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## 1 | PIONEERS FOR COVERAGE: LOCAL SOLUTIONS FOR INSURING ALL CHILDREN IN CALIFORNIA

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### Introduction

A decade has passed since the last serious debate on reforming the nation's health care system. Continued growth in health care costs, a sputtering economy and increasing instability in health insurance coverage for a majority of working families and individuals have again prompted calls for action in 2004. Unlike the situation in 1994, however, the faces of the uninsured now transcend income strata, geography, race and ethnicity. Access to affordable health coverage has squarely hit home for all Americans.

In 2004, most states struggled to remain solvent and were often faced with the challenge of maintaining rather than expanding health coverage to vulnerable populations. Like most other states, California experienced three consecutive years of budget shortfalls and is struggling to keep its Medicaid and State Children's Health Insurance Program (SCHIP) programs affordable and accessible despite difficult budgetary times, greater demands for coverage, and increasing cost of services. Without increased revenues the State will need to make difficult decisions around benefits and eligibility to balance the budget in future years.

Like the rest of the nation, California also faces sizable challenges in stabilizing its private insurance markets and containing health care costs. As insurance premiums continue to increase, many employers have reduced their benefit packages or eliminated health insurance for workers and their dependents. A recent study by the Center for Studying Health System Change found that declines in employer-provided health coverage were pronounced for children younger than age 18 who had coverage through a parent's employer—dropping by nearly four percentage points to 59.5% in 2003 from 63.4% in 2001.<sup>1</sup> Data from 2003 indicate that California mirrors national trends in the declining affordability and availability of employer-based dependent coverage.<sup>2</sup>

Employer-based coverage, however, remains the predominant form of coverage for California's children, with 55% of children receiving coverage through a parent's employer.<sup>3</sup> This percentage has been below the national average for a number of years, and relates to both the

higher percentage of uninsured children and the higher percentage of children enrolled in public coverage.

The good news is that the rate of uninsurance among California's children, which peaked in 1998 at 21%, has declined to approximately 12% largely as a result of public coverage expansions.<sup>4</sup> These expansions in Medi-Cal and Healthy Families (California's implementation of SCHIP) have evolved over the years and cover as many as four million children at any one point in time.<sup>5</sup> In spite of these gains, many of California's children – an estimated one million or 12% of children 0-18 years of age – remained uninsured in 2001.<sup>6</sup> Approximately two-thirds (670,000) of these children are eligible for Medi-Cal and Healthy Families and one-third (350,000) are ineligible due to their immigration status or because their families' income is too high to qualify for existing programs.<sup>7</sup> Many of the uninsured children are in mixed status families that include both citizen and immigrant members.<sup>8</sup>

According to 2002 Current Population Survey data, California is ranked first in the nation with the largest immigrant population at 28% of the total foreign-born population.<sup>9</sup> California is also home to over 2.4 million, or 26%, of the total 9.3 million undocumented immigrants in the United States.<sup>10</sup> One in two California children lives in a family where either the child or at least one parent is an immigrant.<sup>11</sup> Immigrant children are three times more likely to lack health insurance coverage than U.S. born children. This lower coverage rate is due both to reduced access to employer-based insurance for these children (less than 45% of children in immigrant families have access to employer-based insurance) and the absence for many children of qualifying documentation status for existing public programs.<sup>12</sup> Parental misunderstanding about eligibility requirements and the possible immigration consequences of seeking insurance for children also contribute to keeping eligible children uninsured.<sup>13</sup>

Until policymakers and the public prioritize and commit resources to providing affordable health coverage to all children, many children will continue to fall into the uninsured or underinsured gap. At the same time, the health care system will expend far more resources addressing the consequences of children's lack of insurance than the actual cost of providing health coverage for this 12% of all California's children. Real costs borne as a result of lack of insurance for children include costs for inappropriate treatment, lost parental work days, lost days in school, and numerous behavioral and developmental interventions over the course of a child's first eighteen years.<sup>14</sup>

### **Local Innovation and Momentum: Children's Health Initiatives Take Flight**

For more than 20 years, California counties have assumed the primary responsibility for providing health care to the uninsured and underinsured. With the number of uninsured children hovering at or above one

million, local coalitions have stepped up to the challenge by creating a nationally recognized model for expanding health coverage and creating systems change for children and families called the Children's Health Initiative (CHI). Although the state's fiscal situation has directly affected local budgets, since 2000 localities have advanced innovative coverage solutions through their CHIs. Santa Clara County launched the first of these in January 2001 with core financial support from the County of Santa Clara and the City of San Jose, the local First 5 Commission, the local Medi-Cal managed care plan, and private foundations. Two community-based organizations, one labor-affiliated and one faith-based, played an essential organizing role in securing the funding and policy resolve to launch the program.<sup>15</sup>

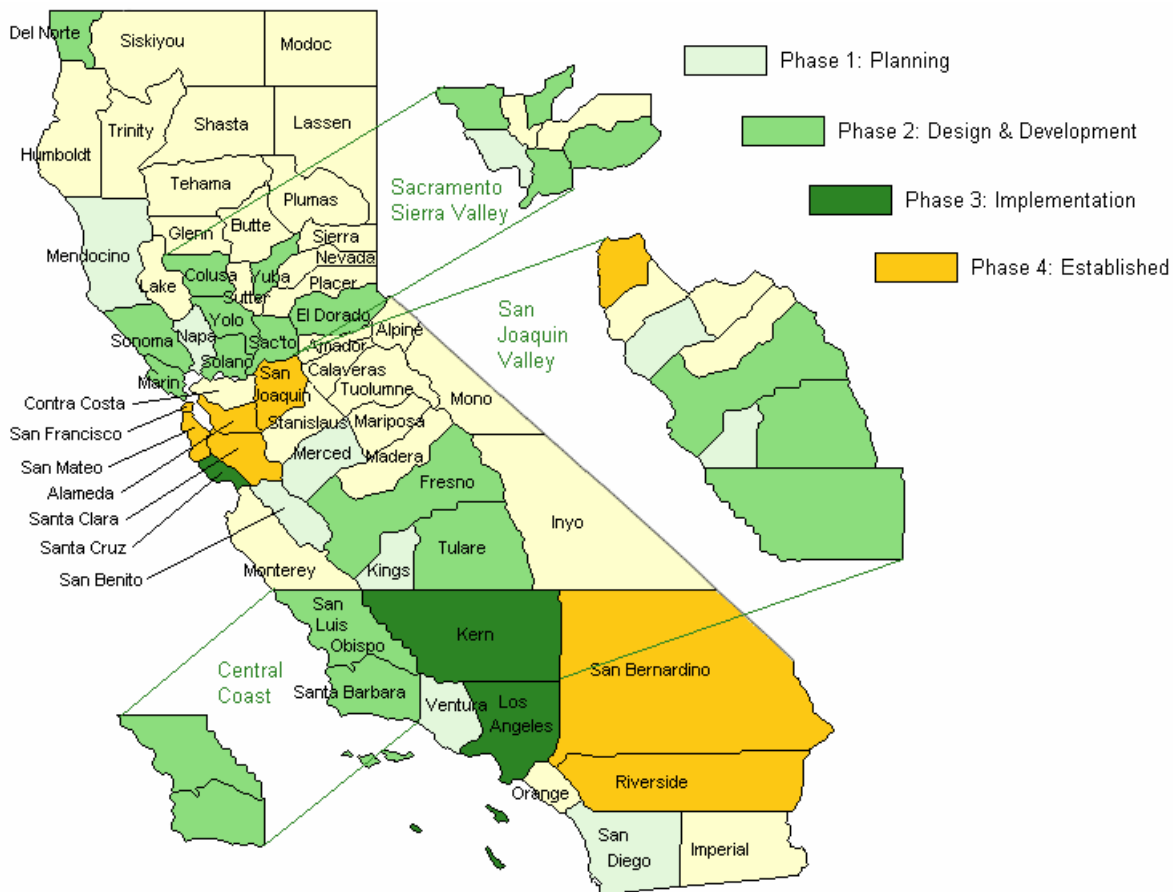
To some degree the structure, financing, and political dynamics have varied in each county with a CHI, but the vision, target population, and expansion products have been fairly similar in scope. The programs seek to reach all children living in families with incomes up to 300% of the federal poverty level (FPL), who do not qualify for existing public coverage.<sup>16</sup> Through peer-to-peer support and external technical assistance, the CHI model has been pioneered in a total of nine counties and is under development in at least twenty others.<sup>17</sup> While their circumstances and approaches differ, most CHIs share a bold vision of **health coverage for all children** and three key supporting strategies. These strategies include:

Cultivating New Public-Private Partnerships for Children's Coverage. Many CHIs have evolved as a shared responsibility across the public and private sectors, including various branches of local government, public and commercial health plans, hospitals, physicians, community clinics, educators, business, labor unions, faith-based organizations and philanthropy.

Creating a Single "One Open Door" Outreach and Enrollment Pathway. The CHI model has helped to facilitate the organizational transformation of several county social and human services agencies. Where once they focused primarily on enrolling families in Medi-Cal, in most counties with CHIs these public agencies now provide a single point of enrollment for multiple programs and benefits and strive to better meet the needs of the typical CHI "consumer"—families with children. As a result, agencies are implementing a single pathway, often called "One Open Door," for enrolling and retaining children in health care coverage. County staff and community-based assisters have been cross-trained to enroll families in *all* available public programs. In some counties, the One Open Door approach has been enhanced by a universal web-based application called One-e-App.<sup>18</sup> The One-e-App streamlines an entire family's enrollment into multiple programs by electronically routing client information to multiple agencies through a single point of entry, making it much easier for families to apply for and receive confirmation of their children's enrollment across multiple public programs.

Creating a New and Comprehensive Healthy Kids Insurance Program. Generally the CHIs offer health coverage to children in families up to 300% FPL, filling the numerous age, income and eligibility gaps across all children’s health insurance programs. The local CHIs have created a new coverage expansion called Healthy Kids, which typically mirrors the Healthy Families program. Healthy Kids provides a comprehensive scope of benefits (see Appendix F), and affordable premiums and cost-sharing for families (an average of \$4-\$6 per child per month) who are not eligible for Medi-Cal or Healthy Families and whose incomes are below 300% FPL. Each of the nine operational CHIs partners with their local public plan (or local initiative) or county organized health system to administer their Healthy Kids product, which serves as the designated health plan for Healthy Kids members.

**Figure 1.1**  
**Status of Children’s Health Initiatives in California**  
**October 2004**



## **First Generation CHI Results**

The first generation CHI pioneers have been tremendously successful in articulating a bold vision and leveraging multiple financing sources to support this vision. While some have had more success than others in securing financing and facilitating systems change, as a group these CHI pioneers have set a standard that other localities are now seeking to understand and emulate. In a relatively short period of time they have significantly increased the number of insured children in their areas and helped maximize health-related revenues to the counties.

To date, the nine operating Children's Health Initiatives have cumulatively enrolled more than 50,000 children in their Healthy Kids programs and covered tens of thousands more under Medi-Cal and Healthy Families.<sup>19</sup> Researchers from Mathematica Policy Research found that in Santa Clara County the increase in Medi-Cal and Healthy Families enrollments was 28% higher over the initial two year period (2001-2002) than if the CHI had been absent.<sup>20</sup> This increase in enrollments brought an additional \$24.4 million in state and federal revenues into the county during the program's first two years of operation. In addition, three CHIs—Santa Clara, Alameda and San Francisco—were also important pioneers in the passage of AB495 in 2001. This legislation expands the state's SCHIP program by allowing counties to utilize their own local funds to draw down federal SCHIP funding for children in families between 250 and 300% of the federal poverty level.<sup>21</sup>

Although local budgets remain severely constrained, the momentum created by the first generation CHIs has been sustained through the commitment and investments of local First 5 Commissions, several large philanthropies, and First 5 California.<sup>22</sup> Inspired by these pioneers, a second generation of innovators are currently working to develop CHIs across California, including regional collaborations in the Sacramento Sierra Valley region, the San Joaquin Valley region and along the Central Coast.

## **The Second Generation of CHI Innovators**

Currently there are a number of counties and regions in the planning or early implementation stages of Children's Health Initiatives (for a complete explanation of the four stages of CHI development, see Chapter 3). This second generation will develop new approaches to coverage that reflect their environmental realities while navigating the challenges identified by the first generation of innovators. While there is an established base of learning that they can draw from, the second generation CHIs will in many ways craft new approaches that will bring their own set of implementation challenges. Several CHIs are in the early stages of creating new CHI variations, including partnering with a licensed commercial health plan, stimulating expansion of an existing public plan into a neighboring county, and creating multi-county CHI coalitions.

Commercial plan participation. The Healthy Kids Kern program located in the San Joaquin Valley is the first CHI to launch its Healthy Kids program in partnership with a licensed commercial health plan, Health Net of California. At least three other counties—Tulare, Sacramento and Fresno—are likely to develop variations of this approach in the coming twelve to eighteen months. This model is an important variant since 38 California counties do not currently have access to coverage through a local initiative or county organized health system. Unless the State’s Medi-Cal redesign process expands Medicaid managed care to some of these counties, expanding CHIs to include commercial health plans is a viable alternative for smaller rural counties seeking to provide coverage to uninsured children in their areas.

Public plan expansions. Two counties along the Central Coast are coordinating their planning and pre-implementation activities with a single public health plan, the Santa Barbara Regional Health Authority (SBRHA). As a result of CHI planning in San Luis Obispo, where SBRHA will administer the Healthy Kids product, conversations began in earnest with the SBRHA to also administer a Healthy Kids program in Santa Barbara County. Similar coordination may also occur in several counties in the North Bay region.

Multi-county purchasing and collaboration. Two counties in the San Joaquin Valley are coordinating in the planning and implementation of One-e-App, and five counties in the Sacramento Sierra Valley region are examining the feasibility of a regional Healthy Kids insurance product. A regional CHI model has the added benefits of insuring portability of coverage for families across county boundaries, increasing local coalitions’ purchasing power and creating administrative economies of scale. Joint planning and action also allows individual counties to share expertise and build a broader base of political and public support. Regionalization of CHIs in some areas may also facilitate small and rural county participation in expanding children’s coverage statewide, as smaller rural counties generally lack the infrastructure and provider capacity to fully implement a Children’s Health Initiative.

### **Establishing a Vision and Principles for Health Coverage for All Children in California**

The time has come to learn from earlier attempts at reform and subsequent incremental expansions and develop policy solutions that are as bold in their approach as they are practical in their effect. As outlined by the Institute of Medicine’s Committee on the Consequences of Uninsurance, an important reform objective is to provide financial access to appropriate and effective health services – and financial access is best achieved when all Americans, and certainly all children, have affordable health insurance.<sup>23</sup>

A working vision, put forth for consideration by the Institute for Health Policy Solutions and adapted from the American Academy of Pediat-

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rics, the Institute of Medicine,<sup>24</sup> and a number of local stakeholder groups, states that:

**“All children in California will have comprehensive health coverage and access to a medical home that enhances their health, well-being, and readiness to learn.”**

Six core principles underlie this vision:

- (1) All children should have comprehensive health care coverage, regardless of income or immigration status.
- (2) Health care coverage should be affordable and sustainable for all children and families.
- (3) Health care coverage should be stable and continuous for all children and families.
- (4) All children should have a medical home.<sup>25</sup>
- (5) Health care coverage affects children’s health and well-being and promotes access to high-quality care that is effective, efficient, safe, timely, family-centered, equitable and culturally and linguistically appropriate.
- (6) Improving children’s health through access to affordable health insurance will have positive long-term impacts on children’s readiness to learn and participation in learning environments.

These principles are grounded in a significant body of research documenting the costs and consequences of not providing health care coverage to children.<sup>26</sup> Health care coverage has been shown to greatly facilitate children’s access to care for acute and chronic illness, and essential primary and preventive care.<sup>27</sup> Furthermore, there is strong evidence that when children develop long-term relationships with a health care provider as a result of being insured, they will receive more accurate diagnoses, require fewer hospitalizations, and incur lower health care costs.<sup>28</sup>

Improved access to timely and appropriate health care can improve children’s health status over time, which has important implications for their development and well-being as well as their families’ economic well-being. Ensuring the affordability and accessibility of insurance coverage reduces stress on parents and improves families’ quality of life by reducing the financial risks uninsured families face.<sup>29</sup> By improving children’s health and reducing families’ stress, a 2003 evaluation of California’s SCHIP program found that coverage had an important bearing on improving children’s school performance and readiness to learn.<sup>30</sup> It’s clear that providing health coverage to all children makes good sense on numerous levels – covering all children is good for our society, good for our economy, and it will help to ease the strain on our health care system by ensuring that parents seek and receive appropriate and timely care for their children.<sup>31</sup> Getting children insured also sets an important expectation for parents that their children will have access to health care throughout childhood and adolescence, and this has crucial implications for children’s capacity to reach their full potential and thrive as adults.

## **How to Use this Guidebook**

This guidebook is designed to assist local and regional coalitions in designing and implementing CHIs to provide health coverage to low-income children in their communities. As such, this resource focuses on practical issues associated with CHI planning and implementation. A secondary, but equally important goal is to inform policymakers, administrators, and state and local leaders of the successful approaches in expanding coverage to children through local innovation. In addition, health plans, providers, and administrative vendors that want to participate in local and regional CHIs may also find the guidebook's practical information helpful for their planning efforts.

The authors have drawn on the collective expertise offered by existing Children's Health Initiatives and the experience of providing technical assistance to a number of the operating and emerging programs. Although these experiences have informed the content, we readily acknowledge that there is no single right way to accomplish all of the design and implementation tasks associated with creating a CHI. Thus, although the necessary steps are discussed, readers should not conclude that a particular approach is required or that other approaches will not work. Each CHI must be tailored to local circumstances and conditions.

**In addition, the information contained herein offers approaches that have been and will continue to be created in highly dynamic environments.** This has made the task of synthesizing and updating CHI developments an ongoing and challenging endeavor. Our goal in developing the guidebook has been to lay out the major design options and decisions that architects of a CHI will need to consider. The guidebook is intended to provide sufficient information about the various options available to facilitate informed decision-making at each step of the process. As they continue to expand and refine their programs, updates on leading examples, lessons learned and in-depth profiles from CHIs will be available through the IHPS California Web Resource Center ([www.ihps-ca.org](http://www.ihps-ca.org)).

## **Contents Overview**

The relative ease with which a Children's Health Initiative can be started and operated depends on factors that vary by county and by region. Key enabling factors that have been present in the environments of operating CHIs are introduced and discussed in Chapter 2. Chapter 3 includes a general discussion of the CHI's evolution and presents a four stage conceptual framework along with a brief description of key activities in each stage. This chapter also provides options for creating an effective governance structure and securing the appropriate staffing and technical assistance resources.

Chapters 4 through 9 focus on core functional areas of the CHIs, including financing, program design, budgeting, outreach/enrollment/retention, plan and administrative vendor selection, and program evaluation. Chapter 10 provides a glimpse ahead at the policy and sustainability options in creating a seamless system of coverage for all children in California.

Finally, this guidebook includes a number of tools and resources for CHIs to utilize in the creation of their own expansions. Most of these resources have been “road tested” by and adapted from operational programs. Through their commitment and creativity, the CHI pioneers will continue to inspire new approaches that could prove informative to other local, state and federal programs seeking to provide health coverage for all children.

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1. Strunk BC and Reschovsky JD. *Trends in U.S. Health Insurance Coverage, 2001 – 2003*. Tracking Report No. 9. Washington, DC: Center for Studying Health System Change, August 2004.
  2. Kaiser/HRET. *California Employer Health Benefits Survey, 2003*. Menlo Park, CA: The Henry J. Kaiser Family Foundation, March 2004.
  3. RAND analysis of the 2003 Current Population Survey.
  4. Schauffler HH and Brown ER. *The State of Health Insurance in California, 1999*. Berkeley, CA: Regents of the University of California, 2000; and Brown ER, Ponce N, Rice T, and Lavarreda SA. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, June 2002.
  5. Managed Risk Medical Insurance Board. Medi-Cal Administrative Data.
  6. Brown ER, Ponce N and Rice T. *The State of Health Insurance in California: Recent Trends, Future Prospects*. Los Angeles, CA: UCLA Center for Health Policy Research, March 2001; and see note 4, Brown et al.
  7. Analysis conducted by the UCLA Center for Health Policy Research.
  8. Fix M, Zimmerman W, and Passell J. *The Integration of Immigrant Families in the United States*. Washington, DC: Urban Institute, 2001.
  9. Capps R, Fix ME, and Passell J. *The Dispersion of Immigrants in the 1990's*. Immigrant Families and Workers: Facts and Perspectives, Brief No. 2. Washington, DC: Urban Institute, 2002.
  10. Passell J, Capps R, and Fix ME. *Undocumented Immigrants: Facts and Figures*. Washington, DC: Urban Institute, 2004.
  11. See note 4, Brown et al.
  12. See note 4, Brown et al.
  13. Lessard G and Ku L. Gaps in Coverage for Children in Immigrant Families. *The Future of Children* (Spring 2003) 13(1).
  14. Institute of Medicine. *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academies Press, 2003.
  15. Working Partnerships USA. *The Children's Health Initiative Handbook*. San Jose, CA: WPUSA, July 2003.
  16. With one exception, the Children's Health Initiative in San Mateo County expanded eligibility criteria up to 400% FPL due to the high cost of living in the county.

17. See the Institute for Health Policy Solutions California website at <http://www.ihps-ca.org> for up-to-date enrollment numbers.
18. To date, the four counties that have implemented One-c-App are San Mateo, Santa Cruz, Alameda and Santa Clara.
19. San Bernardino has implemented a Healthy Kids insurance product, but does not currently meet the other criteria for a CHI.
20. Trenholm C. *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative*. Trends in Insurance Coverage Issue Brief Number 3. Washington, DC: Mathematica Policy Research, Inc., June 2004.
21. See the Managed Risk Medical Insurance Board website at <http://www.mrmib.ca.gov> for more information on the evolution and implementation of AB495.
22. Local First 5 Commissions were created through the passage of Proposition 10 in 1998. Proposition 10 dedicated revenues from taxes on cigarettes and other tobacco products to support early childhood development for children up to age five. There are 58 local commissions that receive 80 percent of the dedicated revenues, with the other 20 percent being allocated to the State Commission or First 5 California. For more information about Proposition 10 and the First 5 Commissions go to <http://www.cfc.ca.gov/>.
23. Institute of Medicine. *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academies Press, January 2004.
24. See note 23, Institute of Medicine.
25. The American Academy of Pediatrics (AAP) released its policy statement and an operational definition of a medical home in July 2002. The AAP's definition of a medical home is that "medical care of infants, children and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. Physicians should seek to improve the effectiveness and efficiency of health care for all children and strive to attain a medical home for every child in their community."
26. See journal issue on health insurance for children, *The Future of Children* (Spring 2003) 13(1).
27. Eisert S and Gabow P. Effect of Child Health Insurance Plan Enrollment on the Utilization of Health Care Services by Children Using a Public Safety Net System. *Pediatrics* (2002) 11(5):940-45; Newacheck PW, Stoddard JJ, Hughes DC, and Pearl M. Health Insurance and Access to Primary Care for Children. *New England Journal of Medicine* (1998) 338(8):513-519; and Institute for Medicine. *America's Children: Health Insurance and Access to Care*. Washington, DC: National Academies Press, January 1998.
28. Starfield B. *Primary Care: Balancing health needs, services and technology*. New York: Oxford University Press, 1998, p. 438.
29. Available online at [www.mrmib.gov/MRMIB/HFP/PedsQLYr2CHHS.pdf](http://www.mrmib.gov/MRMIB/HFP/PedsQLYr2CHHS.pdf).
30. See note 29.
31. The California Endowment. *Health Insurance Coverage for All Children: A Goal Within Reach*. Health...In Brief, Volume 3, Issue 2. Woodland Hills, CA: The California Endowment, June 2004.