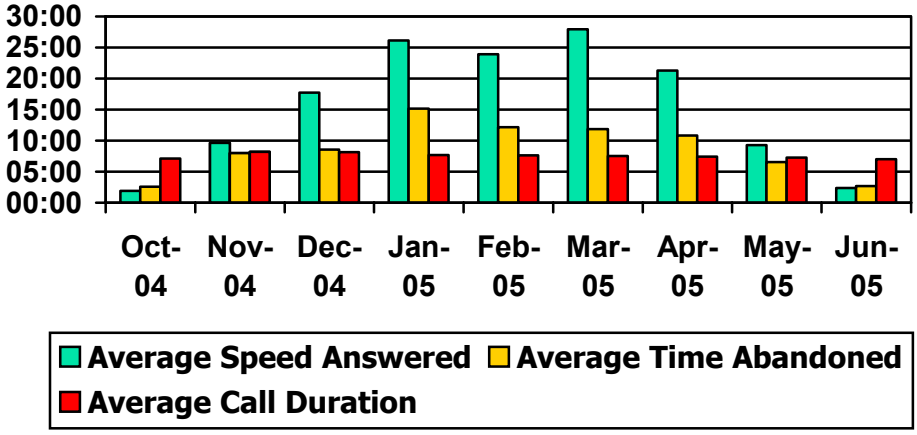
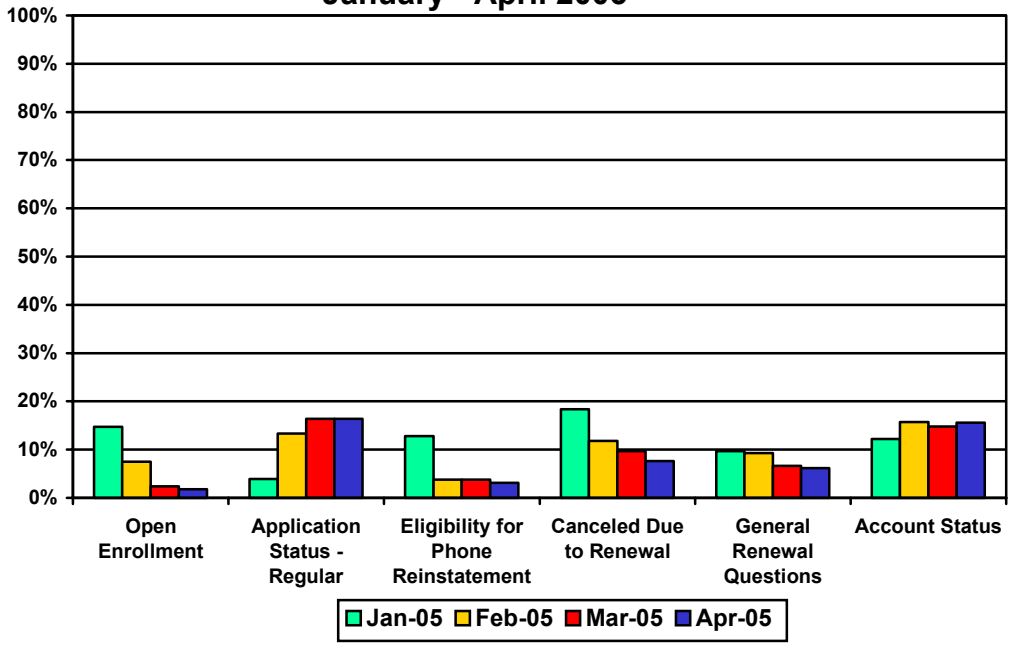


Figure 3: Average Speed Answered,
Time Abandoned
and Call Duration (Minutes)
November 2004 - June 2005



In January 2005, the Florida Healthy Kids Corporation began tracking calls by type, using a random sample of calls each day. Figure 4 summarizes the percentage of calls related to open enrollment and renewal for the period January 2005 to April 2005.[4] Not surprisingly, calls about open enrollment represented a greater percentage of all calls during the month of January, accounting for almost 15 percent of the calls, declining to 7.5 percent in February and to 1.8 percent in April. Calls regarding eligibility for phone reinstatement also were relatively high during the month of January, accounting for almost 13 percent of calls received, declining to less than 4 percent in subsequent months. But the impact of the January open enrollment period on call volume continued to be felt in subsequent months as inquiries regarding application status increased from 3.9 percent in January to 13.3 percent in February and holding constant at 16.4 percent in March and April.

Figure 4: Enrollment and Renewal Calls
January - April 2005



Although calls related to open enrollment accounted for almost 15 percent of the calls during January (27.5 percent if questions about eligibility for phone reinstatement are included), calls related to renewal accounted for 28.1 percent of the calls (18.4 percent concerned cancellations due to renewal and 9.7 percent were general renewal questions). Calls related to renewal declined through April 2005 but continued to account for a significant percentage of calls. In April 2005, canceled due to renewal and general renewal questions accounted for 13.8 percent of calls. The high percentage of renewal calls may be attributable to two factors. First, there was a change in the renewal process from passive renewal to active renewal, which would lead to general questions about the renewal process as individuals come up for renewal during the year. Second, cancellations due to renewal were suspended in the fall of 2004 due to the hurricane grace period, resulting in a spike of cancellations in December 2004, which would contribute to the increased volume of calls during December 2004 and January 2005.

B. Applications Distributed

The Florida Healthy Kids Corporation sent out 10,516 applications. In addition, applications were available for download on the Healthy Kids website. Although the specific number of downloads is not available, the Healthy Kids website page for downloading the application experienced a significant increase in traffic during open enrollment, with approximately 30,000 visits in January compared to about 9,000 visits in February and about 5,000 visits in May.[5] Most of the application distribution occurred at the local level through agency partners, county offices, health plans, providers, and community based organizations. For example, the 18 organizations surveyed by the Institute about their open enrollment activities collectively distributed more than 2 million applications. These survey results are described in Section V: *Health Plan and Community Organization Outreach Efforts*.

C. Training Workshops and Toolkits

The Florida Healthy Kids Corporation also conducted regional outreach training workshops in October 2004 and November 2004 in Miami, Orlando, Tallahassee, and Tampa. Approximately 120 individuals representing health plans, hospitals, agency partners (e.g., local CMS offices), public county partners (e.g., county health departments and school districts), and private community-based organizations participated in these workshops. The Florida Healthy Kids Corporation also provided a Marketing and Public Relations Tool Kit, which had three CDs that contained information about marketing and provided camera or print-ready files and spots for television and radio. The toolkits were sent to everyone who participated in the workshops and were available for download on the Healthy Kids website (www.healthykids.org/marketing).

V. Health Plan and Community Organization Outreach Efforts

Two sources of data were used to identify the strategies employed prior to and during the open enrollment period by health plans and other organizations and the effectiveness of those strategies: (1) the Institute for Child Health Policy conducted a survey of health plans, hospitals, and public and private community organizations that participated in the January 2005 open enrollment process, and (2) the Florida Healthy Kids Corporation provided the Institute with responses to the open enrollment marketing questions included on the registration forms for the June 27, 2005 Healthy Kids and KidCare Planning Meeting.

A. ICHP Surveys

The Institute for Child Health Policy surveyed health plans, hospitals and health systems, public county partners (e.g., county health departments and school districts), and private community organizations that participated in the October 2004 and November 2004 outreach training workshops conducted by Florida Healthy Kids Corporation staff. In addition, surveys

were sent to several agencies that were mentioned by other survey respondents as being especially active in marketing and open enrollment efforts. The surveys were conducted between June 13, 2005 and July 15, 2005. A cover letter and the survey were sent by email to 36 organizations. Follow-up attempts were made by both email and telephone to encourage response. The Institute obtained responses from 18 organizations:

Agency Type	N
Hospitals/Health Systems	4
Health Plans	4
Public County Partners	6
Private Community-based Organizations	4

The following counties were represented in these responses: Alachua, Broward, Calhoun, Collier, Duval, Flagler, Hillsborough, Holmes, Jackson, Leon, Liberty, Manatee, Marion, Miami-Dade, Monroe, Polk, Volusia, and Washington. A summary of the main highlights from these responses is provided below. A more detailed summary is provided in Appendix A.

Summary of ICHP Survey Responses

The survey questions addressed the usefulness of the strategies used to reach uninsured children and their families, barriers to disseminating information about the open enrollment period, the effectiveness of different strategies, how the outreach activities were funded, and what types of assistance would be beneficial for future enrollment efforts.

Marketing and Public Relations Tool Kit. The survey asked respondents to identify the Tool Kit items that they used and, if so, whether they were helpful. Table 6 summarizes the responses (N=18):

Table 6: Use and Usefulness of Tool Kit Items		
Marketing Material	**Used by you/your agency % Yes**	**If used, useful to agency?**
Templates		
a. Guest editorial	22%	100%
b. News release	44%	86%
c. Newsletter article	28%	100%
d. Media timeline	19%	100%
e. Telephone hold message	19%	100%
PDF/Viewable, Printer-ready Files		
a. 4/color Button, 2.5" square	14%	100%
b. 4/color "Get Ready" piece	50%	100%
c. B&W flier/newspaper ad	0.06%	100%
d. B&W grocery bag art	0%	--
e. 4/color flier, 8.5X11	50%	100%
f. 4/color poster, 22x29	50%	75%
g. 4/color poster, 11X17 with perforated web/phone number tabs	17%	75%
h. 4/color tray liner	0.06%	100%
i. 4/color bookmark	0.06%	100%
j. 4/color tent card	36%	100%
k. 4/color transit card	0%	--
l. 4/color tee shirt artwork	7%	100%
m. 4/color billboard, 12' x 24'	0%	--
n. 4/color banner, 3' x 6'	36%	100%
o. 1/color doorhanger bag	14%	100%
p. 4/color truck graphics	0%	--
q. 4/color general info brochure	64%	89%
r. 4/color application instructions	50%	100%
s. 4/color application	55%	100%
t. B&W application instructions	55%	100%
u. B&W application	55%	100%
Broadcast Spots		
a. .30 second television spot	28%	100%
b. .60 second radio spot	31%	100%
Web Downloads	50%	100%

The most used items from the Tool Kit include: the general color brochure (64 percent), B&W application instructions (55 percent), B&W application (55 percent), color application (55

percent), color application instructions (50 percent), color "Get Ready" piece (50 percent), color flier (50 percent), color poster (50 percent), and website downloads (50 percent). For each Tool Kit item used, 75 percent to 100 percent of the agencies and organizations that used that item found it to be useful.

The least used tools – those used by one or no respondents - included the B&W flier/newspaper advertisement, grocery bag art, tray liner, bookmark, transit card, color billboard, and color truck graphics. Although no one indicated that they used the truck graphics, one of the respondents indicated that the cost of such a media tool was prohibitive given the short timeframe for the open enrollment period. This observation was echoed in another respondent's answer about the least effective strategies: "Some marketing materials were not utilized due to an extensive time to implement and the short duration of open enrollment. Some examples include: transit cards and t-shirts, door hangers and tent cards, truck graphics and billboards, tray liners and grocery bags." Therefore, some of the more costly marketing materials, such as truck graphics and billboards, might be more useful for ongoing marketing efforts associated with the recent return to year-round open enrollment. Although no one indicated that they used the grocery bag art, one of the respondents indicated that this would be a good strategy to try in the future.

Other Strategies Used and Their Effectiveness. The organizations' major efforts included significant collaboration and communication with community partners; engaging in various forms of promotional activities such as posting flyers, placing advertisements in newspaper, radio, and on television; printing, mailing, and distributing applications through local sites and mailouts; staffing KidCare hotlines; and providing application assistance. Application distribution and participation in community events were cited most frequently as the most

effective strategies. General awareness and promotional strategies, such as radio interviews, were cited as effective, and several respondents also indicated that a combination of strategies was effective because different strategies were often mutually reinforcing. Strategies that involved large expenses were cited as the least effective because of financial constraints facing the respondents and the short time period over which to spread those costs. One respondent found that some of the artwork provided was not printable. Another respondent indicated that fliers without applications were not effective.

Barriers in Disseminating Open Enrollment Information. The major barriers cited were insufficient time and money to print and disseminate information. Many respondents indicated difficulties with distributing applications, including getting the applications to the public in time to meet the deadlines, not having hard copies of applications provided by the state, difficulty downloading the application from the website, and difficulty printing them in the format provided. Other barriers listed were confusion among families about the limited open enrollment period and changing documentation requirements.

Application Distribution and Partnerships. Despite the difficulties cited above with distributing applications, the respondents collectively distributed a substantial number of applications. One health plan indicated that it distributed 1.7 million applications. The remaining 17 organizations collectively distributed more than 450,000 applications. The respondents also noted significant partnerships at the local level in getting the word out about open enrollment with private-public collaborations among the different types of organizations.

Funding. A range of funding mechanisms was used for marketing and outreach strategies. Approximately eight of the organizations indicated that they used funds from an existing operating or outreach budgets or reallocated their budget. Six organizations indicated

that they received funding assistance and in-kind support through local public and private partners and through private donations. Two organizations indicated that they only used those strategies that involved minimal or no cost. Two respondents indicated that they pursued grant funding to promote open enrollment. Some organizations used a combination of funding strategies.

Assistance for Future Open Enrollment Efforts. Many respondents indicated that they would either like hard copies of the open enrollment materials or funding for printing with particular emphasis on applications. Respondents also indicated an interest in having updated literature and promotional materials made available to them. Other assistance recommendations included providing clearer application instructions (at an elementary school level), providing more efficient processing of applications, and increasing access to applicants so that they can more easily check their account status (e.g., through an automated system or website). Some respondents suggested ways that the Florida Healthy Kids Corporation could help to facilitate greater partnerships including:

(1) coordinate partnerships with statewide organizations, such as major retailers, that are willing to collaborate with local outreach efforts;

(2) designate a primary contact or coordinator at the county level who can facilitate communication so that local partners know of each others' efforts and can coordinate more effectively;

(3) coordinate a statewide marketing campaign with local outreach efforts; and

(4) host statewide meetings to coordinate marketing efforts and share resources.

Respondents also provided other general suggestions at the end of the survey, which are summarized in Appendix A.

B. Registration Responses

The Florida Healthy Kids Corporation held a Healthy Kids and KidCare Planning Meeting on June 27, 2005. Registrants for this meeting were asked to complete a short written survey to submit with their registration form. The survey questions asked registrants to offer marketing ideas for a back-to-school enrollment campaign, describe past marketing activities and their effectiveness, identify what they would have done differently, list special populations they work with, and identify key partners that they plan to work with to market Florida KidCare. The Institute for Child Health Policy was provided with survey responses for 30 unique respondents:

Type of Organization/Agency	Number of Unique Responses
Health or Dental Plans	5
Hospitals/Health Systems/Health Providers	6
KidCare Partner Agencies (e.g., DCF, AHCA, and CMS)	8
Public/County Organizations (e.g., schools and health departments)	5
Private Community-based Organizations (e.g., Healthy Start and United Way)	6
Total	30

The following counties were represented in these responses: Alachua, Brevard, Broward, Collier, Duval, Escambia, Flagler, Highlands, Hillsborough, Lee, Miami-Dade, Nassau, Orange, Palm Beach, Polk, and Volusia. A summary of the main highlights from these responses in provided below. A more detailed summary is provided in Appendix B.

Ideas for Marketing a "Back to School" Campaign. A consistent theme among the suggestions for marketing a "back to school" enrollment campaign was to work with local partners – including health departments, hospitals, pediatricians' offices, primary care clinics, schools, libraries, and grocery stores – to get the word out about open enrollment and to coordinate efforts. There was a particular emphasis on coordinating with schools to provide

information and applications to parents through school programs and activities, such as summer school, PTA meetings, and back-to-school activities, open houses, and health fairs, as well as with school materials such as class schedules, free and reduced lunch applications, and school newsletters. Another frequent recommendation was to use various forms of promotion, such as: placing posters or brochures in doctors' offices, primary care clinics, and hospital emergency rooms; putting posters up in major retail outlets, such as Wal-Mart, Kmart and Target, during the school supply tax-free week; using English and Spanish news releases and public service announcements in newspapers, radio, and television.

What worked? Although media activities were cited as reaching the greatest number of families, many respondents emphasized the importance of direct, one-on-one contact with families through such efforts as booths at health fairs, participation in back-to-school programs, direct phone calls, and any activities where applications could be provided to families and where families could receive assistance in completing the applications. Also cited were targeted and coordinated outreach efforts, high publicity activities, and local partnerships/collaborative campaigns.

What hasn't worked? Generally, respondents indicated that activities that had insufficient preparation time, coordination, or funding. As one respondent summed up, "activity on the fly" was not effective. Some respondents indicated that first-time or low attendance open enrollment events did not justify the resources used for the small turnout. One respondent indicated that many families do not think that they need well-child care.

What would you have done differently? Many respondents indicated that they simply had insufficient time and resources prior to and during the January 2005 open enrollment period to be as organized and effective as they would have liked. With more time, respondents

indicated that they would have organized and coordinated with local partners in outreach activities, engaged in more advance planning, developed additional partnerships, enlisted broader community support, started advertising and outreach activities earlier, and use phone and mail follow-up.

Special Populations. Hispanic populations were cited most frequently among the special populations that respondents work with. Various other ethnic and minority groups were indicated (such as African-Americans, Haitians, and Russians) as were migrant and farm worker families, immigrants, children with special health care needs, economically disadvantaged families, and families from rural areas. Low levels of literacy and language barriers were cited as particular issues for families in completing more complicated applications.

Partners. Respondents, individually and collectively, cited a wide array of partners that they planned to work with for upcoming KidCare marketing efforts that include health plans, providers, hospitals, county organizations (e.g., public health departments, schools, and libraries), and private community-based organizations.

VI. Families' Enrollment Experiences and Satisfaction

The Institute for Child Health Policy conducted telephone surveys of families who applied for coverage during the January 2005 open enrollment period and were eligible for Healthy Kids coverage. The primary focus of the surveys was families' experiences during the open enrollment process. Questions about unmet medical needs, access to other types of insurance coverage, and demographics also were asked. The Institute interviewed a total of 400 families: 200 families who completed the enrollment process and whose children moved to coverage and 200 families who had not completed the process at the time of the survey. The surveys were

conducted from June 2005 through August 2005 in both English and Spanish. The cooperation rate was 93 percent.

A. Sample Selection

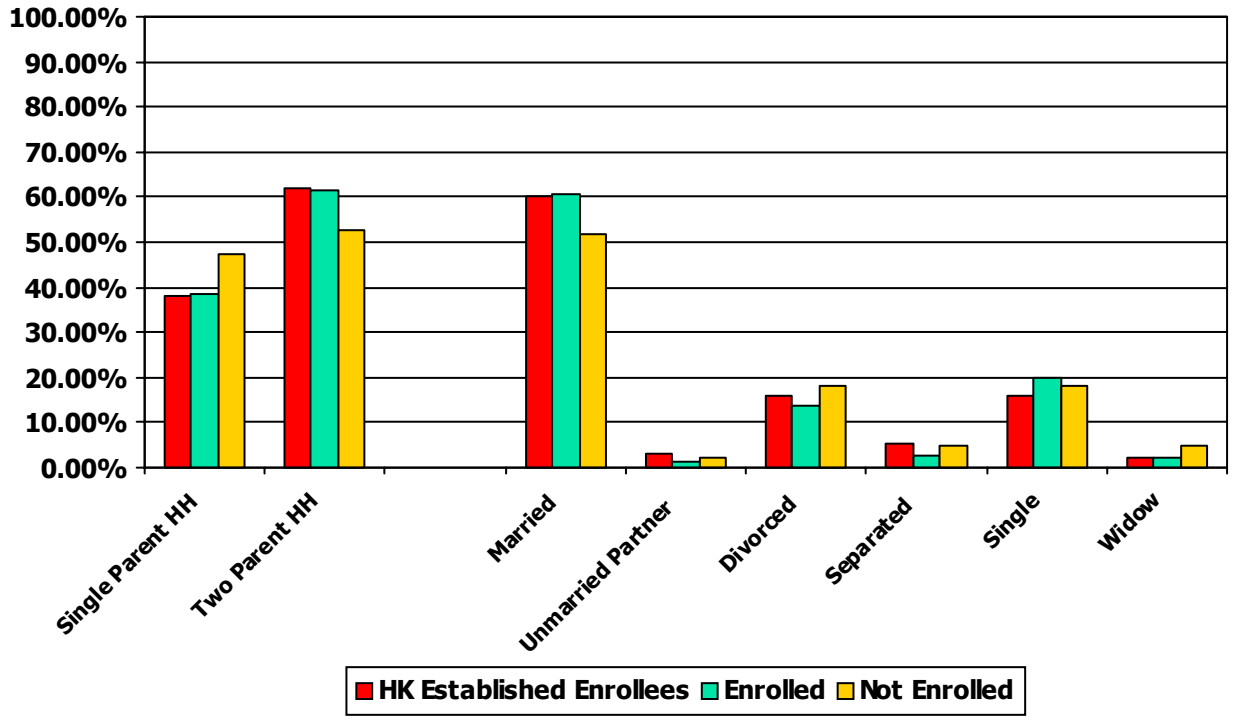
The "applied and enrolled" population was determined by: (1) identifying those applications physically scanned during the month of January and eliminating duplicates (64,170 applications); (2) identifying which applicants were sent an approval letter; (3) confirming through administrative enrollment records that the approved applicants moved to coverage in the Florida Healthy Kids Program as of May 16, 2005; and (4) deleting children with critical missing information (e.g., phone numbers) and duplicate family members. The resulting eligible population from which the random sample was drawn was 4,466 children. Two hundred interviews were completed. Using a 95 percent confidence interval, the survey responses provided in this report are within +/-6.77 percentage points of the "true" response.[6]

The "applied but not enrolled" population was determined by: (1) identifying those applications physically scanned during the month of January and eliminating duplicates (64,170 applications); (2) applying age and income criteria for Healthy Kids eligibility; (3) eliminating children enrolled in or referred to (and still in process) other program components (Medicaid, MediKids, and CMS) as of May 16, 2005; (4) deleting children with critical missing information (e.g., phone numbers) and duplicate family members.[7] The resulting eligible population from which the random sample was drawn was 9,584 children. Using a 95 percent confidence interval, the survey responses provided in this report are within +/-6.86 percentage points of the "true" response.[8]

B. Survey Results

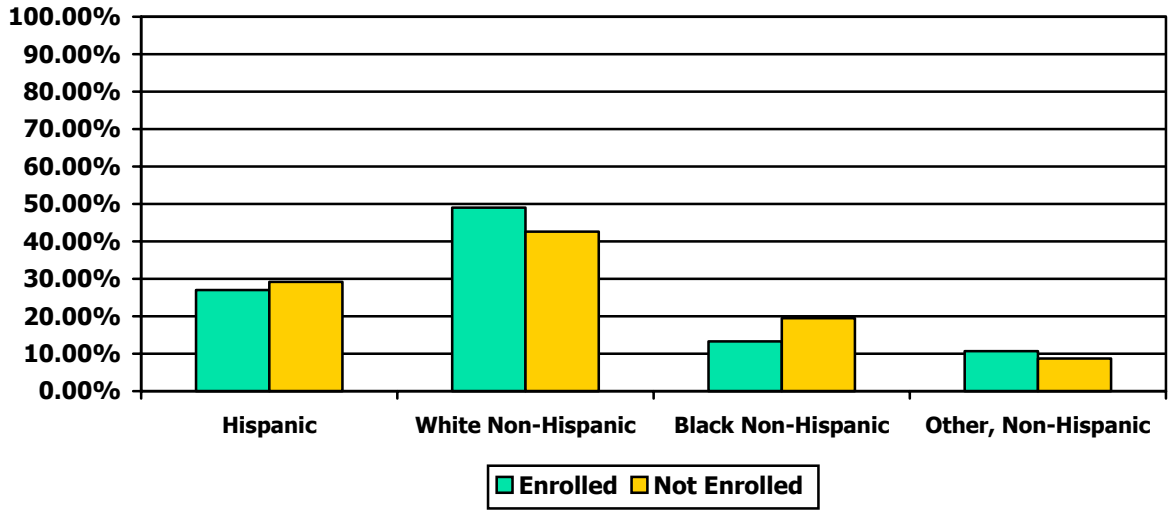
Sociodemographic Characteristics. In general, the household characteristics of applicants who completed the process are more similar to established enrollees in the Healthy Kids program[9] compared to those who did not complete the process (Figure 5). For example, approximately 60 percent of established enrollees and of those who completed the process are married, compared to 52 percent of those who did not complete the process. Approximately 38 percent of successful applicants and established enrollees reside in a single-parent household compared to 47 percent of non-enrolled children. Single parents may have fewer resources, particularly time, to complete the application process.

Figure 5: Respondent Household Type and Marital Status



The percentage of children who are Hispanic is similar (28 percent overall) for those who did and did not complete the enrollment process (Figure 6). The percentage of children who are non-Hispanic black is greater for the non-enrolled group at 20 percent, compared to 13 percent for the enrolled children. Approximately 49 percent of children who completed the enrollment process are non-Hispanic white, compared to 43 percent of children who did not complete the process.

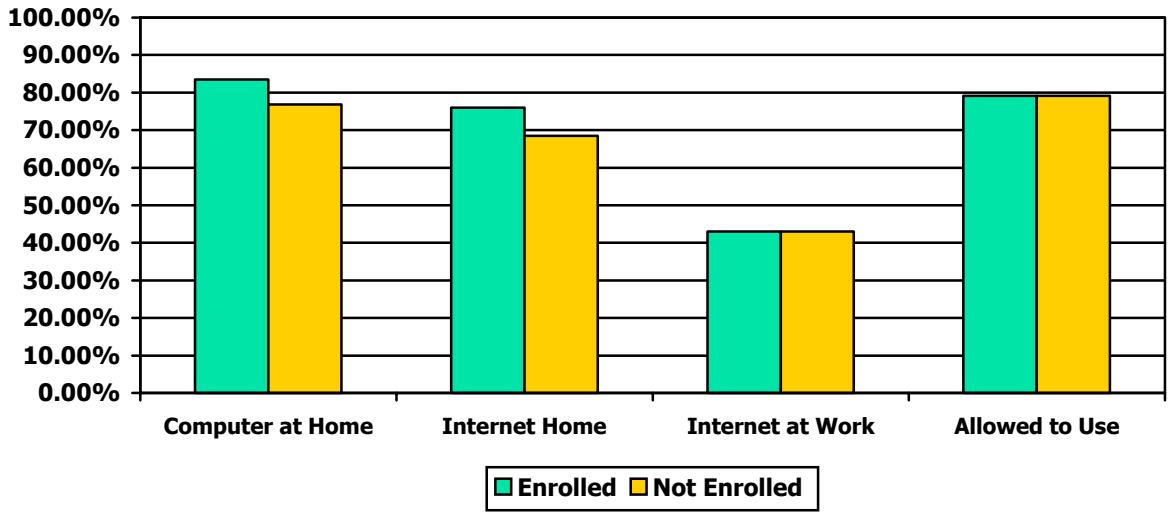
Figure 6: Children's Race and Ethnicity



Computer and Internet Access. The majority of respondents had both computer and Internet access. Respondents who completed the enrollment process had somewhat better access to computers and the Internet at home (Figure 7). Eighty-four percent of those in the "enrolled" group had access to a computer at home compared to 77 percent of those "not enrolled"; 76 percent of those enrolled had access to the Internet at home compared to 69 percent of those in the "not enrolled" category. Forty-three percent of both groups reported having access to the Internet at work; among those, 79 percent of respondents (in both groups) indicated that their employer would allow them to use the Internet to access health information. Because the

majority of respondents have access to the Internet, the Internet can serve as an important resource for communicating program information to families. With more than 25 percent of respondents indicating that they do not have Internet access, however, other methods of communication remain essential.

Figure 7: Respondent Computer and Internet Access



Usual Source of Care. Having a usual source of medical care is associated with early detection of health care problems, and insured children are more likely than uninsured children to have a usual source of care. Table 7 shows the percentage of children among the survey respondents who have a usual source of care. Families who completed the enrollment process were much more likely to report having a usual source of care for their child (91.5 percent) than those who did not complete the enrollment process (69.0 percent). The two reasons cited most frequently for not having a usual source of care among those families who did not complete the enrollment process were not having health insurance (50.8 percent) and not being able to afford medical care (19.7 percent).

Table 7: Usual Source of Care		
	Enrolled	**Not Enrolled**
Does your child currently have a particular doctor's office, clinic, health center, or other place that you would take him or her if he or she was sick or you needed advice about his/her health?		
Yes	91.5%	69.0%
No	7.0%	30.5%
Don't know	1.5%	0.5%
If no usual source of care, what is the main reason?		
Child seldom or never gets sick	14.3%	6.6%
Frequently or recently moved	14.2%	4.9%
Did not know where to go for care	14.3%	11.5%
Did not have health insurance	21.4%	50.8%
Could not find provider/place where my language is spoken	7.1%	3.3%
Cost of medical care (cannot afford it)	0.0%	19.7%
Waiting (or was waiting) for Healthy Kids	7.1%	1.6%
Other	14.3%	1.6%
Don't know	7.1%	0.0%

Unmet Health Care Needs. Children who lack health insurance often have unmet health care needs or face difficulty in receiving needed care. Families who applied for coverage during the open enrollment period were asked a series of questions about their children's unmet health care needs "during the past 12 months." They also were asked how difficult it was to get needed care for their children. Their responses are summarized in Table 8 below.

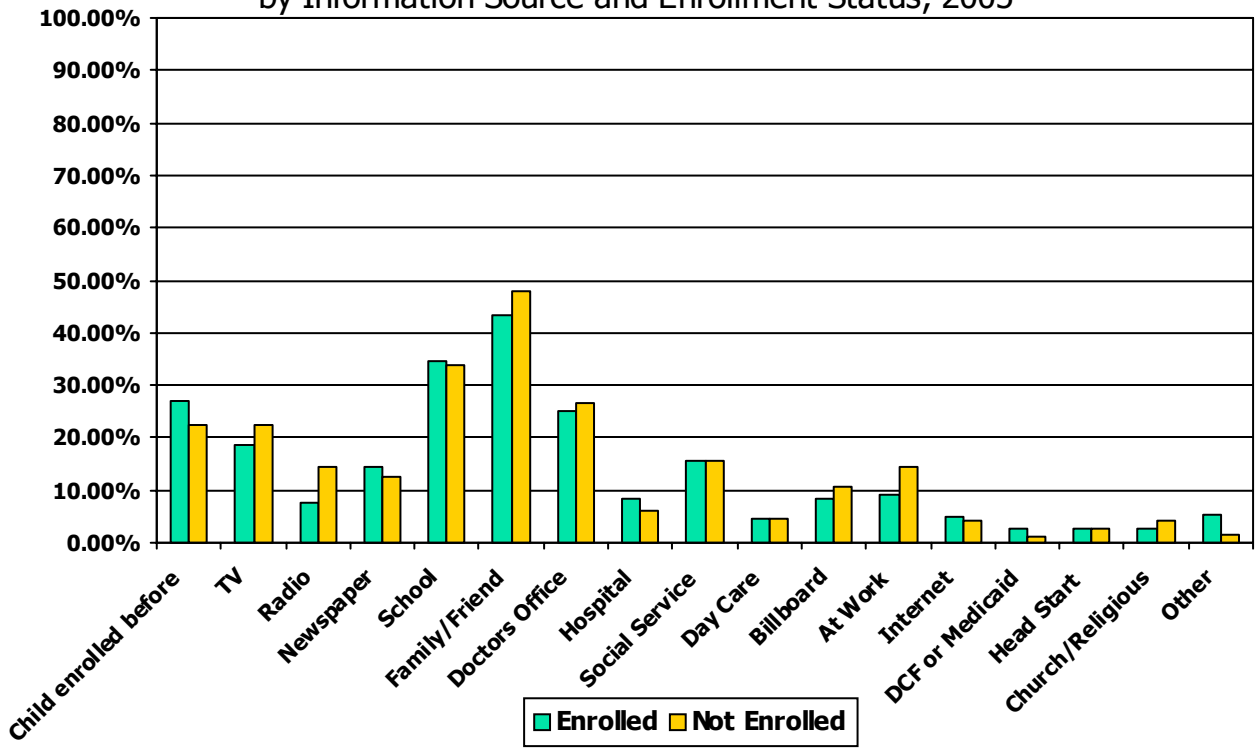
With the exceptions of emergency care and surgical care, families who had not completed the enrollment process reported greater unmet needs during the previous year. Dental care is the largest unmet need for both groups: 43 percent of the "not enrolled" children and approximately 16 percent of "enrolled" children who needed dental care did not receive it. In every category, families whose children did not become enrolled in Healthy Kids were much more likely to report problems in obtaining needed care during the past year. For example, 54.2% of "not enrolled" children requiring specialty care reported that obtaining such care was a "problem" compared to 20.7% of "enrolled" children.

Table 8: Unmet Health Care Needs		
	Enrolled	Not Enrolled
Preventive Care		
Needed care	57.5%	47.5%
Did not receive (of those who needed)	5.2%	10.5%
Received but a problem (of those who received)	15.6%	35.7%
Minor Problem or Illness		
Needed care	39.0%	36.0%
Did not receive (of those who needed)	2.6%	11.1%
Received but a problem (of those who received)	21.1%	39.1%
Emergency Care		
Needed care	15.0%	14.0%
Did not receive (of those who needed)	6.7%	7.1%
Received but a problem (of those who received)	46.4%	65.4%
Surgical Care or Medical Procedure		
Needed care	7.5%	4.5%
Did not receive (of those who needed)	13.3%	0.0%
Received but a problem (of those who received)	7.7%	33.3%
Specialty Physician Care		
Needed care	15.0%	13.5%
Did not receive (of those who needed)	3.3%	11.1%
Received but a problem (of those who received)	20.7%	54.2%
Prescription Medication		
Needed care	40.0%	31.5%
Did not receive (of those who needed)	3.8%	7.9%
Received but a problem (of those who received)	23.4%	48.3%
Dental Care		
Needed care	44.0%	39.5%
Did not receive (of those who needed)	15.9%	43.0%
Received but a problem (of those who received)	30.6%	46.7%

How Respondents Heard of Healthy Kids. Families were asked how they heard about the Florida Healthy Kids Program and were allowed choose more than one of many sources of information (e.g., family and friends, prior experience with the program, television, and so forth). As Figure 8 shows, families learn about the Healthy Kids Program from a variety of personal interactions and media sources. The information source cited most frequently is family and friends, followed by their children's schools, doctors' offices, and prior program experience (i.e.,

the child or another family member had been enrolled before). Families also report learning about Healthy Kids though formal media outlets, such as television, newspaper, and radio.

Figure 8: Percentage of Families Who Learned about Healthy Kids by Information Source and Enrollment Status, 2005



Families' Attitudes toward Limited Enrollment Periods. Most families surveyed – more than 80 percent overall – knew there was a limited time period during which their application could be submitted (Table 9). But less than one-third of all respondents knew of the recent legislative change allowing for a return to year-round enrollment.

Table 9: Attitudes toward Limited Enrollment		
	Enrolled	**Not Enrolled**
Knew there was a limited time period during which child's application could be submitted	89.0%	79.5%
Knew of recent legislative change allowing for year-round enrollment	33.0%	26.6%
Agree or strongly agree that a limited enrollment period would be no problem for their family	27.5%	32.5%
Agree or strongly agree that a limited enrollment period would be a problem because child is in poor health and needs insurance now	34.0%	38.0%
Agree or strongly agree that limited enrollment periods are common when purchasing health insurance	50.5%	35.5%
Agree or strongly agree that it is important to be able to apply for insurance for child at any time in case job or employment benefits are lost	92.0%	90.5%
Agree or strongly agree that it is important to be able to apply for insurance at any time for child in case child gets sick or has an accident.	92.5%	92.0%

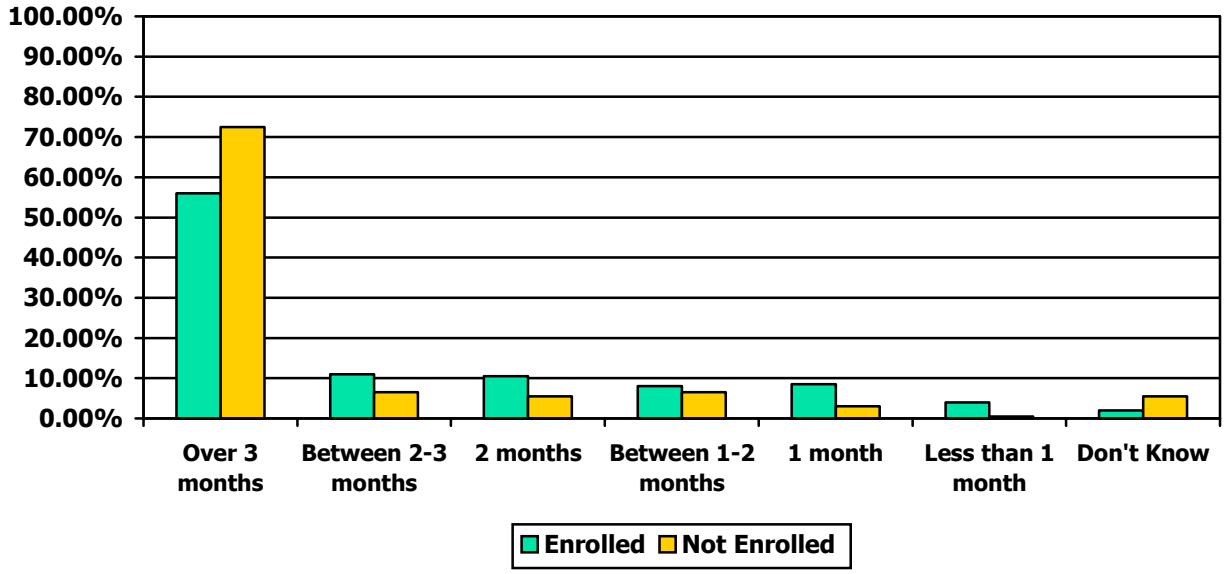
When asked about their opinions about limited enrollment periods, more than one-fourth indicated that a limited enrollment period would be no problem for their family. At the same time, however, more than 90 percent of respondents indicated that it would be important to be able to apply for coverage at any time in case they lost their job or if their child became sick. Respondents who had not completed the application process were significantly less likely to agree that limited enrollment periods are common when purchasing health insurance.

Application Process and Experiences. More than 90 percent of all respondents indicated that the felt the application form was easy to understand (Table 10). Less than 40 percent of all respondents, however, felt that they were kept well informed about their application status while waiting to hear about coverage.

Table 10: Application Process		
	Enrolled	Not Enrolled
Agree or strongly agree that application form was easy to understand	95.0%	90.0%
Respondent felt that s/he was kept well informed about the application status while waiting to hear about coverage	41.0%	33.0%
Waited more than 3 months from time of application to hearing about coverage	56.0%	72.5%

Respondents were asked to indicate how long it took for them to hear about whether they received Healthy Kids coverage after they submitted the application. Well over half of all respondents indicated that they waited more than three months from the time they submitted their application until they heard about whether their child had received Healthy Kids coverage (Table 10 and Figure 9). Approximately 73 percent of families who had not received coverage for their child at the time of the interview indicated that they had waited more than three months, compared to 56 percent of those who had completed the enrollment process.

Figure 9: Time From Application to Learning of Coverage



Families were only asked about the length of time until they learned about their coverage and not how soon they received any acknowledgement or follow-up from the program after submitting their application. As indicated in the discussion of Table 5 in Section III above, many applications had errors or were missing supporting documentation which delayed the determination of coverage. Because coverage is not retroactive, however, it is important to identify ways to facilitate completion of the application process so that eligible children can get health insurance coverage as quickly as possible.

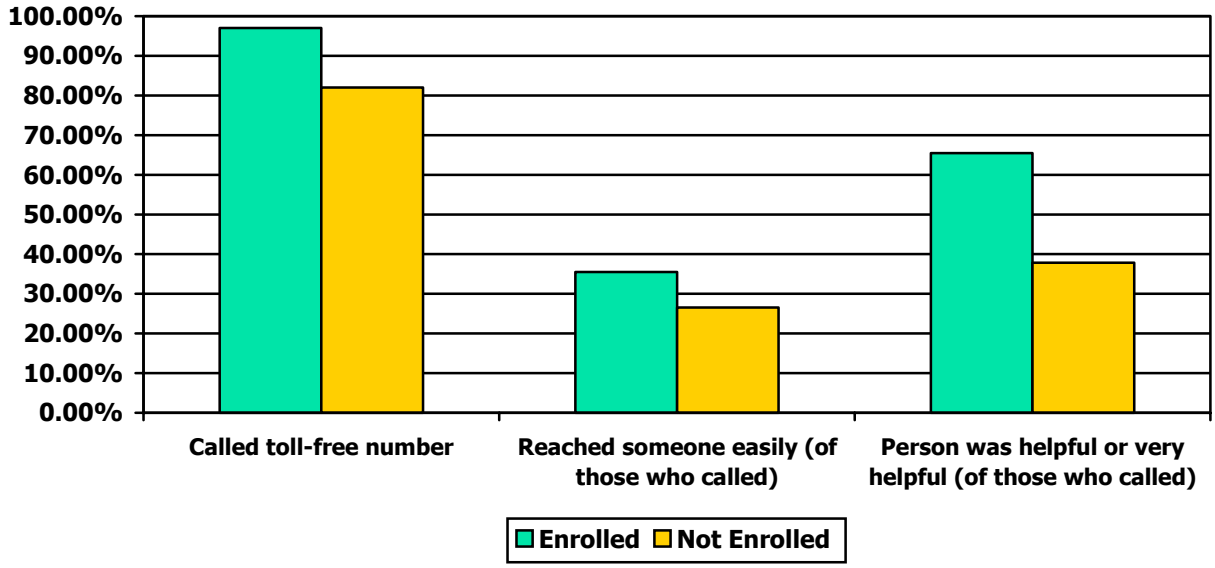
During the open enrollment period, applicants had several ways that they could submit their application to the program: mail, e-mail, or fax. Applicants who previously had been enrolled also had the option to be reinstated by telephone. Survey respondents were asked to rate the convenience of these options or to indicate if that option was not applicable because they did not use that option. The results are reported in Table 11 below. The responses among those who did and who did not complete the application process were similar. The option most frequently used was the mail-in application process. Among those who used each option, most indicated satisfaction with the convenience of that option. Each of the four application options was considered to be convenient as indicated by the high percentages of those indicating "strongly agree" or "agree."

Table 11: Convenience of Application Submission Options		
	Enrolled	Not Enrolled
Was the mail-in application process convenient?		
Strongly agree	32.5%	28.5%
Agree	53.0%	59.5%
Disagree	6.5%	6.0%
Strongly disagree	3.5%	2.0%
Not Applicable – did not use	4.0%	3.5%
Don't Know	0.5%	0.5%
Was the option to fax the application convenient?		
Strongly agree	22.0%	18.5%
Agree	30.0%	32.0%
Disagree	5.5%	6.0%
Strongly disagree	4.0%	3.5%
Not Applicable – did not use	38.0%	38.5%
Don't Know	0.5%	1.5%
Was the option to e-mail the application convenient?		
Strongly agree	15.0%	17.5%
Agree	28.5%	26.5%
Disagree	5.5%	6.5%
Strongly disagree	3.5%	2.5%
Not Applicable – did not use	45.5%	46.5%
Don't Know	2.0%	0.5%
Was the option to be reinstated by phone convenient?		
Strongly agree	22.0%	17.5%
Agree	28.0%	27.0%
Disagree	4.5%	4.5%
Strongly disagree	4.0%	4.5%
Not Applicable – did not use	41.0%	45.0%
Don't Know	0.5%	1.5%

Call Center Experiences. Families who successfully completed the application process were more likely to have called the toll-free number and were more likely to have had positive experiences in getting assistance than those who did not complete the process (Figure 10). Almost all (97 percent) of those who completed the enrollment process called the toll-free number compared to compared to 82 percent of those who did not complete the process. Both groups had difficulty reaching someone (of those who called), with the families who completed the process reporting more success in reaching someone (36 percent) than those who did not complete the process (27 percent). Significantly more of those in the enrolled group (66 percent)

reported that the person they spoke to was helpful or very helpful compared to those in the non-enrolled group (38 percent).

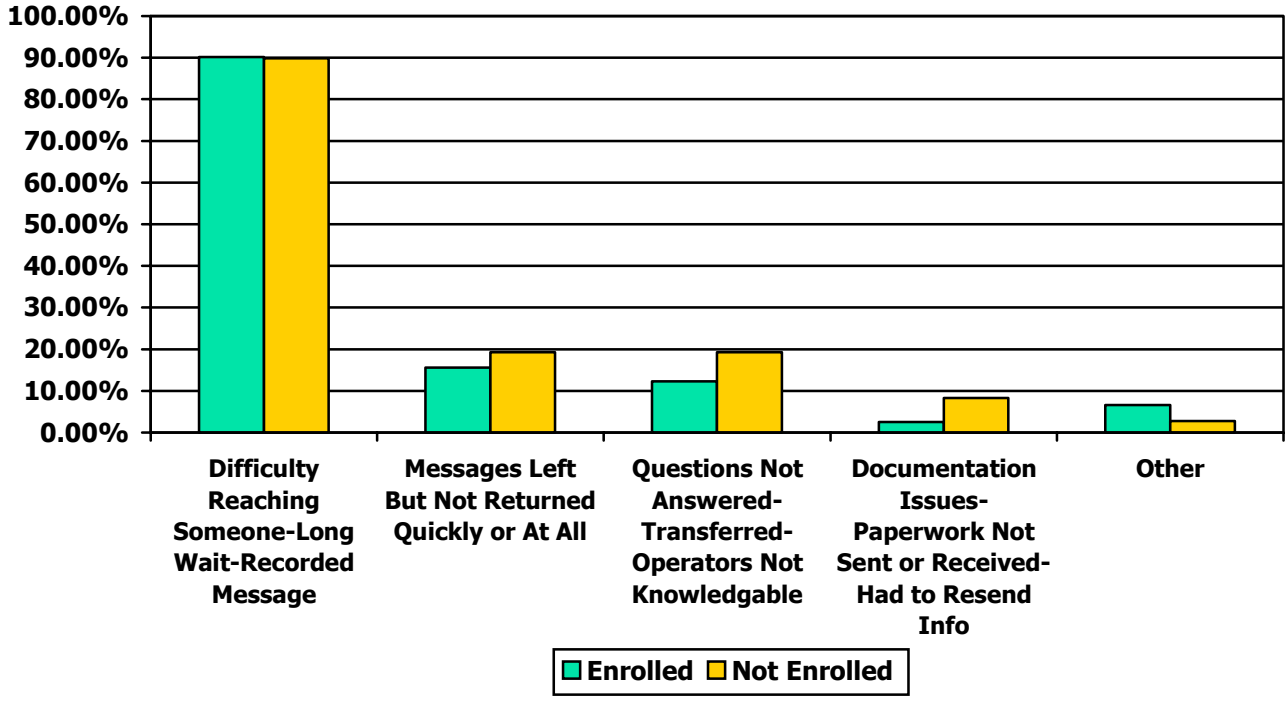
Figure 10: Toll-Free Number Call Experiences



Those who indicated that they did not reach someone easily were asked to describe in their own words (i.e., an open-ended response) the problems that they encountered in calling the toll-free number. Their responses are summarized in Figure 11. An individual's response could fall into more than one of the categories indicated in Figure 11. The problem cited most frequently was the difficulty in reaching someone. Respondents indicated frustration with the amount of time spent on hold and with receiving automated messages instead of a person. Their experiences are consistent with the administrative data (reported in Section III above) that indicate a substantial increase in call volume and the time it took to answer calls during the months surrounding open enrollment. Respondents also were frustrated that when they left messages on the automated call system, they did not receive a response quickly or their messages were not returned at all. Compared to those who completed the enrollment process, respondents

who did not complete the process were more likely to indicate that their questions were not answered once they did reach someone, and they were more likely to cite documentation problems such as being asked to resend paperwork to the program.

Figure 11: Problems Experienced with Calling the Toll-Free Number By Those Who Did Not Reach Someone Easily

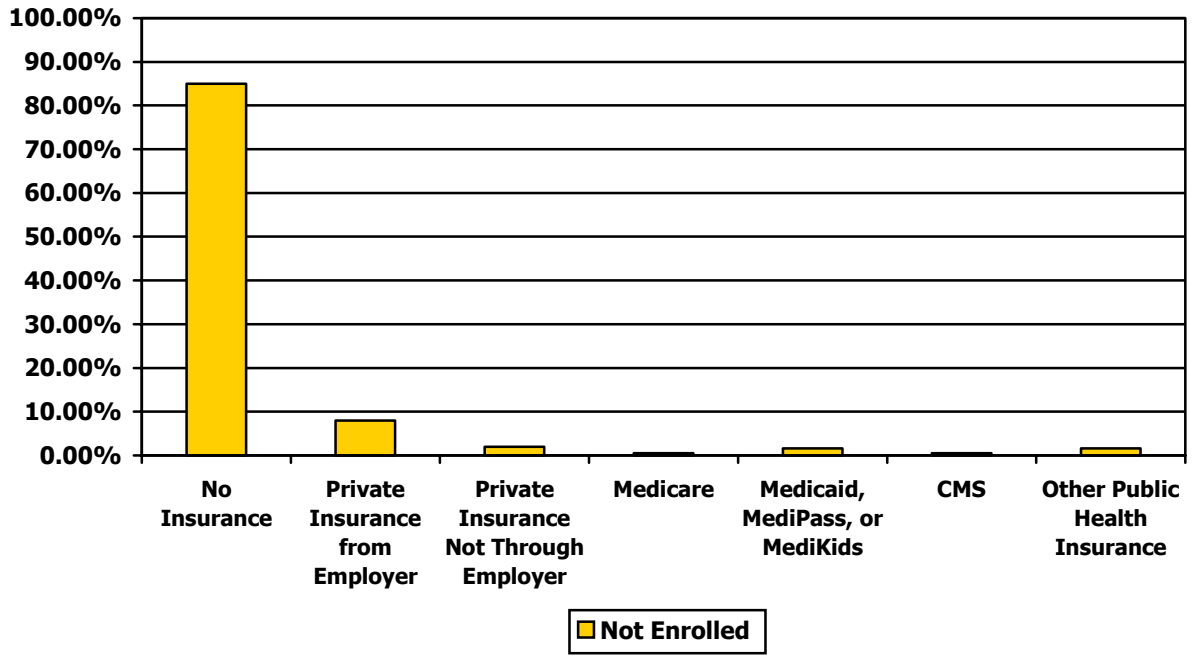


Other than the toll-free number, respondents also were asked whether they contacted a social service agency or health care provider to get information about the status of their application (Table 12). Only about 10 percent of all respondents indicated asking for help from another source. The places contacted more frequently were the Department of Children and Families (DCF) and Children's Medical Services (CMS).

Table 12: Percentage of Respondents Who Asked for Help From Other Social Service Agency or Health Care Provider about Application Status		
	Enrolled	Not Enrolled
(Other than the toll-free number) Have you asked for help from a social service agency or health care provider about the status of your application?		
Yes	8.5%	10.5%
No	91.5%	89.5%
If yes, from whom did you get help (respondents can choose more than one)?		
CMS	29.4%	28.6%
DCF	35.3%	23.8%
County Health Department	11.8%	4.8%
Personal Doctor or Nurse	17.6%	14.3%
Case Worker	11.8%	0.0%
Social Worker	11.8%	0.0%
Healthy Kids Program Office	17.6%	23.8%
Medicaid	11.8%	9.5%
Other	11.8%	14.3%
Don't Know	5.9%	9.5%
Would you say that they were able to provide the help needed?		
Strongly agree	17.6%	9.5%
Agree	35.3%	38.1%
Disagree	35.3%	33.3%
Strongly disagree	5.9%	19.0%
Don't Know	5.9%	0.0%

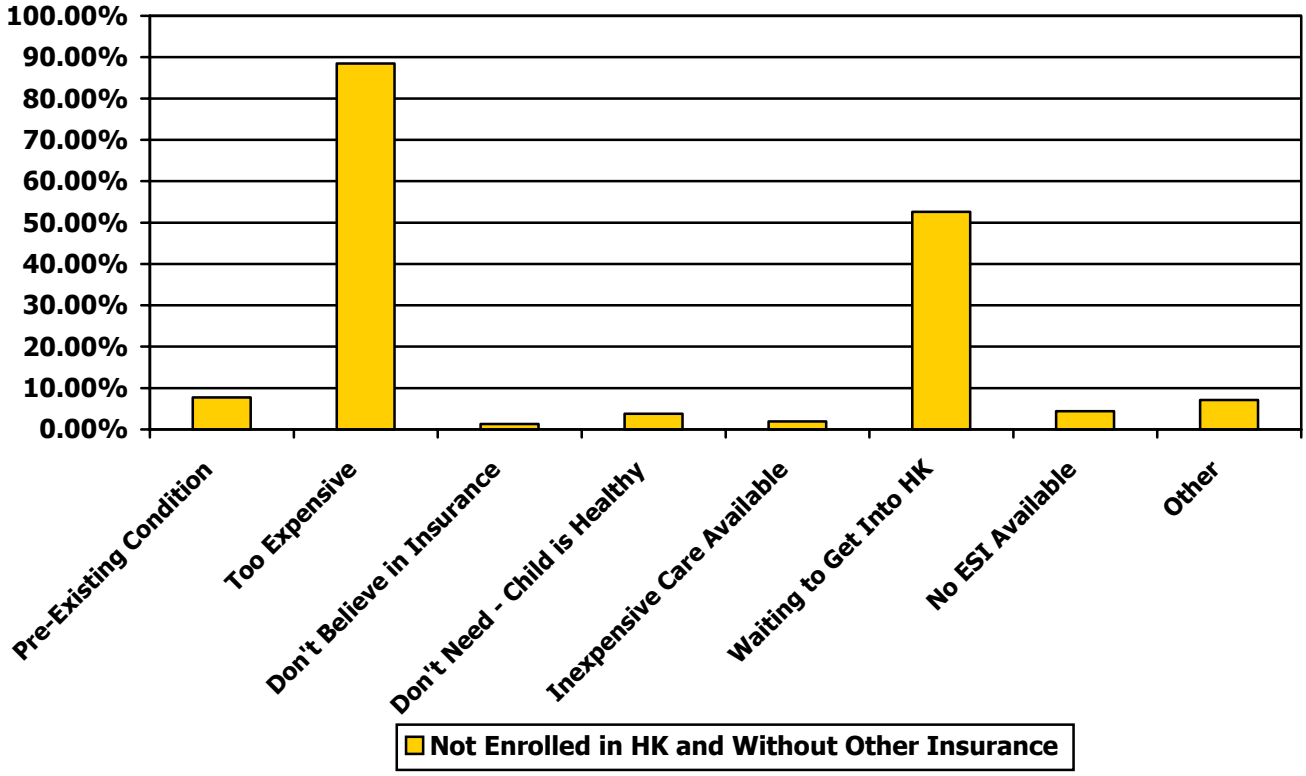
Insurance Status of Children Not Enrolled in Healthy Kids. Approximately 15 percent of the respondents who did not complete the process have another source of insurance coverage for their child. Of these, 55.6 percent (or about 8 percent of all of those who did not complete the process) have employer-sponsored insurance, 14.8 purchased private insurance directly themselves, 3.7 percent have CMS, 11.1 percent have Medicaid, MediPass, or MediKids, 3.7 percent have Medicare, and 11.1 percent have some other form of public health insurance. These results are summarized in Figure 12, which shows insurance coverage as a percentage of all children not enrolled in Healthy Kids.

Figure 12: Insurance Status of Children Who Applied For Coverage and Did Not Complete the Enrollment Process



The 85 percent of respondents who indicated that they did not have insurance coverage for their children were asked to indicate the reasons for not having selected another health insurance policy, and respondents were allowed to state more than one reason. By far, the reason most frequently cited is the cost of getting other coverage (88.5 percent of respondents). More than half (52.6 percent) indicated that they are waiting to get into the Florida Healthy Kids Program.

Figure 13: Reasons for Not Selecting Another Health Insurance Policy For Child as a Percentage of Children Not Enrolled in HealthyKids and Who Do Not Have Other Insurance



Access to Employer-Sponsored Insurance. Respondents were asked about their access to employer-sponsored insurance (ESI) that would cover their child (Table 13). Approximately 64 percent of all respondents reported not having access to ESI that would cover their child. Among those not having access to ESI: almost 50 percent indicated that their employer does not offer health insurance coverage, 35 percent to 42 percent do not have access because the parent is not employed, about 12 percent of respondents indicated that their employer offers insurance but they are not eligible for coverage (e.g., because they are a temporary or part-time worker), 10 percent to 14 percent of respondents indicated that the employer only offers single coverage and not family coverage, and 10 percent to 14 percent indicated that they are self-employed.

Table 13: Access to Employer-Sponsored Insurance		
	Enrolled	Not Enrolled
Does your family currently have access to employer-based insurance that would cover your child?		
Yes	33%	32%
No	63%	65%
Don't Know/Refused	4%	3%
IF NO (family does not have access), why does child not have access to ESI (respondents can choose more than one)?		
One or both parents not employed	35%	42%
Employer does not offer health insurance	47%	51%
Employer offers only single coverage (not family)	10%	14%
Employer offers coverage but parent is not eligible	11%	13%
Parent is self-employed	10%	14%
Other	12%	10%
Don't Know/Refused	4%	2%
IF YES family has access and child does <u>not</u> have ESI coverage, why is child not covered through an employer (respondents can choose more than one)?		
Too expensive	93%	91%
Did not like benefits package	2%	3%
Did not like doctors in the plan	0%	0%
Other	10%	17%

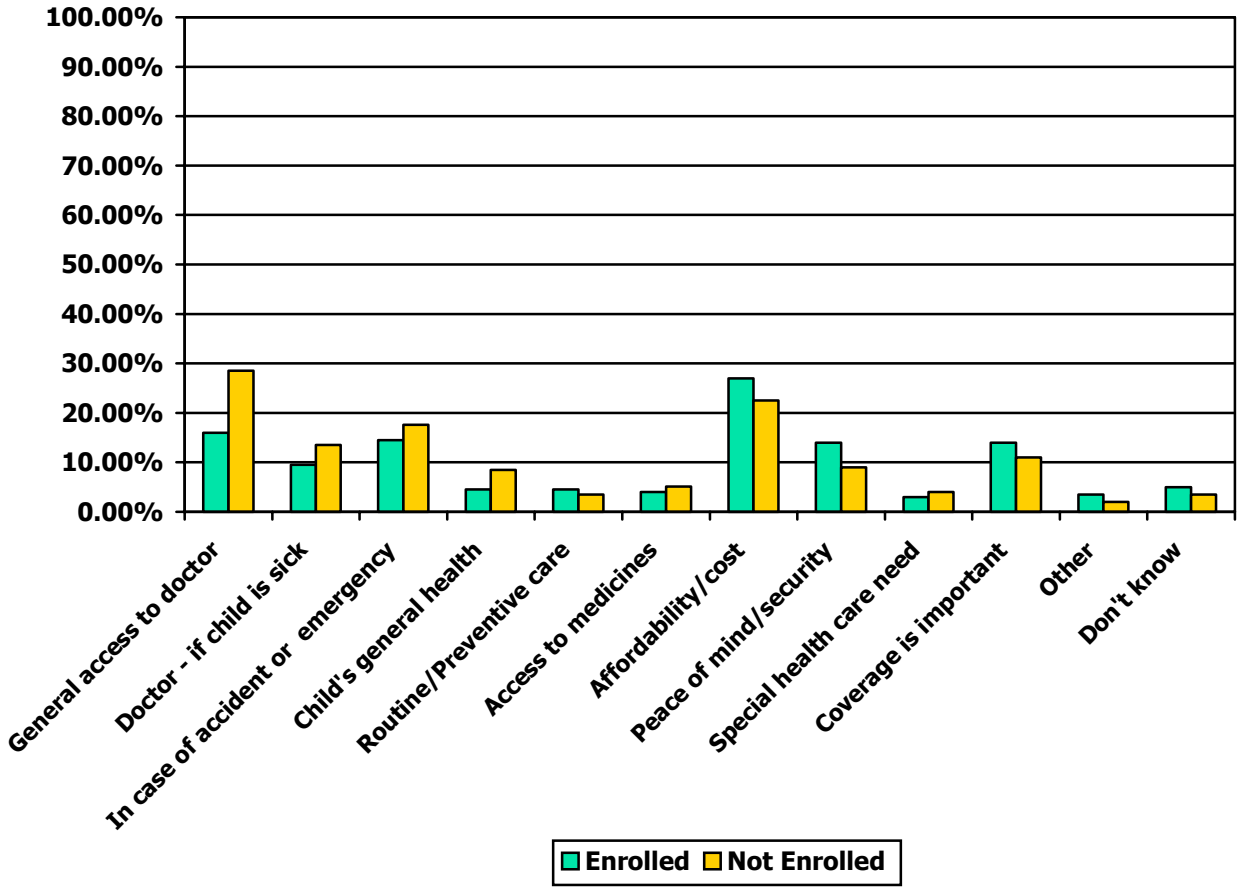
Approximately one-third of families who did not complete the enrollment process reported having access to ESI that would cover their child, but only 30 percent of those with access actually have ESI for their child. When asked why their child was not covered through ESI, more than 90 percent indicated that it was too expensive to do so. A few (less than 3 percent) indicated that they did not like the benefits package offered by their employer, and none indicated that they were dissatisfied with the doctors in the employer-sponsored plan.

Respondents who have access to ESI that would cover their children but elected not to do so were asked to indicate how much they would have to pay for their share of the premium each month to get ESI for their children. The responses ranged from $20 per month to $987 per month among those who completed the enrollment process, and the average monthly cost reported by respondents was $408.55. Among those who did not complete the process, the responses ranged from $70 per month to $900 per month, and the average monthly cost reported was $424.59. When asked how confident they were that their estimate is within $20 of the actual

employee share of the premium, 73 percent of the enrolled and 66 percent of the non-enrolled respondents indicated that they were "very confident" or "confident." However, these estimates appear to be somewhat high. According to the Kaiser Family Foundation, the average cost of employer-based family premiums in 2004 is $9,950 annually, with employees paying 28 percent of that amount.[10]

Families Attitudes Toward Insurance. To assess families' attitudes regarding the benefits of health insurance in general, respondents were asked the following open-ended question: "What do you view as the primary benefit of having health insurance coverage for your child?" Their responses are summarized in Figure 14 below, and an individual's response could be classified into more than one category. More than 20 percent of respondents in each group (those who did and did not complete the process) cited a reduced financial burden as a primary benefit of having health insurance coverage for their children. Respondents also cited general access to a physician and being able to take their child to a physician "anytime" as being a primary benefit, with some noting that without coverage they would not be able to get a physician to see their child.

Figure 14: Families Perspective of the Primary Benefit of Having Health Insurance Coverage for Their Children



Some respondents noted that it would be important to have insurance specifically if the child were sick or had an accident or emergency. Less emphasis was placed by respondents on having insurance for general health benefits and for preventive and routine care. More than 10 percent of all respondents indicated that a primary benefit was security and peace of mind. More than 10 percent of all respondents did not articulate a specific benefit, but indicated generally that health insurance coverage generally is very important – "it is a must."

What Families Say About Improving the Enrollment Process. Respondents were asked to reflect upon their experiences and suggest ways that the enrollment process could be

improved. Their responses are summarized in Table 14 below, and an individual's response could be classified into more than one category. Approximately 16 percent of respondents who completed the process indicated that they had "no complaints," compared to only 4 percent of those who did not complete the process. Generally, the suggestions for improvement offered most frequently were: (1) process applications more quickly, (2) improve customer service and the handling of phone calls, (3) provide better and more frequent communication to keep families updated about their application status, and (4) hire more workers to answer calls and process applications. Families were frustrated that they waited more than a month, even several months, to find out about coverage, especially if their child had a health care need during that time. Families also were upset by the difficulties they encountered when calling the toll-free number for assistance, with more families who did not complete the process citing this as an area for improvement (26.6 percent) compared to those who completed the process (16.0 percent). Families indicated that their messages were not returned and expressed a desire for operators who were more knowledgeable and helpful.

Families who did not complete the enrollment process also were more likely (20 percent) to indicate that they would have liked to have received more updates and better communication about the status of their application, compared to those who completed the process (12 percent). Many respondents recognized that the problems they encountered were related to the high volume of applications and inquiries during open enrollment and recommended hiring more staff as well as recommending more than one open enrollment period during the year or returning to year-round enrollment. Other suggestions for improvement were to provide other ways for families to apply for coverage and check their application status (such as through email or the

Internet) to develop a tracking system for applications, and to have better program organization during the process.

Table 14: Families Perspectives of How the Enrollment Process Could Be Improved

	Enrolled	Not Enrolled
Process applications more quickly	22.0%	24.0%
Improve customer service and handling of phone calls	16.0%	26.6%
Provide better and more frequent communication; keep applicants better updated about their applications; and contact applicants sooner if additional information is needed	12.0%	20.0%
Increase clarity regarding process; let applicants know up front what documentation is required	2.5%	4.0%
Provide other methods for communication between program and applicants, such as email and the Internet	3.0%	4.0%
Reduce/simplify paperwork	3.0%	2.0%
Provide clearer information about program details, including eligibility requirements and costs (premiums and co-pays)	1.5%	2.0%
More frequent open enrollment periods or year-round enrollment	11.0%	5.0%
Hire more staff to answer phones and process applications	13.0%	13.5%
Generally make process easier	2.0%	3.0%
Improve organization and computerization of information - paperwork was lost; received conflicting information from customer service representatives	7.5%	6.5%
Establish local offices and contacts for assistance	0.5%	1.0%
No complaints	15.5%	4.0%
Other	13.5%	13.5%
Don't Know/Refused	10.5%	7.5%

VII. CONCLUSIONS

The Title XXI Program in Florida has returned to a continuous open enrollment process. However, this report provides valuable information about the experiences of KidCare Project Partners and families during the January 2005 open enrollment that can be used by the State of

Florida if interest in set open enrollment periods arises in the future. In addition, this information may be valuable to other states.

Given the limited time period available, the Florida Healthy Kids Corporation and their partners launched a strong marketing campaign to reach families. However, the Healthy Kids systems were not designed to handle the resulting call volume. In addition, the project partners did not have the funds or the time to implement the full range of outreach strategies in the Healthy Kids Tool Kit. Expanding call center capabilities and providing sufficient planning time is essential if set open enrollment periods are ever used in the future.

Those who applied but did not become enrolled in the program are at great risk for having uninsured children. About 85 percent of children whose parents applied to the Florida Healthy Kids Program on their behalf but did not become enrolled were uninsured at the time of the telephone survey. The children who did not become enrolled also were less likely to have a usual source of care and more likely to encounter problems in getting needed medical care. A substantial literature documents the importance of health insurance for access to needed health care. Therefore, it is essential to consider various strategies to improve families' experiences with the enrollment process.

The findings in this report indicate the importance of providing assistance to families with the application form and the documentation requirements. A substantial percentage of those who applied but did not become enrolled had missing information on the application (38 percent) or did not supply needed documentation (16 percent). Families who applied but whose children were not enrolled were also less likely to seek assistance from the toll-free number compared to those whose children became enrolled in Healthy Kids.

Families whose children did not become enrolled differed in terms of their sociodemographic characteristics when compared to those whose children did become enrolled. Specifically, those who applied but did not become enrolled were more likely to be non-Hispanic black (20 percent) than those who became enrolled (13 percent). In addition, children who were not enrolled were more likely to reside in a single parent household (47 percent) compared to those whose children were enrolled (38 percent). These findings suggest that some families may be at greater risk for problems during the enrollment process. Even with the reinstatement of continuous open enrollment, families with the aforementioned sociodemographic characteristics may benefit from additional assistance during the application process. It is also important to consider an array of options for families to apply to the program. While some families specifically said they wanted to apply online, more than one-fourth of all respondents indicated not having Internet access. Therefore, options like applying over the phone may need to be considered.

Endnotes

[1] Due to the passage of year-round enrollment, enrollment re-opened in June 2005.

[2] These applications represent those that were sent by mail, fax, or email during the January 2005 open enrollment period after eliminating duplicate submissions. Phone reinstatements are not included in this analysis.

[3] These data reflect enrollment status as of May 16, 2005.

[4] In May 2005, the categories for call tracking were revised. For comparison across months, we have only included January 2005 – April 2005.

[5] These estimates were provided by the Florida Healthy Kids Corporation.

[6] The confidence intervals are presented for hypothetical items with uniformly distributed responses. These numbers are a "worst case" generality presented for reference purposes only.

[7] Initially, if children moved to coverage prior to their parent being interviewed, the survey was structured so that they would move into the "applied and enrolled" category for the survey. After enrollment re-opened due to the return to year-round enrollment, this practice was discontinued.

[8] The confidence intervals are presented for hypothetical items with uniformly distributed responses. These numbers are a "worst case" generality presented for reference purposes only.

[9] Established enrollees are those children enrolled in the Healthy Kids Program for 12 months or longer. Surveys with parents of established enrollees in the Healthy Kids Program are conducted as part of the Florida KidCare program evaluation. The Florida KidCare Program Evaluation Report, 2004, is available at: http://www.healthykids.org/documents/evaluation/institute/2005/2004_kidcare_evaluation.pdf.

[10] Kaiser Family Foundation. Employer Health Benefits 2004 Annual Survey.