5 | PROGRAM DESIGN

Core Coverage Objectives

To achieve the overall goal of affordable health insurance for all children, a local CHI focuses its financial and leadership capital in two main areas: 1) coordinated outreach and enrollment into Medi-Cal, Healthy Families and Healthy Kids programs; and 2) the development of a comprehensive health coverage program for children under 300% FPL who are ineligible for Medi-Cal and Healthy Families. This approach to insuring all low to moderate income children is built upon the following core coverage objectives:

Coverage objective 1

Coordinate outreach and enrollment structures and processes for subsidized insurance programs into a seamless system. This is also known as the "One Open Door" approach to outreach, enrollment and retention that is addressed in Chapter 7. Such coordination improves the ease with which families can navigate complex insurance programs and enroll all of their eligible children into comprehensive coverage. Central administrative coordination also allows counties to maximize enrollment in state and federally funded programs, bringing valuable resources into the county. With the development of a Healthy Kids product (discussed below), families will have coverage options for all of their children, regardless of immigration status.

Coverage objective 2

Develop a comprehensive Healthy Kids product for all children ineligible for Medi-Cal and Healthy Families. Counties with established CHIs have designed and developed comprehensive insurance products called Healthy Kids. This approach stands in contrast to the more typical fragmented approaches of providing episodic non-emergent care to children in emergency departments or in providing a more limited scope of services. Figure 5.1 below illustrates the continuum of alternatives for providing health services to the uninsured.

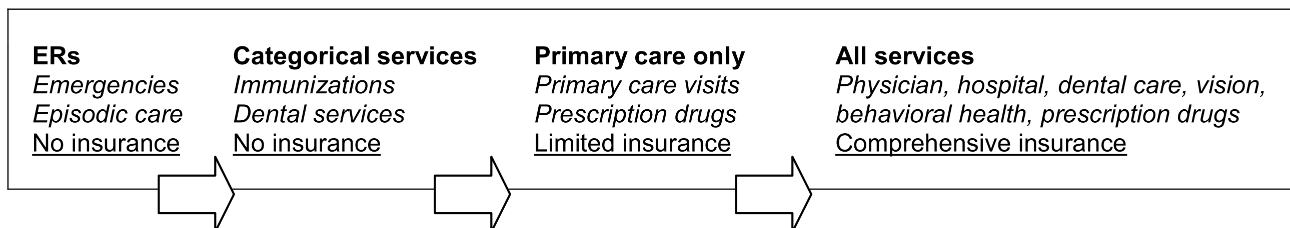
There is strong evidence supporting comprehensive coverage for children. Most notably, a comprehensive coverage product allows for a medical home where children's care can be continuous and well coordinated. Some counties have decided to cover uninsured children by funding community clinics to provide primary care or by purchasing a lim-

ited scope benefit package from the California Kids Program.[1] While these are worthy options, current funding support for Children's Health Initiatives focus on the development of comprehensive children's coverage programs.

Coverage objective 3

The Healthy Kids product should mirror the Healthy Families program. In each of the nine operational CHIs, the Healthy Kids product is designed to mirror the Healthy Families program. This standardization has a number of important justifications. First, the Healthy Families-equivalent coverage provides comprehensive benefits, including professional services, preventive care, hospital services, prescription drugs and dental services (a more comprehensive list is shown in Appendix F). For many families, this would allow children access to the same set of services and providers even though they may receive coverage through different programs (for example, one child may be enrolled through Healthy Families or Medi-Cal and the other through Healthy Kids). The approach also has practical benefits since it allows Healthy Kids programs to build on the state's existing coordination with the California Children's Services program and leverages established Healthy Families and Medi-Cal provider networks.[2]

Figure 5.1
Continuum of Coverage Alternatives



Second, a standardized Healthy Kids product allows for easier program replication across counties and will be crucial to statewide policy development and adoption. As multiple counties address a CHI regionally, including the Sierra Sacramento Valley and Central Coast regions, a standardized program will be an imperative. With a common program across counties, statewide financing and adoption of expanded children's coverage will be politically and administratively more viable.

Lastly, a standardized Healthy Kids product modeled after Healthy Families will be easier for health plans and providers to administer, thereby encouraging their participation. Healthy Kids plans will likely contract with the same plans and providers currently serving Healthy

Families enrollees in the county. In addition, families with children in Medi-Cal, Healthy Families and Healthy Kids will be able to enroll their children in the same health plan and the same provider network.

Coverage objective 4

Create and maintain standardized and comprehensive coverage, even if expansion to population groups needs to be staged over time. CHI leaders will grapple with the philosophical and operational issues about how to best move forward with limited resources. Some funding realities may force CHIs to limit program eligibility to specific subpopulations such as children 0-5 or to offer the Healthy Kids product to a limited number of eligibles and maintain a waiting list. Several CHIs grappling with funding limitations have decided to focus at least initially on children 0-5 years of age because of their vulnerability to preventable health problems and the greater likelihood of available local First 5 funds to support their coverage. See the text box about the Los Angeles CHI experience.

Los Angeles County Healthy Kids

In early 2003, First 5 LA initiated the Children's Health Initiative with a grant of some $100 million over five years to provide coverage to all children 0-5 under 300% FPL. The goal was to launch a comprehensive Healthy Kids product on July 1, 2003. With the short timeline, it was not possible for the coalition to raise the necessary funding to cover the 6-18 population as well. Rather than wait until all funding could be raised, the Healthy Kids product was launched on July 1, 2003 for the children 0-5e and a specific subcommittee was established to raise the funds necessary to cover the 6-18 old population. Enrollment opened to the 6-18 population in May 2004.

If a Healthy Kids comprehensive coverage product cannot be provided to all children due to funding limitations, CHI leaders can consider various staging alternatives, including:

- *Comprehensive coverage for children 0-5 only:* Rather than delay the launch of a Healthy Kids product due to insufficient funds for all children, a program can launch if sufficient funds exist for the 0-5 population. CHI leaders will determine how best to use other funds from among the options below.
- *Comprehensive coverage for siblings of children 0-5 enrolled in Healthy Kids:* This option focuses on the family unit to ensure that all children in a family have comprehensive coverage. Siblings of children 0-5 would be identified during outreach and enrollment and simultaneously enrolled.
- *Comprehensive coverage for children turning 6 years old:* Limited funds could also be used to continue comprehensive coverage for children "aging out" or turning six, when the First 5 funding would no longer pay for their coverage. This option puts emphasis on the continuity of coverage over time and avoids the difficulties of removing a child from coverage.

Healthy Kids Program Design and Policy Decisions

Once the broad coverage principles have been addressed, the coalition will need to make a series of design and policy decisions before launching a Healthy Kids program. These program design decisions include eligibility criteria, hardship fund criteria, family premiums and cost-sharing. While the covered benefits under Healthy Kids are fairly consistent across the operational CHIs, program policies in these areas do differ. Below is a discussion of the main design considerations.

Eligibility

These Healthy Kids programs cover children and youth ages 0-18 in families with incomes up to 300% of the FPL who are ineligible for Medi-Cal and Healthy Families. There are two exceptions: San Mateo County has an upper family income threshold of 400% FPL and Riverside County's Healthy Kids program has a 250% FPL threshold. CHI leaders in San Mateo determined that the high cost of living in the county warranted a higher income threshold for their Healthy Kids program. In each county, children are eligible for Healthy Kids programs regardless of immigration status. In addition to income eligibility requirements, families must also show proof of county residency by providing documents such as utility bills, rental agreements, pay stubs, etc.

Family premiums and other cost-sharing

Families can make financial contributions to the Healthy Kids product in two ways, by paying a share of the monthly premium and through co-payments when their child or children receive services. CHI leaders may consider establishing cost-sharing levels based on a family's gross monthly income as in other public insurance programs. The Medi-Cal program, for example, does not collect premiums as these families are below 150% FPL. In the Healthy Families program where family incomes are higher, premiums range from $4-$9 per child per month, with a maximum of $27 per family. Riverside and San Bernardino counties do not have a family premium but rather a one-time enrollment processing fee of $5 to $20 depending on the network selected. Table 5.2 below compares family premium contributions and co-payments in selected CHI counties.

Payment plans can also be structured to facilitate family participation. For example, premiums in most counties are paid quarterly rather than monthly. Discounts for pre-payment of a year's premium costs also encourages families' participation and ensures 12 months of continuous coverage. The Santa Clara, San Mateo and San Francisco CHIs have policies in place that provide three months of free coverage if the family pays the entire 12 months of coverage upon enrollment.

Annual eligibility renewal

Another significant program policy involves the stated enrollment period and the process for eligibility redetermination at the end of the cur-

Table 5.2
Family Premium Contributions and Co-Payments

	Santa Clara	Riverside	San Mateo	San Francisco
Family premium per child	$4 – 6 Maximum $12 – 18 per month per family	No premiums but an "enrollment processing fee" of $5 or $20 depending on plan selected.	$4 <150% FPL $6 151-250% FPL $12 250-300% FPL $20 300-400% FPL No maximum	$4 Maximum $12 per month per family
Co-payments	$5 for some services including office visits and prescription drugs	$5 co-payments for most services; $10 for dental visits	$5 for office visits and prescription drugs; preventive visits are free.	$5 for some services including office visits
Payment schedule	Monthly	One time	Quarterly	Quarterly
Payment incentives	If first 9 months paid in advance, remaining three months are free.	Processing fee paid at time of enrollment	If first 9 months paid in advance, remaining three months are free	If first 9 months paid in advance, remaining three months are free

rent enrollment period. All Healthy Kids programs except Los Angeles currently offer coverage for a full twelve months, with renewal processing occurring on an annual basis. In Los Angeles, eligibility renewal is assessed in six-month intervals.

Twelve months of continuous coverage and successfully renewing coverage at the annual eligibility renewal period is known as "retention." Recent reports have demonstrated that children lose their public insurance coverage for a number of avoidable reasons.[3] CHIs can structure administrative processes to facilitate children's retention in the Healthy Kids programs. For example, databases can be designed to send reminders to families well in advance of their renewal deadline and list the steps necessary to reapply. Families that do not respond can be contacted by phone as well. Renewal applications can also be pre-completed with information already known about the family such as income level, address and number of children.

Hardship funds

Santa Clara, San Mateo, San Francisco and Santa Cruz counties have hardship funds that will pay a family's share of Healthy Kids premiums in the event of a demonstrated financial hardship. In Santa Clara County, hardship fund applications are automatically sent out to families with income under 150% FPL. Families can also apply for hardship funds either through the official application or through a letter. The Santa Clara Family Health Plan will call families if they miss a monthly premium payment to inform them of the hardship fund. After a second missed premium and a termination notice, more calls are made notifying the family of the hardship fund. In each case, families self-declare their income and existence of a hardship and their premiums are then subsidized for duration of enrollment period. To date, there are between

700 and 800 families in the Santa Clara County receiving hardship assistance. An example of a hardship fund policy and procedures is included in Appendix G.

Although the Tulare County CHI is still in the planning stages, one of their first accomplishments was to establish a similar hardship fund to support children currently enrolled in Healthy Families. Eligible children are identified by Certified Application Assistors and eligibility specialists and a completed hardship application is forwarded to United Way Tulare County for processing and payment to the Managed Risk Medical Insurance Board. Families self-declare income or document their hardship circumstances and premiums are then subsidized for the duration of the enrollment period. Once the Healthy Kids product is launched in Tulare County, the hardship fund will be available to these enrollees as well.

Enrollment caps and waiting lists

First 5 Commissions have generally provided funding to cover the cost of Healthy Kids premiums for eligible children 0-5. For the greater number of Healthy Kids eligible children 6-18, local CHI coalitions are struggling to raise enough local funding to cover all eligible children in the county. The difficulties faced in securing funding for older children has resulted in four of the operational CHIs to implement policies that cap enrollment for eligible children ages 6-18 in their Healthy Kids programs. Likewise, a number of the newly emerging CHIs are uncertain as to whether or not they will be able to secure adequate funding to launch their Healthy Kids programs for all eligible children 0-18.

The two strategies that CHIs have implemented to manage enrollment in their Healthy Kids programs have been enrollment caps and enrollment freezes. Enrollment caps maintain a certain level of enrollment

Table 5.3
County Healthy Kids Enrollment Caps and Waiting Lists
(as of October 2004)

County	Cap 0-5	Cap 6-18	Wait List for 6-18
Alameda	No new enrollment	No new enrollment	No
Santa Clara	No cap	10,000	Yes
San Francisco	No cap	No cap	No
Riverside	2,000	4,485	Yes
San Mateo	No cap	4,800	No
Los Angeles	15,000	No cap	No
San Bernardino	1,700	1,065	Yes
San Joaquin	750	1,000	Yes
Santa Cruz	804	725	No

and as children leave the program, new children are enrolled. All CHIs with enrollment caps in place have created waiting lists (see Appendix H for an example of waitlist policies and procedures). Enrollment freezes stop enrollment after a certain date. As children leave the program, new children are not enrolled until a target enrollment level is reached and enrollment is reopened.[4]

As of May 2004, four counties have capped enrollment in their Healthy Kids program. The high demand for these programs exceeds the amount of funds currently available, leaving counties with the difficult task of determining how to allocate limited resources. In general, the four CHIs have enrollment caps in place only for Healthy Kids eligible children 6-18. In almost all of the counties, funding for all children 0-5 has been available through the First 5 Commissions. Under these circumstances, families enrolling their children in CHIs are often faced with difficult choices. If they have children of different ages, they may be able to enroll a child under age 6 immediately into Healthy Kids, but they are required to put their children 6 years of age or older on the waiting list for the same insurance program. Table 5.3 above summarizes CHI caps and waitlists.

Coordination with other programs

Most established Healthy Kids insurance products have been able to "carve out" California Children's Services (CCS) coverage.[5] In other words, these Healthy Kids programs have been able to transfer financial and treatment responsibility for CCS conditions to the CCS program once a child has been determined CCS eligible. While the management of CCS children varies somewhat between CHI counties and the local public plans, the process of referring potentially eligible children generally follows a similar pathway. Typically, a provider identifies a potentially eligible child and refers him/her to the local CCS office for eligibility determination. The health plan may also educate physicians about screening for CCS conditions, facilitate the early identification process, and assist families with the necessary paperwork for applying. If determined eligible for CCS, a child typically remains enrolled in the Healthy Kids program but must receive treatment for the CCS eligible condition through the specialized network of CCS providers and specialty centers.

Minimizing "crowd-out"

This term refers to the phenomenon where the availability of publicly subsidized insurance premiums reduces enrollment in existing employer-sponsored coverage—public coverage "crowds out" the employer-sponsored coverage. This may occur for two main reasons. First, employers may drop existing dependent coverage knowing that the public coverage is available in the county for children. Alternatively, families may decline employer coverage for dependents because of high cost-sharing requirements, finding the publicly subsidized coverage more affordable.

Counties can consider eligibility restrictions or "firewalls" to help focus public coverage on those most in need of it and to discourage employers from dropping and workers from declining existing coverage. Established CHIs have endeavored to avoid substantial employer dependent coverage "crowd-out" in two main ways:

- *Sliding scale premium contributions:* As discussed earlier in this chapter, family premiums can be determined based on family income. No premiums or very low premiums for families who are income-eligible for Healthy Kids (i.e., 250% to 300% of poverty), may lead them not to take up dependent coverage offered by their employers. Families in this income bracket are more likely to be offered employer-sponsored dependent coverage with cost-sharing. Consequently, premiums for this income group may be at set a level that deters them from declining dependent coverage from their employers.
- *"Look-back" periods:* Similar to the Healthy Families program, applications for Healthy Kids coverage can require applicants to have been without employment-based health insurance for some period of time in order to qualify for public coverage (see Appendix L for an application example). The Healthy Families program has a "look back" period of three months, as do Los Angeles, Santa Clara and Santa Cruz counties. San Mateo has a six-month look back period because its Healthy Kids program extends to children in families with incomes up to 400% FPL.

Families above 300% FPL are more likely to have employer-based coverage but with increasing cost-sharing requirements. CHIs can consider making Healthy Kids coverage available to these families with higher cost-sharing requirements. This option may also include a employer contribution option, where employers and employees share the premium costs.

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1. The California Kids (CalKids) Healthcare Foundation was founded by Blue Cross of California in 1992 to provide access to basic health services for uninsured children. It currently enrolls some 17,500 children between 2 and 18 years of age. For more information visit http://www.californiakids.org/. CalKids insurance, for a family premium of $15 with co-payments, covers these benefits: Primary and preventive medical care; Prescription drugs; Vision care; Dental care; and Behavioral health care. Hospital inpatient services are not covered.

2. California Children's Services (CCS) is a state-sponsored program that treats children with certain physical limitations and chronic health conditions or diseases.

3. Testa K, Mohamadi L, Horner D, Lazarus W, Richards J, and Finocchio L**.** *Children Falling Through the Health Insurance Cracks: Early Observations and Promising Strategies for Keeping Low-Income Children Covered by Medi-Cal and Healthy Families.* Oakland, CA: The 100% Campaign, January 2003. Also see the 100% Campaign materials at http://www.100percentcampaign.org/resources/priorities/retention-main.htm

4. For a more detailed discussion of enrollment caps and freezes in specific counties, please see the IHPS Issue Brief - *Local Experience with Healthy Kids Enrollment Caps* (June 1, 2004**) -** on the publications page of the IHPS Web Resource Center at http://www.ihps-ca.org.

5. The Inland Empire Health Plan's Healthy Kids program in San Bernardino does not have a memorandum of understanding with the CCS program for the transfer and financial responsibility of eligible children.