
6 | BUDGETING

Budget Considerations

Development of financial projections and a global budget for a Children’s Health Initiative is an ongoing, dynamic process. Fluidity of the budget process reflects the fluidity of county-level data estimates of uninsured children, the transitional nature of many CHI revenue sources, and the status of a county’s children’s coverage programs. CHI planners should expect to develop start-up and multi-year budgets under several different scenarios to account for these factors. Planners should assume that some scenarios will change because of changes in the external environment, including the amount of future statewide funding that may be available for Children’s Health Initiatives.

CHI planners need to keep the following in mind in developing practical financial projections. First, the annual rate of enrollment into the Healthy Kids program will vary by county. The actual “ramp up” of enrollment into the Healthy Kids program – the program that is entirely locally funded rather than a state/federally funded program like Medi-Cal or Healthy Families – is largely within the control of the CHI and those entities conducting in-reach and outreach activities. Consequently, the governing board and the coalition can calibrate their activities to enroll the number of children for which they have secured premium support. If enrollment surpasses expectations, children usually are placed on a waiting list. While this is not optimal, this approach insures that the program will not run up a deficit or cease to function due to a funding shortfall. Waiting lists also demonstrate a community’s level of need to policymakers and funders in actual numbers.

Second, each CHI also has options for “scaling” the scope of the initiative to the amount of financing secured. For example, if a CHI has secured funding for all uninsured ineligible children ages 0-5, but only a percentage of the funding needed to enroll those ages 6-18, program planners could develop policies to cover the older siblings of the 0-5 year olds enrolled through the CHI or set aside funding for children that would first age out of the program. This strategy involves creating program policies appropriate to the amount of funding secured by the program launch date. It is better to build the program to cover children as soon as possible rather than waiting to raise all the funding needed to

cover all the estimated uninsured children ages 0-18. This is probably a more likely scenario in smaller or more rural counties where resources and funding are scarce.

Third, program planners have the option of covering some portion of the target population in other coverage programs (such as California-Kids or Kaiser’s Child Health Plan) transitionally if only a small percentage of the total budget will be secured in the first year of operations. Agreements can be made with some programs to help secure full or partial funding to enroll or retain children in an existing program and then transition them to the Healthy Kids program once the necessary funding is secured.

In summary, CHI planners have a number of options and assumptions to consider and build into their budgeting process. Unlike other local programs, however, CHIs have a significant amount of control to build or “scale” their program based on available financing. The CHI governing board and staff should establish a regular process to assess the accuracy of budgetary assumptions by line-item and over time. In addition to allocation decisions across key program areas and activities, budgeting must also reflect the budgetary cycles and funder requirements associated with program planning activities, startup and maintenance of program operations.

Table 6.1
Sample CHI Budget Items

<p>Premium and enrollment costs</p> <ul style="list-style-type: none">• Insurance premiums• Hardship fund• Outreach, enrollment and retention<ul style="list-style-type: none">○ Eligibility determination staff○ Certified Application Assistors○ Training and materials○ Advertising and promotions• Optional: Universal application and information system development and implementation (One-e-App) <p>Planning and administrative costs</p> <ul style="list-style-type: none">• CHI personnel• Administration• Expert technical assistance:<ul style="list-style-type: none">○ Actuarial○ Legal○ Information technology specialists• Evaluation planning and implementation <p>Income and revenues</p> <ul style="list-style-type: none">• Planning and operating grants• Premium subsidy grants• Family premium contributions
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Global Budget Items

The global budget can be separated into three main areas. These areas are premium and enrollment costs, planning and administrative costs, and income and revenues.

Table 6.2
Generic Premium Cost Model

	<i>Per Member Per Month (PMPM)</i>
Physician Primary Care	\$ 19.00
Physician Specialty Care	\$ 12.00
Pharmacy	\$ 5.00
Hospital Inpatient	\$ 9.00
Hospital Outpatient	\$ 6.00
Other	\$ 7.00
<i>Total Medical</i>	\$ 58.00
Dental services	\$ 22-28.00
Vision services	\$ 2.00
Health Plan Administration (not outreach)	\$ 4.00
<i>Total Non-Medical</i>	\$ 28-34.00
Total Monthly Premium	\$ 86.00-92.00
Total Annual Premium	\$ 1,032-1,104.00

Source: Pacific Health Consulting Group, 2004

Premium and Enrollment Costs

Insurance premium costs, the largest portion of the budget, are typically based on an actuarial valuation of a comprehensive Healthy Families-like benefit package for comparable child populations. This is a critical component in establishing Healthy Kids premium rates on a per member per month (PMPM) basis. It is also normally appropriate that the actuarial valuation age-adjust the annual premium cost.

There are also a number of local factors, such as the availability of providers and prevailing contracting arrangements, that will affect premium rates on a county by county basis. The component of the PMPM with the greatest variance by CHI is dental services. The table above shows a generic premium cost model derived from Healthy Kids programs in several first generation CHIs.

There are two important caveats to consider in this budget model derived from Healthy Kids programs in counties with local initiatives (LI) and county organized health systems (COHS). First, the LIs and

COHSs contract with experienced actuarial firms in pricing a comprehensive health, dental, vision and behavioral health benefit package for low to moderate income child populations. The final Healthy Kids premiums have been consistent with local Healthy Families costs. Second, commercial health plans may have a slightly higher PMPM rate, as their administrative costs can be higher than LIs and COHSs, which have reduced their administrative cost allocations primarily to marginal costs for Healthy Kids.

A hardship fund may support both Healthy Families and Healthy Kids premiums (see Chapter 5 for a more detailed explanation of a hardship fund). Several counties have established hardship funds that pay the full Healthy Kids premiums for families experiencing temporary financial difficulties. Should a CHI decide to offer such family premium support, this would be reflected in the budget.

Each CHI will also develop or expand outreach, enrollment and retention activities for the Medi-Cal, Healthy Families and Healthy Kids programs. Budgeted costs for outreach, enrollment and retention will include community outreach workers, promotores, certified application assisters, and eligibility specialists. Marketing and public relations costs should also be budgeted as outreach and enrollment activities. Typical marketing and public relations expenses include Healthy Kids logo development, advertising on radio and in local print publications, CHI website development and promotional materials.

Several counties have also invested in an electronic application system to maximize children's and families' access to the full range of available public programs, including Healthy Kids. CHI planning should anticipate that the cost to test and implement One-e-App will vary by county based on the number of programs and interfaces required, the number of expected users and the desired workflow process.

Depending on the administrative capacity of the CHI organizational sponsor and the contractual relationship with the health plan, the budget may also include hardware and software to handle enrollment, utilization monitoring and retention. The One-e-App enrollment system may not be feasible in some counties and therefore other information systems may be required to track children's eligibility, enrollment and renewal status over time.

Planning and Administrative Costs

The budget will also include the costs of administrative personnel to coordinate the programmatic, organizational and technical aspects of the CHI. These personnel costs, and associated fringe benefits, will vary depending on the initiative and the degree to which participating organizations provide staff and other in-kind administrative support. Other related administrative costs include rent, postage, supplies, phone and other operating overhead items necessary to support the program.

CHIs have also required outside expertise to develop actuarial valuations, financial projections, data estimates, policy analysis, information systems support and evaluation. Some CHIs have also contracted with fundraising experts to identify target markets and high yield fundraising strategies.

CHI Income and Revenues

Lastly, the budgeting process will also take into account income and revenues from planning and implementation grants, premium subsidy grants, and family premium contributions. As discussed in Chapter 4, CHIs have numerous sources of support that are often earmarked for specific initiative items.

Many CHIs receive initial start-up grants for planning, program design and implementation. These grants, often from statewide foundations or local First Commissions, might support personnel, meeting costs and technical assistance. Specific grants may also be available to support outreach, enrollment and retention activities, One-e-App feasibility and evaluation.

The premium costs will be the single largest line-item of the budget. Financial support to cover premium costs will come from several sources as funders may focus on specific populations. For example, premium support for children 0-5 may come from local First 5 Commissions. In addition, the California First 5 Commission will provide matching funds for 20% of 0- 5 premiums as long as certain programmatic conditions are met. Other private funders have programs to subsidize a portion of premiums for the children ages 6-18. Lastly, family premium contributions will also offset the total premium cost in the budget.

Budgeting Phases

Under direction from the steering committee, CHI staff and the finance subcommittee will develop two separate but inter-related budget components: 1) the “start-up” budget; and 2) a three-year global budget. The “start-up” budget includes the initiative planning phase, the costs of hiring and recruiting program staff, and initial outreach, eligibility, training and marketing activities. Table 6.3 illustrates a sample start-up budget and Table 6.4 provides a sample global three-year budget based on enrollment of 1,000 children each in years one, two and three, for a sample total enrollment of 3,000 children by year three.

Table 6.3
Sample Start-Up Budget

Budget item	Pre-Launch (6 mo.*)
Outreach and enrollment initiatives - CBO contracts that include five Certified Application Assistants, outreach and enrollment objectives. Includes annual increase of 3%.	\$30,000
Training - Training of community-based CAAs and others to enroll children into Medi-Cal, Healthy Families and Healthy Kids.	\$5,000
Marketing & promotional materials - flyers, brochures, posters, radio spots to publicize CHI. Development of promotional materials.	\$10,000
Eligibility determination - 1 FTE eligibility specialist (including fringe benefits) and salary & fringe increases totaling 3%.	\$18,000
Administration - 1.5 FTE administrative personnel (including fringe benefits) and salary & fringe increases totaling 3%.	\$43,750
Operating overhead - Supplies, phone, postage, travel, rent, etc.	\$0
Technical assistance - consultants for data estimation, strategic planning, RFP development.	\$10,000
Evaluation - Grant subcontract for planning and first six months.	\$10,000
Sub-Total	\$126,750
One-e-App: IT staff, hardware, consultants	
Feasibility analysis	\$50,000
Implementation	\$450,000
One-e-App Sub-total	\$500,000
Total	\$626,750

**This sample budget reflects estimated expenses for a period of Six Months prior to launch.*

Table 6.4
Sample Three-Year Global Budget

Budget item	Year 1	Year 2	Year 3	Total Global Budget
Premiums - This covers 1,000 children in year 1, then 2,000 in year 2 and 3,000 in year 3. Assumes \$90 PMPM in year 1 with no rate increase in years 2 - 3.	\$1,080,000	\$2,160,000	\$3,240,000	\$6,480,000
Outreach and enrollment initiatives - CBO contracts that include five Certified Application Assistants, and additional county staff for outreach and enrollment activities. Includes annual increase of 3%.	\$400,000	\$412,000	\$424,360	\$1,236,360
Hardship Fund - Premium assistance for families demonstrating financial need.	\$10,000	\$10,000	\$10,000	\$30,000
Training - Training of community-based CAAs and others to enroll children into Medi-Cal, Healthy Families and Healthy Kids.	\$20,000	\$10,000	\$10,000	\$40,000
Marketing & promotional materials - flyers, brochures, posters, radio spots to publicize CHI. Logo, website and promotional materials.	\$100,000	\$100,000	\$100,000	\$300,000
Eligibility determination - 1 FTE eligibility specialist (including fringe benefits) and annual salary & fringe increases totaling 3%.	\$72,000	\$74,160	\$76,385	\$222,545
Administration - 1.5 FTE administrative personnel (including fringe benefits) and annual salary & fringe increases totaling 3%.	\$125,000	\$128,750	\$132,613	\$386,363
Operating overhead - Supplies, phone, postage, travel, rent, etc.	\$30,000	\$25,000	\$25,000	\$80,000
Technical assistance - consultants for data estimation, strategic planning, RFP development.	\$5,000	\$5,000	\$5,000	\$15,000
Evaluation - Grant subcontract for planning and conducting three-year performance monitoring.	\$150,000	\$150,000	\$150,000	\$450,000
Sub-Total	\$1,992,000	\$3,074,910	\$4,173,358	\$9,240,268
One-e-App: IT staff, hardware, consultants. Implementation, including program customization, development of system interfaces and documentation, and IT support.*	\$150,000	\$150,000	\$150,000	\$450,000
Total	\$2,142,000	\$3,224,910	\$4,323,358	\$9,690,268

*Note that implementation of One-e-App is optional, and the cost can vary greatly from one program to another, based on existing IT capacity and other local conditions. Implementation can be estimated to cost between \$450,000 and \$1,000,000, and annual maintenance between \$120,000 and \$200,000.

Key Budget Assumptions

There are several assumptions that pertain to the sample start-up and three-year global budgets.

Start up budget:

1. Start-up expenses are typically underwritten by a few CHI partners and foundations to help build local program momentum. Between \$100,000 to \$150,000 will be needed for start-up expenses, not including One-e-App feasibility and testing.
2. The estimated cost for One-e-App testing and implementation is between \$450,000 to \$1,000,000, depending on the complexity of implementation, systems interfaces required, number of users and desired workflow process.
3. The estimated timeframe for pre-launch activities is six to nine months.

Three year global budget:

1. Outreach, enrollment and retention activities will be coordinated between county staff and community CAAs. Achieving seamless coordination among county and non-county staff that serve the target population will maximize enrollments in the Medi-Cal and Healthy Families programs. Budget estimates include equal allocations for county staff and certified application assisters and/or community outreach workers.
2. The Healthy Kids product will mirror the comprehensive scope of services provided by the Healthy Families program. It is assumed that CHIs will be able to negotiate premiums that are within 5% of the prevailing Healthy Families rates within the county or region.
3. Premium estimates will remain fairly constant over the first three years of the program, even if program expansion to different population groups is phased in over time. A blended per member per month (PMPM) rate may be negotiated for all children 0-18 or a number of CHIs are moving towards tiered rating for 0-5 year-olds (the most expensive children, most of whom will qualify for Medi-Cal or Healthy Families), and then 6-18 year-olds based on actual claims experience.
4. A number of line-items are largely fixed costs, including marketing/promotional materials, outreach and enrollment, eligibility determination, administration, technical consultation, evaluation, and One-e-App feasibility and implementation. Premium costs will vary based on the actual number of children enrolled in years one, two and three.
5. The planning and administrative costs (CHI program staff, administration, and technical consultation) will vary by governance structure and the existing capacities of the program's organizational "home" or sponsor.