CONNECTICUT VOICES FOR CHILDREN

Health and Health Care Disparities in HUSKY A: Impact of Coverage

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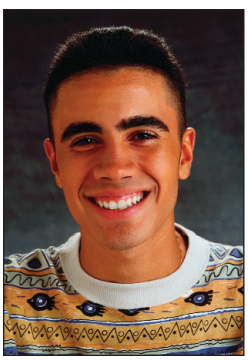
Major Findings

For newly enrolled children, coverage in HUSKY A led to improved access to care and reduced disparities among children of different racial and ethnic backgrounds. In the year after enrolling, preschool and school-aged children experienced increased access to primary care, increased preventive care and dental care, decreased reliance on the emergency room for routine care, and decreased unmet need for care. While the percentage of children with unmet needs decreased, the percentage with any visits also decreased, suggesting better access to primary care for addressing routine and acute care needs. Most changes in access and utilization occurred in the first six months after children enrolled. Coverage in HUSKY A reduced differences between Black/African American children, Hispanic children and White children in terms of health status, access to care, preventive care, and trust in health plans and providers. Over time, individual Black/African American children became less reliant on the emergency room for routine care, had increased access to primary care providers, received preventive care and dental care, and experienced less unmet need for care.



Individual Hispanic children became less reliant on the emergency room for routine care, received dental care, and experienced less unmet need for care. Over time, families of White children became increasingly more likely to report differential treatment from providers.

Introduction

Connecticut children enrolled in HUSKY A (Medicaid managed care) are entitled to timely and comprehensive preventive care and medically necessary treatment. This benefit package was designed to meet the health care needs of low-income children and those with chronic or disabling conditions, that is, children who are otherwise at risk for not getting all the care they need. However, analysis of health services data show that there are persistent and troubling disparities in children's health care access and utilization in HUSKY A.[1]

What is the impact of HUSKY coverage on children's health, health care, and disparities associated with race/ethnicity? In order to study the impact of HUSKY coverage in the first year after enrollment, the Children's Health Council conducted a statewide longitudinal survey of parents with newly enrolled children.[2] The survey was designed to determine whether the impact of coverage differs, depending on the racial/ethnic background of newly enrolled children. The Connecticut Health Foundation provided funding for the survey.[3]

This brief is the second of two reports based on the results of this survey. Results reported in the first brief showed that at the time of enrollment, there were very few differences associated with race/ethnicity when White, African American, and Hispanic children were compared in terms of insurance status prior to enrollment, preventive care, unmet health care needs, and feelings of trust and respect in recent health care visits.

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Results

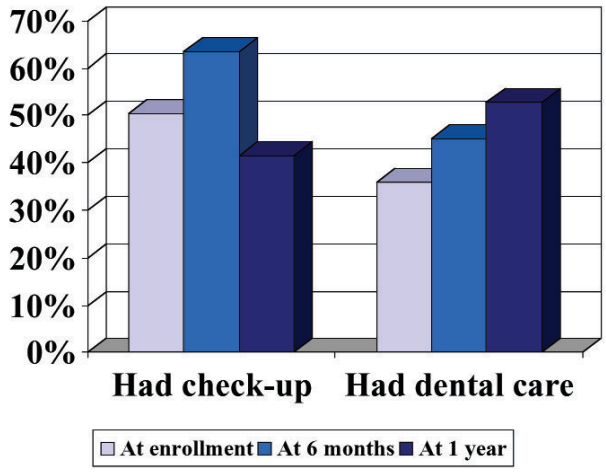
- **Health status:** Over the course of the year, there was no change in the percentage of children who were reportedly in fair/poor health (5.8%). At the time of enrollment, Hispanic children were more likely than White children to be in fair/poor health; however, this difference narrowed and was not statistically significant one year later.

- **Access to care:** At the time of enrollment, 90 percent of children reportedly had a usual source for care, a rate that was essentially unchanged one year later. The disparities between Black and Hispanic children, compared to White children, that were evident at the time of enrollment, were not found after one year of coverage. Overall, there was a significant increase in the percentage of children with a primary care provider (86% to 93% by 6 months) and the disparity between Black and White children that was evident at enrollment was eliminated. The percentage of children who reported that the emergency room was the usual source for care dropped from 4.5 percent at the time of enrollment to less than one percent by 6 months. The percentage of Hispanic children who relied on the emergency room dropped from 11 percent to less than 2 percent, eliminating the difference between Hispanic children and White children that was evident at enrollment. The distribution of children across other types of providers did not change overall or within racial/ethnic groups.

- **Unmet need for care:** At the time of enrollment, over 15 percent of families reported having been unable to get needed care for their children. After 6 months in HUSKY A, the rate dropped to just 4 percent and remained at this significantly lower rate. There were no significant differences between racial/ethnic groups at baseline or 12 months later. Over the course of the year, unmet need for care was reduced for individual Black, Hispanic and White children. Unmet need for dental care, reported for about one in five children, did not decline over the course of the year.

- **Health care utilization:** The percentage of children with a check-up in the past 6 months increased from 50 percent to over 63 percent in the first 6 months after enrollment, then dropped to 41 percent at one year. Disparities in preventive care between Black and White children and between Hispanic and White children were eliminated. The percentage of children who had had any recent visits for care declined over the course of the year, from 92 percent to 88 percent. Dental care utilization increased steadily throughout the year from 36 percent to 53 percent of children reporting a recent visit by 12 months. Access to dental care increased for Black and Hispanic children.

Utilization Increased:
Children with Preventive Care



- **Trust and respect:** More than 90 percent of families with newly enrolled children reported trust in health plans and providers, a level of confidence that did not change over the course of the year. However, at the time of enrollment, families of Black children were less likely than families of White children to report trust in health plans and trust in providers, differences that were eliminated after one year in the program. Close to 95 percent of families reported that they were usually or always treated with respect by providers and office staff; this rate did not change over the course of the year. Overall, few families reported experiencing different treatment than other families. However, after one year in HUSKY A, the percentage of White families who reported differential treatment increased to a rate (11.5%) that was significantly higher than rates for families of Black children (4.9%) and Hispanic children (1.5%).

Effect of One Year of HUSKY A Coverage on Health and Health Care Disparities

- Differences between Black and White children in terms of having a usual source for routine care, having a primary care provider, having had a check-up in the past six months, and trusting health plans and providers were eliminated.
- Differences between Hispanic and White children in terms of health status, reliance on emergency room for care, and having had a check-up in the past six months were eliminated.

Conclusion

These findings show that while coverage in the HUSKY program did not have an effect on health status, children who were newly enrolled in the program experienced increased access to primary care, reduced unmet need for care, increased utilization of preventive care, including dental care, and decreased reliance on the emergency room for routine care. By most measures, the positive impact of HUSKY A coverage was apparent within the first 6 months in the program. Health and health care disparities associated with race/ethnicity that were evident at enrollment among children who were followed for one year was eliminated.

Recommendations

Strategies to improve access to care and reduce disparities should be targeted to reach families whose children are most at risk for not obtaining care, especially those who have not received care in the first 6 months after enrolling.

Over the course of the year, there was no change in the percentage of children who were reportedly in fair/poor health (5.8%).

[1]Children's Health Council. Health and Health Care Disparities Associated with Race/Ethnicity: A persistent problem in HUSKY A. Hartford, CT: Children's Health Council, September 2003.

[2]**Methods:** All White, African American, and Hispanic children aged 3 to 10 who were newly enrolled in HUSKY A between January and April 2002, and who lived in households with telephones were identified for the survey and sent advance letters. Families of 893 newly enrolled children (276 Black children, 318 Hispanic children, 299 White children) were interviewed in English or Spanish about their children's health and health care in the six months prior to enrollment. For comparison, families of 301 children who had been enrolled at least 6 months were asked about their children's health and health care in recent months. Responses were grouped by child's race/ethnicity. At 6 months and again at 12 months after enrollment, families were sent reminder postcards and over 5 attempts were made to reach each family. In the group followed for 1 year, there were 500 children, including 155 Black children (56% of those interviewed at baseline), 145 Hispanic children (46%), and 200 White children (67%). Differences in four indicators of access to care and utilization (usual source of care, unmet need for care, time since last check-up, any visit for dental care) and three indicators of experience with the health care system (trust in the health plan, trust in providers, treated differently than others) were compared for change over time (between-group differences), by race/ethnic group at baseline and at 12 months to identify disparities (between-group differences), and by child within racial/ethnic groups to assess change over time (within-subject differences). This survey was begun by the Children's Health Council and completed by Connecticut Voices for Children. A detailed report describing the methods and results is available from Connecticut Voices for Children.

[3]**The Connecticut Health Foundation** is the state's largest independent, non-profit grant-making foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. Since it was established in 1999, the Foundation has focused its resources on improving access to children's mental health services, reducing racial and ethnic health disparities, and expanding access to and utilization of oral health services.

[4]The first brief, "Health and Health Disparities in HUSKY A: How Do the Health Needs of Newly Enrolled Children Differ?" is available at www.ctkidslink.org.

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